Requires improvement

Lincolnshire Partnership NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

Ash Villa, Willoughby Road, Greylees, Sleaford
NG34 8QA
Tel: 0303 123
4000
Website:http://www.lpft.nhs.uk/our-services/specialist-services/camhs/ash-villa

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RP7MA	Ash Villa	Ash Villa, Willoughby Road, Greylees, Sleaford	NG34 8QA

This report describes our judgement of the quality of care provided within this core service by Lincolnshire 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 Lincolnshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Lincolnshire 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 the service	Requires improvement 
Are services safe?	**Inadequate** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Lincolnshire Partnership NHS Foundation Trust child and adolescent mental health wards as requires improvement because:

- We were concerned about the physical environment of Ash Villa. The unit was noncompliant with same sex accommodation guidance and no action had been taken by the trust to address this, despite being aware of the issue for at least two years. The trust had not addressed known ligature points in the unit or made the garden area safe and fit for purpose, despite identifying that it was not suitable for the young people. The ligature audits and environmental risk assessments undertaken by the service had failed to identify significant risks. These included ligature points, a large number of issues in an unsafe garden area, blind spots in the building and electrical plant equipment in the clinic room.
- Staffing levels were low and potentially unsafe, particularly at night.
- The governance systems were not robust. Where risks were identified by the trust they were not always addressed, in particular the lack of compliance with the same sex guidance and the isolation of the unit at night.
- There was no clear strategic leadership for the service. Senior staff within the unit did not meet to discuss issues affecting the service.

However:

- Ash Villa had a committed and effective clinical team which cared for the young people.
- The service was effective, with young people using the service achieving good outcomes.
- Staff were skilled in de-escalation with low levels of restraint.
- Staff were caring, positive and enthusiastic, with a focussed patient orientated approach.
- The service was innovative in its use of a discharge liaison nurse and a ward therapy dog.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as inadequate because:

- The service did not comply with same sex guidance. Bedrooms were not ensuite so young people had to pass bedrooms of another gender to get to toilets and bathrooms. The trust had been aware of this for at least two years.
- There were numerous ligature points. In the unit there were points within the shower rooms, which had not been identified in the ligature audit. A ligature point that had been identified for removal by the trust in 2014 was still present at the time of our inspection.
- The garden area was unsafe. It was a very large unsecure area with easy access to a housing estate and a main road, and it was also possible to climb onto the roof. The area was not well maintained and had numerous ligature points. The trust had not identified these issues as it did not assess outside areas for such risks. This meant staff were obliged to restrict access to the garden and fresh air.
- We found inappropriate electrical equipment in the clinic room, which was a potential hazard because of the heat it gave off. We also found oxygen stored in the same location. Nursing staff had to lean over the electrical equipment to reach the controlled drugs cabinet.
- Staffing levels were low and potentially unsafe, particularly at night. The unit had only three night staff on duty to look after 13 young people. Ash Villa is an isolated unit, in a semi-rural location, with no other trust services nearby which meant it was hard for other trust staff to respond in an emergency.
- Young people in the service had restricted access to drinks and snacks.

However:

- There were good risk assessments in place for young people in the service.
- Safeguarding was robust.
- Staff were skilled in de-escalation, resulting in very few incidents of restraint.
- There was good learning from incidents.

Are services effective?

Good

We rated effective as good because:

- Young people achieved good outcomes.

Summary of findings

- Staff were focussed and took a patient oriented approach.
- The multidisciplinary team worked well together, with good access to professionals such as dieticians and pharmacists.
- Care planning was effective and physical health was monitored well.
- A ward dog helped young people engage with staff and therapies on the unit.
- There was good adherence to the Mental Health Act.

However

- There was limited access to psychology in the service, with one clinician providing majority of the interventions.
- Recording of capacity and consent, and understanding of the Mental Capacity Act was inconsistent.

Are services caring?

Good

We rated caring as good because:

- Young people and their parent/carers told us that staff were respectful and friendly.
- We observed good interactions between all staff and young people.
- There was good involvement by young people and their family/ carers in their care, in particular the use of family slots in the ward round.

However:

- Care plans did not always show patient involvement, despite it being evident in practice.
- Care plans were not written in an accessible way for young people.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The ward responded swiftly to referrals. Commissioners of the service were positive in how the ward considered referrals.
- The ward helped facilitate young people to return from out of area placements back to Lincolnshire as soon as it was appropriate.
- The ward was comfortable and pleasant.
- There was good education provision on site, in a school run by the local authority.
- Spiritual needs were supported.

Summary of findings

- Complaints were well managed.

However:

- There not many activities at weekends.
- Young people were concerned about their mattresses and bedding. Mattresses were not comfortable and the duvets had plastic covers, which meant covers constantly slipped off.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- The governance systems did not identify all risks within the unit. Where risks were identified by the trust they were not always addressed, in particular the lack of compliance with the same sex guidance and the isolation of the unit at night.
- There was no clear strategic leadership for the service. Senior staff within the unit did not meet to discuss issues affecting the service.

However:

- There was effective leadership of the nursing team.
- Staff morale and job satisfaction was high.

Summary of findings

Information about the service

Ash Villa is a 13 bed acute child and adolescent mental health inpatient unit for young people aged from 13 to 18.

Ash Villa primarily serves young people from Lincolnshire, but like all Tier 4 child and adolescent mental health services (CAMHS) inpatient units they can take young people from across England.

Ash Villa is located in a semi-rural setting on the outskirts of Sleaford and is a stand-alone unit. The building is an older single storey hospital style property within large grounds. Ash Villa school is sited within the same building.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell, Chief Executive of Oxford Health NHS foundation trust.

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

Inspection Manager: Lyn Critchley, Inspection Manager, mental health hospitals, CQC

The team that inspected this core service consisted of a CQC inspection manager, a CQC Mental Health Act reviewer; and a consultant psychiatrist and a nurse, as our specialist advisors with experience of working in child and adolescent mental health services.

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

Why we carried out this inspection

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

How we carried out this inspection

To fully understand 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 and spoke to commissioners of the service.

During the inspection visit, the inspection team:

- Spoke to six young people currently using the service.
- Spoke to three parents or carers of young people currently using the service.
- Reviewed 29 comment cards from people who used the service and staff working there.
- Interviewed the acting manager of the service.
- Interviewed 11 staff, including nurses, psychiatrists, psychologist and housekeeping.
- Reviewed eight care records.

- Reviewed 13 medication records.
- Attended a ward round.
- Observed two episodes of care.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

The young people we met were positive about the quality of their care. When asked to rate staff attitudes the group told us that they were mostly “10 out of 10”. One patient said that some staff “interact with the kids less like nurses and more like friends, [but] we’re still supported”. Another patient told us that their care had been “fantastic” when they were going through a rough patch. However, young people also commented that some staff seemed to spend more time than others in the office.

We also received 29 comment cards from young people who used the service. One of these was very positive about the service.

Good practice

The service had employed a therapy dog as a member of the team on the unit. We heard about numerous examples from young people and staff of how the dog defused and de-escalated situations. We saw that young people responded positively to the dog and it helped them engage with their care.

Parents/carers had regular slots in the ward round to ensure good communication and effective sharing of the decisions surrounding young people’s care.

The service had a dedicated discharge liaison nurse, who worked with community services and other agencies from the young person’s admission, to ensure packages of care were in place as soon as the young person was ready for discharge. The liaison nurse also attended care programme approach meetings for those young people who were placed out of area, for example, if they needed more secure provision. The nurse stayed in contact with those units to be able to facilitate a return to the home area and admission to Ash Villa, as soon as it was appropriate for the young person. Commissioners and community teams said this worked well.

Areas for improvement

Action the provider MUST take to improve

- The provider must address the breach in the guidance for same sex accommodation.
- The provider must ensure that the environmental and ligature risk assessment tools are fit for purpose. Risk assessments should cover all areas, including outside spaces.
- Staff must be fully trained to identify concerns.The provider must address the safety of the garden and ensure access is not restricted.

Action the provider SHOULD take to improve

- The provider should ensure capacity and consent is recorded and fully individualised to the young person’s needs and treatment.
- The provider should review staffing levels on the unit.
- The provider should review the pressure on psychology within the unit.
- The provider should ensure that access to hot drinks and snacks is not restricted.

- The provider should ensure that staff have an understanding of how the Mental Capacity Act applies to under 18's.

Lincolnshire 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
Ash Villa	Ash Villa, Willoughby Road, Greylees, Sleaford, NG34 8QA

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 within the unit displayed a good knowledge of the Mental Health Act. All qualified staff received mandatory training for this and the ward manager ensured healthcare assistants also attended, although it was not mandatory for them to do so.

At the time of our visit there was no one detained under the Mental Health Act. One patient had been detained at the start of their admission to the ward. Their records had been completed well, section 17 leave was clearly set out and recorded that a copy had been given to the patient and family carer.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the young people, where possible, in the decision making regarding their care.

Staff members understanding of how the Metal Capacity Act applied to young people was variable. Staff told us that their training said the Mental Capacity Act did not apply to under 18's so felt it was not applicable to their service. However, the training did cover Gillick competency in detail.

Capacity and consent recording was present but inconsistent. The ward had a standard admission form,

signed by the young person and their parent, recording their consent to admission and treatment. The ward doctor told us that patients' consent to medication was recorded in ward round notes. However six out of eight records had the same wording of "[the patient] demonstrated capacity to consent to [his / her] treatment plan including medication". On two records, including those of the patient who had been detained under the Mental Health Act, this section was blank.

Inadequate

Are services safe?

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

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

Our findings

Safe and clean environment

- The ward was an older single story building that had been converted to its current use. The ward was very clean and well maintained. However, there were blind spots across the unit because of the building's age and conversion. Staff were aware of this and managed these well with relational security, knowing where young people were and attempting to engage them if they were isolating themselves.
- We found several ligature risks within the unit. One of these was a known risk that had been identified in an audit by the trust in May 2015. It had not been addressed and was also present on the ligature audit of January 2014. This was a door closure on the telephone room, which the trust intended to remove but was still there on the day of our inspection. The bathrooms and toilets were fitted with some good anti-ligature fittings, such as blinds with magnetic drop rails. However, in the boys' shower and girls' shower there were blinds with permanent fixings which a person could weight bear on. There was a gap in the fixings that a cord could loop through. This was not identified in the recent trust health and safety audit in November, nor was it on the ward's most recent ligature risk assessment in May 2015. The trust had reported that in the most recent cycle of ligature audits there were no high levels of risk with regards to ligatures on Ash Villa. When we drew the to The trust acted immediately by removing the blinds in the showers and arranging for new safer blinds to be fitted once this was drawn to their attention
- The unit had innovative observation panels fitted on bedroom doors, which had privacy frosting on them that was removed electronically when staff pressed a button. This system also logged when staff activated the privacy panel, which gave the unit an accurate audit trail of when observations were completed.
- The garden was unsafe. It was not on the ligature risk assessment, despite numerous ligature risks. These included three strong light fittings at head height, trees, and play equipment. There were also several climb points to the roof which had not been identified on the trust health and safety visit. The garden was the size of a small park, with numerous places which staff would find difficult to observe. The back fence, by a housing estate, had blown down two weeks prior to our inspection and had not been repaired. The garden was not secured and had access to the main road. The unit had supervised access only to the garden, unless a patient had leave when they would be risk assessed. Staff assessed absconsion risk for young people using the garden and did not consider ligature risk. Young people said there was not enough access to fresh air, but they had used the garden more in better weather. The paths were a hazard due to very slippery and had not been pressure washed in some time. This had also not been identified.
- Staff on the ward wanted the garden to be improved. The previous ward manager had submitted a capital bid to address the garden in November 2014. However this had not been acted on by the trust.
- We raised our concerns about the safety of the garden to the trust at the time our inspection. The trust stated, "all service users are escorted in the garden area at Ash Villa". All young people currently on the unit were informal which meant the lack of fresh air access without supervision would be restrictive practice. The trust said a full ligature re-audit was to take place at Ash Villa the week after our inspection and that the capital bid had been approved to "create a safe outside space to allow unescorted access for service users". The trust said that following our concerns they had reviewed their policy guidance to ensure outside spaces were considered in future audits.
- Sleeping accommodation was down one long corridor. The bedrooms did not have ensuite facilities. Staff were able to zone the corridor to separate the young men from the young women. There were separate washing and toilet facilities for both males and females. However, young people would have to pass bedrooms occupied by the opposite sex to reach them. This is in breach of the Mental Health Act code of practice and same sex accommodation guidance. The trust was aware of this prior to our visit. The outline business case, prepared by the trust in November 2013 to consider a new unit, stated that "Ash Villa unit is not compliant in the provision of gender specific accommodation".

Inadequate

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- The ward had two clinical rooms which were well ordered, clean and tidy. One was a converted bedroom, with a couch and other equipment for physical exams such as scales and a spyghmometer for taking blood pressure.
- The second clinic room had medication cabinets, drug fridge and emergency response equipment. Young people accessed this room for interventions such as having blood taken. We were concerned that this room also contained industrial electrical equipment that would normally be found in a plant room. Nursing staff had to lean over this equipment to reach the left side of the drug cabinet where the controlled drugs were stored. The clinic room was hot with heat from the equipment. Daily monitoring by staff showed the fridge was maintaining a safe temperature. Opposite the electrical plant equipment was the emergency response bag and a bottle of oxygen. Under the Dangerous Substances and Explosive Atmospheres Regulations 2002 the trust has a responsibility to identify dangerous substances in their workplace and what the inherent risks are. This would include oxygen. On both the fire risk assessment and environmental risk assessment, dated the 19th November 2015, the trust did not identify the oxygen stored in the clinic room as a risk or consider the close proximity to the electrical plant equipment. The trust relocated the oxygen and were considering moving the clinical room after we raised this with them.
- The unit had regular housekeeping staff who knew the unit well. The ward was very clean at the time of our inspection, with cleaning schedules followed. In the most recent patient led assessment of the care environment (PLACE) data Ash Villa scored 100% for cleanliness, better than the 97.6% England average.
- Equipment within the unit was clean and well maintained. Clinical equipment had service dates clearly displayed and also the dates they were cleaned. Electrical equipment was regularly PAT tested. The only exception to this was the suction machine in the clinical room. Although staff checked this daily, it had not been serviced or PAT tested since 2006. Other equipment in the same room had been tested and serviced.
- The seclusion room had not been used at all in 2015. It was being decommissioned and work had commenced to install electrics to enable the room to be used as a quiet room. Sensory equipment and bean bags had been placed in the extra care area which was being used for de-escalation and relaxation.
- Staff within the unit had individual alarms, which were tested regularly.

Safe staffing

- The ward ran on staffing levels of two qualified nurses and two support workers during the day. There was an activities coordinator every day during the hours of nine to five. On weekdays the ward manager, one of the deputy managers and a discharge liaison nurse were on the unit during office hours. On evenings a support worker worked from 5pm to midnight.
- Staffing levels were low and potentially unsafe, particularly at night. After midnight the unit had only three night staff on duty to look after 13 young people. This did not provide enough staff if a restraint took place and there had been incidents. Ash Villa is an isolated unit, in a semi-rural location, with no other inpatient units nearby that would be able to provide support in an incident. For example, the risk was demonstrated in the week prior to our inspection when there was an incident at night. A young person was so agitated that the staff on duty called the police. When the police attended the young person was placed in handcuffs until de-escalation was successful. There were only three staff on duty on the night of this incident. We raised our concern about night staffing levels with the trust and they immediately raised the staffing levels to four staff at night. This was identified as a concern on the trust risk register as a lone site. The trust risk register stated there was a mitigation plan in place. Staff on the unit could not tell us what the mitigation plan was and the trust did not provide one when requested. Staff said that if they needed emergency support they would call for extra staff, ring the oncall manager or call 999 at night. There was not a formalised protocol in place for this. Staff could not explain who would be calling for assistance or observing the other 12 patients if they had to restrain a young person..
- Staffing at weekends was also low. Although there was supposed to be an activities coordinator on duty during the day, one was currently on long-term sick leave. This left four staff on duty at weekends during the day, when no activities coordinator was available. Young people did raise lack of activities at weekends as an issue.

Inadequate

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- The ward did not use agency nursing and was able to fill all of its shifts using the trust bank or its own staff team. The service had several regular bank staff, including staff who had retired from the unit but regularly returned to cover shifts.
- Sickness rates were low; the previous three months had all been below 4%. August had only been 0.7%.
- The trust ran a band five nurse rotation scheme, providing newly qualified nurses a two year fixed contract where they would rotate for six months at a time between specialties including acute wards, forensic and Ash villa. The ward manager described how this had been successful in attracting staff to work in CAMHS inpatients.
- Mandatory training rates showed that whilst the trust target of 95% was not reached, the compliance was acceptable. For example, only 2 out of 25 staff were not up to date with safeguarding training.
- Both doctors on the unit had clinical time in the community each Thursday. Although they were contactable by phone this did cause delays. The ward had asked the clinical director for the scheduling of this to be reviewed, but this had not yet been resolved.

Assessing and managing risk to patients and staff

- Risk assessments and care plans were in place and were updated when appropriate. For example, when one patient was involved in an incident on the ward their risk assessment and care plan was updated to reflect this.
- There had been very few restraints on the unit, with only five incidents in the six months before our inspection. Three of these had been in the previous week for one young person. We saw detailed discussion of this in the ward round, with risk assessments and care plans in place to address the person's needs. Staff were skilled in de-escalation techniques and able to describe how they would only use restraint as a last resort.
- Young people said they felt safe as staff always managed incidents calmly and well. Young people said staff moved others quietly out of the area of the incident and offered support to everyone on the unit, checking on their well being afterwards. For example, young people told us they had all been offered support after an incident the previous week when the police had been called.
- There were clear guidelines on when staff could search patients, with consent sought each time. If there was a refusal then observations on that young person were increased.
- We heard from young people and staff that there were scheduled break times for hot drinks and snacks. Coffee and tea had to be drunk in the dining room, but young people were provided with refillable bottles for water which they could carry throughout the unit.
- Medicines management practice was good. We reviewed all 13 medication charts and found them to be well completed with no errors. A pharmacist regularly attended the unit ward round and worked with the doctors. There was an effective system for the doctors and pharmacist to ensure medication was correct when young people were admitted.
- Safeguarding on the ward was good. There were issues in accessing the mandatory training, which was provided by the local authority safeguarding board. However, staff displayed good safeguarding knowledge. Staff told us they had good access to the trust safeguarding nurse who visited the unit regularly. The ward and trust safeguarding nurse had been proactive in looking at safeguarding issues with the local authority as they had been concerned that they were not always receiving responses to alerts they raised. This resulted in a new protocol on how the local authority would respond to alerts from the unit. A recent safeguarding concern had been acted on promptly and appropriately by the trust and other agencies. Staff had kept the young person's family/carers informed of all actions taken.

Track record on safety

- There had been one serious untoward incident in the last 12 months at Ash Villa, involving a young person on home leave. There had been a comprehensive review of this, with appropriate support put in place and learning from the incident shared with all staff.

Reporting incidents and learning from when things go wrong

- The trust's electronic recording system showed that 379 incidents had been reported at Ash Villa in the last 12 months. All staff in the unit could record incidents, and we saw that they were comprehensively doing this. For

Inadequate

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example, if a patient had a disturbed period over several hours with more than one incident of self-harm, each occurrence of self-harm was recorded as a separate incident.

- Incidents were discussed in the ward round and at team meetings. Lessons learnt were disseminated and acted upon. For example, we saw that in the emergency response bag there was a set of wire cutters. Staff explained that there had been an incident where a young person had used the spiral wire from a notebook to make a ligature. The standard ligature cutters which are designed for fabric were unable to cut this easily, so the trust purchased wire cutters to ensure safe practice in future.

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.

Our findings

Assessment of needs and planning of care

- Comprehensive assessments were completed in all the care records we reviewed. These were updated regularly as patients' needs evolved.
- Physical examinations had taken place on or near admission. The unit used a "track and trigger" health monitoring system, with patient observations being taken on at least a weekly basis, with any concerns being swiftly addressed.
- Care plans covered a wide range of needs and were updated when appropriate. For example, one young person had a "positive and proactive management of violence and aggression care plan" which detailed the action to be taken, should that patient (who had a particular medical condition) need to be restrained. The unit had involved other departments in the trust, including their physical intervention trainers, in the development of the risk assessment and care plan. However, although care plans were wide ranging and individualised, they were formally written rather than age appropriate accessible plans. Young people's involvement was not clearly recorded.
- Staff were confident in the use of the electronic record systems and were able to demonstrate where different parts of records were stored.

Best practice in treatment and care

- The service was innovative in its approach to engaging young people. The service had employed a therapy dog as a member of the team on the unit. We heard numerous examples from young people and staff about how the dog defused and de-escalated situations. Young people responded positively to the dog, who was calm and placid. Young people engaged with staff because the dog was present. Staff and young people said that because the dog goes to the ward round with the psychologist, young people often go in because the dog is there and they get to sit with it.
- We saw good evidence of staff following NICE guidance when prescribing medication. For example, during a ward round the psychiatrist and pharmacist discussed the high levels of medication that a young person, who had just been admitted to the unit, had been prescribed in the community. The multidisciplinary team agreed to change this in line with NICE guidance and agreed how to mitigate any side effects with support from the nursing team.
- The unit offered a range of psychological therapies recommended by NICE for this patient group. This included eye movement desensitization and reprocessing (EMDR) therapy, cognitive behaviour therapy, art therapy and attachment work. The unit also provided family work, although no formal family therapy was offered which was unusual for as it is part of the NHS England service specification for CAMHS inpatient services.
- Young people told us that the doctors responded quickly to any physical health concerns and that they would get swift treatment. For example, staff had arranged a prompt dental appointment for a young person who was experiencing pain.
- The service had access to a dietician who attended the ward round. Kitchen staff received regular updates on any recommendations they made to young people's diets.
- The unit used a variety of rating scales, including HONOSCA and the recovery star. Young people's individual outcomes and progress were collated and discussed in ward rounds.

Skilled staff to deliver care

- The service had a range of professions, as well as the nursing team, including the consultant psychiatrist and a specialist doctor. The ward had access to a dietician who attended once a week. A pharmacist provided regular input and an art therapist visited three days a week. The ward occupational therapist was currently acting deputy manager so this reduced their clinical time to half a week. The service did not have access to a family therapist.
- Family work and other therapeutic interventions were coordinated or delivered by the psychologist. The psychologist was well respected and liked by patients and other members of the clinical team and had been the driving force behind the effective innovation of the ward dog. However, the psychologist only worked three days a week on the unit, supported by a psychology assistant three days a week, which put considerable pressure on them.

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.

- The ward dog was employed by the trust with full risk assessments completed, including infection control. The dog wore a trust lanyard for a collar and had a personnel file. The dog lived with the ward psychologist, with other ward staff looking after him when the psychologist took annual leave.
- The ward had volunteers who visited the unit and led activities, such as bingo. This was in addition to two full time activity coordinators who worked seven days a week. A yoga instructor was employed to visit the ward three times a week to provide sessions for young people.
- Housekeeping staff, including cooks and cleaners, were employed specifically for the ward and had regular training appropriate to their needs.
- Clinical staff were appropriately qualified, had a comprehensive induction and had regular training specific to the unit's needs and their development.
- There was regular supervision for staff every four to six weeks and yearly appraisals.
- The ward had its own school on site. Teaching staff were employed by the local authority who ran the school.

Multi-disciplinary and inter-agency team work

- There was a well-functioning multidisciplinary team. We observed a focussed patient orientated approach from all the clinicians.
- The ward round discussed all young people open to the service, and new referrals and young people out of area. Young people could attend the ward round each week. Although this was not compulsory, the staff gave a lot of encouragement for young people to attend to discuss their care. Each week the ward allowed parent/carers to join the ward round. There were six slots a week, which parent/carers could book into or were invited to. The invites could be more frequent if there were concerns. This worked well as parent/carers told us that they felt involved in the decisions and had an understanding of their child's progress. The ward round followed a clear process. There was a team discussion, followed by the patient and then parent/carer joining the meeting. A plan was agreed. This was then recorded on the patient's electronic record during the meeting, which was displayed on a screen for all in the team and the young person and family/carer to see. The screen also allowed reports to be displayed, along with outcome measures, to help the young person and clinical team understand their progress.
- The service had a dedicated discharge liaison nurse who worked with community services to ensure a smooth transition back into the community. This work started from admission. This worked well and ensured good working relationships with the other agencies involved in young people's care.

Adherence to the MHA and the MHA Code of Practice

- Staff within the unit displayed good knowledge of the Mental Health Act. All qualified staff received mandatory training for this and the ward manager ensured healthcare assistants also attended, although it was not mandatory for them.
- One patient had been detained under the Mental Health Act at the start of their admission but was now informal. A review of their records showed them completed well, for example section 17 leave was clearly set out and had recorded that a copy had been given to the patient and family carer.

Good practice in applying the MCA

- The Mental Capacity Act does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the patients where possible in the decision making regarding their care.
- Staff told us that their training said the Mental Capacity Act did not apply to under 18s which is not the case. However, the training did cover Gillick competency in detail.
- Capacity and consent recording was present but inconsistent. The ward had a standard admission form, signed by the young person and their parent, recording their consent to admission and treatment. The ward doctor told us that the consent to medication was recorded in ward round notes. However six out of eight records had the same wording of "[the patient] demonstrated capacity to consent to [his / her] treatment plan including medication". On two records, including those of the patient who had been detained under the Mental Health Act, this section was blank.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- The patients we met were positive about the quality of their care. When asked to rate staff attitudes the group told us that they were mostly "10 out of 10". One patient said that some staff "interact with the kids less like nurses and more like friends, [but] we're still supported". Another patient told us that their care had been "fantastic" when they were going through a rough patch. However, patients also commented that some staff seemed to spend more time than others in the office. Young people told us that all staff were caring, including housekeeping.
- We received 29 comment cards from young people who used the service. One of these was very positive about the service.
- We observed that staff were polite, respectful and caring to young people, and in their interactions with their parents/carers. For example, one young person was isolating themselves and refusing to engage with staff or activities. Throughout our visit staff repeatedly tried to engage, being calm and respectful to the young person even when the response back was challenging. This approach was successful with the young person engaging briefly in activities later in the day. Staff showed they could be assertive whilst being respectful in enforcing boundaries and encouraging young people to engage.
- Staff were able to communicate at an appropriate level to the young people, with a good rapport and humour, whilst maintaining professional boundaries.
- All staff had a good understanding of the individual patient's needs. This included housekeeping staff, who were aware of any concerns or risks surrounding young people, even if they didn't know all the details. The housekeeping staff also displayed good rapport with the young people.
- All staff, including clinicians, housekeeping and teachers, spoke of the satisfaction they had at seeing young people progress during their stay. One staff member described it as a "joy" and couldn't think of doing anything better.
- The PLACE data for privacy, dignity and wellbeing for Ash Villa was low at 79%.
- The trust surveyed young people on discharge about their experience of Ash Villa. 71% said it was certainly true that "I feel that the people who saw me listened to me" and 29% felt that was partly true. 86% of young people felt that "I was treated well by the people who saw me" was certainly true, with 14% stating it was partly true.

The involvement of people in the care they receive

- Although care plans were wide ranging and individualised, they were formally written rather than age appropriate accessible plans. However, this appeared to be in the way that they were recorded and written not reflecting the involvement that young people had. Care plans were reviewed and updated each week in ward round with the young people present and young people told us that staff would go over them individually.
- The involvement of families and carers in the ward round, on a regular basis, was good practice and ensured that the progress of the young person was shared.
- There were regular visits from advocacy and information about accessing the service available.
- Young people were encouraged, in regular community meetings, to be involved in decisions surrounding the service. Examples of this included picking soft furnishings, art decals for the walls, being involved in the recruitment of new staff and working on the welcome packs.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Ash Villa had an average bed occupancy of 96% and was full at the time of our visit. Although primarily serving young people in Lincolnshire and surrounding counties the service could take young people from anywhere in the country.
- Commissioners in NHS England described the service as responsive to referrals and that they considered admissions carefully.
- The service had a dedicated discharge liaison nurse, who worked with community services and other agencies from the young person's admission to ensure packages of care were in place as soon as the young person was ready for discharge. The liaison nurse also attended care programme approach meetings for those young people who were placed out of area, for example, if they needed more secure provision. The nurse stayed in contact with those units to facilitate a return to the home area and admission to Ash Villa, as soon as appropriate for the young person. Commissioners and community teams said this worked well. The smooth transition out of the unit when young people were ready resulted in the service being able to facilitate up to six admissions a month, with an average stay of 73 days.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had three separate lounge areas, one designated for females only, with a separate dining area which was locked when not in use. There were also separate therapy rooms, such as an art room and visiting room.
- The unit was pleasant and decorated appropriately for the young people, with stencil murals they had chosen across several large walls.
- Furniture was comfortable and in good condition, with young people involved in the choice of soft furnishings such as cushions. Although young people agreed the furniture was comfortable they said that the mattresses were not and the duvets had plastic covers, which meant covers constantly slipped off. This concern had been raised by young people previously and was recorded in the community meeting minutes, with the ward response being that it was necessary for infection control.
- Young people were able to personalise their bedrooms to some extent by putting pictures and posters on a small white board. There was a secure place to store possessions in the laundry room, with individual lockers. Staff facilitated access to these.
- The ward had scored 87% in its PLACE score for food and hydration, slightly lower than the England average of 89%. However, all the young people we spoke to said there was a good choice and quality of food was good. The ward had its own kitchen staff who cooked the meals fresh on site. It was a set six-week rotation menu with a wide range of options. However, the kitchen staff had the ability to change this and purchase their own supplies to meet young people's dietary needs and to respond to advice from the dietician. The kitchen had received a five star rating for hygiene by environmental health in February 2015 - our inspector was immediately requested to wear PPE on entering the kitchen by the kitchen manager.
- Young people and staff said there were scheduled break times for hot drinks and snacks. Coffee and tea had to be drunk in the dining room, but patients were provided with refillable bottles for water which they could carry throughout the unit. Young people described the break times as regimented.
- Young people were able to use mobile phones (without a camera function) in the evenings and at weekends. There was also a wall mounted telephone in a room which offered privacy.
- Ash Villa had its own school on site that was run by the local authority. The school had last been inspected by Ofsted in 2012 and was given an overall rating of good. Ofsted had rated the leadership within the school, the behaviour and safety of children, as outstanding. The school was connected to the main unit, but the local authority owned the building. There were three well-equipped classroom areas, each designed for different key stages. The post-16 classroom was used the most. The school was a clean, safe and visually stimulating environment, with lots of natural light. In addition to the classrooms there was a well-equipped music studio and gym. The school also had a small-enclosed safe garden area that young people attending had helped develop.

Are services responsive to people's needs?

Good

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

This was not available to the main unit outside of school time. The school provided a broad curriculum and had good links to the local schools to help continue young people's learning. The school was also able to demonstrate how they had helped young people to re-engage with education during their time at Ash Villa and recommence education at their local school following discharge. Communication between the clinical staff and the school was good, with teachers receiving a daily handover and the headteacher attending ward round. The school provided reports to the multidisciplinary team on young people's progress and also for discharge. Young people reported that they enjoyed the trips out the school undertook with the ward staff, in particular the morning walks. One person said they wished there were weekend walks too.

- Three young people said that there weren't enough groups and therapies, especially at weekends. The activities co-ordinator post covered seven days per week, but one of the two part time post holders was not currently at work. One young person said that it could be quiet at weekends and that they played on a games console.

Meeting the needs of all people who use the service

- The unit was on the ground floor and had appropriate access for disabled people.
- Information and welcome packs had been designed with young people on the unit and were age appropriate, with relevant information delivered in a style the young people had chosen. There was a separate pack for parents.
- The ward did not hold any information in different languages as they had never been needed due to the demographics of the local population. However, there was a clear system to send information to the trust communication department who would provide a translated version within 24 hours if necessary. Access to interpreters could be booked when required.
- Information was available on services, patients' rights, how to complain and advocacy.
- Staff supported young people to follow their beliefs. The ward had a prayer cupboard with a range of materials including prayer mats. The ward also helped young people attend worship. For example, staff had recently facilitated a young person to attend a local church and its week night youth group. Initially staff escorted the young person, but as their health improved the ward checked the DBS clearance for the youth workers at the church and then arranged for these youth workers to collect and take the young person to church activities.

Listening to and learning from concerns and complaints

- Young people and families told us they knew how to raise concerns.
- There had been seven complaints within the last year. One of these was still currently open and being investigated. All the complaints had been fully reviewed by the manager and resolved locally, with a full record of the concerns, decisions and outcomes available.
- The unit had a large compliments folder, full of thank you cards and letters from families and young people who used the service. This was available for staff to read, however the ward did not log or collate the numerous compliments it received.

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.

Our findings

Vision and values

- Staff on the unit were not aware of the trust's vision and values. However, they were all committed to the young people they looked after with a shared ideal to see young people progress.
- Senior managers within the trust visited the service regularly. For example, the trust chair and chief executive had visited at the beginning of October, and the previous director of nursing had visited to say goodbye to staff before they retired.

Good governance

- The governance systems, including the application of the ligature audit and environmental risk assessments, did not identify all the risks within the unit. Where risks were identified by the trust they were not always addressed, in particular the lack of compliance with the same sex guidance and the isolation of the unit at night. The trust was aware that Ash Villa was noncompliant for same sex accommodation in 2013, however, this was not on the risk register and action had not been taken to address this. The unit was on the trust risk register as a lone site. However, staff on the unit were not aware of the mitigation plans the trust cited, and staffing at night had not been adjusted until we raised it to mitigate this risk.
- The ward had better compliance with mandatory training than the trust records showed. This appeared to be because of delays in the governance systems recording of the training on people's records.
- Other governance systems, including incident reporting and complaints, were robust.
- There was good supervision, both managerial and clinical, with high quality of supervision records.
- The unit used a variety of clinical rating scales, including HONOSCA and the recovery star. Young people's individual outcomes were collated and used in clinical decision making, including discharge, but the unit did not aggregate all young people's data to monitor the service's performance as a whole.
- The service collected feedback data from young people and parents on a regular basis using a variety of methods, including an ipad application and questionnaires to people's homes. The data for this was collated in a visual pie chart format and displayed in the unit.

Leadership, morale and staff engagement

- There was no clear strategic leadership for the service. There was no business section to the ward round and the doctors did not attend staff meetings. Senior staff within the unit, such as the ward manager, psychologist and consultant psychiatrist, did not meet to discuss issues affecting the service.
- Staff were not engaged in decisions surrounding the service by the trust. The decision for the unit not to be moved to a new build had not been communicated well. Staff were not aware of what was happening with essential work, such as the capital bid for the garden.
- The ward manager was acting up from the deputy manager role following the previous ward manager being moved in May 2015 to help another service. The acting ward manager was due to move at the beginning of 2016 to be the ward manager of another service. The permanent position had been recruited to.
- The acting ward manager was well respected by staff, young people and commissioners, who spoke highly of them. Staff felt supported by the manager. The manager was due to leave the service at the beginning of 2016 and the permanent position had been recruited to.
- Morale was good amongst the staff team, with a sense of satisfaction and enjoyment by the staff team in the work they did. One member of staff told us that if their child were ill they would be happy for them to be treated on the ward.
- All staff felt able to raise concerns without fear of victimisation and all believed those concerns would be acted upon.
- Staff understood duty of candour. We saw records of when the ward manager had contacted parent/carers following complaints or incidents explaining what had happened.
- Staff were actively encouraged by the trust to develop leadership skills. For example, the acting deputy ward manager was the unit's occupational therapist whose leadership potential was identified and they were given the opportunity of a management role with leadership training provided.

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.

Commitment to quality improvement and innovation

- The service was registered with the quality network for inpatient CAMHS (QNIC). A submission had been made for accreditation, but this was deferred pending more survey results of young people and carers' experience.
- The service had been innovative in the introduction of the ward dog and a dedicated liaison discharge nurse.

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 The trust are not effectively ensuring that care and treatment is provided in a safe way for patients, by assessing the risks to the health and safety of patients of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. 12 (2) (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. • The provider must address the safety of the garden and ensure access is not restricted. • The provider must ensure that the environmental and ligature risk assessment tools are fit for purpose. Risk assessments should cover all areas, including outside spaces. Staff must be fully trained to identify concerns.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Ensuring the privacy of the service user: People using services should not have to share sleeping accommodation with others of the opposite sex, and should have access to segregated bathroom and toilet facilities without passing through opposite sex areas to reach their own facilities. • The provider must address the breach in the guidance for same sex accommodation. Regulation 10 (2)(a)