Hertfordshire Partnership University NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

The Colonnades
Beaconsfield Close
Hatfield
AL10 8YE
Tel: 01707253900
www.hpft.nhs.uk

Date of inspection visit: 25 November 2021 and 9 December 2021
Date of publication: 30/03/2022

Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Child and adolescent mental health wards

Inadequate ↓↓↓

Hertfordshire Partnership University NHS Foundation Trust provides child and adolescent services throughout the county. There are approximately 250,000 children and adolescents (under 18 years) in Hertfordshire. For the core service child and adolescent mental health wards, Hertfordshire Partnership University NHS Foundation Trust has one location.

Forest House is a 16-bed unit that provides specialist inpatient care and treatment for young people living in or outside Hertfordshire, aged 13 to 18 years, requiring admission as a Tier 4 provision. The unit is based at Radlett in Hertfordshire and the beds available are for female, male and non-binary gender young people. At the time of inspection three of these beds are specifically for young people with eating disorders.

The service aims to help young people and their families cope with psychological, social, emotional and behavioural problems. Young people have access to a school on site to support educational needs during their admission.

At the time of inspection, the unit had reduced the bed numbers to 13 to enable additional building works on the High Dependency Unit (HDU) area. A further decision to reduce the overall capacity to 10 beds was made before 25th December 2021. The 20th January 2022 was when Forest House had two further discharges and were, therefore, able to reduce the overall capacity to 10. It was not safe or appropriate to discharge earlier in consideration of the individual young people.

During 2020 and 2021, the Forest House service encountered a significant increase in the acuity of the presentations of the young people who were admitted to it. This was in part as a consequence of the pandemic, and the well-publicised deterioration in the mental health of some individuals. At the same time, half of the General Assessment Unit beds in the East of England region (both NHS and Private) were closed to new admissions for young people, which meant more reliance on the Forest House unit and less availability to other alternatives to access an inpatient bed, and to treat and care for more young people. Additionally, young people suffering from eating problems and needing access to trust services had risen by 50%, with a corresponding increase of admissions required, but there were insufficient specialist inpatient beds within the region and nationally to admit these young people to. The impact of this change in the volume and presentation of the client group at Forest House, meant that the young peoples' length of stay had increased in many cases and the risk that young people presented with had also increased, with more incidents of self-harming, increased violence, aggression, verbal and racial abuse as well as behavioural difficulties. Staffing challenges arose as a consequence of the above changes, as those presenting required more safe and supportive observations and expert care.

Forest House was last inspected in March 2019 and was rated as outstanding overall.

We carried out this unannounced focused inspection of Forest House unit because we received information giving us concerns about the safety and quality of the service. We visited the ward on 25 November 2021 and 9 December 2021 and carried out remote interviews of young people and staff between 7 December and 30 December 2021. We primarily focused on specific key lines of enquiry within the safe and well-led domains and some key lines of enquiry within effective, responsive and caring domains.

Our findings

Following this inspection, the trust was served with a Section 29A warning notice as the Care Quality Commission formed the view that the quality of health care provided at the trust's inpatient service for children and young people required significant improvement. The trust was required to take immediate action to make improvements at this service.

We rated the safe, effective, caring, responsive and well led domains.

SUMMARY OF FINDINGS

- Access to a clinical psychologist was limited to young people which reduced the ability to provide therapeutic interventions in line with best practice.
- There were a number of vacancies within the therapy team and the ongoing refurbishments had also impacted on room availability to enable therapists to conduct therapy sessions.
- Staff did not consistently enforce the unit's mobile phone policy to ensure the safety and wellbeing of all young people on the unit.
- The unit did not have effective systems in place to ensure staff administered and recorded administration of medication to young people in accordance with their prescription charts.
- Staff did not adhere to the trust guidelines when completing physical healthcare checks for young people following administration of medication administered for the purpose of rapid tranquilisation.
- There was insufficient management and oversight of the running of the service to ensure all policies, procedures and local governance arrangements were maintained, monitored, accurately documented and effective.
- There were not always enough suitably trained, competent, skilled and experienced staff to deliver safe care and treatment and develop therapeutic relationships with the young people. Compliance with key training requirements did not meet the trust target.
- Some young people told us they did not always feel listened to and did not feel safe on the unit due to bullying by other young people and felt this was not managed appropriately by staff.
- Staff morale within the unit was poor. Some staff described low morale due to significant staff changes, increased level of acuity of young people accessing the service, incidents of assault, the impact of major refurbishment within the unit and difficulties with maintaining staffing levels.
- Most parents and carers were dissatisfied with the level of care and treatment offered to young people and there were delays in the response from the trust to formal complaints.

However:

- Staff knew about potential ligature anchor points and mitigated the risks.
- Most regular staff worked hard and showed compassion and kindness to the young people they supported.
- Whilst risk management plans were not always up to date, we found overall the risk assessment and care plans to be holistic and person centred.
- The trust had taken the decision to keep Forest House operating to the maximum capacity possible, despite recent challenges, in order to provide appropriate placements for young people and support the wider healthcare system. At the time of the inspection, all other similar units across the East of England had either closed to admissions or had significantly reduced their bed numbers.

Our findings

How we carried out the inspection

During the inspection we:

- Spoke with the clinical director and interim senior service line lead
- spoke with head of nursing and service line lead for tier 4 children and adolescent mental health services
- spoke with a total of ten staff which included the modern matron, team leaders, lead therapist, counsellor, psychologist, nurses and health care workers
- spoke with six young people
- spoke with eight parents & carers
- spoke with one external social worker
- reviewed eight care plans and risk assessments
- reviewed three care records and 4 observation records
- observed a daily handover meeting
- reviewed a range of policies and procedures, data and documentation relating to the running of the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We spoke with six young people who said they felt there were enough staff present on the unit but two told us that often staff were busy. Three young people said there had been incidents or bullying on the ward and this was not managed appropriately by staff, they felt unsafe on the ward and not listened to by staff. Three young people said there was a lack of therapeutic interventions, including psychology, although another young person said they had accessed art therapy three times per week. One young person told us staff were respectful and polite but three did not and that their concerns were not always addressed, some staff lacked empathy and there was lack of consistency with staffing. One young person told us they felt their complaints were disregarded and another said a lot of the time their views were not heard. However, one young person said a number of staff were helpful.

One young person told us activities were often cancelled due to staff shortages. The current refurbishments on the unit also impacted on the ability to access quiet space areas.

We spoke with eight parents who said that overall, the quality of care for their children was very poor. They cited that communication between staff and themselves was poor and they were not always consulted regarding their child's care or there was a delay in them being updated following an incident on the unit.

The parents of one young person told us there was no single point of contact for families to alleviate a lot of the confusion around the care and running of the unit. Most parents did not feel their children's needs were being met and there were significant delays in response to complaints they had made. Three parents told us their child's self-harming behaviour had increased since admission to the unit. Some parents said they were frustrated at the lack of therapeutic support available to their child and there was a lack of psychiatrists and consistent staffing within the unit. Some expressed a lack of meal support and expertise from staff for young people with a diagnosis of an eating disorder.

Our findings

Is the service safe?

Inadequate 

Safe and clean care environments

The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. Major refurbishment was underway but this was managed safely.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe young people in all parts of the ward.

The ward offered mixed sex accommodation, but staff managed this appropriately and all rooms had en-suite facilities.

Staff knew about any potential ligature anchor points and mitigated the risks to keep young people safe. The trust had a ligature and environmental safety audit. The audit included a heat map of the ward area and the health-based place of safety, which included photographs of specific areas, and the mitigation in place to manage each identified risk.

Staff had easy access to alarms and young people had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Most ward areas were clean, well maintained, well-furnished and fit for purpose. However, the unit was undergoing major refurbishments which impacted on the environment and space available to young people. The trust's audits of cleanliness on the unit were not effective. We reviewed the latest cleaning audit, dated 16 November 2021, which scored 96% for compliance overall. Where areas were assessed as demonstrating unacceptable levels of cleanliness, actions were not recorded. Re-audit dates were not included. We were not therefore assured that staff acted on the findings of the audit to ensure all areas maintained the correct level of cleanliness. One parent also expressed concern as to the frequency of the laundering of bed linen as per the trust's policy of three times per week as they did not feel this was happening. The Trust confirmed that there is no policy which states bed linen should be laundered three times a week, although the young people are encouraged and supported to have their linen cleaned regularly. If a young person wants their bed linen washed, then the linen needs to be placed with the dirty laundry and it will be washed. The young person will be supported by the housekeeper to do this. Bed linen is washed as required on site.

Staff did not make sure cleaning records were up-to-date, however the premises were clean. The trust's audit for infection prevention and control was incomplete. The Trust completed a quarterly audit for infection prevention and control. Quarter 2 (July to September 2021) scored as 87% fully compliant, 8% partially compliant and 5% non-compliant, for which there was an included action plan for any areas found to be non-compliant. The audit for Quarter 2 (July to September 2021), showed three actions. We were concerned that one action included a requirement for all staff in patient facing roles to complete a two weekly lateral flow test for COVID-19 infection. We were not therefore assured that this area of non-compliance had been adequately addressed to protect staff and young people within the service.

Our findings

The most recent young person-led assessment of the care environment (PLACE) was completed in July 2021 with two young people. The audit identified the service as "confident" to deliver a good level of patient care and experience within the unit.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency medications.

Staff checked and maintained equipment but there was no evidence of regular cleaning for November 2021 as no records were found. We were not assured that regular audits were being completed. However, we found the equipment to appear clean during our inspection.

Safe staffing

The service did not have enough nursing and medical staff, who knew the young people. Not all staff received basic training to keep people safe from avoidable harm.

Nursing staff

Overall, the trust was using an increasing amount of bank and agency staff to ensure safe staffing levels. During October 2021, the combined bank and agency use was 12% for registered nurses and 69% for healthcare support workers. In November 2021, registered nurses accounted for 11% and healthcare support workers had risen to 73%. The trust recognised the high-level use of bank and agency staff and were working towards ensuring that agency workers were familiar with the service by block booking regular staff with the same agency. The trust also used a specific agency supplying agency workers with experience in caring for young people and where possible ensured regular agency staff worked on the unit. The trust was experiencing an increase in acuity of the young people during the inspection period. Therefore, staffing level requirements were unprecedented and linked to the prescribed safe and supportive observations, which were, in turn, linked to the young people in Forest House awaiting specialist beds. Forest House was providing care and treatment for two young people who required a psychiatric intensive care bed and two young people who required a low secure bed. The unit was unable to transfer the individuals to a more appropriate setting, owing to the wider external system pressures.

The trust reported high turnover rates for staff within the service. For the year to October 2021, turnover was recorded as 53%. The highest turnover was for healthcare support workers, with nine staff leaving during this period. In mid-2021, members of the senior management team left for reasons of retirement and promotion, during which time there were gaps in the recruitment to the posts. We were told by managers and staff that significant turnover of experienced staff had acted to de-stabilise the team during a time when acuity amongst the young people was known to be increasing. To address the ongoing staffing issues the trust had a planned recruitment drive for 2022, looking at international recruitment.

Managers did not always make sure all bank and agency staff had a full induction and understood the service. Staff spoken to could not describe a robust induction process and records of staff induction were incomplete. We were not assured agency or temporary staff received sufficient induction to support them to deliver safe care and treatment. The Trust was aware of this challenge and staff induction was already included in the Forest House Action Plan.

Our findings

Whilst managers supported staff who needed time off for ill health the trust reported a steady increase in staff sickness rates in September 2021, with a total of 17 (15%) cases in comparison to August with eight (4%) cases. The main reason recorded for sickness in September and October 2021 was anxiety, stress, depression, or other psychiatric illness. Some of the reported increase related to long term sickness. Managers ensured staff were supported during sickness absence, including signposting to additional support services and occupational health involvement.

Five out of ten staff interviewed raised concerns about staffing on the ward and staff wellbeing. Two staff told us they did not always feels safe when responding to alarms as new staff did not always know how to respond. Three staff told us the continuous lack of enough staffing on the unit impacted on young people and staff safety. Evidence within the team meeting minutes for November 2021 further highlighted the challenges faced by regular staff of working a shift with primarily bank and agency staff and the pressure this placed on them.

The trust did not ensure there were sufficient staff deployed to deliver safe care and treatment to young people. We were provided with evidence that demonstrated a significant number of unfilled shifts during October and November 2021. In October 2021, the trust reported a total of 231 unfilled shifts, of which 51 were for registered nurses. This increased in November 2021, where there was a total of 264 unfilled shifts, of which 67 were for registered nurses. Many of these unfilled shifts resulted from the unit requiring additional staffing to support the complex needs of the young people and increased acuity on the unit. Managers supported the ward to backfill staff shortages, where possible, and the ward manager adjusted staffing levels according to the needs of the young people and evidence showed for the majority of shifts, with support from managers, safe staffing levels were maintained. However, the unit remained heavily reliant on bank and agency staff supporting shifts and young people did not always have regular one to one sessions with their named nurse.

Staff shared key information to keep young people safe when handing over their care to others, however, some of the agency staff told us despite receiving sufficient information from the comprehensive handovers they did not have access to records via the electronic patient record system. Following our inspection visit, we were advised by the trust that temporary arrangements were being put in place to enable regular agency staff to have access to the electronic patient record system as a short-term solution.

Medical staff

The service had enough medical staff in line with the Royal College of Psychiatry's requirements, which consisted of three Consultant Psychiatrists, trainee doctors and staff grade doctors. However, due to current sickness, a rota of cover was provided by the three consultant psychiatrists.

Mandatory training

Not all staff had completed and kept up-to-date with their mandatory training. Data provided by the trust showed overall compliance with local training requirements was 98% against the trust target of 92%. Compliance with essential training was 84%, whilst compliance with statutory mandatory training was lower at 74% overall. However, some statutory training subjects reported lower compliance. For example, staff compliance with safeguarding children training level 3 was 53%, intermediate life support was at 50%, and moving and handling level 2 was 43%. However, managers monitored mandatory training and alerted staff when they needed to update their training.

Staff did not receive all necessary training to support them in their roles. Staff were not in receipt of specialist training in the management of young people with eating disorders, despite the unit having young people with this diagnosis on the unit during the inspection There was a risk that staff would not have the required skills to appropriately care for these young people, in accordance with best practice.

Our findings

Staff required training in the management of violence and aggression (restraint). Not all staff were up to date with RESPECT training (a programme of training that is used in education, health and social care settings to prevent, de-escalate and manage behaviour of concern). Evidence showed that Forest House staff were 100% compliant with Relating to People Module 3a (every 3 years) However, Relating to People (yearly) was only 53% and Relating to People Module 3b, (yearly) was 0%. Some regular staff told us they consistently worked with staff members who were untrained in the management of violence and aggression and/or had not received refresher training to ensure their practice was safe and up-to-date. This posed a risk to the safety of young people and staff.

The trust included RESPECT training within their improvement plan. However, the improvement plan identified two dates for staff training, but did not include detail of how many staff had attended. In November 2021 the trust trained two staff within the unit as RESPECT trainers. This ensured additional training could be provided to staff within the unit as and when required.

Assessing and managing risk to young persons and staff

Staff did not always assess and manage risks to young people and themselves well, but followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of young people's risk

Staff completed risk assessments for each young person on admission, using a recognised tool.

Staff used a recognised risk assessment tool and had a policy for clinical risk assessment which referenced national guidance.

Management of young person's risk

Most staff identified and responded to any changes in risks to or posed by young people and acted to prevent or reduce risks. However, risk management plans were not always updated in a timely manner. We reviewed two risk management plans during the first site visit, and both did not fully reflect the risks presented by the young person and the management plan was not in date. However, at the second visit a further six risk assessments and care plans were reviewed, and all were comprehensive and in date. Compliance training for clinical risk assessment and management was 90% for staff. Following inspection, the trust action plan indicated weekly audits of risk assessments were being completed with feedback provided to leaders and designated workers.

Staff followed procedures to minimise risks where they could not easily observe young people. However, out of the six young people we spoke with one reported staff falling asleep whilst on one-to-one observation and that staff did not always complete the minimum checks as regularly as they should. The Trust was made aware of the allegation of a staff member falling asleep but had not been provided with sufficient information to investigate this further. Another young person told us that the temporary staff were often not helpful and did not engage with young people when they completed observations.

Staff did not adequately complete observation records for the young people. We reviewed observation records for four young people between 10 November 2021 and 2 December 2021 and found twenty were of very poor quality. The records often had not documented the reason for the observations and therapeutic intervention required, and often there was no summary of risk factors, no indication of reasons why observations were to increase or decrease, and no

date of birth or record of the allocated responsible clinician. We also found gaps in signing of the forms and some gaps where nothing was documented for the specific time period. It was therefore difficult to ascertain if the observations were completed as clinically directed via young people's risk assessments and care plans. This posed a significant risk to patient safety. The trust subsequently included completion of patient observations sheets in their action plan.

Staff followed trust policies and procedures when they needed to search young persons or their bedrooms to keep them safe from harm. The trust had policies for the management of young people's access to mobile phones, including a specific protocol for the children's services. Whilst this gave staff access to guidance and contracts for the use of mobile devices this was not consistently applied. We were told that some young people had self-harmed as a result of accessing inappropriate content on websites. Data submitted advised the staff team continued to remind young people within the daily community meeting about access to inappropriate websites, but we were not assured that staff enforced the policy consistently.

Use of restrictive interventions

The trust reported 31 incidences of restraint between 1 October and 30 November 2021. Between 1 October 2021 to 30 November 2021 there were no reported incidents of prone restraint.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained young people only when these failed and when necessary to keep the young person or others safe. The trust introduced the use of safety pods in July 2020 to support the safety of young people and staff when restraint was required. A safety pod is a large bean bag that young people can be laid on when restrained to reduce the risk of harm from physical restraint. We were told since using the pod on the unit the time of restraint had significantly reduced and most young people were able to de-escalate in a shorter period of time. The use of the pod had also reduced injuries to both staff and young people, however no detailed analysis was provided.

Safeguarding

Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role.

Overall, staff kept up to date with their safeguarding training. At the time of inspection compliance with safeguarding adult and children training level 2 was 87%. However, the trust required staff to complete level 3 safeguarding training in accordance with national guidelines, which was below trust target at 53%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The trust maintained a safeguarding log to record all incidents where safeguarding referrals were required. The log contained eight current records. Two were raised in October 2021 and six during November 2021. Of the eight records, four were open to the local authority designated officer (LADO) and investigations were ongoing.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Our findings

Staff access to essential information

Not all staff had access to clinical information for them to maintain high quality clinical records – whether paper-based or electronic.

Not all staff could access clinical records as we were told that agency staff did not have access to the electronic patient records or the electronic incident reporting system. However, following inspection we were told managers were rectifying this issue to ensure agency staff who regularly worked were provided with appropriate access.

Records were stored securely but we saw a significant backlog of paperwork that required scanning onto the electronic system. There was a risk that staff did not always have access to relevant information related to the young people on the unit.

Medications management

The service did not always use systems and processes to safely prescribe, administer, record and store medications. Staff did not regularly review the effects of medications on each patient's mental and physical health.

Staff did not always follow systems and processes to prescribe and administer medications safely. We found there were gaps in staff signing the medication records to evidence that young people had been administered their medications. For example, we reviewed three medications charts for one young person and there were ten gaps in signing in one of the charts and one of the medications was of critical importance. Therefore, we were not assured patients were receiving their medications in a timely manner. The trust pharmacist had also audited the records and identified where staff had not signed the charts.

Staff reviewed each young person's medications regularly but one young person told us they were not provided advice about their medications and another told us they regularly had to remind staff of their medication regime due to irregular staff on the unit.

Staff stored and managed all medications and prescribing documents safely.

Most staff followed National Institute for Heath and Care Excellence (NICE) guidance when using rapid tranquilisation but there were gaps in recording and inconsistencies of physical health monitoring of young people post rapid tranquilisation. The trust was not ensuring staff were following their own policy and this placed young people at risk as their physical health was not always monitored for side effects. The trust's practice audit and clinical effectiveness (PACE) team completed an audit of prescription charts for rapid tranquilisation on 30 November 2021. The audit found that, in 95% of incidents the rationale for using rapid tranquilisation was documented in the young persons' electronic records. In over 50%, the rationale provided was due to the young person displaying self-harming behaviour. The auditor found that, in all cases reviewed, rapid tranquilisation was used after other alternative de-escalation techniques were attempted.

The fridge temperature within the clinic room had fluctuated between September to November 2021 and was above the required maximum temperature of eight Celsius on many occasions. We were concerned of the viability and safety of medications stored in the fridge as the fridge temperature recording had not been signed for three months. Managers had not identified these omissions via audit and no action had been taken to understand why readings were so high or to ensure medications were safe for administration. The trust informed us this had been rectified following the inspection when the unit installed a new thermometer.

Our findings

Track record on safety

Reporting incidents and learning from when things go wrong.

The service generally managed young people's safety incidents well. Whilst staff recognised incidents and reported them appropriately there were delays in them being reviewed by managers. Serious incidents were investigated, and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them via the electronic incident reporting system.

Staff raised concerns and reported incidents and near misses in line with trust policy. However, we found 144 electronic incident reports awaiting review and sign-off by managers. Managers were not reviewing these in a timely fashion.

Staff reported serious incidents clearly and in line with trust policy. The trust reported one serious incident between September and November 2021. This incident was still under investigation. The trust reviewed all potential serious incidents at their moderate harm review panel, where grading for serious incidents was determined and ongoing actions were discussed and implemented.

Managers took part in serious case reviews and made changes based on the outcomes. We saw evidence of incidents being reviewed, for example a young person on the unit using the toilet paper dispenser as a ligature anchor point. Following the incident, the dispenser was removed from the young person's bathroom. The trust also sent out an immediate alert to all clinical leads and on call managers and a safety alert advising of the potential risk. At the time of inspection, the head of safety and young person safety specialist were conducting a task and finish group to identify an alternative product as a replacement.

The service had no never events. Staff understood the duty of candour. They were open and transparent, and gave young persons and families a full explanation if and when things went wrong but some parents told us there was often a delay in being informed of incidents and the parents of one child told us they were given updates on another young person by mistake. The trust advised this incident was reviewed by the the data protection officer and head of information rights and compliance and no further action was necessary.

On most occasions' managers debriefed and supported staff after any serious incident. Three out of eight staff told us debriefs did not always happen routinely. The trust had a robust incident management policy, which included key information on assessing the degree of harm and process and responsibilities for reporting and investigation. However, we observed this policy required an update, having expired in June 2021.

Is the service effective?

Requires Improvement 

Our rating of effective went down We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all young persons on admission. They developed individual care plans which were reviewed regularly through multi-disciplinary discussion and updated as needed. Not all care plans reflected young persons' assessed needs, and were personalised, holistic and recovery oriented.

Our findings

Staff completed a comprehensive mental health assessment of each young person either on admission or soon after. Although one parent told us their child's needs had not been fully assessed and they had sought further assessment independently from the unit, and another parent told us their child's care plan had not been updated for four weeks.

All young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each young person that met their mental and physical health needs. However, one parent told us despite the care plan for their child being available to staff in their bedroom this was not always adhered to. Another parent told us staff did not appropriately support their child's eating disorder at mealtimes and the menu was not sufficiently varied.

Staff regularly reviewed and updated care plans when young persons' needs changed. We reviewed six care plans and found they were personalised, holistic and recovery orientated. However, feedback from the parents of one young person was that the assessments and care plans were not always holistic and five parents had written to the trust raising several concerns which included the lack of multi-disciplinary ward rounds to enable young people's care to be fully discussed to ascertain if the care plan was meeting their child's needs.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for young persons based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Due to staffing issues the unit did not provide a full range of care and treatment suitable for the young persons in the service. The unit had a significant number of staff vacancies including; psychologists, dietician, dietician assistant, senior social worker, nursing staff & health care workers. Whilst the trust had an improvement plan which detailed plans to recruit, we remained concerned that a significant proportion of the multidisciplinary team were not in post, resulting in significant pressure on remaining staff, a lack of specific skills input into the multidisciplinary team to support the young people, and ongoing reliance on agency staff.

Five parents had written to the trust citing the lack of one-to-one psychological therapy available to young people as there had been no dedicated psychologist at the unit since July 2021. However, the Trust was fully aware of these staffing issues and had sought to put in place interim measures to address it, whilst recruitment took place. As such, at the time of the inspection, psychology input was provided on the unit by two psychologists, working 1.5 days per week (seconded from other service areas), and one psychologist supporting staff for another half day per week. The two vacant posts were currently in the recruitment process.

An external professional supporting a young person on the unit also expressed concerns that no therapy had been offered since their admission in September 2021. This was investigated by the Trust, who responded to say that Forest House's therapy team had been present throughout the named young person's admission and formulated a therapy and activity programme for that individual. Unfortunately, the young person had unsettled periods which impacted on their ability to attend and complete the therapies programme. Staff are continuing to attempt to encourage the young person to attend the therapy sessions.

Staff made sure young people had access to physical health care, including specialists as required but there was a vacancy for a dietician and a dietician assistant on the unit. We were told by two parents that staff were not in receipt of

sufficient training to care for young people with an eating disorder. The trust did not provide eating disorder training to the staff working on the unit. However, the Forest House team had one dietetic assistant. In addition, there were existing permanent staff, a matron and two team leaders as well as other registered nurses working on the unit and who were experienced working with young people with an eating disorder. A team leader was an eating disorder trained nurse, having moved from the community eating disorder team to take up the team leader position. At the time of the inspection, there was also in place a core group of existing support workers/health care assistants who were experienced in providing meal support. The service also worked very closely with the community eating disorder team who support the client group and engage in the care of the young people. However, given the large numbers of bank and agency staff working with these young people, we were not assured all staff had the required skills and knowledge to support young people with eating disorders.

Skilled staff to deliver care

The ward team did not have access to a range of specialists required to meet the needs of young people on the ward. Managers did not always make sure they had staff with the range of skills needed to provide high quality care and did not always provide a full induction programme for new staff. However, overall staff were supported with appraisals and supervision.

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the young persons in their care, including bank and agency staff. We found there were not always enough suitably trained, competent, skilled and experienced staff to deliver safe care and treatment to the young people on the unit. Compliance with key training requirements did not meet the trust target.

Managers supported staff through regular, constructive appraisals of their work. Appraisal rates for October 2021 was 94%. However, staff were not consistently in receipt of supervision in accordance with the trust's policy. Staff compliance with supervision showed a slight decline in October 2021 (70%) but had achieved 100% in July, and 94% in August and September 2021.The trust policy stated that staff should receive supervision every 4-6 weeks, with a maximum interval of eight weeks. Data was provided against the eight-week maximum interval. We were concerned there was a growing risk that staff would not receive the appropriate support for their roles.

Managers made sure staff attended regular team meetings or gave information to staff who could not attend. Since November 2021 managers had increased team meetings to three times per week to provide staff with opportunities to raise concerns, give praise to the team and to keep them updated of the upcoming plans for the unit.

The trust told us they had begun running weekly teaching sessions on a rolling programme for nursing staff in April 2021. This included a number of subjects relevant to the care and treatment of young people. Sessions were advertised for staff information. However, we did not receive information of staff attendance and some staff we spoke with told us there had been little training delivered since August 2021 due to staffing issues on the unit.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit young persons. They supported each other to make sure young people had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Our findings

Staff held regular multidisciplinary meetings to discuss young persons and improve their care. Staff made sure they shared clear information about young persons and any changes in their care, including during handover meetings. We observed the handover meeting which contained all relevant information required by the teams to deliver safe care and treatment. Agency staff told us they found these handovers informative, with opportunities to ask questions if needed.

Ward teams had effective working relationships with other teams in the organisation and with external teams and organisations.

Is the service caring?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Most staff treated young people with compassion and kindness and respected their privacy and dignity. Most staff understood the individual needs of the young people and supported them to understand and manage their care, treatment or condition.

Feedback from young people, parents and carers about the attitude of staff was mixed. We were told some staff provided emotional support and advice and behaved kindly towards young people. Whilst most staff were discreet, respectful, and responsive when caring for the young people we were told some were disrespectful and unprofessional in their conduct.

Regular staff supported the young people to understand and manage their own care treatment or condition and understood and respected the individual needs of each young person.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep young peoples' information confidential.

Involvement in care

Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that young people had easy access to independent advocates.**

Involvement of young persons

Staff introduced young people to the ward and the services as part of their admission, although we found the welcome pack was out of date with inaccurate information about the unit. The Trust had identified this as an action within its Action Plan and new welcome packs were supplied to the unit on 6th December 2021.

Staff often involved young people and gave them access to their care planning and risk assessments. However, two out of six young people told us they did not feel listened to or involved in their care decisions.

Our findings

Staff supported young people to understand their care and treatment. Managers told us young people had access to ward round information sheets which could be used prior to their weekly ward round meeting where they could make requests or suggestions to be discussed.

Staff involved young people in decisions about the service, when appropriate. The most recent young person-led assessment of the care environment (PLACE) was completed in July 2021 with two young people which audited the level of care and experience within the unit. The outcome of the assessment found that both young people were confident that a good level of patient care and experience was delivered on the ward.

Daily community meetings were held with young people to discuss aspects of the running of the unit. A resolution group was held monthly with the team leaders to discuss any issues raised and explore if any solutions could be actioned.

Staff supported young people to make decisions on their care and had various co-production tools to ensure their involvement. For example, safety plans, which were a co-production tool and were developed with the young person and shared with parents and carers prior to leave or discharge. These could be personalised for the young person if they wished and were written in the first person.

Staff made sure young people could access advocacy services and the advocate provided weekly visits to the unit, although this was offered remotely during COVID-19 restrictions.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Most parents and carers told us they were not always kept up-to-date about their child's care and often the care review meetings were cancelled at short notice or they were not always involved. One parent told us doctors make decisions without consulting them and treated parents with disdain.

Staff helped families to give feedback on the service. In October 2021, the management team had met with a group of parents to help address a number of concerns they had raised regarding the level of care within the unit.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support young people's treatment, due to the refurbishments taken place on the unit. Each young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There was limited quiet areas for privacy.

Each young person had their own bedroom, which they could personalise and had en-suite facilities.

Young people had a secure place to store personal possessions.

Our findings

Due to the major refurbishments taking place on the unit, staff could not use a full range of rooms and equipment to support their treatment and care. This impacted on the opportunities for activities and therapeutic interventions.

The service did not have enough quiet areas, but they had a room where young people could meet with visitors and they could make phone calls in private.

The service had an outside space that young people could access easily but the space was limited due to the major refurbishments being completed at the unit at the time of inspection.

Young people's engagement with the wider community

Staff supported young people with activities outside the service and made sure young people had access to high quality education throughout their time on the ward.

Whilst most staff made sure young people had access to opportunities for education and work, one young person out of six told us they had not accessed the education on site during their entire stay which was over six months. The trust provided an explanation for this non-attendance. Another young person said they had frequently asked to go for a walk but there was not enough staff to facilitate this.

Staff helped young people to stay in contact with families and carers.

Staff encouraged young persons to develop and maintain relationships both in the service and the wider community.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. However, there was a lack of communication between managers and parents and carers and there were significant delays in responding to their concerns.

Young people, relatives and carers knew how to complain or raise concerns. The trust reported seven formal complaints received between 1 August 2021 and 31 November 2021. The trust reviewed the themes from these complaints and used this information within their improvement plan for the unit. Themes identified included; standards of care, observations, staffing levels, psychology provision, incidents (including self-harm), activities, transfers of care and leave facilities under section 17 of the Mental Health Act. However, not all complaints were investigated in accordance with timeframes indicated within the trust's policy. The trust reported four complaints currently ongoing, two of which were overdue at the time data was submitted.

The service clearly displayed information about how to raise a concern in young person areas.

Staff understood the policy on complaints and knew how to handle them.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Our findings

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for young persons and staff. However, leaders had not been fully effective in identifying and implementing required improvements.

Overall, the trust was sighted on a majority of the current issues within the service. In September 2021, the trust senior leadership set up a task and finish group to support the challenges being escalated by the clinical leadership of Forest House. The group met three times each week. The service line lead for the unit provided a link between this group and the staff team, with professional leads also linking to professional groups. The trust had a core management team which met monthly with attendance of senior operational and clinical leadership with professional groups represented. The trust also had a dedicated monthly quality and risk meeting with attendance of senior operational and clinical leadership, extended also to service level clinical leadership staff. The executive team ran fortnightly 'Catch Up with the Execs' sessions open to all staff.

Between September and December 2021, the service was visited regularly by senior leaders, including members of the trust executive team.

An improvement plan was developed and regularly monitored and updated. However, not all of the concerns we identified at this inspection were already included in the trust's ongoing action plan. In November 2021, the modern matron for the unit increased the frequency of multi-disciplinary meetings from weekly to three times per week to support accessibility of staff to engage in the improvement plan.

Managers held daily 'safe care' calls to discuss staffing issues and monitor rosters, led by members of the senior leadership team. Whilst managers backfilled for vacancies on the wards, we were told, and evidence showed, this distracted them from their managerial responsibilities, for example completing, reviewing and actioning the findings from audits, oversight of physical health monitoring and medication management which resulted in a deterioration in the quality of key management and oversight processes. The service line lead and head of nursing worked in close liaison with the unit. Frequency of visits to Forest House were increased to provide additional support and oversight and maintain regular contact outside of these times. The interim senior service line lead and clinical director worked closely with operational and clinical leadership of the service.

The trust had a Core Management Team which met monthly with attendance of senior operational and clinical leadership with professional groups represented. The trust also had a dedicated monthly quality and risk meeting with attendance of senior operational and clinical leadership extended also to service level clinical leadership staff.

The Executive Team ran fortnightly 'Catch Up with the Execs' sessions open to all staff.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The trust had a five year strategy entitled the "Good to great" and the overarching values embedded within the strategy were welcoming, kind, professional, positive and respectful.

Culture

Most staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Our findings

The trust had a freedom to speak up policy and a freedom to speak up guardian. Staff were also encouraged to apply to become freedom to speak up advocates across services. The trust reported two concerns raised to the guardian in the three months to November 2021. The guardian was not aware of any other concerns since commencing the role in the last year. Both concerns related to service delivery and potential impact on the care of the young people. The guardian also visited the unit on two occasions during December 2021 to speak with staff.

Staff we spoke with acknowledged the current pressures on the service but acknowledged that they were encouraged to raise concerns with senior leaders. However, two staff felt their concerns had not been adequately addressed in a timely manner. For example, lack of therapy staff on the unit, insufficient numbers of permanent staff and lack of sufficient space to conduct therapeutic sessions.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not always managed well.

There was insufficient management and oversight of the running of the service to ensure all policies, procedures and local governance arrangements were maintained, monitored, accurately documented and effective. Managers were not completing regular audits of care plans are per the fundamentals of care audit and providing regular feedback to staff to improve quality of care and practice. However, the trust had included plans for improvement in their improvement plan.

Managers did not maintain oversight of some essential records for care and treatment of patients in accordance with their care plans. For example, records of staff completion of patient observations to manage individual risk. The nurse in charge of each shift was responsible for signing off the records and there was no evidence that poor recording had been addressed with staff. There was also a significant backlog of scanning of the observation sheets on patient records. This poses a significant risk to young people's safety as staff may not have all relevant up to date information.

We found 144 electronic incident reports awaiting review and sign-off by managers. Managers were not reviewing these in a timely fashion.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The trust maintained a risk register for the unit. At the time of inspection, the risk register identified five key risks for the service. For example, the national shortage of mental health beds for young people, including psychiatric intensive care and low secure provision. This had impacted significantly on the service. The trust was unable to secure more appropriate placements for young people requiring more intensive support, which resulted in significantly more staff needed to maintain safety on the unit and a lack of available beds for young people requiring admission.

Other risks recorded, included high staff vacancy rate, staff training in physical interventions, RESPECT training, and violence and aggression. All risks were regularly reviewed and reflected the risks on the unit and had identified control measures recorded. However, risk ratings were not always reduced by the available control measures. In July 2021, the trust escalated two risks to the trust risk register to ensure board oversight.

1. The risk on the national shortage of mental health beds for young people and
2. The reduction on face-to-face mandatory training, which included RESPECT training.

Our findings

High staff vacancies remained unchanged on the local risk register with controls which included ongoing recruitment and block booking of agency staff.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff were not consistently completing audits of care in accordance with the trust's process. The fundamentals of care audit should be completed weekly. The most current audit at the time of the inspection was dated 4 October 2021. The audit contained multiple gaps in recording and areas identified as not completed. The attached action log was blank. Therefore, we were not assured that managers utilised this audit effectively to monitor assurance around key areas of quality and safety.

The trust offered parents and carers of young people the opportunity to participate in research projects. For example, a study to understand the experiences of parents and carers of young people admitted to services far from home. We were not provided with numbers of participants.

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The Trust was a member of the Quality Network for Child and Adolescent Inpatient Services (QNIC) and participated in peer reviews; the last was undertaken on 24th March 2021. The Trust's latest certificate showed commitment scores between 84% and 100% across seven key domains. These were estates and facilities, staffing, access admission and discharge, care and treatment, information, consent and confidentiality, young people's rights and safeguarding and Clinical Governance.

Our findings

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Requirement notices:

The trust must ensure that young people's risk management plans are updated in a timely manner and mitigations to manage risks are clearly documented to ensure young person safety. Regulation 12 (2)(a)(g)

The trust must ensure that staff consistently enforce the unit's mobile phone policy to ensure the safety and wellbeing of all young people on the unit (Regulation 12 (a)(b)

The trust must ensure that formal complaints are investigated in accordance with timeframes indicated within the trust's policy Regulation 16 (1)(2)

The trust must ensure that staff fully complete young people's observation allocation sheets (Regulation 17 (2)(c)

Enforcement Action:

The trust must ensure that sufficient psychological interventions are part of the care and treatment for young people to assist in them in their recovery (Regulation 9 (1)(a)(b)(c)

The trust must ensure that effective systems are in place to ensure staff administer and record medicines given to young people in accordance with their prescription charts (Regulation 12 (2)(g)

The trust must ensure that staff complete physical health checks for young people following administration of medication administered for the purpose of rapid tranquilisation Regulation 12 (2)(g)

The trust must implement robust systems and sufficient management oversight of the running of the service to ensure all policies, procedures and local governance arrangements are maintained, monitored, accurately documented and effective (Regulation 17 (1)(2)(a)(c)

The trust must ensure there are suitably trained, competent, skilled and experience staff to deliver safe care and treatment to young people and that all staff receive a full induction Regulation 18 (1)(a)

Action the trust Should take to improve:

The trust should ensure that risk assessments are updated in a timely manner to reflect current risks posed by young people.

The trust should ensure that young people and their parents and carers are fully involved in care planning and decision making.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and one CQC Inspection Manager. The inspection team was overseen by a Head of Hospital Inspection.

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance