Essex Partnership University NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

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Ratings

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

Our findings

Child and adolescent mental health wards

Requires Improvement 

Essex Partnership University NHS Foundation Trust provide community health, mental health and learning disability services for a population of approximately 1.3 million people across Bedfordshire, Essex, Suffolk and Luton.

Essex Partnership University NHS Foundation Trust provides child and adolescent mental health inpatient services to young people and their families living across the country where a community setting would not be a safe or appropriate place for children and young people's treatment. The child and adolescent mental health inpatient service consists of three wards located across two sites at the St Aubyn Centre, Colchester and Rochford Hospital.

We carried out this unannounced focused inspection to follow up on the conditions placed on the Trust's registration after our previous inspection. The conditions included restricting the service from admitting any new children and young people without the prior written agreement of the Care Quality Commission and a condition to ensure all three wards are staffed with the required numbers of suitably skilled staff to meet the new children and young people's needs and to undertake children and young people's observations as prescribed.

During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. As result of this, the imposed conditions have now been removed.

At this inspection, we inspected all three wards of the child and adolescent mental health service; Larkwood ward, Longview ward and Poplar adolescent unit.

The St Aubyn Centre accommodates Larkwood ward and Longview ward. Larkwood ward is a ten bedded, mixed sex, locked psychiatric intensive care unit. It provides acute and intensive psychiatric care and treatment for young people between the ages of 13 and 18, who are experiencing acute, complex and / or severe mental health problems.

Longview ward is a 15 bedded, general psychiatric mixed sex ward, providing inpatient assessment and treatment for young people aged 13 to 18 years.

Rochford Hospital accommodates Poplar adolescent unit, a 13 bedded general psychiatric, mixed sex ward providing inpatient assessment and treatment for young people aged 13 to 18 years.

All three wards had education facilities on site, providing education and vocational opportunities in line with the national curriculum.

The Care Quality Commission have registered this service for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

1.

Our rating of services improved. We rated the service as requires improvement because:

Our findings

- The service did not manage the disposal of medicines and sharps safely. The service did not dispose of out of date stock items as required.
- Staff did not always follow the Trusts' policies and procedures with regards to the use of mobile phones and wearing personal protective equipment.
- The service did not ensure children and young people had access to snacks at all times without being dependant on staff.
- Not all staff respected children and young peoples' privacy and confidentiality. Staff did not give carers information on how to find the carer's assessment.

However

- The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well and followed good practice with respect of safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the children and young people and in line with national guidance about best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of children and young people on the wards. Managers ensured these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment.

How we carried out the inspection

For this inspection we reviewed all the key lines of enquiry; safe, effective, caring, responsive and well led.

The inspection team visited all three wards between 1 March and 29 April 2022 and completed off-site inspection activity during this time. We returned to Poplar adolescent unit twice during this time following concerns raised during the inspection. During the inspection we:

- Visited the service and observed how staff cared for children and young people
- Visited the Poplar adolescent unit at night and observed how staff cared for children and young people
- Viewed eight extracts of CCTV from Poplar adolescent unit
- Viewed five pieces of body camera footage from Poplar adolescent unit
- Toured the clinical environment
- Spoke with nine children and young people who were using the service
- Interviewed 23 staff members and managers
- Spoke with five carers
- Observed one community meeting

Our findings

- Reviewed 11 children and young people care records
- Reviewed 15 prescription charts
- Reviewed policies and procedures relevant 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 nine children and young people across all three wards.

One young person told us not all staff knock on their door before entering.

One young person told us some staff ignore them and don't engage with them. Four children and young people told us they do not always know the night staff, they were always different, and this makes them feel uncomfortable.

Two children and young people told us they never meet with their named nurse.

Three children and young people from either Longview ward or Larkwood ward, told us their leave had been cancelled due to the wards being short staffed.

Two children and young people told us there is a lot of restraint on the wards and one young person told us they feel non-regular staff panic and don't de-escalate incidents as often as they should. One young person told us they felt they were restrained more than they should have been.

One young person told us some staff talk about other children and young people in front of them.

Five children and young people from Larkwood ward or Longview ward told us snacks are on a timetable and they cannot access fruit or snacks when they want.

Five children and young people told us they did not like the food and the quality of the food is poor. Two children and young people told us the level of choice was limited.

Three children and young people told us staff were nice, kind, respectful and felt like they cared.

Two children and young people told us they knew all about their medications and side effects.

Two children and young people told us education was good and had helped them.

We spoke to five children and young peoples' carers. Two carers told us they were not involved in their relatives' care and it is left to the young person to phone them to inform them what is happening.

Three of the carers we spoke to had not been asked to give feedback on the service.

Three carers told us they had not been informed about the carer's assessment.

Our findings

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

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. Each ward had detailed accessible environmental risk assessments.

Staff could observe children and young people in all parts of the wards. Managers installed convex mirrors in all areas that had blind spots on the ward to aid the observation of children and young people.

The ward complied with guidance and there were no mixed sex accommodation breaches. Staff ensured each area of the wards were single sex. Two bedrooms were available on each ward, which were separate from the main bedroom areas. Staff could change use of these two beds to accommodate male or female young people, as demand required. Staff also used these areas for transgender children and young people.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. Where there were potential ligature anchor points, staff mitigated the risks by always being with children and young people in those areas.

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

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. The service employed staff specifically to maintain the cleanliness of the wards.

We found staff did not always follow infection control policies with regards to wearing personal protective equipment. We reviewed eight extracts of CCTV across six different night shifts on Poplar adolescent unit. We observed eight different occasions of staff not wearing masks correctly involving 10 different staff members. Only three of the eight pieces of CCTV reviewed show all staff correctly wearing their masks. We informed the Trust of our findings at the time of reviewing the CCTV and they took immediate action to put measures in place to respond to this. We attended the ward the following night and found all staff had been made aware of our findings. Instructions had been given from the Trust reminding all staff to wear their masks at all times. All staff wore masks correctly during our visit.

Our findings

Seclusion room

The seclusion room on Larkwood ward allowed clear observation and two-way communication. It had a toilet and a clock. Only Larkwood ward had a working long-term segregation suite, including a seclusion room at the time of our inspection. If patients from Longview ward required seclusion staff would support them to transfer to Larkwood ward to use the facilities. The seclusion data reviewed did not show there were any seclusions required for patients on Longview ward.

At the time of our inspection there were building works to improve the long-term segregation suite at Poplar adolescent unit and a long-term segregation suite was being built on Longview ward.

Clinic room and equipment

Not all clinic rooms were well managed. The medication destruction bin on Larkwood ward contained sharps as well as the medication to be disposed of which was an infection risk to staff. We found out of date items in the clinic room on Longview ward including a blood collection kit, 12 COVID-19 test kits, and a box of blood sample tubes.

However, clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs.

Safe staffing

The service had enough nursing and medical staff, who knew the children and young people and received basic training to keep people safe from avoidable harm.

Nursing staff

Managers accurately calculated and reviewed the number and grade of qualified staff and nursing assistants for each shift. The service had enough qualified and support staff to keep children and young people safe. We reviewed multiple documents the managers used to identify where staff were required on the wards. We identified initial documents which showed understaffing due to sickness and leave but we tracked these through and for each of the examples we looked at the wards were all supplied with staff over their planned staffing numbers. The ward manager could adjust staffing levels according to the needs of the children and young people.

The service had low vacancy rates. As of January 2022, Larkwood ward had a vacancy rate of three qualified staff and had over recruited two nursing assistants. For the same time period, Longview ward had no qualified staff vacancies and had over recruited three nursing assistants. Poplar adolescent unit had no qualified staff vacancies and two nursing assistant vacancies. The service had over-recruited some roles to increase their staffing capacity.

The service had low rates of bank and agency qualified staff. We reviewed bank and agency usage from 1 October 2021 to 28 February 2022. We found bank and agency staff were mainly being used to cover night shifts. Larkwood ward used the most bank and agency qualified staff across the three wards with an average of 19 agency qualified staff a month and 30 bank qualified staff a month. For the same time period Longview ward used an average of four agency qualified staff a month and 23 bank qualified staff a month, and Poplar adolescent unit used an average of six agency qualified staff a month and 22 bank qualified staff a month.

The service had high rates of bank and agency nursing assistants. We reviewed bank and agency usage from 1 October 2021 to 28 February 2022. We found bank and agency staff were mainly being used to cover night shifts. Longview ward used the most bank and agency nursing assistants across the three wards with an average of 45 agency nursing assistants a month and 172 bank nursing assistants a month. For the same time period Larkwood ward used an average

Our findings

of 42 agency nursing assistants a month and 146 bank nursing assistants a month, and Poplar adolescent unit used an average of 32 agency nursing assistants a month and 157 bank nursing assistants a month. Four children and young people told us they did not always know the night staff, they were always different, and this made them feel uncomfortable.

Managers requested bank and agency staff familiar with the service where possible.

Managers did not always make sure all bank and agency staff had a full induction before starting their shift. We reviewed induction figures correct at the time of our inspection. Temporary staff on Larkwood ward had a compliance rate of 49% with their inducton. Temporary staff on Longview ward had a compliance rate of 52% with their induction and temporary staff on Poplar adolescent unit had a compliance rate of 73% with their induction. However, the service made sure all new bank and agency staff completed a walk around of the wards on their first shift to become familiar with the layout of the ward and safety procedures. We spoke with one bank staff member who told us they were made familiar with the ward before they commenced their shift and was very positive about their familiarity experience.

The service had variable turnover rates.We reviewed the staff turnover rates from October 2021 to January 2022. Larkwood ward had the highest staff turnover rate in this time period and was 12.75%. The staff turnover rate in this time period for Poplar adolescent unit was 4% and the staff turnover rate in this time period for Longview ward was 0%.

Managers supported staff who needed time off for ill health.

Levels of sickness were high. The wards had a lot of staff off sick due to COVID-19. We reviewed sickness levels from October 2021 to January 2022. The staff sickness rate in this time period for Longview ward was the highest at 12%. The staff sickness rate in this time period for Larkwood ward was 5.25%. The staff sickness rate in this time period for Poplar adolescent unit was 4.25%.

The Care Quality Commission recognises that over the time period we reviewed, there was a national pandemic which caused staffing shortages across all NHS services. The Care Quality Commission also recognises at the time of the inspection there were national challenges for wards for children and adolescents relating to children and young people's needs and bed availability.

Not all children and young people had regular one to one sessions with their named nurse. We spoke with nine children and young people across all three wards. Two children and young people told us they never meet with their named nurse.

Children and young people sometimes had their escorted leave, or activities cancelled when the service was short staffed. Three children and young people from either Longview ward or Larkwood ward, told us their leave had been cancelled due to the wards being short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep children and young people safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was an out of hours rota for doctors to cover each of the wards.

Our findings

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Permanent staff had an overall compliance rate of 93% across the three wards. Non-permanent staff had a compliance rate of 92% for March 2022.

The mandatory training programme was comprehensive and met the needs of children and young people and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children, young people and themselves well and 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 Trust's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff updated risk assessments at the weekly multi-disciplinary meetings and more frequently where required.

Staff used a recognised risk assessment tool which was part of the children and young people's electronic care records.

Management of patient risk

Staff did not always follow the Trusts' policies and procedures with regards to the use of mobile phones. We reviewed eight extracts of CCTV across six different nights. We observed 10 different staff using personal mobile phones. Only three of the eight pieces of CCTV reviewed showed staff not on a mobile phone.

Staff knew about any risks to children and young people and acted to prevent or reduce risks. Staff completed risk management plans and positive behaviour plans for all children and young people. Staff formulated all risk management plans in the weekly multi-disciplinary meetings. Children and young people were central in the development of both risk management and behaviour support plans.

Staff identified and responded to any changes in risks to, or posed by, children and young people. Staff reviewed risk assessments and positive behaviour support plans; where children and young people who required them had them, regularly. Children and young people had access to areas such as de-escalation and chill out rooms. Children and young people on Poplar adolescent unit could also access the sensory room, which contained a range of equipment including weighted blankets and visual displays.

Staff followed procedures to minimise risks where they could not easily observe children and young people. We saw convex mirrors up in the wards to support the observation of children and young people.

Staff followed Trust policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were increasing across all three wards. We viewed data from 1 December 2021 to 28 February 2022. The Trust provided data in two formats. There were discrepancies in the data provided by the Trust. For

example, for Longview ward, on one format the data evidenced restraints had increased from 47 in January 2022 to 62 in February 2022, but on the other format the data evidenced restraints had increased from 26 in January 2022 to 70 in February 2022. Two children and young people told us there was a lot of restraint on the wards and one young person told us they felt non-regular staff panic and did not de-escalate incidents as often as they should have.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep children, young people and others safe. During the review of body camera footage, we saw staff using multiple de-escalation techniques with children and young people which were personal to them. This included comfort toys, the use of ice and the use of weighted blankets. However, one young person told us new or unfamiliar staff did not use de-escalation and they felt they were restrained more than they should have been.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed The National Institute for Health and Care Excellence guidance when using rapid tranquilisation. Staff recorded in children and young peoples' case records when they used rapid tranquilisation and carried out physical health monitoring in line with guidance.

When children and young people were placed in seclusion, staff kept clear records and followed best practice guidelines. We reviewed seclusion records and found a clear rational for seclusion to continue.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if children and young people were put in long-term segregation. We reviewed the records of a young person in long-term segregation which showed staff had followed best practice and guidance.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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

Staff kept up-to-date with their safeguarding training. At the time of our inspection the compliance rate for training in Safeguarding Adults and Children Level 2, including Mental Capacity Act, Deprivation of Liberty and Prevent for permanent staff on Poplar adolescent unit was 96%, permanent staff on Larkwood ward had a compliance rate of 100% and permanent staff on Longview ward had a compliance rate of 91%. Non-permanent staff had a compliance rate of 92%. At the time of our inspection the compliance rate for training in Safeguarding Adults Level 3, including Mental Capacity Act, Deprivation of Liberty and Prevent for permanent staff on Poplar adolescent unit was 91%, permanent staff on Larkwood ward had a compliance rate of 88% and permanent staff on Longview ward had a compliance rate of 100%. Non-permanent staff had a compliance rate of 93%.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Our findings

Staff followed clear procedures to keep children visiting the ward safe. There was a family room adjoined to each ward where visits could be held so young children did not have to go onto the ward.

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

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Children and young peoples' notes were comprehensive, and all staff could access them easily. All permanent and bank staff had a log in to access children and young peoples' notes and electronic systems and records. There were guest log ins for agency staff.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Staff ensured any paper records were scanned onto the electronic care recording system.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Although the Trust used two different electronic recording systems, staff could access the alternative system via an overarching system to review children and young peoples' care records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on children and young people's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed 15 prescription charts across the three wards and found no errors or omissions.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. We saw evidence of this in children and young peoples' records.

Staff stored and managed medicines and prescribing documents in line with the Trust's policy.

Staff followed current national practice to check children and young people had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. We saw examples of safety alerts that had been shared with staff.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We saw evidence of this in regular meetings clinicians had with children and young people.

Staff reviewed the effects of children and young people's medication on their physical health according to The National Institute for Health and Care Excellence guidance.

Our findings

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed children and young people's safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Staff knew what incidents to report and how to report them. We saw evidence of the different categories of incidents staff reported.

Staff raised concerns and reported incidents and near misses in line with Trust policy. Since our most recent inspection the Trust added additional criteria to their incident reporting system to allow staff to identify if they believed the incident impacted children and young people's safety or if staffing levels or staffing issues were a factor in the incident. We reviewed incidents from 1 September 2021 to 1 March 2022. We found 14 incidents where staff believed the incident impacted children and young people's safety and staffing levels or issues were a factor in the incident.

Staff reported serious incidents clearly and in line with Trust policy.

The service had no never events on any wards. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. We saw evidence of robust and regular support for staff with psychological input for both children and young people and staff.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to children and young people's care. These were discussed in team meetings.

Managers shared learning from incidents with their staff and across the Trust. These were available in folders on each ward. Posters were also available for staff. Staff received a regular email with lessons learned and they were also discussed in team meetings.

Is the service effective?

Good

Our rating of effective went down. We rated it as good.

Our findings

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of children and young people either on admission or soon after.

Children and 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 children and young people that met their mental and physical health needs. We reviewed 11 care plans. Staff developed care plans with children and young people, which were personalised, holistic and recovery-orientated. Care plans were up to date, reviewed regularly and updated through multidisciplinary discussion when children and young people's needs changed.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff provided a range of care and treatment suitable for the children and young people in the service. Care and treatment interventions were those recommended by, and delivered in line with, guidance from the National Institute for Health and Care Excellence. Staff delivered a wide range of structured psychological therapies and occupational therapy techniques. Including one to one psychotherapy, emotional regulation, sensory integration, family therapy and Dialectic Behavioural Therapy. Children and young people also had access to a wide range of other activities on the wards.

Staff identified children and young people's physical health needs and recorded them in their care plans. We saw specific physical health care plans for children and young people who required them.

Staff made sure children and young people had access to physical health care, including specialists as required. Staff used the modified early warning signs documentation to record children and young peoples' vital signs.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. Children and young people had access to physical activities. Children and young people on Larkwood ward and Longview ward had access to a gym and pedal bikes.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. These included the Health of the Nation Outcome Scale for children and adolescents.

Staff used technology to support children and young people. All wards had electronic tablets available and the facilities to make conference calls with other clinical teams. Staff also used tablets to record children and young people's

observations. These were newly implemented. Staff identified the internet signal dropped out when using these around the ward and they had to revert to paper observation records at times. We observed this in practice on multiple occasions during our inspection visits. The tablets were either not working or the internet signal had dropped, and staff reverted to paper records. The trust were aware of these issues and they were being addressed by the Trust prior to the inspection. At the time of the inspection the use of tablets to record children and young people's observations was part of a live trial to identify any issues when used in a real patient setting.

Qualified staff took part in clinical audits. Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of children and young people on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals and supervision. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the children and young people on the wards. The multi-disciplinary team included consultant psychiatrists, speciality doctors, nurses, occupational therapists, clinical psychologists, family therapists, teachers and support workers.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff. Managers kept a record of the training compliance of bank staff.

Managers gave each new permanent member of staff a full induction to the service before they started work. We reviewed induction figures at the time of our inspection for permanent staff. Permanent staff on Poplar adolescent unit and Larkwood ward had a compliance rate of 100%. Permanent staff on Longview ward had a compliance rate of 96% with their induction.

Managers supported permanent staff to develop through yearly, constructive appraisals of their work. At the time of our inspection, Larkwood ward had a compliance rate of 93%, Longview ward had a compliance rate of 89% and Poplar adolescent unit had a compliance rate of 78%.

Managers supported staff through regular, constructive clinical supervision of their work. At the time of our inspection, Poplar adolescent unit had a compliance rate of 90%, Longview ward had a compliance rate of 86% and Larkwood ward had a compliance rate of 80%.

Managers made sure staff attended regular team meetings or gave information to those who could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had weekly 'time to learn' sessions with therapists to complete bespoke training based around the presentation of the children and young people group admitted at that time.

Managers made sure staff received any specialist training for their role. All staff had access to a wide range of mandatory and specialist courses. We saw evidence some staff had been trained in Avoidant/Restrictive Food Intake Disorder, hearing voices, attachment, Dialectic Behavioural Therapy skills, emotion regulation skills, trauma training, psychosis training, Dialectic Behavioural Therapy distress tolerance skills, Dialectic Behavioural Therapy training session on interpersonal effectiveness skills, disordered eating, psychological informed all day induction which is to be rolled out across all staff. Monthly skills share sessions facilitated by therapy staff and doctors.

Our findings

Managers recognised poor performance, could identify the reasons and dealt with these. Managers described the visions and values of the organisation and expected these to be evident in practice.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. We reviewed minutes of these from 6 December 2021 to 23 February 2022 and saw different types of multidisciplinary meetings occurred regularly involving a range of professionals.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. Nursing staff received a detailed handover at the commencement of each shift. Staff provided a daily structured handover to the multidisciplinary team daily.

Ward teams had effective working relationships with other teams in the organisation. The Trust safeguarding team worked closely with the wards to provide training and safeguarding supervision as well as external local authority teams.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure staff could explain children and young people's rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of our inspection Mental Health Act training compliance for staff across all wards was 95%

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff were aware of these and how to access them.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. Staff displayed posters relating to advocacy services and independent mental health advocacy services. Children and young people were aware of their legal status and knew they could speak to an advocate. Advocates regularly visited the wards.

Staff explained to children and young people their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in children and young people’s notes each time. We reviewed

the Mental Health Act documentation in the care records of three children and young people on Poplar adolescent unit. In two children and young people's records, staff had provided them with information about their legal position and rights, as required under section 132 of the MHA, at the point of the children and young people's detention and/or admission to the ward. However, in one record there was a two-day delay.

Section 17 leave of absence (permission to leave the hospital) was discussed with children and young people in their ward rounds and at other times when the responsible clinician was visiting the ward. We checked two children and young peoples' section 17 leave authorisation forms on Poplar adolescent unit. Children and young people's leave authorisation forms clearly set out the escort arrangements and the conditions of leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed. These were scanned and stored electronically on the Trusts' electronic recording system.

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those children and young people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. Staff assessed and recorded consent and capacity clearly. They understood the Trust policy on the Mental Capacity Act 2005 and how it applied to young people. However, not all staff were aware of the term Gillick competency.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles. Mental Capacity Act training was included as part of the Safeguarding Adults and Children Level 2 training and Safeguarding Adults' level 3 training. At the time of our inspection, the compliance rate for training in Safeguarding Adults and Children Level 2 for permanent staff on Poplar adolescent unit was 96% and Safeguarding Adults Level 3 was 91%. Larkwood ward had a compliance rate for permanent staff of 100% for Safeguarding Adults and Children Level 2 and Safeguarding Adults Level 3 was 88%. Longview ward had a compliance rate for permanent staff of 91% for Safeguarding Adults and Children Level 2 and Safeguarding Adults Level 3 was 100%. Non-permanent staff had a compliance rate of 92% for safeguarding adults and children level 2 training and 93% for safeguarding adults' level 3 training.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding if children and young people did not have the capacity to do so.

Our findings

Staff assessed and recorded capacity to consent clearly each time children and young people needed to make an important decision. Staff made a record of children and young people's mental capacity to consent to treatment, in all care records we reviewed.

When staff assessed children and young people as not having capacity, they made decisions in the best interest of the them and considered their wishes, feelings, culture and history. This was clearly detailed in the records we reviewed.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

Staff knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this. Staff understood how to support children under 16 wishing to make their own decisions. However, not all staff were aware of the term Gillick competency.

Is the service caring?

Good

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

Most staff were discreet, respectful, and responsive when caring for children and young people. Most staff gave children and young people help, emotional support and advice when they needed it. Most staff followed policy to keep children and young peoples' information confidential. However, one young person said not all staff knock on their door before entering, some staff ignore them and don't engage with them and some staff talk about other children and young people in front of them.

Staff supported children and young people to understand and manage their own care treatment or condition. Two children and young people told us they knew all about their medications and side effects.

Staff directed children and young people to other services and supported them to access those services if they needed help.

Children and young people said staff treated them well and behaved kindly. Three children and young people told us staff were nice, kind, respectful and felt like they cared.

Our findings

Staff understood and respected the individual needs of children and young people. Staff on all wards now had access to adequate tear proof clothing items including different items and appropriate sizes for children and young people. Children and young people wore tear proof clothing if they were at risk of ripping and using their normal clothing to self-ligature. One young person told us there was adequate clothing available. However, one young person told us their tear proof clothing was too big.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people.

Involvement in care

Staff involved children and young people in care planning and risk assessments. They ensured children and young people had easy access to independent advocates. However, staff did not always involve families and carers appropriately or actively seek their feedback on the quality of care provided.

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission. We saw admission packs detailing information about the wards which children and young people were given on admission to the ward.

Staff involved children and young people and gave them access to their care planning and risk assessments. We saw children and young peoples' involvement in all of the care plans we reviewed.

Staff made sure children and young people understood their care and treatment. Children and young people had weekly meetings to discuss this.

Staff involved children and young people in decisions about the service, when appropriate. Children and young people had input into how they wanted the sensory room and chill out room on Poplar adolescent unit.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. Children and young people had weekly community meetings on all wards.

Staff supported children and young people to make decisions on their care.

Staff made sure children and young people could access advocacy services.

Involvement of families and carers

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

Staff did not always inform and involved families or carers. We spoke to five children and young peoples' carers. Two carers told us they were not involved in their relatives' care and it was left to the young person to phone them to inform them what was happening. Following the inspection, the Trust provided evidence to show they were contacting carers after children and young people had their ward reviews and shared outcomes from meetings.

Staff did not always help families to give feedback on the service. Three of the carers we spoke to had not been asked to give feedback on the service.

Staff did not give carers information on how to find the carer's assessment. Three carers told us they had not been informed about the carer's assessment.

Our findings

Is the service responsive?

Requires Improvement

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

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. As a result, children and young people did not have to stay in hospital when they were well enough to leave unless there was an issue at their next placement.

Managers made sure bed occupancy did not go above 85%. We saw evidence of this across all three wards from June 2021 to the time of our inspection. However, from 9 June 2021 to 21 March 2022 there were conditions placed on the Trusts' registration preventing admission without prior written permission from the Care Quality Commission.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. Data provided by the Trust showed the average length of stay for children and young people on Poplar adolescent unit as of February 2022 was 137.5 days, Longview ward was 18.5 days and Larkwood ward was 0 days due to no patients being discharged from Larkwood ward in February 2022. Data is based on the young people who were discharged that month and their average length of stay.

Managers and staff worked to make sure they did not discharge children and young people before they were ready.

When children and young people went on leave there was always a bed available when they returned.

Children and young people were moved between wards during their stay only when there were clear clinical reasons or it was in their best interest. Due to the conditions placed on the service by the Care Quality Commission following the previous inspection in 2021 the service also had to ask the Care Quality Commission to move children and young people between wards if necessary. This occurred on one occasion in the previous nine months.

Staff did not move or discharge children and young people at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of children and young people whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The service told us there were 10 children and young people whose discharge was delayed due to waiting for alternative beds in different placements.

Children and young people did not have to stay in hospital when they were well enough to leave.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. However, children and young people were not always involved in their discharge planning. We reviewed care plans and weekly review meeting minutes. Discharge planning was only discussed in one young persons' weekly review meeting.

Our findings

Staff supported children and young people when they were referred or transferred between services. For example, if they required treatment in an acute hospital. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. Children and young people had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. However, the food was not of good quality and children and young people could not always make hot drinks and snacks at any time.

Children and young people had their own bedroom, which they could personalise.

Children and young people had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Children and young people had access to a range of rooms including activity rooms and single sex seating areas.

The service had quiet areas and a room where children and young people could meet with visitors in private. All wards had separate visitors' rooms off of the ward so visitors could bring children and keep them safe and away from the ward environment.

Children and young people could make phone calls in private. The wards had cordless phones which children and young people were able to use. Children and young people also had access to a basic mobile phone.

Larkwood ward and Longview ward had an outside space that children and young people could access easily. Poplar adolescent unit did not have access to an outside space unless escorted due to the ward being on the first floor.

Not all children and young people could make their own hot drinks and snacks as access is provided by staff. Larkwood ward and Longview ward had set snack times for children and young people to be offered a snack. We saw no facilities on these wards for children and young people to make or access hot drinks without staff support. Five children and young people from Larkwood ward or Longview ward told us snacks are on a timetable and they cannot access fruit or snacks when they want. However, children and young people on Poplar adolescent unit had access to a kitchenette in the lounge to make hot drinks.

Patients were unhappy with the quality and variety of food offered. We spoke to nine children and young people. Five children and young people told us they did not like the food and the quality of the food is poor.

Children and young people's engagement with the wider community

Staff made sure children and young people had access to high quality education throughout their time on the ward.

Staff made sure children and young people had access to opportunities for education and work and supported them. Children and young people had access to an educational facility onsite during the week. Children and young people who were unable to leave the ward were brought educational materials to complete with staff support if required, for example, children and young people who were in long term segregation. Two children and young people told us education was good and had helped them.

Our findings

Staff helped children and young people to stay in contact with families and carers. Staff facilitated regular family and carer visits on the ward.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. Children and young people had access to 'smart' phones and the internet during a daily 'phone club' and supervised sessions allowing children and young people to use these in a safe and controlled environment.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Children and young people could access Poplar adolescent unit via a lift. Children and young people had easy access to both Larkwood ward and Longview ward which had been purpose built with disabled access. Children and young people had access to a disabled bathroom and a range of equipment including a hoist and wheelchair. The service met children and young peoples' specific communication needs on an individual basis.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain. The information provided was in an age appropriate format.

The service could access information leaflets in different languages spoken by children, young people and the local community as required.

Managers made sure staff, children and young people could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. However, two children and young people told us the level of choice was limited.

Children and young people had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service did not treat concerns and complaints seriously raised by children and young people. However, the service investigated external complaints and learned lessons from the results, and shared these with the whole team and wider service.

Children, young people, relatives and carers knew how to complain or raise concerns. Poplar adolescent unit was the only ward to receive any complaints in the last 12 months and received two complaints in total. One of the complaints was partially upheld and the other was not upheld.

We saw in multiple community meeting minutes across all wards children and young people complaining about the food. Children and young people were not always listened to or actions taken with regards to issues brought up by the children and young people. We found in most of the community meeting minutes from 1 December 2021 to 21 February 2022 children and young people had raised issues with the food and although in some cases actions had been recorded no outcomes had been recorded. We spoke to two staff members who told us children and young people continue to raise complaints with regards to the food.

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

Our findings

Staff understood the policy on complaints and knew how to handle them. The complaint is discussed with children and young people as part of a complaint investigation.

Managers investigated complaints and identified themes.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. We reviewed team meeting minutes across the service and found learning points from complaints were discussed at team meetings. Lessons identified from complaints were shared at the quarterly Learning Oversight Sub-Committee, where attendees (representatives from all areas) are asked to disseminate these to staff.

The service used compliments to learn, celebrate success and improve the quality of care. There were 22 compliments received for Longview ward between May 2021 and February 2022. All 22 compliments related to the staff at Longview Ward. There were four compliments received for Larkwood ward between August 2021 and February 2022. All four compliments related to the staff at Larkwood Ward.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were approachable for children, young people, families and staff.

Leaders had a good understanding of the needs of the children and young people and how to address these. Leaders had a comprehensive understanding of the services they managed. Leaders could explain clearly how the teams were working to provide high quality care.

Staff told us leaders were supportive and approachable. Staff knew who the local leaders were. Most staff knew who the most senior managers in the organisation were or where to find that information.

Vision and strategy

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

During the inspection we observed staff displaying the Trust values of care, learn and empower in their interactions with children and young people and colleagues.

The Trust's senior leadership team successfully communicated the Trust's vision and values to the frontline staff in this service. Staff were able to identify these and how these were displayed in care and treatment on the ward.

Our findings

Culture

Staff felt respected, supported and valued by their colleagues and leaders. They could raise any concerns without fear.

Staff did not always follow the Trusts' policies and procedures with regards to the use of mobile phones and wearing personal protective equipment. We reviewed eight extracts of CCTV across six different nights. We observed eight different occasions of staff not wearing masks correctly involving 10 different staff members. We also observed 10 different staff using personal mobile phones. There was no evidence of other staff on shift challenging this behaviour.

Staff said they felt leaders and their colleagues were supportive and felt respected and valued in their teams.

Staff knew how to use the whistle-blowing process if they needed to. Staff at all levels were actively encouraged to speak up and raise concerns. Staff consistently stated they felt able to raise concerns without fear. Staff described an open and supportive culture.

Leaders dealt with poor staff performance when needed. Leaders dealt with areas of concern including behaviours and attitudes of staff.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well. Details can be found in the report sections for safe, effective, caring and responsive.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear framework of what must be discussed at a ward and senior management team level meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

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.

Managers did not ensure they consistently implemented or monitored adherence to the government guidelines relating to the use of face masks in the hospital to reduce the risk of transmission of COVID-19. Managers had not identified staff failure to adhere to this guidance. Managers assured us they completed night visits to the wards where any issues were resolved. Managers did not routinely sample CCTV footage. The Trust took immediate action following our feedback and sent an urgent communication to all staff reminding them of government guidelines.

The service had systems and processes in place to monitor risk and performance. The service held daily morning meetings to review staffing across the wards. The service also held handover meetings to discuss incidents, children and young peoples' risks, and any issues of concern. Managers formed plans and actions to address these.

The Trust had a risk register in place which they used to record, review and manage risks to the service.

Information management

Staff engaged actively in local and national quality improvement activities.

Our findings

Staff told us they had access to the equipment and information technology needed to do their work however the WIFI was intermittent for technology that required it, such as tablets that staff used to record children and young peoples' observations on, in different areas of the wards.

Engagement

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.

There were consistently high levels of constructive engagement with staff and children and young people. Staff and children and young people had access to up-to-date information about the work of the Trust and the services they used. The Trust used several methods to communicate with staff, children and young people and carers that included its own website, bulletins, emails, displays, intranet, live senior leadership virtual engagements, children and young peoples' community meetings and carers' forums. However, staff told us they felt they did not always get the opportunity to give feedback on services and input into service development.

Learning, continuous improvement and innovation

Larkwood ward had been accredited onto the Quality Network for Inpatient CAMHS scheme.

Our findings

Areas for improvement

Action the Trust MUST take is necessary to comply with its legal obligations. Action a Trust 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.

Action the trust MUST take to improve:

- The trust must ensure staff follow infection control policies with regards to wearing personal protective equipment. (Regulation 12(1)).
- The trust must ensure all medication and sharps are disposed of as per trust policy. (Regulation 12(1)).
- The trust must ensure clinic rooms do not contain out of date items. (Regulation 12(1)).
- The trust must ensure children and young people are not reliant on staff for access to snacks at prescribed times. (Regulation 14(1)).
- The trust must ensure staff follow the trusts' policies and procedures with regards to the use of mobile phones in ward areas. (Regulation 12(1)).
- The trust must ensure all bank and agency staff have a full induction and understand the service before starting their shift. (Regulation 18(1)).

Action the trust Should take to improve:

- The trust should ensure children and young people have regular one to one sessions with their named nurse
- The trust should ensure all staff maintain children and young people's privacy, dignity and confidentiality at all times for all patients.
- The trust should ensure the service offers a variety of good quality food focussing on the patient group and responds to patient feedback on this topic.
- The trust should ensure staff provide children and young people with information about their legal position and rights, as required under section 132 of the MHA, at the point of the young person's detention and/or admission to the ward.
- The trust should ensure all staff are aware of the term Gillick competency.
- The trust should ensure staff get the opportunity to give feedback on services and input into service development.
- The trust should ensure staff inform and involve families and carers including enabling families or carers to give feedback on the service.

Our inspection team

The team that inspected the service comprised a Care Quality Commission lead inspector, two other Care Quality Commission inspectors, a Care Quality Commission inspection manager, two specialist advisors and an expert by experience. 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
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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

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