Requires Improvement

Sussex Partnership NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Chalkhill	RX2X4	Chalkhill	RH16 4EX

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

Summary of findings

Ratings

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

Overall rating for Child and adolescent mental health wards	Requires Improvement 
Are Child and adolescent mental health wards safe?	**Requires Improvement** 
Are Child and adolescent mental health wards effective?	**Good** 
Are Child and adolescent mental health wards caring?	**Good** 
Are Child and adolescent mental health wards responsive?	**Good** 
Are Child and adolescent mental health wards well-led?	**Requires Improvement** 

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

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

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

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

Summary of findings

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Overall summary

We gave an overall rating for child and adolescent inpatient mental health services of **requires improvement** because:

- There were appropriate numbers of staff on shift, though these were not always the required amount of qualified staff, with absences covered by healthcare assistants.
- Ligature risks were not always appropriately managed, which put young people at risk of harm.
- Staff did not receive annual updates in mandatory training to ensure staff they were carrying out current practice with this.
- Staff lacked training in physical health issues to meet the needs of the high number young people with eating disorders nursed on the ward.

The ward was clean, well-maintained and provided a range of therapeutic activities for young people.

Young people had access to a range of therapies including psychology and psychotherapy.

The aims of the service were clear and focussed on the needs of the young people. Staff morale was good and the team supported each other.

Summary of findings

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

Are services safe?

Requires Improvement

We rated safe as **requires improvement** because:

- There were appropriate numbers of staff on shift, though these were not always the required amount of qualified staff, with some absences covered by healthcare assistants.
- Ligature risks were not always appropriately managed, which put young people at risk of harm.
- Staff did not receive annual updates in mandatory training to ensure staff they were carrying out current practice with this.

The ward was clean, well-maintained and provided a range of therapeutic activities. Young people were risk assessed on admission to ward and monitored throughout their stay. Accidents and incidents were reported. These were reviewed and lessons learned through feedback to staff so they could make changes to their work. Staff regularly checked the emergency resuscitation equipment.

Are services effective?

Good

We rated effective as **good** because:

Young people received a comprehensive assessment of their needs on admission and these were monitored throughout their stay. Treatment and monitoring were based upon best practice from appropriate bodies, such as NICE and Royal College of Psychiatry. Young people had access to a range of therapies including psychological and psychotherapy. There was inconsistent use of the Fraser Guidelines/ Gillick Competency with young people under 16 years. For those aged 16 yrs and over we found that the service did not fully take in account the capacity of the young person, or use to the Fraser Guidelines or Mental Capacity Act 2005.

However;

- Staff lacked training in physical health issues to meet the needs of the high number young people with eating disorders nursed on the ward.

Are services caring?

Good

We rated caring as **good** because:

Young people praised the quality of care they received, though felt that more activities were needed to keep them occupied. Most staff treated young people with kindness and respect. We observed positive interactions between young people and the staff. However,

Summary of findings

some young people said they were spoke to in a 'belittling' way by staff and not given support when they wanted it. The majority of young people spoke of being involved in their care, but this was not always reflected in the care records.

Are services responsive to people's needs?

Good

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We rated responsive as **good** because:

The ward was designed to provide a range of different treatments and care. Adjustments were made to meet the religious and cultural needs of young people using the service. Young people could access therapeutic activities. Complaints were responded to and acted upon appropriately, although some young people did not know how to make a complaint, or felt they would be taken seriously. However, due to a national shortage of inpatient beds for young people, some were placed out of area due to number of referrals made to unit. Discharges from the ward generally took place during the daytime, with no weekend or night-time discharges.

Are services well-led?

Requires Improvement

We rated well-led as **requires improvement** because:

- Staff were not up to date with mandatory training and there was not an effective plan in place to get people up to date on training.
- Staff were not all trained in physical health care. There was not a plan in place to manage this.

However;

The aims of the service were clear and focussed on the needs of the young people. Staff knew the vision and values of the organisation. There were action plans in place where services needed to improve. Staff morale was good and the team supported each other. Staff were aware of senior managers and they had visited the ward.

Summary of findings

Background to the service

The child and adolescent mental health services of Sussex Partnership NHS Foundation Trust (SPFT) provide mental health care and treatment for children and young people up to the age of 18 years across Hampshire, Sussex and Kent. They work with children and young people who are experiencing a range of emotional and mental health difficulties. The services also work closely with families and carers as well as other services including schools, children's social care and voluntary sector organisations who offer other types of help and support.

The inpatient mental health services of SPFT are provided on one location at Chalkhill within the Princess Royal Hospital site. Chalkhill is a16 bedded ward providing acute inpatient services to young people aged 12-18 years.

This was the first inspection of Chalkhill by the Care Quality Commission.

Our inspection team

The team that inspected the adolescent inpatient services consisted of four people: one expert by experience, one inspector, one Mental Health Act reviewer and a mental health nurse.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for young people
- spoke with nine young people who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with nine other staff members; including doctors, nurses, therapy staff and locum staff
- attended and observed a hand-over meeting and multi-disciplinary team meeting

We also:

- looked at nine 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 young people who were using the service. Most were positive about their experience of care on the ward. They told us the majority of staff were caring and supportive, though some were not. Some felt that staff were too strict and some practices of the ward were too restrictive, such as access to outdoor space and their bedrooms. The feedback from young people, who had not been on the ward for a long time, was that they did not know why they had been admitted to the ward and staff had not informed them of this.

Most young people knew how to make a complaint, though some felt they would not be taken seriously if they raised any concerns.

Young people felt safe on the ward, found the facilities to be "excellent" and were generally happy with the weekly activities, though felt these could be improved upon to keep them more occupied during evenings and weekends.

Young people said they were generally involved in identifying their needs and the support they needed.

Good practice

There is nothing specific to note

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve the adolescent inpatient services

- The staffing returns showed that there was a shortage of qualified nurses on the majority of shifts throughout the day and night. The records indicated that some of these were covered by healthcare assistants. The covering of shortfalls of qualified nursing staff with healthcare assistant's staff did not promote the health, safety and welfare of people who use the service, and put young people at risk of inadequate care.
- There were a number of ligature risks within the environment. The ligature risk assessment showed the provider was aware of these, though had not taken appropriate action to mitigate the risk to young people.
- Staff said that they lacked training in physical health issues to meet the needs of the high number young people with eating disorders nursed on the ward. Staff did not receive regular mandatory training updates.

Action the provider SHOULD take to improve the adolescent inpatient services

- The ward had ligature cutters in three sites however, the location of one of these could cause delays in an emergency. Similarly, one set of cutters could potentially be insufficient in an emergency, as the scissors should be supplemented by a ligature knife.
- The purpose of the de-escalation room should be confirmed and designed as appropriate to ensure that young people at risk to themselves or others were not nursed in this area.
- We found a number of 'as required' medicines were not reviewed in a timely manner to ensure they were appropriate for use with young people.
- Medicines no longer in use were stored in unsecured box within clinic room, which could put people at risk.
- There was inconsistent use of the Fraser Guidelines/ being Gillick Competent for use with young people under 16 years. The nine care records we viewed stated that many young people were treated under 'parental responsibility'. This did not fully take in account the capacity of the young person, or use to the Fraser Guidelines or Mental Capacity Act.
- The care plans did not always demonstrate the active involvement of young people in identifying their needs and goals for treatment.

Summary of findings

- Discharge planning should be carried out as part of the assessment and care planning of the young people.
- Some young people said that not all staff were supportive and spoke with them in a belittling way.

Sussex Partnership NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Chalkhill	Princess Royal Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

Staff working with children and young people have particularly complex areas to manage when considering treatment and in making decisions about competence or capacity to give consent. It was evident that thought is given to these issues and there was considerable evidence from multi-disciplinary teams, observation and interviews that the legal issues are generally well managed. Sometimes it was not always clear in recording what the individual steps taken were in decision making; an example of this was a decision made that an informal patient no longer had capacity to consent to treatment. How this decision was reached was unclear.

Efforts were made to involve young people in their treatment and in their care planning. Sometimes the evidence in recording of young peoples' views about their care plan was unclear but there were good examples where the patient's own words were used.

Legal documentation for detention under the MHA were found and correctly completed and weekly ward audits were done for detained patients, confirming that information about rights were regularly carried out. Evidence was on the files of detained patients to show that regular reminders occurred.

Community treatment orders (CTO) are only used infrequently but we were told that a young person was currently on a CTO as this allowed them to return to their family sooner than would otherwise have been possible.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

There was good evidence of knowledge about 'Gillick competence' and capacity and the application of these. A recent unannounced MHA visit had identified a misapplication of the MCA because the patient was under 16. This had been promptly responded to by the trust and an audit responsibility was taken on by one of the senior doctors.

Requires improvement

Are services safe?

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

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

Summary of findings

Are child and adolescent inpatient mental health services safe?

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

We rated safe as **requires improvement** because:

- There were appropriate numbers of staff on shift, though these were not always the required amount of qualified staff, with absences covered by healthcare assistants.
- Ligature risks were not always appropriately managed, which put young people at risk of harm.

The ward was clean, well-maintained and provided a range of therapeutic activities. Young people risk assessed on admission to ward and monitored throughout their stay. Accidents and incidents were reported. These were reviewed and lessons learned through feedback to staff so they could make changes to their work. Staff regularly checked the emergency resuscitation equipment

Our findings

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Safe and clean ward environment

- The unit was purpose built. The main communal areas were on the ground floor with bedrooms on the first floor. Also on the first floor was the school which was used by inpatients and day patients. Consideration had been given to developing rooms such as the 'Pod' where young people could go for peace and quiet. Weekly fire tests were carried out, along with annual emergency evacuation testing to promote the safety of the environment.
- Chalkhill was situated within the grounds of an acute hospital, where there was easy access to the accident and emergency services if necessary.
- We were informed that the room used for 'de-escalation' was used very infrequently. The records showed that during 2014 this was used on 16 occasions for six young people. There were two instances where this was used as a psychiatric intensive care unit (PICU), although the room was not designed for this purpose, and could put young people at risk.
- We identified a number of ligature risks within the environment. The ligature risk assessment showed the provider was aware of these, though had not taken appropriate action to mitigate the risk to young people.
- A food safety inspection had taken place in January 2015, where no issues were identified and they scored a positive food hygiene rating of 5.
- The most recent Patient-Led Assessment of the Care Environment (PLACE) was carried out in March 2014, where the ward scored above the national average for areas such as cleanliness, condition appearance and maintenance.
- We observed the ward was clean, with two dedicated housekeepers for the ward. Young people using the service told us the ward was always kept clean. A cleaning rota was in place and completed weekly to demonstrate that deeper cleaning was carried out in all areas periodically.
- An infection control report dated 2012/13 showed that previous areas of concern had been acted upon to make the environment safer for young people. A follow up audit in January 2015 found some areas that needed addressing and these were being acted upon at the time of the inspection. We were informed that the estates department carried out regular water safety checks, such as for Legionella to ensure the water was safe for use.
- Emergency equipment, including resuscitation equipment and anaphylaxis treatment was situated on the ward. It was checked weekly to ensure it was fit for purpose and could be used effectively in an emergency. The ward had ligature cutters in three sites, however, the location of one of these could cause delays in an

Requires improvement

Are services safe?

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

emergency. Similarly, one set of cutters could potentially be insufficient in an emergency, as they were domestic-style scissors. We alerted the manager to these findings at the time.

Safe staffing

- At the time of the inspection we were informed that only one qualified nurse worked during the night, of the two they should have. The ward manager told us that they can get extra staff where needed, through use of permanent staff working bank hours, or agency staff.
- The staffing returns for the period July 2014 – end of December 2014 showed that there was a shortage of qualified nurses on some day and night shifts. The records indicated that some of these were covered by healthcare assistants. The covering of shortfalls of qualified nursing staff with healthcare assistants staff did not promote the health, safety and welfare of people who use the service, and put young people at risk of inadequate care.
- Staff had been working on the ward for a number of years and felt there was an established staff team who worked well together.
- Young people using the service said there were generally enough staff on duty, and they were available when they needed to speak with them.

Assessing and managing risks to patients and staff

- Individual risk assessments had been carried out for young people on the ward to ensure their safety needs were assessed and managed. This was initially carried out on their admission to the service. For example, the level and frequency of observations of young people by staff were determined on admission and through daily reviews of their needs.
- Males and females were accommodated on the wards. There were gender-specific bedroom corridors and toilets, and a lounge could be used to provide a female only communal area.
- We observed on the computers there was a 'Speak Out Safely' campaign by the trust to promote 'whistleblowing' and staff raising concerns about their workplace.
- The staff we spoke with knew about different types of abuse and how to recognise this in young people. They were aware of the trust procedures for raising a safeguarding concern and gave us examples of where they had needed to raise an alert. There was a safeguarding lead nurse on the ward that staff who refer to with any safeguarding concern.
- The staff used the 'Prevention and Management of Violence Aggression' techniques for supporting people. They told us they aimed to use the least restrictive methods, such as using verbal de-escalation. There was a de-escalation room that people could use.
- The trust pharmacist attended ward reviews and provided teaching for staff on the use and effects of different medicines. Some of the young people we spoke with received medicines for their needs. They understood the reasons why they were prescribed medicines and had an awareness of potential side effects. We reviewed the medicine administration records of several young people on the ward. The pharmacist regularly audited medicine records to ensure recording of administration was complete. The results showed that areas such as undated entries had been identified. However, we found a number of 'as required' medicines were not reviewed in a timely manner. We also found unused medicines were stored in unsecured box within clinic room

Track record on safety

- A recent incident had occurred where a young person had been inappropriately admitted to the ward and had been subject to de-escalation for long periods. This had led to work to improve the assessment of the risks of young people prior to their being admitted to the ward, to ensure it was the most appropriate environment for their needs.
- In the last year a young person had used a ligature to harm themselves. Some of the learning from this was the identification of a new ligature point, which was made safe in all areas of the service.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew how to recognise and report incidents on the trust's electronic incident recording

Requires improvement

Are services safe?

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

system. All incidents were reviewed by the ward manager, matron and forwarded to the trust's safety and risk team. Bulletins that contained recent incidents were forwarded to all ward managers to cascade to the staff.

Are services effective?

Good

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

Summary of findings

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.

We rated effective as **good** because:

Young people received a comprehensive assessment of their needs on admission and these were monitored throughout their stay. Treatment and monitoring were based upon best practice from appropriate bodies, such as NICE and Royal College of Psychiatry. Young people had access to a range of therapies including psychological and psychotherapy.

However;

- Mandatory training had not been completed to ensure staff had received training in these areas. Staff lacked training in physical health issues to meet the needs of the high number young people with eating disorders nursed on the ward.

Our findings

Assessment of needs and planning of care

- The needs of young people was assessed as part of their admission, including educational, physical and mental health needs. Physical healthcare was managed within the ward without the need to use GP services. Documentation showed that regular routine checks/ monitoring took place and was reinforced if there were particular concerns. We were told that there is ready access to specialist nursing for conditions such as diabetes and that the specialist nurse would visit the ward as a matter of course.
- We observed a handover meeting between shifts. The staff conveyed an in-depth understanding of each young person and of their needs. Staff of all disciplines were able to input into the meeting and daily planning to ensure that all activities for young people took place and relevant information was communicated.
- Care plans had been developed that addressed young peoples' assessed needs. However, it was not always clear in the care records which was the most current care plan, and when care plans were discontinued these were not always dated to enable an audit trail. These findings could put young people at risk of inappropriate care.

Best practice in treatment and care

- Within the care records we found regular use of Health of the Nation Outcome Scales

Child and Adolescent Mental Health (HONOSCA) and the Children's Global Assessment Scale (CGAS) on the admission and discharge of young people. We also saw evidence of the use of the Junior Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) for the work with young people with eating disorders. This ensured that young people received a service based on best practice.

- NICE guidance was followed in relation to medicine management, psychotherapy and family therapy.
- We also saw that National Prescribing Observatory for Mental Health (POMH) audits were carried out around prescribing for Attention Deficit Hyperactivity Disorder.

Skilled staff to deliver care

- The staff working on the acute wards came from a range of professional backgrounds including nursing, medical and psychology. Psychotherapists also worked on a sessional basis with young people. External professionals provided support to the young people, such as teachers and social workers.
- Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training relevant to their role, including eating disorders, cognitive behavioural techniques and motivation enhancement. Staff said that they lacked training in physical health issues, which they needed in light of the high number of young people with an eating disorder nursed on the ward. All staff acknowledged that they were not up-to-date with mandatory training.
- The staff spoke of working well as a team and providing support to each other. They told us they should have received clinical and managerial supervision every month, to reflect on their practice and incidents that

Are services effective?

Good

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

had occurred on the ward. However, these did not always take place due to ward pressures. Annual appraisals took place and each nurses' development was reviewed every quarter.

- There were regular team meetings and staff felt well supported by their manager and colleagues on the ward.

Multi-disciplinary and inter-agency team work

- We were informed that staff from the community CAMHS teams were generally unable to attend ward rounds, due to the pressures they were under. Staff also told us that they often struggled to speak with care co-ordinators on the telephone. They said that this often meant that discharge planning was affected, due to no one able to provide and organise the care in the community.
- We observed a multi-disciplinary meeting and found they were effective in discussing the holistic needs of the young person and reviewing their progress. Different professionals worked together effectively to assess and plan people's care and treatment.
- Safeguarding issues were considered as part of the MDT meetings, particularly in relation to the social circumstances of the young person and their family environment.

Adherence to the MHA and MHA Code of Practice

- The charge nurse oversaw the adherence to the Mental Health Act 1983 (MHA) on the ward and carried out regular audits. The trust MHA team carried out trust-wide audits.
- The use of the MHA was mostly good. The staff told us they had good access to the MHA administrative staff within the trust. Audits of the use of the MHA were carried out, and actions taken where discrepancies were identified. For example, where there was a lack of information of how to access an Independent Mental Health Advocate, and non-compliance in relation to Section 17 leave from the ward.

Good practice in applying the MCA

- Staff told us that issues regarding capacity and consent were discussed as a team. They gave us examples of actions they would take, e.g. If a young person refused their medicine to ensure that they understood the consequences of their decision. Similarly, young people not wishing to be involved in particular therapies was respected, though re-visited with them during their stay on the ward.
- The issue of rights on a children and young person's ward is complex. Although a young person may be informal they may also be regarded as lacking competence or lacking capacity to consent and therefore were treated under parental authority. We were concerned about the lack of evidence of recording of discussions with young people about their rights at a given time. We found that consent to sharing information with parents of young people was not sought or recorded. We also found inconsistent use of the Fraser Guidelines/ being Gillick Competent for use with young people under 16 years. For example, in one care record it recorded that a young person was Gillick Competent, yet also stated that they were being treated under 'parental responsibility'. The nine care records we viewed stated that many young people were treated under 'parental responsibility'. This did not fully take in account the capacity of the young person, or use to the Fraser Guidelines or Mental Capacity Act 2005 for those over 16yrs.
- We also observed in the MDT a decision that had been made by a ward doctor, which did not follow a clear process of involving the MDT or the young person concerned.

Good

Are services caring?

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

Summary of findings

Are child and adolescent inpatient mental health services caring?

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

We rated caring as **good** because:

Young people praised the quality of care they received, though felt that more activities were needed to keep them occupied. Most staff treated young people with kindness and respect. We observed positive interactions between young people and the staff. However, some young people said they were spoke to in a 'belittling' way by staff and not given support when they wanted it. The majority of young people spoke of being involved in their care, but this was not always reflected in the care records.

Our findings

Kindness, dignity, respect and support

- The young people we spoke with said most of the staff were caring and supportive. They said they could approach staff at any time to discuss their concerns, and they felt listened to. However, some did say that when staff were stressed they became less supportive, where young people reported 'strict' staff and being shouted at. Others spoke of some staff as being 'patronising'.
- Young people felt respected by the staff and that confidentiality was maintained.
- Young people told us they were not able to access their bedrooms during the day, and could only do so with staff escort if they wanted something from their room.

The involvement of people in the care they receive

- When young people arrived on the ward they were shown around and told about the general rules, such as no smoking and no use of mobile phones. There was welcome pack which gave them information about the service.
- Young people were involved their care and treatment. On admission to the ward the young person and their family (where necessary) met with the named nurse to discuss their needs and aims for using the service, as well as options for treatment. Where young people wanted they could write their own care plan. Young people were involved in reviews about their care and treatment through weekly meetings with their named nurse and ward rounds with the MDT. Whilst observing an MDT meeting we saw that young people's requests for particular gender of therapist was considered and arranged where agreed to be beneficial to their treatment.
- The young people were generally aware of the content of their care plans, and some said they were involved in the development and review of these. Of the nine files we viewed we saw one example where young persons' views were clearly documented. We also saw a good example of a young person having made an advance decision, which indicated what they would need at times of stress. However, in the other care records the comments were much more about the person. Some young people spoke of not being involved and 'just going along with it'. Similarly, others spoke of not knowing if they were allowed to attend ward round reviews about their care and treatment. The care plans did not demonstrate the active involvement of young people in identifying their needs and goals for treatment.
- The feedback from young people who had not been on the ward for long was that they did not know why they had been admitted to the ward, and staff had not informed them of this.
- Young people were aware of the advocacy available to them on the ward. An advocate visited the ward three times a week. They and the ward staff made referrals to the Independent Mental Health Advocate (IMHA) when this was required. We saw email evidence of the advocate bringing young peoples' concerns to the ward's attention and the response from the ward manager. The records of these and feedback received from young people was that the quality and selection of food was an ongoing issue.
- Young people and staff spoke of the involvement of significant family members on their care and ongoing treatment, through invites to care programme approach

Good

Are services caring?

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

meetings and updates when they visited the ward. The care records showed the concerns of parents/ carers were taken into account as part of the assessment of the young person. Feedback from parents was discussed as part of the MDT, such as in relation to concerns about the treatment of medicines their child was receiving or their access to day-care.

Good

Are services responsive to people's needs?

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

Summary of findings

Are child and adolescent inpatient mental health services responsive to people's needs?

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

We rated responsive as **good** because:

The ward was designed to provide a range of different treatments and care. Adjustments were made to meet the religious and cultural needs of young people using the service. Young people could access therapeutic activities. Complaints were responded to and acted upon appropriately, although some young people did not know how to make a complaint, or felt they would be taken seriously. However, due to a national shortage of inpatient beds for young people, some were placed out of area due to number of referrals made to unit. Discharges from the ward generally took place during the daytime, with no weekend or night-time discharges.

Our findings

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Access, discharge and bed management

- The staff confirmed that young people who went on leave from the ward would have access to a bed on their return, but this might be a different bedroom.
- Staff told us that discharges from the ward generally took place during the daytime, with no weekend or night-time discharges. They said that the process for discharge would be through the young person taking increasing periods of leave away from the ward, and their progress assessed during the ward rounds.
- We were informed that delays to discharges were generally due to non-clinical reasons such as family circumstances. However, some young people were not aware of plans for their discharge or moving on from the service.

The ward optimises recovery, comfort and dignity

- The wards had a full range of rooms and equipment for use. This included space for therapeutic activities, treatment and spiritual needs.
- The ward offered access to an outside space, which some young people could access with the support of staff, however, others said they were not allowed to go outside.
- Young people had access to education, which was provided for 22.5 hours during the week. This was provided onsite.
- Young people said they would like the opportunity to be involved in preparing their own meals.
- The ward provided activities such as sports, music and dance therapy and an independent living support group. Some young people said there were generally sufficient activities to keep them occupied during the week, but that this could be improved at the weekends. However, where some young people had been at the service for long periods of time, they said that activities had become boring, and they felt there should be more for them to do.

Meeting the needs of all people who use the service

- The service was purpose built and had lifts to the first floor and areas could be accessed by wheelchairs users. Information leaflets were written in English, though the staff said this could be provided in different languages on request. Similarly, interpreters could be requested where necessary.

Listening to and learning from concerns and complaints

- Information on how to make a complaint was available through leaflets on the wards, and this was available in an easy read format. There was information on the patient advice and liaison service (PALS) and independent advocacy services.
- Young people knew how to raise concerns and make a complaint. They said they would raise this with staff initially, and take this further if they were not happy with the response. Most said that they felt able to raise a concern should they have one and believed that staff would listen to them. However, others did not feel they would be supported.

Are services well-led?

Requires Improvement

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

Summary of findings

Are child and adolescent inpatient mental health services unit 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.

We rated well-led as **requires improvement** because:

- There were appropriate numbers of staff on shift, though these were not always the required amount of qualified staff, with absences covered by healthcare assistants.
- Ligature risks were not always appropriately managed, which put young people at risk of harm.
- Mandatory training was not up to date and adequately monitored

However;

The aims of the service were clear and focussed on the needs of the young people. Staff knew the vision and values of the organisation. Action plans were in place where the services needed to improve. Staff morale was good and the team supported each other. Staff were aware of senior managers and they had visited the ward.

Our findings

Vision and values

- The staff spoke of the values of the child and adolescent mental health services (CAMHS) was to focus on the young persons' needs. They said that senior management were supportive with helping them achieve this, and felt that they listened to their clinical judgements. Staff said the new Chief Executive of the trust had visited the ward, along with other senior managers, where they had the opportunity to show them their work and discuss areas for improvement.

Good governance

- The service used outcome measures, feedback from the young people, family and friends test, and feedback from the Quality Network for Inpatient CAMHS peer reviews to gauge their performance and identify areas for improvement.

Leadership, morale and staff engagement

- Staff spoke of having a lot of autonomy in their work. Though some spoke of pressures on the trust CAMHS and this not being recognised by senior managers, or relevant support put in place.
- Some staff spoke of the effects that incidents had on their morale and that local managers were supportive and helped to keep the team focussed and motivated. Staff spoke of local managers as being very involved and promoting the rights and treatment needed for young people in need of mental health services.
- There were significant gaps in training.
- The covering of shortfalls of qualified nursing staff with healthcare assistants staff did not promote the health, safety and welfare of people who use the service, and put young people at risk of inadequate care.

Commitment to quality improvement and innovation

- Chalkhill is accredited with the Royal College of Psychiatrists and received visits from the Quality Network for Inpatient CAMHS. The feedback from the visits enabled areas of good practice to be highlighted, and also aspects of the service that required improvement. The most recent visit in March 2014 rated the service as excellent

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing The covering of shortfalls of qualified nursing staff with healthcare assistants over long periods of time did not promote the health, safety and welfare of people who use the service, and put young people at risk of inadequate care. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12: Safe care and treatment We identified a number of ligature risks within the environment at Chalkhill. The ligature risk assessment showed the provider was aware of these, though had not taken appropriate action to mitigate the risk to young people. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Staff did not receive regular mandatory training updates and lacked training in physical health issues to meet the needs of the high number young people with eating disorders nursed on the ward.

This was in breach of regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.