Tees Esk and Wear NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

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Date of inspection visit: 20-21 August 2019
Date of publication: 11/10/2019

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX3LF	West Lane Hospital	Evergreen Centre	TS5 4EE
RX3LF	West Lane Hospital	Westwood Centre	TS5 4EE

This report describes our judgement of the quality of care provided within this core service by Tees Esk and Wear NHS Foundation Trust . Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Tees Esk and Wear NHS Foundation Trust and these are brought together to inform our overall judgement of Tees Esk and Wear NHS Foundation Trust .

Summary of findings

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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Overall summary

Due to the concerns we found during this inspection, we used our powers under section 31 of the Health and Social Care Act to take immediate enforcement action and placed conditions on the trust's registration. The conditions we placed upon the trust's registration have closed the wards we inspected meaning that all the young people need to be moved to alternative services to ensure they receive safe, good quality care.

We rated the service as inadequate following the inspection in June 2019. We inspected this service again on 6 August 2019 and did not re-rate the service. This inspection on 20-21 August 2019 did not re-rate the service. We found the following issues of significant concern:

- The service was not delivering safe care. Staff did not record young people's observations in line with trust policy, so it was unclear whether staff were undertaking observation as they should. Many of the nursing staff, including both registered nurses and support workers did not have the knowledge or experience to provide safe care to young people with complex needs. The trust did not ensure that the wards were not staffed at all time with staff who had completed the required mandatory training. Staff at all levels told us that they were struggling to maintain the right balance between managing safety and implementing the principles of least restrictive practice. Staff did not consistently report incidents accurately, including whether physical interventions had been used to restrain young people.
- The service was not delivering effective care. Staff did not deliver care in accordance with the young people's intervention plans which detail the care that young people should be receiving. We saw examples of where care being delivered was not in line with intervention plans. One of the intervention plans contained contradictory information. There were limited therapeutic activity on the wards. Staff told us that they were spending most of their time trying to maintain safety and therefore did not have time to deliver therapies that would aid recovery.
- The service was not well-led. Some staff described the service as 'traumatised' and told us that there was a divide between managers, the trust and staff working directly with young people. Audits were not effective and did not identify areas of concern in relation to observation records and incident reports. Managers had not ensured that all staff were familiar with young people's intervention plans. There was limited oversight of the wards from senior managers who understood how quality care for young people should be delivered. In addition, the service did not have effective governance systems in place to ensure that the young people received high-quality care.

However:

- During the inspection we saw a number of interactions between staff and young people that were kind, caring and compassionate.

Summary of findings

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

Are services safe?

We rated safe as inadequate following the inspection in June 2019. We inspected this service again on 6 August 2019 and did not re-rate the service. This inspection on 20-21 August 2019 did not re-rate the service. We found the following issues of significant concern:

- Staff did not record continuous supportive engagements in line with trust policy. There were unexplained gaps in young people's observation records.
- In the week prior to inspection there were a number of shifts where the only qualified member of staff based on the ward did not have the required mandatory training.
- Staff at all levels told us that they were struggling to maintain the right balance between managing safety and implementing the principles of least restrictive practice. During the inspection a young person identified risk items to the inspection team which had not been identified and managed by staff.
- Staff did not consistently report incidents accurately. Incident reports did not consistently identify whether staff had used physical restraint.

Are services effective?

We rated effective as requires improvement following the inspection in June 2019. We inspected this service again on 6 August 2019 and did not re-rate the service. This inspection on 20-21 August 2019 did not re-rate the service. We found the following issues of significant concern:

- Staff demonstrated inconsistent and limited knowledge of young people's risks, individual needs, intervention plans and positive behavioural support plans. We saw examples of where the intervention plan did not match the staff understanding of the intervention plan and the care being delivered. One of the intervention plans contained contradictory information.
- There were limited examples of therapeutic activity on the wards. Staff told us that the service was in a state of business continuity where the focus was on maintaining safety and not on therapy.

Are services caring?

We rated caring as requires improvement following the inspection in June 2019. We inspected this service again on 6 August 2019 and did not re-rate the service. This inspection on 20-21 August 2019 did not re-rate the service.

Summary of findings

- During the inspection we saw a number of interactions between staff and young people that were kind, caring and compassionate.
- Young people were positive about their experience of care from permanent staff.

However:

- We received mostly negative feedback from young people about their experience of care received from agency staff.

Are services well-led?

We rated well-led as inadequate following the inspection in June 2019. We inspected this service again on 6 August 2019 and did not re-rate the service. This inspection on 20-21 August 2019 did not re-rate the service. We found the following issues of significant concern:

- There was inconsistent feedback in relation to the culture of both wards. Some staff described the service as 'traumatised' and told us that there was a divide between managers, the trust and staff working directly with young people.
- Audits were not effective and did not identify areas of concern in relation to observation records and incident reports.
- Managers had not ensured that all staff were familiar with young people's intervention plans.
- There was limited oversight of the wards from senior managers who understood what service and care should be delivered.
- The service did not have effective governance systems in place to ensure that the young people received high-quality care.

Summary of findings

Information about the service

Tees Esk and Wear Valleys NHS Foundation Trust provides specialist assessment and treatment for children and young people who have severe and complex mental health conditions, learning disabilities, autism and eating disorders that require treatment in hospital. These types of services are also called tier four services.

We inspected two of the trust's three child and adolescent wards at West Lane Hospital:

- The Westwood Centre is a 12-bed ward, providing assessment and treatment for young people within a low secure environment. The ward accepts young people between 12 and 18 years of age. At the time of the inspection there were four young people receiving care and treatment on this ward.
- The Evergreen Centre is a 16-bed ward, providing specialist eating disorder treatment for children and young people. At the time of the inspection there were seven young people receiving care and treatment on this ward.
- The Newberry Centre was a 14-bed ward, providing assessment and treatment for young people aged between 12 and 18 years of age experiencing serious mental health problems. At the time of inspection this was closed, and the young people formerly admitted to the Newberry Centre were receiving care in the Evergreen Centre and Westwood Centre.

We had previously inspected the wards at West Lane Hospital twice in 2019. We undertook a comprehensive unannounced inspection on 20-24 June 2019 which looked all five key questions. This inspection was undertaken in response to concerns raised about low staffing levels and a concerning culture as well as a serious incident. We rated these services as inadequate overall with ratings of requires improvement for the effective and caring domains and inadequate in the safe, responsive and well-led domains. We identified:

- The service was not safe. Young people were at high risk of avoidable harm due to breaches of regulation which included but was not limited to: inadequate assessment and management of individual and environmental risks, frequent staff shortages, unexplained gaps in observations of young people, and poor practice in relation to blanket restrictions, recording restrictive interventions and medication management.
- The care and treatment of young people was not appropriate and did not meet their needs and reflect their preferences. Care and treatment of young people was not always provided with the consent of the relevant person. Carers at West Lane Hospital were not fully involved in their relatives care where this was appropriate.
- The service was not well-led. Systems and processes were not established and did not operate effectively. The service did not assess monitor and improve the quality and safety of the services provided. The service did not assess and monitor and mitigate the risks relating to the health, safety and welfare of young people. The service did not provide sufficient numbers of suitably qualified, competent, skilled, experienced and appropriately supervised staff.

Because of our findings we issued the trust with a Notice of Decision and Section 29A Warning notice. The wards were restricted from admitting new young people and the trust was providing ongoing monitoring data to the CQC regarding the care and treatment of young people.

We undertook a responsive focused inspection on 6 August 2019. We inspected the two wards at West Lane Hospital and specific aspects of the key question "Are services safe?". The key areas of focus were the recording of staff observations of young people, up to date care plans and risk assessments, staffing levels and the safety of the environment.

Our inspection team

The team was comprised of two CQC inspectors, one CQC inspection manager, and two specialist professional

Summary of findings

advisors. The specialist professional advisors were a social worker and a consultant psychiatrist with experience of working in child and adolescent mental health services.

Why we carried out this inspection

We undertook this focused inspection because of whistleblowing concerns about the safety of young people at West Lane Hospital. We undertook this focused, unannounced inspection (staff did not know we were coming) on 20 -21 August 2019. We inspected the two open wards at West Lane Hospital.

Prior to this a focused unannounced inspection took place between 20 June 2019 and 24 June 2019 for all five key questions at this location as a result of concerns raised about low staffing levels and a concerning culture as well as a serious incident. Because of our findings the trust was issued with a Notice of Decision to impose conditions on the trust's registration and Section 29A Warning notice.

A Notice of Decision to impose conditions is a legal enforcement action available to CQC to ensure that providers comply with their legal obligations and hence ensure that people who use services are kept safe, receive an acceptable standard of care and to ensure that providers take action to manage specific risks. We can serve a warning notice under Section 29A of the Health and Social Care Act 2008 when we identify concerns across either the whole or part of an NHS trust or NHS foundation trust and we decide that there is a need for significant improvements in the quality of healthcare.

Because of the action we took the trust was not able to admit any new young people and the trust has to provide CQC with specific information to allow us to closely monitor the care and treatment of the young people currently admitted.

We undertook a further focused, unannounced inspection on 6 August 2019 as the result of the sad death of a young person on one of the wards. We inspected the two wards at West Lane Hospital and specific aspects of the key question "Are services safe?". The key areas of focus were the recording of staff observations of young people, up to date care plans and risk assessments, staffing levels and the safety of the environment.

How we carried out this inspection

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

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

However, as this was a focused inspection we looked specifically at the key questions are services safe, effective, caring and well-led.

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited both wards at West Lane Hospital and looked at the quality of the ward environment and observed how staff were caring for young people
- spoke with five young people who were using the service
- spoke with two ward managers
- spoke with 19 other staff members including doctors, nurses, a psychologist and a positive behavioural support specialist
- interviewed four senior managers with responsibility for these services
- attended and observed two multi-disciplinary meetings
- looked at 11 treatment records of young people
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of findings

What people who use the provider's services say

We spoke with five young people during this inspection. Two young people were from Westwood Centre and three were from Evergreen Centre. Two young people told us that they did not feel safe on the wards due to the high use of agency staff and staff not knowing how to properly respond during incidents. One young person told us that some staff were rude. Most of the negative feedback we received in relation to staff attitudes was in relation to agency staff. Young people were more positive about their experience of care from permanent staff.

Tees Esk and Wear NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Evergreen Centre	West Lane Hospital
Westwood Centre	West Lane Hospital

Are services safe?

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

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

Our findings

We rated safe as inadequate following the inspection in June 2019. We inspected this service again in August 2019 and did not re-rate the service. This inspection did not re-rate the service. We found the following issues of significant concern.

Safe Staffing

During the inspection staff raised concerns with us that the service was relying on a high use of agency staff to provide safe staffing levels and that agency staff were not familiar with the young people. Young people told us that there was often not enough staff and that they did not feel that their care was delivered safely and appropriately by agency staff. We reviewed staffing rotas for the week prior to inspection as this was raised as an issue in the whistleblowing concerns we received. Staffing rotas for the period 12-19 August 2019 showed that 47% of healthcare assistant shifts were covered by agency staff.

We reviewed staffing rotas for the period 12-19 August 2019. These showed that there were three shifts where the only qualified nurse working on Westwood Centre was trained in life support but not in management of violence and aggression. On one shift on Evergreen Centre the only qualified nurse on shift was trained in management of violence and aggression but not in life support. This meant that not all shifts had qualified staff working who could respond in emergency life threatening situations and to incidents where young people were violent or aggressive.

The service always ensured that a senior nurse acted to provide site coordination but not all the senior nurses who undertook this role had the relevant skills and experience to fully understand the level of care required for the young people. The role of the site coordinator was to ensure that wards were safely staffed and supported staff following incidents. Managers reviewed staffing levels twice per day. Managers used a staffing tool which allowed them to have oversight of the total number of qualified and unqualified staff working on each ward on both day and night shifts. The tool also detailed compliance with mandatory training in basic life support and management of violence and aggression. The role of the site coordinator had not effectively ensured that all shifts were staffed by staff who had received required mandatory training needed to keep young people safe.

Assessment of patient risk

We reviewed the care records of all 11 young people. All young people had a risk assessment which had been updated recently.

Management of patient risk

We reviewed the care records of all 11 young people. All young people had a safety summary within their intervention plan which included a risk management plan which had been updated recently. Staff demonstrated an inconsistent understanding of how to safely manage the risks of each young person. Eight of the 11 risk management plans stated that staff were to use their own discretion to decide whether to intervene during incidents where young people were self-harming by head banging, cutting themselves and/or tying a ligature around their necks. This had the potential for an inconsistent approach between different staff members. One risk management plan contained no information for staff on how to respond to a newly identified pattern of risk behaviours despite a number of incidents. Another young person's intervention plan included contradictory information; their positive behaviour support plan said that staff should use verbal de-escalation, but another section of the plan said that verbal de-escalation would increase the young person's distress. The trust explained that this was due to the positive behaviour support plan requiring staff to use verbal de-escalation except in periods of high distress.

Staff told us that responses to incidents were inconsistent and varied depending on the staff members who were working on shift. Young people told us that staff did not always know how to safely manage their risks. Young people gave us examples of how they had needed to prompt staff, in particular agency staff, to follow their intervention plans. Two of the five young people we interviewed told us that they did not feel safe on the wards.

We identified that staff did not manage risk well. During the inspection a young person showed us risk items in their bedroom which were not in line with the young person's intervention plan and which staff had not identified. These

items could have been used by the young person to self-harm and had not been used due to the young person self-managing their own risk. We raised this with staff. Managers told us afterwards that following a check of the young person's bedroom they had identified additional risk items which were not in line with the young person's intervention plan. In a separate incident, a new member of staff had allowed a young person to access aerosols which the young person subsequently used to self-harm. A member of staff told us that this incident was the result of the staff not being aware of the young person's risks.

Staff did not follow policies and procedures for the use of observation (including to minimise risk from potential ligature points). The trust's policy referred to continuous observations of a young person by one or more members of staff as continuous supportive engagements. The policy required staff to make a record within the case notes of a young person's continuous supportive engagements after each period of allocation. This produced an hour by hour timeline of each young person's continuous supportive engagements. We reviewed the case notes of all 11 young people for the period 15-19 August 2019. At the time of inspection there were seven young people on continuous supportive engagements. We found gaps in records of continuous supportive engagements in six young people's case notes.

Use of restrictive interventions

The service had joined a national pilot programme which aimed to reduce the number of restrictive interventions such as restraint, rapid tranquilisation and seclusion within inpatient services. Staff and managers told us that there was general confusion within the staff team over the distinction between reducing restrictive interventions (i.e. restraint, rapid tranquilisation and seclusion) and certain restrictive practices which were in line with the duty of care such as individualised restrictions on electronic devices, mobile phone access and measures including bed times designed to encourage proper sleep hygiene. Case notes showed young people routinely were allowed access to mobile phones throughout the night which meant that often young people slept for most of the day. This meant that young people did not experience age-appropriate limit-setting and had limited opportunity to participate in therapeutic activity.

Staff also told us that the focus on reducing restrictive interventions meant that staff were reluctant to appropriately challenge young people as this risked escalating situations leading to the use of restrictive interventions such as restraint, rapid tranquilisation and seclusion.

We reviewed three incidents involving the use of rapid tranquilisation. Staff had completed physical health observations following the use of rapid tranquilisation.

Staff access to essential information

All information needed to deliver care was not available in an accessible form to all relevant staff (including agency staff) when they needed it. The trust used an electronic system for young people's records. Only permanent staff and bank staff had access to the electronic record system. Agency staff did not have access to the electronic record system. The service did not have alternative methods of ensuring that agency staff had access to and were familiar with young people's intervention plans. Our review of staffing rotas showed that almost half of all shifts were covered by bank or agency staff during the week prior to inspection which meant that there was a significant proportion of staff working on the wards who did not have access to the information needed to properly care for the young people.

Reporting incidents and learning from when things go wrong

The service had experienced two serious incidents in the three months prior to inspection. Both serious incidents had subsequently resulted in the deaths of the young people. Managers told us that following the incidents staff were supported and received debriefs. Most staff told us that they had received some support following the incidents.

We reviewed incident reports for the period 6-19 August 2019. Staff did not consistently complete incident reports accurately. In a number of incident reports staff did not correctly identify that physical restraint had been used during the incident, although the narrative of the incident supported that physical restraint had been used. This meant that there was under-reporting of the use of physical restraint in the service. The trust did not effectively scrutinise incident reports to identify these errors.

Are services effective?

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

Our findings

We rated effective as requires improvement following the inspection in June 2019. We inspected this service again in August 2019 and did not re-rate the service. This inspection did not re-rate the service. We found the following issues of significant concern.

Assessment of needs and planning of care

We reviewed the care records of all 11 young people admitted to the service at the time of inspection. All young people had an intervention plan which had been recently updated. Care records showed evidence of ongoing physical health monitoring. The focus of intervention plans was to ensure that staff kept young people safe. There was limited evidence within care plans of how staff planned to support young people to make therapeutic progress. This finding was supported by managers and members of the multidisciplinary team who told us that the service was currently heavily focussed on risk management and that further work was needed to evidence how the service was ensuring the young people's therapeutic progress. Positive behaviour support and/or intervention plans for five young people did not include any consideration of the function of risk behaviours, which meant that staff were reliant on reactive verbal de-escalation and distraction strategies rather than being able to meet the unmet need that was underlying service users' actions. For another young person there was some formulation around the function of behaviours, but this was not reflected in the guidance for staff around risk management.

Staff demonstrated inconsistent and limited knowledge of young people's risks, individual needs, intervention plans and positive behavioural support plans. Most front-line nursing staff and healthcare assistants told us that they had never seen or were unfamiliar with young people's positive behavioural support plans. Managers told us that there was an expectation that staff made time to familiarise themselves with young people's intervention plans.

We saw examples of where intervention plans, staff understanding of intervention plans and what was actually happening on the wards did not match. For example, one care record detailed in the intervention plan how a young person used a mood band (a band that young people put round their wrist so that they can signal to staff how they feel without having to verbally explain) to signal to staff their emotional state. Staff demonstrated inconsistent knowledge of the young people' intervention plan in relation to the mood band and the young person told us that they had stopped wearing the band for some time.

Staff told us that they provided a range of care and treatment interventions suitable for the young people. However, during the inspection we saw limited examples of young people engaging in therapeutic activities or care provided in line with national best practice. Staff were reluctant to impose boundaries such as appropriate bed times which meant that often young people stayed awake through the night and slept during the day. This meant that young people had limited opportunities to participate in therapeutic activity and to engage with the multidisplinary team who predominantly worked during the day.

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of young people on the ward. The service had consultant psychiatrists, consultant psychologists, occupational therapist, dietitians, nurses and nursing assistants. The service was supported by a speech and language therapist from the trust's children and young people's service and planned to recruit a speech and language therapist to work within the service. Managers told us that they had recognised there was a need for a social worker in the multidisciplinary team and they planned to recruit. Some staff were new in post and we saw limited examples of a multidisciplinary approach to the delivery of care.

The service had lost a significant number of staff due to sickness, turnover and as a result of suspensions pending investigations. The trust had responded by bringing in staff from other services, including from adult mental health services, and by increasing the use of agency staff. This meant that the service increasingly relied on, and was led by, staff and managers who did not have a background in child and adolescent mental health services or had the skills and experience to provide care for young people with complex needs. Some staff expressed concern that agency staff and staff new to the service did not have the skills and abilities necessary to care for young people. Other staff told us that the new staff brought new skills and experience and had benefitted the team.

Managers ensured that new staff or staff who had time away from the services received an induction prior to re-joining the service.

Are services effective?

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.

Multidisciplinary and interagency team work

Staff held regular multidisciplinary meetings. Both wards had daily handovers and daily 'report out' meetings. The report out meeting allowed clinicians to discuss each young person in detail and allocate tasks to the front-line staff.

Are services caring?

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

Our findings

We rated caring as requires improvement following the inspection in June 2019. We inspected this service again in August 2019 and did not re-rate the service. This inspection did not re-rate the service.

Kindness, dignity, respect and support

During both days of inspection, we saw a number of interactions between staff and young people that were kind, caring and compassionate. Staff attitudes and behaviours when interacting with young people showed that they were discreet, respectful and responsive. Young people said most staff treated them well and behaved appropriately towards them. Young people gave us negative feedback about agency staff and told us that they felt agency staff did not know how to care for them appropriately.

The involvement of people in the care they receive

Staff supported young people to understand and manage their care, treatment or condition. Case note summaries showed examples of staff working with young people to have insight into their conditions.

Our observations of care showed that staff communicated with young people so that they understood their care and treatment. Intervention plans were mostly written in clinical language which was not accessible to young people. One young person told us that they did not feel involved in making decisions about their care and were not sure of how they were working towards discharge.

Managers gave us examples of how young people were able to be appropriately involved in decisions about the service including in staff recruitment and in changes to the ward environments.

Are services well-led?

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

Our findings

We rated well-led as inadequate following the inspection in June 2019. We inspected this service again in August 2019 and did not re-rate the service. This inspection did not re-rate the service. We found the following issues of significant concern.

Leadership

Both ward managers were new to the service and were relatively new in post. The leadership team also included modern matrons and heads of service. Not all members of the leadership team had previous experience of working in child and adolescent mental health services and lacked knowledge and experience of the care required by young people with complex needs.

Leaders were not able to articulate how the service had reached the current level of concern and how they were effectively planning to move the service out of a reactive 'crisis mode'. Whilst there was general consensus from staff that the leadership team was visible in the service, there was feedback from some staff that there was a divide between managers and staff and that staff did not always feel listened to by managers.

Culture

We received inconsistent feedback from staff and managers in relation to the culture within the service. Some staff described the service as 'traumatised' and in 'crisis mode'. Some staff told us that they felt stressed and burnt out. Staff told us that there was a divide between managers, the trust's senior leaders and staff working directly with young people. Other staff told us that in recent weeks there had been an improvement in the culture on both wards and that the service was actively seeking to improve.

Several staff told us that they did not feel able to raise concerns without fear of retribution or that they felt managers would act to resolve concerns.

The service's culture was significantly impacted by the events and incidents within the service in the previous year. Managers told us that there were significant issues with team building within the service as it had a new and transient staff team with a heavy reliance on non-permanent agency staff. Staff told us that the high-profile investigations in November 2018 meant that the staff faced significant additional scrutiny. This had led some staff to feel unable to properly implement intervention plans out of fear of being seen to be uncaring by placing boundaries on the young people's behaviours. Senior clinicians within the service told us that there was a cohort of staff who felt aggrieved by the trust's response to the investigations in November 2018 and that work was needed to improve relationships within the team.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The service's modern matrons told us that following the two serious incidents the trust had provided additional services including counsellors and drop-in sessions to help support staff.

Governance

The service had a significant and persistent number of areas of concern. There was limited evidence of improvement in the service. We therefore concluded that the service did not have effective governance systems in place to ensure that the young people received high-quality care.

Managers undertook daily audits of care records specifically focussing on compliance with record keeping in relation to continuous supportive engagements. However, the audits had failed to identify multiple instances of gaps in record keeping in the records of six of the seven young people who were allocated continuous supportive engagements.

The service did not have effective quality checks within the service to ensure that intervention plans were appropriately actioned. Young people identified risk items in their bedrooms which staff had not identified and managed appropriately. Staff demonstrated inconsistent understanding of young people's risks and individual needs. There were examples of where the care being delivered did not match the intervention plan or what staff thought was happening.

The trust did not effectively scrutinise incident reports to identify errors. This meant that information on the use of physical restraint in the service was not accurate.

There was a heavy reliance on non-permanent staff to maintain safe staffing levels. Managers had not ensured that there was an effective system to ensure that all non-permanent staff had access to essential information

Are services well-led?

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.

necessary to effectively care for young people. Managers had not ensured that the wards were staffed on all shifts with qualified nurses who had received the mandatory training necessary to keep young people safe.

Managers had not addressed and could not tell us how they planned to address a culture within the service which significantly impacted on the ability of the service to appropriately care for young people. Managers had not implemented any additional systems to accurately assess and improve staff morale.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not ensure that care and treatment was provided in a safe way for service users. Staff demonstrated inconsistent and limited knowledge of young people' risks, individual needs, intervention plans and positive behavioural support plans. Risk management plans did not provide clear guidance for staff on how to manage the risks of each young person. We found examples of risks which were not being safely managed. Staff did not complete and record young people' continuous supportive engagements in line with the trust's policy. We identified unexplained gaps in the continuous supportive engagement records of six young people.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust did not have effective systems and processes to ensure compliance with regulations. Managers did not have effective plans in place to address significant concerns and make improvements within the service. Internal audits did not identify gaps in continuous supportive engagements. Internal checks did not identify errors in incident reports. Managers did not ensure that all staff had access to and were aware of young people' intervention plans and safety summaries.

This section is primarily information for the provider

Enforcement actions

Managers did not ensure that the wards were consistently and safely staffed with staff who had completed the mandatory training required to keep young people safe.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust did not ensure that all staff working on every shift had the mandatory training necessary to keep young people safe.