CareQuality Commission

Outstanding ☆

Pennine Care NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

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Date of inspection visit: 14 June 2016
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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)
RT210	Heathfield House	Hope unit	BL9 7TD
RT210	Heathfield House	Horizon unit	BL9 7TD

This report describes our judgement of the quality of care provided within this core service by Pennine Care 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 Pennine Care NHS Foundation Trust and these are brought together to inform our overall judgement of Pennine Care 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	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

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 child and adolescent mental health wards as outstanding because:

The wards provided safe, secure environments. There were effective systems to maintain safety and security.

The Royal College of Psychiatrists' quality network for inpatient child and adolescent mental health services review team had assessed the service in 2015 and both wards were accredited, Horizon as excellent.

Staff respected and valued patients as individuals and empowered them as partners in their care. There was a strong, visible person-centred culture. Putting patients at the centre of the service, involving and empowering them was clearly embedded. Staff treated patients with dignity, respect and kindness and the relationships between them were positive. These relationships were highly valued by staff and promoted by managers.

The emphasis on patient involvement was obvious across the service. There was a genuine commitment from all staff. Patients were involved in recruiting staff and the young people's council had a voice in governance. Through the council, patients were actively involved in plans for service developments and improvements.

There was a strong recovery focused ethos. Staff worked within the principles of the 'my shared pathway' model. They focused on helping patients to concentrate on their goals for recovery and the progress they had made towards the outcomes they wanted to achieve. This meant that staff ensured patients did not stay in hospital longer than necessary and promoted patients' early discharge.

There was a large, outdoor therapeutic space called the woodland retreat that was used by patients for time off the ward in a safe environment.

There was a good governance structure to drive the delivery of high quality person-centred care. Managers prioritised safe, high quality, compassionate care and promoted equality and diversity.

Managers encouraged continuous improvement and there was excellent commitment to quality improvement. There was a culture of collective responsibility across the service.

However:

There was a blanket restriction on the use of mobile phones.

We found that on one occasion when a patient was cared for in the extra care area, staff had not adhered to either the Mental Health Act Code of Practice or the trust policy and did not provide the necessary safeguards to the patient.

Summary of findings

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

Are services safe?

Outstanding ☆

We rated safe as outstanding because:

- There were effective systems to maintain safety and security, including innovative use of technology.

- The wards provided safe environments that were suitable for caring for patients. Staff reviewed risks at daily handover meetings and at ward rounds. They were aware of the risks on each ward and explained how they managed them.

- Staff and patients assessed and managed individual risks together. Risk assessments were person-centred, proportionate and reviewed regularly. Staff recognised and responded appropriately to changes to risks in patients.

- There was a clear culture of positive risk taking. Staff had made efforts to relax restrictions in some areas. Not all patients who had been out were searched on returning to the wards. This was individually care planned and there was a policy that provided guidance for staff.

- Staff showed good understanding of safeguarding issues and explained how to make a safeguarding alert. There were good links with the local safeguarding authority. Safeguarding information was displayed in the wards. The wards had safeguarding leads and there was a trust safeguarding lead. Social work staff also provided guidance.

- Staff understood their responsibilities in relation to reporting incidents. Openness and transparency about safety was encouraged. Managers analysed adverse events to identify any trends and they took appropriate action in response. They fed this back to the teams so that staff understood risks and provided a clear, accurate and current picture of safety.

- Learning from incidents was shared. Lessons learned were communicated widely to support improvement in other areas as well as services that were directly affected. Opportunities to learn from external safety events were also identified.

However:

- There was a blanket restriction on the use of mobile phones.

Are services effective?

Good ●

We rated effective as good because:

Summary of findings

- There was a strong recovery focused ethos. Staff focused on helping patients to concentrate on their goals for recovery and the progress they had made towards the outcomes they wanted to achieve. Patients' individual needs and preferences were central to planning and delivering care.

- Staff were developing baseline assessment tools for relevant national guidelines that considered the action needed to implement the guideline and associated risk if they did not implement it.

- Patients were involved in the development and evaluation of new psychology groups in a number of ways, for example, using group discussions and questionnaires. The psychology team then used this information, alongside guidelines and evidence-based treatment protocols, to develop group programmes that offered accessible interventions that fit with patients' goals, interests and abilities.

- Collaborative team formulation was embedded in clinical practice. Formulation meetings included discussion of reports and observations made by patients, then staff developed a formulation letter with each patient. An article had been published in professional journals highlighting the service's work on team formulation.

- Staff had set up physical health clinics and developed a physical health file to standardise physical health care and monitoring and ensure it was safe and robust. They had presented this innovative approach at the Royal College of Psychiatrists' quality network for inpatient child and adolescent mental health services national forum in June 2015.

- The Royal College of Psychiatrists' quality network for inpatient child and adolescent mental health services review team had assessed the service in 2015 and both wards were accredited, Horizon unit as excellent.

- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Most staff had received additional training to enable them to carry out their roles.

- Staff recognised the benefit of close working with allied health professionals and care from a range of different disciplines was coordinated. The multidisciplinary team worked closely to plan patients' care and treatment in a holistic way. There was frank, open and respectful discussion with patients. In light of risk evidence, the multidisciplinary team explored options to increase levels of patient responsibility.

Summary of findings

- There were established positive working relationships with other service providers such as GPs, schools and colleges. Education staff from mainstream schools and colleges attended patients' care programme approach meetings and so were kept informed of their progress whilst in hospital.

However:

- Staff had not adhered to either the Mental Health Act Code of Practice or the trust policy when caring for a patient in the extra care area and did not provide the necessary safeguards to the patient.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- There was a strong, visible person-centred culture. Staff respected and valued patients as individuals and empowered them as partners in their care. There was clear evidence that staff recognised and respected patients' needs. Patients were involved in influencing their care and treatment or the service at the hospital in a number of ways, including planning for their discharge.

- Staff had secured funding to train a parent as an 'expert parent' who would provide support for others. Staff offered support to patients' families and friends to ascertain their needs and that of the family. There was a group for parents and carers that offered support and training and information sessions on topics such as recovery and anorexia.

- Staff had reviewed the effectiveness of community meetings to ensure they promoted participation and inclusion. They ran focus groups on both wards to understand what patients wanted from their community meetings and how to improve them. Patients developed a format for the meetings and requested that senior staff attend.

- Patients were involved in delivering group therapy sessions alongside the psychology team. Staff and patients had co-developed new psychology groups called 'fighting talk', against illness or difficulties, drawing on narrative therapy approaches, and 'becoming yourself again', a programme to explore values and ways to work with these despite difficulties, using acceptance and commitment therapy approaches.

- Patients were involved in governance via the 'young people's council'. The council's role was to be involved in the design and commissioning of services. It offered consultations and input to

service level developments by meeting with senior managers, joining service level discussions and reviewing documents and ideas. Managers provided feedback to the council about how their input had influenced decisions.

- The wards used iPads to encourage patients to take part in surveys. Staff found patients were more likely to complete a survey using this method, as it was immediate. Patients had devised the questionnaires. The completed surveys were sent to the trust patient experience team and the findings could be received the same day.

- There was an information board designed by patients that explained various sections, rights and responsibilities under the Mental Health Act using collage, pictures and colourful lettering. This made the legal complexities of the Mental Health Act easier and straightforward to understand.

- On the walls all around the wards, there were posters with tear off strips that had a positive affirmation written on them. Patients could tear these off as they moved around the ward and use them to help improve their confidence and self worth.
- Staff actively promoted advance decision making so that all staff could understand how each patient would like to be cared for when they were not well.

Are services responsive to people's needs?

Outstanding ☆

We rated responsive as outstanding because:

- Planning for discharge, transfer or transition to other services, including potential future placements or a return to school or college, began at the earliest possible stage. The model of care included a clear discharge pathway. Discharge arrangements were considered from the time patients were admitted, to ensure they stayed in hospital for the shortest possible time.

- Care and treatment was coordinated with other services and other providers. Staff worked closely with care coordinators to ensure that patients received help through their discharge. Discharges or transfers were discussed in the multidisciplinary team meeting and managed in a planned and coordinated way.

- Patients were involved in the design and delivery of services via the young peoples' council. Their individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, offered choice and ensured continuity of care.

Summary of findings

- Staff took a proactive approach to understanding the needs of different groups of patients and to delivering care in a way that met their needs and promoted equality.

- There was a large, outdoor space, known as the woodland retreat, that patients used for time off the ward in a safe, therapeutic environment. It was used for many activities including social, educational and therapeutic. The woodland retreat had been developed through grant funding from the King's fund, secured by a joint bid between patients and trust staff.

- The wards each had a full timetable and each patient had an individual timetable of evidence-based therapies, interventions and planned activities.

Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The leadership, governance and culture were used to drive delivery of high quality person-centred care. Staff understood the vision and direction of the service they worked in and about how their work linked into the trust's vision and values. They described an ethos that promoted safe, early recovery.

- Staff had regular contact with the senior management team. They understood the leadership and management structures in their service and they knew who the senior managers were. The model of leadership encouraged and supported staff to be involved in the governance process.

- There was a good governance structure to oversee the service. Business meetings took place where performance and wider service issues were discussed. This included information from patient community meetings. Meetings were well structured, informative and productive, addressing quality issues clearly.

- Managers encouraged cooperative, supportive relationships among staff. Staff were proud of the service as a place to work and they spoke highly of the culture. They felt respected, valued and supported, and were positive about their jobs. They reported good multidisciplinary team working. Staff were supportive and caring towards each other.

- There was excellent commitment to quality improvement. Staff enjoyed their work and were proud of the culture of care. There was strong collaboration and support across the teams and a common focus on improving patients' experiences.

- There was a culture of collective responsibility across the service. Candour, openness, honesty and transparency and

Summary of findings

challenges to poor practice were encouraged. Staff were encouraged to discuss issues and ideas for service development within supervision, business meetings and with senior managers. There was evidence of a number of initiatives to improve the service, including partnerships with external bodies.

Summary of findings

Information about the service

The service provided tier four child and adolescent mental health services delivered in specialist inpatient settings. The care focused on children and young people who had severe or complex mental health conditions that could not be adequately treated in the community or who needed extended assessment or treatment.

The child and adolescent mental health inpatient services provided by Pennine Care NHS Foundation trust were in two settings.

The Hope Unit was a 12-bed unit opened in 2008. It provided an acute psychiatric inpatient service for patients aged 13 to 18, in an age appropriate environment. The unit provided intensive assessment and treatment for patients with mental illness or psychiatric disorder for which enhanced community treatment was no longer viable or safe. This included patients detained under the Mental Health Act.

The Horizon Unit was a 10-bed unit opened in 2010. It provided a responsive inpatient service for patients aged 13 to 18 with severe or enduring mental health difficulties. This included patients detained under the Mental Health Act, the Children Act or who were admitted on an informal basis. The unit provided a safe environment coupled with therapeutic interventions. Its focus was the rehabilitation of young people with complex and enduring mental health needs.

Both wards had access to the woodland retreat, a large, outdoor therapeutic space that patients used for time off the ward in a safe environment.

Both units admitted patients from across five boroughs of Greater Manchester, those being Bury, Oldham, HMR (Heywood, Middleton and Rochdale), Tameside and Glossop, and Stockport.

We carried out Mental Health Act monitoring visits in January and May 2016.

This core service had not been previously inspected by the Care Quality Commission.

Our inspection team

Chair: Aidan Thomas, Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Sharron Haworth, Inspection Manager, Care Quality Commission

The team that inspected child and adolescent mental health wards comprised two CQC inspectors, a CQC pharmacy inspector, a Mental Health Act Reviewer and three specialist advisors with experience of child and adolescent mental health services in nursing, occupational therapy, social work and psychotherapy.

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?

Summary of findings

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

During the inspection visit, the inspection team:

- visited both wards and looked at the quality of the ward environment and observed how staff were caring for patients
- visited the woodland retreat and looked at the therapeutic environment
- spoke with five patients who were using the service
- spoke with four carers
- spoke with two managers
- spoke with nine other staff members; including activities staff, education staff, health care support staff, psychiatrists, psychologists, qualified nurses and social workers

- attended and observed two hand-over meetings, one multi-disciplinary meeting, one group session and a one-to-one session between a staff member and a patient.

- looked at 17 care and treatment records of patients
- checked 23 prescription charts
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service
- received feedback from commissioners of the service
- looked at 27 staff records.

What people who use the provider's services say

We met with five patients and four carers.

Patients told us they felt well supported by the staff. They said the staff were kind and respectful towards them. All agreed that the staff were approachable, available and caring. Patients felt they had good relationships with all staff. They said staff were always available for one-to-one sessions. Carers said staff kept them up to date with their child's progress and they had a copy of all relevant information and documents.

Patients said the teaching staff were supportive. They had regular lessons and could get help with work if they needed it. Some were taking GCSEs and staff supported them with their studies.

Patients told us they were involved in planning their care and had copies of their care plans. They said staff actively encouraged them to engage. Their families and carers were encouraged to be involved in the care planning

process. Patients felt their mental health had improved because of the service they received. They understood their rights under the Mental Health Act. Their physical health was also monitored.

Patients said there were plenty of activities available to meet their individual needs, including at weekends. They said activities were rarely cancelled. They said there were opportunities to be involved in service provision, through community meetings, the young peoples' council and being involved in staff recruitment.

Patients said the food was good but some did not like the menus and did not think there was enough choice.

Patients told us they had access to spiritual support but had no wish for it.

Two patients said they were not sure how to make a complaint but would speak to staff if they needed to.

Good practice

Staff were developing tools to assess what they needed to do to implement national guidelines, and the associated risk if they did not implement guidance.

Patients were involved in the development and evaluation of new psychology groups.

Collaborative team formulation was embedded in clinical practice.

Staff had set up physical health clinics and developed a physical health file to standardise physical health care and monitoring and ensure it was safe and robust.

Summary of findings

The Royal College of Psychiatrists' quality network for inpatient child and adolescent mental health services review team had assessed the service in 2015 and both wards were accredited, Horizon unit as excellent.

Staff had secured funding to train an 'expert parent' who would provide support for others.

Patients were involved in delivering group therapy sessions alongside the psychology team.

Patients were involved in governance via the 'young people's council'.

The wards used iPads to encourage patients to take part in surveys.

There was an information board designed by patients that explained various sections, rights and responsibilities under the Mental Health Act using collage, pictures and colourful lettering. This made the legal complexities of the Mental Health Act easier and straightforward to understand.

On the walls all around the wards there were posters with tear off strips that had a positive affirmation written on them. Patients could tear these off as they moved around the ward and use them to help improve their confidence and self worth.

Areas for improvement

Action the provider SHOULD take to improve
The provider should:

- ensure that arrangements for using mobile phones are reviewed regularly.

- ensure that the practice of nursing patients away from other patients is compliant with the Mental Health Act Code of Practice and the trust policy.

Care Quality Commission

Pennine Care 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
Hope Unit	Fairfield Hospital
Horizon Unit	Fairfield 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 received training in mental health law although this was not mandatory. They understood the statutory requirements of the Mental Health Act. At the time of our inspection 91% of staff on Hope unit and 92% on Horizon unit had received training in the Mental Health Act.

We found evidence that staff were not always using seclusion in accordance with the Mental Health Act Code of Practice. We found that on one occasion when a patient was cared for in the extra care area, staff had not adhered to either the Mental Health Act Code of Practice or the trust policy and did not provide the necessary safeguards to the patient.

With the exception of this, adherence to the Mental Health Act and associated Code of Practice was good.

All treatment was given under an appropriate legal authority. Staff carried out capacity assessments at first administration of medication and at the three month point.

The trust ensured that detained patients received information about their legal status and rights on admission in accordance with section 132 of the Mental Health Act. Information was available to patients throughout their admission via a Mental Health Act notice board that patients had devised.

Staff had access to support and legal advice from the trust's Mental Health Act office. All statutory detention documentation was in order. The mental health law office monitored adherence to the Mental Health Act.

There was an independent mental health advocate who provided support to patients on request.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards does not apply to people under the age of 18 years. If patients under the age of 18 need to be deprived of their liberty, this can only be done by the courts unless the Children Act or the Mental Health Act can be used.

The Mental Capacity Act 2005 applies to young people aged between 16 and 17 years of age. Staff we spoke with understood the definition of restraint and the least restrictive option principle. They had a good understanding of mental capacity and consent issues and described how they considered patients' capacity to make decisions in planning and delivering care.

For children under the age of 16, their ability to make their own decisions is assessed through Gillick competency. This recognises that some children may have a sufficient level of maturity to make some decisions themselves. Staff considered patients' capacity to consent to hospital admission during the pre-admission assessment. The welcome pack designed by patients contained information about what patients needed to think about before giving consent and when other people could give consent for them.

At the time of our inspection 91% of staff on Hope unit and 92% on Horizon unit had received training in the Mental Capacity Act. Staff had also provided local training that encompassed Gillick competence.

There was a policy that staff could refer to for guidance.

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

Both wards were clean and tidy and the furniture was in good repair. Staff had purchased new furniture following a survey where the patients on the ward said that it needed to be replaced.

There were blind spots and ligature points on both wards. A ligature point is anything that a patient could use to harm themselves by strangulation. There was an annual ligature audit that set out how staff mitigated risks through their presence, observation, staff awareness and care planning. This included clinical risk assessment and individual levels of observation. Staff reviewed risks at daily handover meetings and at ward rounds. The staff we spoke with on each ward were aware of the risks on their ward and explained how they managed them.

On each ward, patients had their own bedrooms with en suite facilities. The wards complied with same-sex accommodation guidelines by separating male and female sleeping areas. Doors had observation panels and were fitted with integral blinds. The bedrooms were spacious but had no lockable space for personal items. Patients had personalised their rooms with photographs and personal belongings.

There was a female only lounge and another lounge that could be used as a male only room if required.

In addition to the single en suite facilities there was an assisted bathroom, which patients only used after risk assessment and under supervision owing to there being several ligature risk points in it. It was kept locked when not in use.

The clinic areas were clean, tidy and well organised. There was an examination couch, scales and blood pressure monitor. Drugs cupboards, trolleys and fridges were tidy and in good order. We checked all equipment including resuscitation equipment and emergency drugs and found it was in good order and in date. Staff checked fridge temperatures daily and the records were all up-to-date.

Each ward had an 'extra care' facility. Patients had designed posters explaining what support to expect. The area was used for de-escalation and as a low stimulus area as well as for seclusion. There was evidence of activities available to support patients to calm, such as football or tennis in the adjoining courtyard.

The seclusion rooms were compliant with the Mental Health Act Code of Practice. They were large and clean, with access to natural light and bathroom facilities. All areas were visible via observation panels in the doors, there was safe bedding, a two way communication system and a clock was visible.

Both wards had spacious communal rooms, activity areas, art room, IT suite, education rooms, lounge, dining area and a kitchen. Patients were able to make their own drinks and snacks but staff supervised access to the kitchen. There were further quiet rooms and visiting rooms. The furniture appeared comfortable, contemporary and in good order. Patients' art work was displayed on the walls. There was access to a payphone in one of the visitors' lounges. This meant patients could make phone calls in private.

There was a CCTV system in the shared areas of the wards. This had been installed following recommendations made by the local authority designated officer following a number of allegations made by patients. Staff told us that discussion had taken place with patients about this and that before it became 'live' all patients and families would be advised in writing.

All the areas we inspected were clean and well maintained. The cleaning records were complete and up-to-date. Staff explained the infection control procedures they followed. The trust carried out a quarterly audit of hand hygiene observation. Both wards were 100% compliant at the most recent audit in March 2016. The trust also carried out a twice yearly environmental infection prevention and control audit. Both wards scored over 90%. However, Horizon unit was non-compliant in one high risk area in that sharps boxes were more than 75% full with sharps protruding. This was due to be reaudited in July 2016. We did not see any evidence of this risk when we inspected the clinic room.

Are services safe?

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

Maintenance records were up to date. Firefighting equipment was maintained and up to date. There was an annual patient led assessment of the care environment. We looked at the most recent reports, which both wards had passed.

Both wards had access to a secure garden area. There was also a woodland retreat that had been developed from money donated by the King's Fund and matched by the trust. The King's Fund is an independent charity working to improve health and care in England. This area was a therapeutic space that patients used for many activities including social, educational and therapeutic. There had been an environmental risk assessment that included ligature points. Staff also carried out risk assessments of the activities. Family visits could be facilitated in the woodland retreat.

Staff used personal alarms to call for assistance from staff on other wards if there was an emergency. There were designated staff on each shift who responded to incidents on other wards.

Safe staffing

There were enough staff to deliver the care and support that patients needed. Managers planned and reviewed the staffing skill mix to ensure patients received safe care and treatment. They used a safe staffing model developed in line with Compassion in Practice (NHS Commissioning Board 2012). The base staffing calculation involved consideration of the number of patients, the level of care they required and the resources needed to provide that care. Managers responded to any staff shortages quickly and adequately. Staffing levels and the skill mix within the teams meant the staff on duty were able to meet patients' needs. Staffing operated via a two-shift system. There were effective handovers to ensure staff understood and could manage risks to patients.

The ward manager explained that due to staff vacancies, long term sickness and increased complex needs on the wards, managers had included staffing on the trust risk register in December 2015. They had carried out recruitment and developed an action plan to address staff retention. This included looking at the reasons for staff leaving, introducing additional responsibility payments for staff, additional training opportunities such as a child and

adolescent mental health diploma and improved access to psychological therapies training, 'mapping' the team and identifying individual areas of interest. They had also created some new posts.

The nursing establishment across both wards was 27 registered nurses and 36 support workers. At 31 May 2016, 20% of staff posts on Hope unit were vacant and 24% on Horizon unit. On the date of inspection, most posts had been filled. Three were awaiting clearances before commencing their employment and five posts were still vacant.

There was no current sickness affecting staffing levels. At 31 May 2016, sickness was 5% across both wards, compared with a national average of 4%. Where sickness and short term absences needed to be covered, staff were able to provide cover using a bank system. In the period 1-31 May 2016, Hope unit had filled 71 out of 77 shifts and Horizon unit had filled 172 out of 181 shifts. Managers had planned for vacancies and longer absences and cover was arranged.

Each patient had a structured timetable that incorporated clear one to one time with their key nurse. The multidisciplinary team and patients planned ahead for escorted leave. Patients kept a leave planner. This meant staff could identify and plan for additional support, such as a safety plan or use of a ward vehicle. Mealtime support for those who needed it was planned and provided by the full multidisciplinary team, including education staff. Activities were timetabled and patients were involved in ward planning, so they understood which days might be better to plan specific activities. Staff accommodated additional ad hoc activities, such as going out for a walk or a drive, wherever possible. None of the patients and family members we spoke with reported that they had experienced any cancelled activities, leave or appointments. Some patients told us that activities had occasionally been postponed but never cancelled.

Patients had prompt access to a psychiatrist when they needed one. There was sufficient medical cover during the day and night. Ward rounds took place every week. A doctor attended in an emergency and was available on call out of hours.

Staff received up-to-date training in all safety systems. We reviewed a training needs analysis that clearly identified the trust's requirements for mandatory training of inpatient staff.

Are services safe?

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

The trust provided a programme of mandatory training that included:

- moving and handling
- conflict resolution
- equality and diversity
- basic life support
- paediatric life support
- immediate life support
- violence reduction and positive behaviour support
- medicines management
- health and safety
- infection control
- adult safeguarding
- child safeguarding
- fire safety
- information governance
- prevent (anti-radicalisation training)

Data provided prior to inspection showed that staff had received and were mostly up to date with appropriate mandatory training. At 31 May 2016, the average rate of compliance with mandatory training was 86% for each ward.

In the following areas, compliance with mandatory training was below 75%:

Hope unit:

Child safeguarding level 3, 60%

Horizon unit:

Conflict resolution level 2, 64%

Immediate life support, 50%

Prevent, 72%

However, records confirmed that training had been booked and that some non-compliance was due to long term sickness or other health related issues.

Managers monitored compliance with mandatory training via an electronic system that alerted managers when refresher training was due. Staff could also view their own mandatory training records with expiry dates flagged and highlighted.

Assessing and managing risk to patients and staff

Staff assessed, monitored and managed risks to patients on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviour that challenged.

Patients were engaged in managing their own personal risks and developing action plans. Risk assessments were person-centred, proportionate and reviewed regularly. Staff recognised and responded appropriately to changes to risks in patients.

We looked at the risk assessments for 17 patients. All the records were complete and up to date.

Staff used a tool called the 'trust approved risk assessment' to assess and monitor risk. Staff completed this on admission. The records we reviewed were well completed. They included a chronology of risk and safeguards. There was a detailed formulation of risk that patients and staff had written collaboratively. It was routinely formally reviewed every month and at ward rounds every week, plus whenever clinically indicated and following incidents. There was a further review on discharge. This practice was compliant with the trust policy on clinical risk assessment.

Staff assessed and managed individual risks on a continuing basis. Risk assessments were comprehensive and recorded appropriately. Staff recorded observation levels clearly.

There was a clear culture of least restrictive practice and positive risk taking. Staff had made efforts to relax restrictions in some areas.

Staff completed risk assessments prior to patients going out on leave. Not all patients who had been out were searched on returning to the wards. This was individually care planned and there was a policy that provided guidance for staff. They recorded searches on a central register.

Patients' access to their bedrooms was individually care planned and where there were restrictions, it was clear that this was a restrictive intervention and should be brought to an end as soon as possible.

The most recent Mental Health Act monitoring visit in May 2016 identified a blanket restriction on the use of mobile phones. The restrictions were still in place when we inspected. However, managers had developed an action plan and draft policy to address this, due to be completed by September 2016. Patients' access to personal mobile phones was to be individually risk assessed by the multidisciplinary team and included in care plans.

Patients had supervised access to the internet during education. After school, ward staff supervised access.

Are services safe?

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

Staff received training in de-escalation and management of violence and aggression techniques.

Data provided by the service showed that in the six months up to 31 May 2016, there had been 95 instances of restraint, 56 on Hope unit (19 patients) and 38 on Horizon unit (eight patients). Five of these were in the prone position (face down on the floor), one on Hope unit and four on Horizon unit. Only one of the four had led to rapid tranquilisation.

In the same period, there were five incidences of seclusion, four on Hope and one on Horizon.

There were no incidences of long term segregation.

Some patients told us that they asked to use the extra care areas when they were feeling agitated or stressed. This meant staff nursed them away from other patients. This was recorded in an advance statement, which staff followed.

Records showed that staff also used the extra care areas to de-escalate patients following incidents of violence and aggression and to promote privacy and dignity during restrictive interventions. Staff informed us that they would escort patients to the extra care areas and that they would remain there with patients, using restraint on occasion.

We reviewed records showing that four patients had been nursed in the extra care areas on seven occasions. Six of these occasions lasted for one hour or less but the seventh continued for more than four days. Care plans for all four patients discussed circumstances when the extra care area might be used, supplemented by the patients' own views and information. However, written records for these episodes did not clearly state whether patients were informed and understood that they could leave the extra care area and return to the main ward at any time.

There was a policy that provided guidance for staff on the use of seclusion, time out and nursing patients away from other patients.

There were clearly defined and embedded systems, processes and standard operating procedures to keep patients safe and safeguarded from abuse. Safeguarding arrangements took account of both adult and child safeguarding. Staff received mandatory training in safeguarding. We discussed safeguarding with staff. They showed good understanding of safeguarding issues and explained how to make a safeguarding alert. There were good links with the local safeguarding authority.

Safeguarding information was displayed in the wards. A safeguarding policy was available for staff guidance. The wards had safeguarding leads and there was a trust safeguarding lead. Social work staff also provided guidance. Staff recorded and reported safeguarding incidents appropriately.

There were policies and procedures covering all aspects of medicines management. Staff received training in medicines management and had a good understanding of safe medicines management. Staff explained how to report a medicines incident.

Medicines were obtained from the local acute hospital NHS trust through a service level agreement. Medicines were stored securely and clinic rooms were clean and tidy. Qualified staff carried out a medicines audit every weekend looking at prescription charts. This included checking that appropriate authority to treat had been obtained, ensuring medicine stocks were accurate and in date, checks of the clinic room and equipment including emergency equipment, and to ensure emergency medicines would be suitable for use, if needed. Senior staff also carried out a quarterly clinic room audit and a weekly audit of omitted and delayed medications.

There were appropriate arrangements for supplying patients with leave and discharge medicines.

Nurses told us that the support provided by the ward pharmacist was very good. The pharmacist visited every weekday and was actively involved in the multidisciplinary teams. In response to medicines incidents recorded over the last year on Hope unit, an action plan had been developed to support and monitor improvement in medicines administration. The ward manager was positive about this and felt that the plan was effective in bringing about improvement. The ward pharmacist was completing observations and assessments of nurses administering medicines and delivering further medication training to support this plan. We looked at 23 prescription charts across two wards. The prescription charts were up-to-date and clearly presented to show the treatment people had received. Where required, there was legal authority for treatment. Staff completed an incident report form in response to missed doses of medication.

On occasions patients may be prescribed medicines to help with extreme episodes of agitation, anxiety and sometimes violence. This is known as rapid tranquillisation.

Are services safe?

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

Following rapid tranquilisation, nursing staff were required to record 15 minute observations of the patient's blood pressure, temperature, oxygen saturation and respiratory rate as identified in the trust's policy and in line with the National Institute for Health and Care Excellence guidance. We found that on Horizon unit, three episodes of rapid tranquillisation were recorded on the medication charts. The monitoring charts showed that staff carried out physical observations following two of these episodes. For the third, the patient had refused; however, it was clear that visual observation had been carried out.

There was a policy that set out arrangements for child visitors. Children under 18 could visit with signed authorisation from the ward manager or consultant and prior agreement from the nurse in charge of the shift. They had to be accompanied by an adult. The woodland retreat could be used for family visits away from the main ward and there were designated rooms away from the main ward areas where children could visit.

Track record on safety

Staff were encouraged to report all incidents. In the six months up to 31 May 2016, they had reported 35 incidents resulting in significant or serious harm. Eighteen of these were on Hope unit and 17 on Horizon unit. The incidents comprised a range of causes including self harm, medication errors and assaults by patients against staff. All the incidents had been investigated. There were instances of learning following investigations, for example, an action plan in relation to medicine management that emphasised nursing roles, responsibilities and accountabilities and incorporated teaching and assessment, audit and clinical supervision. There was also evidence of staff receiving training following an incident involving child sexual exploitation.

Reporting incidents and learning from when things go wrong

There was an electronic incident reporting system. Incidents were collated on a governance and quality dashboard. This enabled ward managers and senior managers to review and grade the severity of incidents. All staff took responsibility for reporting and had access to the reporting system.

Openness and transparency about safety was encouraged. Staff explained how to report an incident. They understood their responsibilities in relation to reporting and told us they felt supported in doing so. Managers analysed adverse events to identify any trends and they took appropriate action in response. They fed this back to the teams. This meant staff understood risks and gave a clear, accurate and current picture of safety.

When something went wrong, there was an appropriate thorough review or investigation that involved all relevant staff and patients.

Staff and patients were debriefed and supported following serious incidents. Debriefing was led by psychology staff and incorporated support and reflective discussion. The staff we met with reported feeling well supported by managers and their colleagues. They described an embedded open and supportive culture. Patients also told us they felt well supported. Following a medication error, the pharmacist had provided counselling to the patient around the associated risk.

Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly affected. Opportunities to learn from external safety events were also identified. Recommendations and learning from incidents was shared via service-wide communications such as a "key themes" newsletter, and discussed at monthly business meetings, fortnightly team meetings and team briefing sessions. Lessons learned at other trust locations were also shared. Managers ensured lessons were learnt by discussing learning and actions in team meetings and one-to-one supervision. Minutes of the meetings confirmed this.

Staff made improvements to safety and monitored the resulting changes. We reviewed documentary evidence that showed how the service learned from incidents and made improvements. For example, following Mental Health Act administration errors, all relevant staff had undergone receipt and scrutiny training. Staff had revisited use of the mental health law office during working hours at a team meeting. Following incidents, staff met and reflected on what had happened and how it could be avoided in the future.

There was strong collaboration and support across the multidisciplinary team and a common focus on improving quality of care and people's experiences. There was a culture of collective responsibility where the benefit of raising concerns was valued. Issues raised were investigated in a sensitive and confidential manner, and lessons were shared and acted upon.

Are services safe?

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Duty of candour

Staff understood their responsibilities relating to the duty of candour. They knew what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

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

There was a strong recovery focused ethos and holistic, mutual approach to planning care.

The 'my shared pathway' model of care promoted a recovery and outcomes based approach to care planning. It focused on ensuring that each patient received the most appropriate care and treatment within clearly agreed timeframes and in the least restrictive environment. The records we looked at contained comprehensive accounts of the purpose of admission and goals for discharge.

We examined 17 care records. We found them complete and inclusive, showing evidence of individual diverse needs and patient involvement in developing them. Staff and patients together re-evaluated and updated care plans following changes to care needs. Where patients found it difficult to engage, staff offered encouragement so they were able to contribute. Care plans showed that consideration had been given to minimum restrictions being placed on patients' liberty.

Staff carried out an initial assessment that incorporated mental and physical health assessments and further health investigations where necessary. It included a risk assessment and evaluation of patients' social, cultural, physical and psychological needs and preferences. The assessments focused on patients' strengths, self-awareness and support systems, in line with the model of care. Care records we looked at confirmed that staff assessed patients when they were admitted and made plans for their continuing support from the start of their treatment. Pathways and structure for care were clear.

On admission, staff assessed each patient's educational needs. The teaching staff liaised with the patient's mainstream school or college and had work provided for the patient. Where patients had disengaged from mainstream education, teaching staff provided a personal education plan to meet their needs and aspirations.

There was a service level agreement with an external education provider.

With each patient, staff developed a care plan. The records we reviewed were up to date. The care plans were centred on the patient's diverse needs as identified by them and clearly demonstrated patients' involvement. They were recovery focused and showed knowledge of current, evidence-based practice. There was evidence of good multidisciplinary team working based on the patient's needs. Staff understood the diverse care needs of the patients.

Prior to their ward round, patients completed a 'what I want from my ward review' form that included:

- the reason for their admission
- their goals
- their progress
- their care plan
- 'how my week has been'
- leave
- medication
- observations
- discharge.

Staff encouraged patients to complete this form, which determined the discussion for the ward round. Patients and families were encouraged and supported to attend ward reviews. If a patient did not wish to attend, their thoughts were presented by their key nurse. The key nurse fed the outcomes of the discussions and any decisions made back to the patient after the review.

There were monthly formulation meetings led by psychologists. Formulation summarises the patient's fundamental problems, suggests how they are related, looks for contextual reasons and develops plans for interventions, which remain open to review and re-formulation.

The care records we reviewed contained evidence of ongoing physical health monitoring. Each ward held a weekly physical health clinic.

Patients told us that care planning was progressive and goal-led. They confirmed that they had regular sessions with their key nurse to discuss and review their care plans, and that they attended review meetings with the multidisciplinary team. Families and carers were encouraged to be involved in the care planning process.

Senior staff carried out monthly audits of care records that included checking risk assessments, care plans, physical health care, Mental Health Act documentation and whether service users had received copies of their care plans. All were complete and up to date. They provided feedback to staff in one to one sessions.

Are services effective?

Good ●

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The systems to manage and share the information needed to deliver effective care were not fully integrated but staff did not report any difficulties because of this. Some records were stored in an electronic database and access was protected. Care records were kept in a paper format. These too were stored securely and staff had access to them so that all information they needed was readily available.

Best practice in treatment and care

We looked at 17 care and treatment records. Staff planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation. Staff on all the wards implemented evidence-based guidance within their clinical practice. For example, in line with the National Institute for Health and Care Excellence and Department of Health guidelines such as Positive and proactive care: reducing the need for restrictive interventions, Psychosis and schizophrenia in children and young people: recognition and management CG155, Bipolar disorder: assessment and management CG185, Depression in children and young people: identification and management CG28, Eating disorders CG9, Nutrition support CG32, Smoking: acute, maternity and mental health services PH48 and Self-harm in over 8's: short term management and prevention of reoccurrence CG16. We found evidence that staff followed guidance in care records and supervision notes. They monitored compliance with guidance every month.

Staff were also developing baseline assessment tools for each relevant guideline that considered the action needed to implement the guideline and associated risk if they did not implement it, for example in relation to Depression in children and young people: identification and management CG28.

We checked 23 prescription charts. Records showed that patients had the opportunity to discuss their medicines with their doctor. Additionally, the trust had signed up to the 'choice and medication' website. The website offers information about mental health conditions and medications to help patients make informed decisions about their treatment. Nurses and pharmacists used the information and leaflets when discussing medicines with patients. Some medicines were prescribed 'off-label'. This means that a medicine is being prescribed for use outside the terms of its license. The nurses we spoke with had a clear understanding of this and explained it to patients and carers. Staff used recognised rating scales with patients to monitor possible side effects of antipsychotic medication.

There was a team of psychologists who had developed comprehensive treatment programmes encompassing dialectical behaviour therapy. This is designed to change patterns of behaviour such as self harm by learning about the triggers that lead to such reactive states and help to develop coping skills. Some programmes took place in groups but most of the work was undertaken in one to one personalised programmes. Led by the consultant psychiatrist and clinical psychologist, staff on Horizon unit had developed a dialectical behaviour therapy programme called 'a life worth living'. Due to staffing pressures in 2015 it had not been possible to continue to resource the full programme. However, there was still a weekly dialectical behaviour therapy skills group, supported by individual therapy when appropriate.

Many patients were engaged in psychological therapies. Staff described a range of interventions they used to support patients in their recovery, including:

- acceptance and commitment therapy
- compassion focused therapy
- creative tools
- cognitive behavioural therapy
- cognitive behavioural therapy for eating disorders
- family therapy
- metacognitive therapy
- solution-focused therapy
- systemic work/family meetings.

There was also a range of holistic therapy groups. The therapeutic timetables changed regularly to meet the needs of the changing client population and to offer variety. Groups included:

- pet therapy
- book club
- dance
- sports and team building
- self esteem and pamper sessions
- debate group
- arts and crafts projects
- yoga
- film
- drama

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- current affairs.

Patients were involved in the development and evaluation of new psychology groups in a number of ways, for example, using group discussions and questionnaires. The psychology team then used this information, alongside guidelines and evidence-based treatment protocols, to develop group programmes that offered accessible interventions that fit with patients' goals, interests and abilities.

Staff on Horizon had developed a care pathway for patients with low weight anorexia nervosa. The unit worked with patients with both low weight anorexia nervosa and eating disorder, and co-morbidity, in particular with patients with emerging personality disorder. The Horizon unit eating disorder guideline was compliant with national institute for health and care excellence guidelines for eating disorder and with the Royal College of Psychiatrists' Management of really sick patients with anorexia nervosa guidance.

Collaborative team formulation was embedded in clinical practice. Staff held team formulation meetings. The formulation meetings included discussion of reports and observations made by patients, although they were not present because of the need to allow staff space to reflect together. Afterwards, the clinical psychologist used the team's working formulation to develop a formulation letter with the patient. They could share this with anyone they chose. However, staff only shared it with their permission, and removed details they may not wish to disclose.

An article had been published in professional journals highlighting the service's work on team formulation.

Staff considered patients' physical health needs alongside their mental health needs. Staff had set up physical health clinics and developed a physical health file to standardise physical health care and monitoring and ensure it was safe and robust. They had presented this innovative approach at the Royal College of Psychiatrists' quality network for inpatient child and adolescent mental health services national forum in June 2015. The records we reviewed all contained full physical healthcare checks. Staff completed these on admission and monitored them at weekly physical health clinics on each ward. The physical health file contained all baseline physical health documents including eating disorder charts. It was filed with the clinical notes and used in multidisciplinary meetings and ward rounds.

Smoking status was recorded and smoking cessation counselling was available. There was a nurse lead for smoking cessation on Hope unit but not Horizon unit. We were told that this was due to difficulties in accessing training.

Staff used clinical tools to audit the effectiveness of interventions. They were using nationally recognised assessment tools, such as the children's global assessment scale, the model of human occupation screening tool, social connectedness, the Beck youth inventories and the health of the nation outcome scales for children and adolescents. On Horizon, staff also used the eating disorder examination questionnaire. Patients were using 'my shared pathway' to measure their progress. Information about effectiveness was shared, for example, via multidisciplinary team meetings, business and governance meetings and reports published internally and externally, and used to improve care and treatment and patients' outcomes.

High performance was recognised by credible external bodies. The Royal College of Psychiatrists' quality network for inpatient child and adolescent mental health services review team had assessed the service in 2015 and both wards were accredited, Horizon unit as excellent. The Royal College of Psychiatrists' quality network for inpatient child and adolescent mental health services is an accreditation scheme that has been approved by the Care Quality Commission.

Doctors had recently completed an audit on Hope unit looking at physical health monitoring in patients prescribed antipsychotics (National Institute for Health and Care Excellence psychosis and schizophrenia in children and young people: recognition and management CG155) and how relevant information was communicated to community teams on discharge from hospital. The audit found that although some physical health parameters were well recorded, compliance with anti-psychotic physical health monitoring and communication of these results on discharge could be improved. In response to one of the audit recommendations, an 'antipsychotics monitoring form' had been trialled on Hope unit, with plans to extend this to Horizon unit. Additionally, the discharge letter pro forma had been modified to prompt the completion of physical health results.

Skilled staff to deliver care

Patients had access to a range of mental health disciplines to aid their recovery. There was an effective

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multidisciplinary structure that included input from activities staff, dietitians, education staff, family therapists, health care support staff, nurses qualified in mental health, learning disability and physical health, occupational therapists, psychiatrists, psychologists and social work staff.

New staff underwent a comprehensive induction on the wards as well as the trust induction programme. There was an induction pack for bank staff that included for example, security matters and essential safe practice. Induction incorporated the certificate of fundamental care for non-registered clinical staff and they had protected study time each week. The certificate was developed jointly by Skills for Care, Health Education England and Skills for Health. It sets out national standards that underpin the skills, knowledge and behaviours necessary to ensure staff provide compassionate and high quality care and support.

Managers supported staff to deliver effective care by means of supervision and appraisal of their work performance. They used the supervision and appraisal process to identify additional training requirements and manage performance. The trust's values were linked to supervision and appraisal. Staff had an annual appraisal that included setting objectives for personal development. As at 7 June 2016, 93% of non-medical staff on Hope unit had had an appraisal in the last 12 months and 100% on Horizon unit.

All medical staff revalidations were up to date.

Staff told us they received clinical and managerial supervision every month or more often if necessary. Clinical supervision included group sessions facilitated by the clinical nurse specialist, and team formulation meetings and clinical incident and case management debriefs facilitated by psychology staff, to help support and develop individual practitioners and team understanding of the patients' needs. Supervision records included discussion of appraisal objectives, National Institute for Health and Care Excellence guidelines, training needs and patient engagement. Staff wellbeing was also discussed. Staff said they found supervision helpful and valuable.

On Hope unit, supervision records were not up to date. We could not establish from the records that staff had received managerial supervision since December 2015. However, the commissioning for quality and innovation framework quality indicators showed that at 31 March 2016, 80% of staff had received supervision. On Horizon unit, supervision

records were up to date and showed that 25 out of 29 staff had received regular supervision. The four that had not were all on long term sickness absence. We were assured by our observations, and from speaking with patients and staff, that staff were skilled and competent and that they understood their roles. Staff also felt valued and supported.

Ninety one per cent of staff on Hope unit and 92% on Horizon unit had received additional training to enable them to carry out their roles. This included training on mental health law, together with receipt and scrutiny of Mental Health Act documentation, the Mental Capacity Act, Deprivation of Liberty Safeguards, Gillick competence, Fraser guidelines and the zone of parental control.

Gillick competence refers to the capacity of children to consent to their own treatment. The Fraser guidelines relate to the legality of doctors to provide contraceptive advice and treatment without parental consent providing certain criteria are met.

Some staff had also provided in-house training on competence and capacity that encompassed Gillick competence, Fraser guidelines, the Mental Health Act, the Mental Capacity Act, Deprivation of Liberty Safeguards and human rights legislation, in particular the right to liberty and security and the right to family life.

Senior staff had access to human resource clinics and to leadership training specific to their role. For example, in taking responsibility for embedding improved access to psychological therapies in the service, managers identified staff to undergo training and ensured they were supervised in providing family therapy and cognitive behavioural therapy.

There were opportunities for staff to improve their practice, for example, case formulation groups took place on both wards, led by psychology staff. The staff we spoke with said they found discussion of challenging clinical issues invaluable in exploring ways to improve the service they provided. The team had published articles on formulation in professional journals.

Staff and managers discussed performance in one-to-one supervision sessions. There was evidence of this in the records we looked at. Managers explained the process they followed and told us they felt well supported in dealing with performance matters.

Are services effective?

Good ●

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Multi-disciplinary and inter-agency team work

Staff recognised the benefit of close working with allied professionals and care from a range of different disciplines was coordinated. The multidisciplinary team was well integrated and collaborative working was embedded. All relevant staff, teams and services were involved in assessing, planning and delivering patients' care and treatment. Staff worked together to understand and meet the range and complexity of patients' needs. They provided a range of therapeutic interventions to support patients' recovery in line with best practice guidance.

Each ward held weekly multidisciplinary team meetings to review the mental health of the patients.

We observed one multidisciplinary team meeting. The multidisciplinary team worked closely to plan patients' care and treatment in a holistic way. The review included reports from nursing and medical staff, occupational therapy, the activities coordinator, a school report and a psychology report. Social work staff were invited where appropriate. Physical health care was also discussed and staff were liaising with the acute hospital. Discussion was factual, sensitive and patient focused. The care and concern shown for the patient was evident. There was frank, open and respectful discussion with the patients. In light of risk evidence, the multidisciplinary team explored options to increase levels of patient responsibility. They took great care in seeking the patients' views and opinions to ensure they were involved in developing the plan. There was clear commitment to working collaboratively to provide the best possible care for patients.

There were handover meetings twice daily on each ward, at every shift change. We attended two of these meetings and found them to be well structured, informative and productive.

The inreach/outreach team for the trust was based on the ward. This team worked closely with the wards with regard to admissions and to support patients through discharge. The team also worked with the local child and adolescent mental health service community team and other services to ensure that patients received an appropriate care package to support their care in the community.

Care coordinators from the child and adolescent mental health service community teams and adult mental health teams, where appropriate, attended care programme approach meetings.

There were established positive working relationships with other service providers such as GPs, local authorities, schools and colleges. Education staff from mainstream schools and colleges were routinely invited to patients' care programme approach meetings and so were kept informed of their progress whilst in hospital.

The head of education attended ward rounds and tribunals to report on patients' individual educational matters. The education contracts officer attended the quarterly governance meeting.

Adherence to the MHA and the MHA Code of Practice

Staff received training in mental health law although this was not mandatory. At the time of our inspection 91% of staff on Hope and 92% on Horizon had received training in the Mental Health Act.

We reviewed the care and treatment of young people detained under the Mental Health Act.

We looked at seven records of patients who had been nursed in the extra care areas. We found one example where the extra care area had been used and the correct safeguards had not been followed to ensure that the patient receiving care was afforded the appropriate level of safeguard identified in the Mental Health Act Code of Practice.

There was a policy that provided guidance for staff in the use of the extra care areas. The policy identified the differences between using the extra care areas to provide support in a crisis, and seclusion and longer-term segregations.

The policy required staff to carry out regular reviews and it set out key people who should be informed when patients were cared for in the extra care area. We asked to see the review records for this patient but staff were unable to locate them.

It was not clear to us that staff recognised a point at which use of the extra care areas could meet the definition of seclusion set out by the Mental Health Act Code of Practice. We could not ascertain that staff applied the procedural safeguards required by the code, such as recorded observations, nursing, medical and independent reviews, depending on the length of time the patient spent in seclusion. The Mental Health Act Code of Practice states that if a patient is confined in any way that meets the

Are services effective?   **Good** 🟢

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definition, even if they have agreed to or requested such confinement, they have been secluded and the use of any local or alternative terms do not change the fact that the patient has been secluded. It is essential that they are afforded the procedural safeguards of the code.

The nursing notes provided some evidence that reviews were taking place, as the level of support changed. However, there was no record of how, when, why or by whom that decision was made; similarly, when the level of support continued there was no record of the decision to continue. The records did not cover every shift during the time the patient was being nursed in the extra care area. The policy required a nursing review at each shift. Further, the observation and engagement policy required that when observation levels were changed or discontinued, staff must always document the rationale for the decision in the patient's nursing and medical notes and observation plan.

We did see some evidence of a multidisciplinary team review. At this review, the team decided that the patient should remain in the extra care area, with support, for the next three days. This indicated that staff would not allow the patient to leave the extra care area and return to the main ward area if they wished to do so. The Mental Health Act Code of Practice states that if an individual under long term enhanced observation is also being prevented from having contact with anyone outside the area in which they are being confined, this will amount to either seclusion or long term segregation, which should comply with the Code of Practice. The trust policy did not provide guidance on this. At this point, the team should have recognised that the patient was being secluded and followed the procedural safeguards set out in the Code of Practice.

The multidisciplinary team plan included a plan for reintegration to the ward and a daily review by the multidisciplinary team. Staff did not implement the plan for reintegration until the following afternoon and there was no record of any further multidisciplinary team review.

We did see a note of the multidisciplinary team's decision that the process of being nursed away from other patients should be discontinued but there was no record of how, when or why that decision was reached.

This meant that care for this patient was not being delivered in accordance with either the Mental Health Act Code of Practice or the trust policy and did not provide the necessary safeguards.

In the records that we reviewed, all medication was being given under an appropriate legal authority. In relation to section 58, we found that prescribed medication was authorised by an appropriate certificate (form T2 or T3). Assessments of the patient's capacity to consent to medication was clearly documented prior to the first administration and at the three month point. There was evidence that staff reviewed patients' capacity to consent to medication and took action where a patient either lost or gained capacity. In one such case, we found that treatment was being provided under the emergency provisions of section 62.

The trust ensured that detained patients received information about their legal status and rights on admission in accordance with section 132. There was evidence that this information was repeated at monthly intervals or more frequently where patients had not initially understood.

Information regarding detention and patients' rights was available to patients throughout their admission via the Mental Health Act notice board. Patients had devised the board, which included cartoons and highlighted sections to support young people to understand their legal situation and their rights under section 132.

The Mental Health Act office provided administrative support and legal advice on implementation of the Mental Health Act and associated Code of Practice.

Detention papers were available in the patients' files. These included copies of the approved mental health professional reports, hospital managers' reviews and appeals to the first tier tribunal where relevant.

There was a clear system for the administration of the Mental Health Act that included a checklist for effective receipt and scrutiny of detention documents.

Documentation relating to the authorisation of section 17 leave was well completed. There was evidence that staff completed risk assessments before leave was authorised. We found that leave was granted on an individual basis according to need and stage of recovery.

Are services effective?

Good ●

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Overall adherence to the Mental Health Act was monitored by the Mental Health Act administrators. They provided a weekly ward report to remind ward staff of their responsibilities under the Act and the timeframes within which these should be met.

Patients had access to an independent mental health advocate. Patients who lacked the capacity to instruct an advocate were automatically referred to the independent mental health advocate by the Mental Health Act office.

Good practice in applying the MCA

The Deprivation of Liberty Safeguards do not apply to people under the age of 18 years. If patients under the age of 18 need to be deprived of their liberty, this can only be done by the courts unless the Children Act or the Mental Health Act can be used.

The Mental Capacity Act 2005 applies to young people aged 16 and 17. Staff we spoke with understood the definition of restraint and the least restrictive option principle. They had a good understanding of mental capacity and consent issues and described how they considered patients' capacity to make decisions in planning and delivering care.

For children under the age of 16, their ability to make their own decisions is assessed through Gillick competency. This recognises that some children may have a sufficient level of maturity to make some decisions themselves. Staff considered capacity to consent to hospital admission during the pre-admission assessment. The welcome pack designed by patients contained information about what patients needed to think about before giving consent and when other people could give consent for them.

At the time of our inspection 91% of staff on Hope unit and 92% on Horizon unit had received training in the Mental Capacity Act. Staff had also provided local training that encompassed Gillick competence.

There was a policy that staff could refer to for guidance.

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

Staff respected patients and valued them as individuals. The model of care being used helped staff ensure patients were empowered as partners in their care.

Feedback from patients and the people close to them was positive about the way staff treated them. Patients and those close to them told us that the care they received was exceptional and that staff went out of their way to provide high quality care.

There was good engagement between staff and patients on both wards. Staff were warm and friendly. They treated patients with dignity, respect and kindness during their interactions and the relationships between them were positive. Patients told us they felt supported and said staff cared about them. They described staff as friendly, approachable and helpful. Staff knocked on bedroom doors before entering and patients confirmed this was usual practice.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. Relationships between patients, the people close to them and staff were caring and supportive. These relationships were highly valued by staff and promoted by leaders both at ward level and by the senior management team.

Staff recognised and respected patients' needs. The care records showed that staff considered patients' personal, cultural, social and religious needs.

On the day we inspected, some patients were taking GCSE examinations and were being supported to take them in hospital. Patients we spoke with said that they felt well supported to take their examinations.

The staff ensured patients' dignity, privacy and confidentiality was always respected, for example, by using the extra care areas during restrictive interventions.

The involvement of people in the care they receive

Putting patients at the centre of the service and involving and empowering them was clearly embedded in the ward culture. Patients' involvement was integral to how the service was planned and ensured that the service met patients' needs. There were innovative approaches to providing integrated person-centred pathways of care, particularly for patients with multiple and complex needs.

The clear commitment to genuine patient involvement was exceptional. Staff were fully committed to working in partnership with patients and making this a reality for each patient. Staff empowered patients to have a voice and to realise their potential.

There was a good orientation process. Patients could visit the wards before their admission. There were visible, easy read, pictorial boards to enhance patients' knowledge of the ward and to encourage discussions between staff and patients as part of the ward orientation and induction. Staff introduced patients to their peers and were expected to introduce themselves to patients at their initial meeting. The wards operated a scheme whereby new patients were allocated a 'buddy' to help familiarise and welcome them to the ward. The patients had designed an information pack and welcome booklet with information about the ward and service.

Staff respected and valued patients as individuals and empowered them as partners in their care. Their individual preferences and needs were always reflected in how care was delivered. Patients and staff worked together to plan care. Staff spent time talking with patients. They communicated with them in ways that they could understand. Patients told us they understood their care, treatment and condition. They were involved in influencing their care and treatment or the service at the hospital in a number of ways, including planning for their discharge.

Patients contributed to their own care records. Care plans showed clear evidence of patients' views and their involvement in developing them. Care plans were written in language that patients used. The patient's views were clearly respected even where they differed from the views of the multidisciplinary team. They were supplemented with patients' own information about things that triggered their distress and things they found helpful and that kept them safe. This information was in formats each patient preferred, such as colours, pictures and a poster 'things that help me'. Sharing their information in this way encouraged patients to engage in planning their care.

Are services caring?

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

Outstanding ☆

Family, friends and advocates were involved in care if the patient wished. Patients all had a copy of their care plan and where they did not, the reason for this was documented.

We observed a multidisciplinary meeting at which the patient and their parents were involved and consulted. Staff and the patient and parents discussed progress, risk management and care planning together. They reviewed care plans and risk assessments during the meeting. This meant there was plenty of opportunity for discussion and agreement and ensured the patient had the opportunity to comment on the report as it was written. Discharge planning was incorporated into the discussion. Care coordinators from both child and adolescent and adult community mental health services were involved and attended the meeting. Notes from the previous meeting had been circulated, and notes were taken for circulating following the meeting.

Staff offered support to patients' families and friends. Staff carried out an initial interview with carers to ascertain their needs and that of the family. They made contact with patients' families every week to provide an update and support. We spoke with the parents of four patients who told us they felt supported to participate in shared decision making about their child and were included in specific decisions that affected them as families and carers.

There was a group for parents and carers that offered support and training and information sessions on topics such as recovery and anorexia. A former patient supported the group and staff had secured funding to train a group member as an 'expert parent' who would also provide support. On Horizon unit, there was a monthly eating disorder carer support meeting facilitated by senior staff.

Patients felt supported to maintain and develop their relationships with the people close to them. The welcome pack included postcards designed by patients that they could use to keep in touch.

Each ward held weekly community meetings. These meetings engaged patients and improved communication on the wards. The minutes of these meetings documented discussion about issues patients raised.

Staff had reviewed the effectiveness of community meetings to ensure they promoted participation and inclusion. They ran focus groups on both wards to understand what patients wanted from their community meetings and how to improve them. Patients developed a format for the meetings and requested that senior staff attend.

Key areas that had been improved were the development of a system to report environmental issues to estates so issues were resolved more quickly. Senior staff and managers attended the community meetings. The meeting was held during protected time in which leave, other activities or groups did not run. There was a section for 'star of the week', to bring a positive feel to the meeting and support patients to focus on positive as well as negative aspects of the ward. Patients said they felt their views were valued and that staff listened to them. For example, there had been an open discussion about patients targeting each other and gossiping. It was a good opportunity for people to apologise and arrange further meetings to resolve their issues.

Staff and patients had co-developed new psychology groups called 'fighting talk', against illness or difficulties, drawing on narrative therapy approaches, and 'becoming yourself again', a programme to explore values and ways to work with these despite difficulties, using acceptance and commitment therapy approaches.

Patients were also involved in delivering group therapy sessions. They worked with the psychology team to choose from psychologically informed activities and co-facilitate group sessions. Recent examples included co-facilitating a 'compassionate mind' group session, and using arts and creative activities to explore emotions.

Patients had opportunities to get involved in governance, such as being involved in staff recruitment and training. Patients had also facilitated an open day for staff recruitment.

There was a 'young people's council'. The council's role was to be involved in the design and commissioning of services. It offered consultations and input to service level developments by meeting with senior managers, joining service level discussions and reviewing documents and ideas. Meeting minutes clearly confirmed the respect given to patients' views and opinions. Patients received training to help them fully engage. Managers provided feedback to the council about how their input had influenced decisions. Psychology staff and key nurses offered debriefing where tasks had been emotionally draining.

Are services caring?

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

Outstanding ☆

Patient led assessments of the care environment took place annually. As part of the inspection panel, patients received training to participate in the assessment and join the panel members on the day to work through the inspection with them. We reviewed the assessments for 2015 and 2016.

They had the opportunity to be involved in staff recruitment by sitting on interview panels and being involved in staff induction and training. Patients received training to support them to do this effectively and they were paid for their time.

There were regular patient surveys. The wards used iPads to upload surveys that could be used for one-off surveys such as service and discharge evaluation. Staff found patients were more likely to complete a survey using this method, as it was immediate. Patients had devised the questionnaires. The completed surveys were sent to the trust patient experience team and the findings could be received the same day. Information was then cascaded to staff by email, at team meetings and business meetings. The friends and family test was also collected and sent to the patient experience team for analysis, then returned to the service. Improvements were made following the findings, for example, funding had been secured for a regular pet therapy session and new baking trays were purchased.

There was an independent mental health advocate who supported patients. Patients had direct access to advocacy services and there was information displayed across the wards. The advocate also visited the wards three times each week to ensure that patients were aware of the support that the advocate could provide.

All patients' care plans contained information that was comparable to advance statements, for example, around using the extra care areas should it become necessary. An advance statement is a way for a patient to say how they would like to be treated in the future if they ever lost the ability to decide for themselves.

There were a variety of notice boards around the wards with information that included health and well-being, how to deal with bullying and stigma, therapeutic activities, 'you said, we did', alongside the latest minutes from the community meeting. Most of the noticeboards had been designed and populated by the patients.

There was a notice board with pictures of the staff drawn by patients, with their roles and a caption describing each one. Another board set out the Care Quality Commission domains, with examples of things happening on the wards that demonstrated how the service complied with the essential standards. Patients and staff had created this together, to help them prepare for the inspection. Patients had also developed an 'expectation' board to help orient new staff to helpful ways of working. There was an information board designed by patients that explained various sections, rights and responsibilities under the Mental Health Act using collage, pictures and colourful lettering. This made the legal complexities of the Mental Health Act easy and straightforward to understand.

On the walls all around the wards, there were posters with tear off strips that had a positive affirmation written on them. Patients could tear these off as they moved around the ward and use them to help improve their confidence and self worth.

Are services responsive to people's needs?

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

Our findings

Access and discharge

In the six months to 31 May, bed occupancy on Hope unit was 90% and on Horizon unit 104%, including leave periods. This was by comparison with a national bed occupancy rate of 88% including leave.

NHS England commissioned beds on both Hope and Horizon units. A clear referral process had been agreed nationally, following joint work with providers in the north west. This process recognised that discharge was equally as important as access. Once a referral was received, the wards acted as bed managers. We looked at a simplified version of the referral process that had been produced to provide support for staff. This included guidance on the process for locating an out of area bed if necessary and guidance on admission to adult services for patients aged over 16 as an urgent place of safety.

Care pathways and admissions could be from home, paediatric services, other child and adolescent mental health inpatient units, accident and emergency departments, health based places of safety or police stations under section 136 Mental Health Act or local authority placements.

The multidisciplinary team completed a comprehensive pre-admission assessment. The assessment considered whether patients had the capacity to consent to their own admission.

Staff worked within the principles of the 'my shared pathway' model. They focused on helping patients to concentrate on their goals for recovery and the progress they had made towards the outcomes they wanted to achieve. This meant that staff ensured patients did not stay in hospital longer than necessary and promoted patients' early discharge.

Patients remained on the ward for the duration of their stay unless there was a clinical need to move them elsewhere.

Planning for discharge, transfer or transition to other services, including potential future placements, began at the earliest possible stage. The model of care included a clear discharge pathway. Discharge arrangements were considered from the time patients were admitted, to ensure they stayed in hospital for the shortest possible time. This included providing support to patients during periods of leave. All the care plans we reviewed contained plans for leaving hospital and for staying safe while on leave. All the patients and carers we spoke with were aware of plans for discharge.

Discharge planning included a clear plan for patients to return to school or college, supported by teaching or nursing staff. Where patients did not have guidance from their school or college, the education staff worked with a specialist careers advisor who would meet with patients while they were still in hospital, formulate a transition plan, and offer advice and guidance regarding future opportunities.

Care and treatment was coordinated with other services and other providers. Staff worked closely with care coordinators to ensure that patients received help through their discharge. Discharges or transfers were discussed in the multidisciplinary team meeting and managed in a planned and coordinated way. There was a care pathway from Hope unit to Horizon unit depending on individual need and this was care planned and phased. Staff worked closely with commissioners to facilitate transfers and discharges.

In the six months up to 31 May, three patients had delayed discharges from Hope unit. These were due to factors such as multi-agency difference of view, funding, availability of appropriate social care placement and availability of support from community teams after discharge.

During the same period, there were no readmissions within 90 days.

The average length of stay on Hope unit was four to six weeks and on Horizon unit, 305 days.

The facilities promote recovery, comfort, dignity and confidentiality

The ward facilities and premises were suitable to promote recovery and support care and treatment. Clinic rooms were clean and well equipped. There were numerous information boards that had been designed and created by patients. There was a main lounge and a female only lounge. There was a safe care area and a seclusion suite. There were rooms where patients could relax or engage in therapeutic activities. These included quiet areas, activity and meeting rooms. Some rooms could double as quiet areas or therapy spaces. Each ward had a room where patients could meet visitors. These were away from the main ward area and afforded privacy for patients and their

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visitors. There was a separate room away from the main ward areas for visits with children. Patients had access to a private telephone and access to the internet via a computer on the ward. There was an action plan and draft policy for the introduction of mobile phones. The plan included providing safety training for patients and their families.

Both wards had access to a secure garden area that contained games and seating areas. There was also a large, outdoor therapeutic space called the woodland retreat, a landscaped area with seating and tables, outdoor activity areas and an enclosed room in a tree house. Patients used it for time off the ward in a safe, therapeutic environment. It was used for many activities including social, educational and therapeutic. The woodland retreat had been developed through grant funding from the King's fund, secured by a joint bid between patients and trust staff.

Opinions about the food ranged from 'good' to 'disgusting'. Patients said there was a choice but that it was limited, particularly for patients with dietary requirements. Meal times were set and patients had protected time for their meals, although there was flexibility for those who needed it. There was access to hot drinks and snacks but the kitchen was kept locked so patients had to ask staff when they wanted to make a drink. Patients we spoke with told us that staff would always provide access to the kitchen when they requested it. Patients had their own snack boxes, which were kept in the kitchen, but they could only access those at certain times.

Patients could practice and develop daily living skills such as cooking. The woodland retreat had a small kitchen area and there was a breakfast club at which patients planned and prepared breakfast together. Patients chose the menu during community meetings.

Staff encouraged patients to personalise their bedrooms. The bedrooms we viewed had been arranged with care by the patients, with pictures, books, personal effects, music system etc.

Each ward had a secure locker where patients could store their personal property.

Activities were offered seven days a week. Patients described some ward based activities as relaxing, such as board games, DVD night and a book club. Other activities included bowling, dance groups, pet therapy, current affairs debates, yoga and mindfulness groups, and the woodland retreat had hosted activities such as circus skills

training, birds of prey and a prom at the end of the school year. As well as a weekly timetable of activities, each patient had their own individual plan. Activity focused on promoting safe, early recovery.

There were several initiatives to improve physical health and encourage healthy lifestyles.

There was a physical health clinic every week. Drinks and snacks included sugar free and low fat wherever possible. Patients also took part in walking groups, dance groups and smoking cessation.

Meeting the needs of all people who use the service

Patients' individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, offered choice and ensured continuity of care. Patients were involved in the design and delivery of services via the young people's council.

The ward environments were accessible and there was a lift to the upper level. Staff took a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met their needs and promoted equality. This included patients in vulnerable circumstances or those with complex needs. The needs of different patients were taken into account when planning and delivering services.

There was a range of information available relating to activities, treatment, safeguarding, patients' rights, education, physical health, equality and diversity and complaints information. There was a picture board explaining who staff were and their roles, and a board with information about rights and responsibilities under the Mental Health Act.

There was information about the independent mental health advocacy service and how to contact the advocate.

There was clear information and timetables on notice boards about the range of activities available on and off the wards. The activity board had a full timetable and each patient had their own individual activity plan, including activities that promoted physical activity. Activities included art groups, debate groups, walking groups and specific activities requested by patients. There was a Wii games console and other computer games, such as dance

Are services responsive to people's needs?

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

and yoga DVDs. Patients could hold dance competitions and do fitness activities with staff. There was also a range of equipment such as badminton, tennis, football and hula hoops.

Information leaflets were available in a range of languages and formats appropriate to the age of the patient group. Some had been designed by patients. One patient told us that they had been given a more user friendly information leaflet about their medication when they had found the usual one hard to understand. The welcome pack was available in a number of different languages and formats such as Bangla, Chinese, Polish, Urdu, large print, spoken or braille.

Interpreters were available and accessed as needed. When they were admitted, patients received information booklets about the ward and service and they were allocated a peer 'buddy' to help them settle in and familiarise themselves.

There was a private facility for patients to make telephone calls. Mobile phones were not allowed but this had been reviewed and individually risk assessed and care planned access was due to begin in September 2016.

Patients told us there was a choice of food, which they said was good, but some did not like the menus and did not think there was enough choice. Meal choices included options for vegan and halal diets and for patients with allergies or medical conditions such as diabetes.

Patients' cultural and religious needs were met and they had access to spiritual support, although the patients we spoke with said they had no wish for it. There was a multi-faith room that contained materials relevant to various religions and cultures.

Patients attended education on site on both units. The office for standards in education, children's services and skills had inspected the education facilities in June 2014 and rated them as good. Education was provided via a service level agreement with an external education provider. The education provider was in the process of applying for registration with the office for standards in education, children's services and skills. Staff told us that 25 hours of education were provided each week, and patients could continue with GCSEs and a range of post 16 vocational based courses. We spoke with four teachers during our visit. They told us that communication with ward staff was good and information about patient progress was discussed daily. Teachers and ward staff

supported patients on the wards if they could not attend education. Healthcare staff provided training sessions to teachers every month, which included attachment, eating disorders, risk, self-harm, mindfulness and relational security. The deputy headmaster attended weekly multidisciplinary team meetings.

Education was provided for three hours a day, with added support for patients with behavioural, autistic spectrum disorders or learning difficulties. The education staff provided lessons to meet the national curriculum and examination courses. They also sourced additional subject specific teachers to meet the needs of individual patients.

The education team prepared and entered patients for external examinations, to ensure they had the same opportunities they would have in mainstream education and for some the opportunity to take new qualifications that would help them in their future lives. Some patients were supported with examination courses and entered through their school or college. A variety of qualifications were offered on the unit including GCSEs, functional skills, BTEC awards, entry level certificates, preparation for working life and the BCS e-safety qualification.

Listening to and learning from concerns and complaints

Most patients and carers we spoke with said they knew how to raise concerns. Two patients told us they had not received information about how to make a complaint but also said they would approach staff if they felt the need to complain.

Information on how to make a complaint and how to contact the Care Quality Commission was displayed on noticeboards in the patient areas. The welcome pack that had been designed by patients contained information about how to make a complaint. There was a suggestions box and a 'worry' box on the wards. Staff were able to explain how they dealt with complaints from patients and families by attempting to resolve them at ward level; however, support to make a formal complaint was given if this was the patient's or family's choice.

Staff received feedback from complaints through the 'key themes' report, business meetings and in supervision. As a result of complaints and concerns, improvements were

Are services responsive to people's needs?

Outstanding ☆

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made across the services. These were displayed in patient areas on 'you said, we did' boards. For example, new furniture and ward accessories had been purchased, and funding had been secured for pet therapy sessions.

In the 12 months prior to inspection, Horizon had received one formal complaint. This investigation was still ongoing at the time of our inspection. Hope had received two complaints. Both related to the conduct of bank staff. Both were partially upheld but neither were referred to the parliamentary and health service ombudsman.

Are services well-led?

Outstanding ☆

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

The leadership, governance and culture on the wards were used to drive and improve the delivery of high quality person-centred care.

The trust's vision was to deliver the best possible care to patients, people and families in local communities by working effectively with partners, to help people to live well. This was supported by five overarching strategic goals:

- put local people and communities first
- strive for excellence
- use resources wisely
- be the partner of choice
- be a great place to work

The trust had adopted a further set of principles, the 10 principles of care, that outlined its key values and behaviours. The principles had been developed by staff and were relevant to clinical and support staff, whatever their role.

The 10 principles of care were:

- safe and effective services
- meaningful and individualised
- engaging and valuing
- constructive challenge
- governance procedures enable
- focused and specific
- competent skilled workforce
- clear and open communication
- visible leadership
- shared accountability

Staff and patients had made a short film together about how their service embedded the values and behaviours for the trust's 'principles of care' awards.

Staff understood the vision and direction of the service they worked in and about how their work linked into the trust's vision and values. They described an ethos that promoted safe, early recovery. At each supervision session, managers expected staff to show how they incorporated the vision and values into their practice. The vision and values were integrated into everyday business via key themes reports, 'you said, we did', lessons learned and effective handover meetings. The young people's council had a voice in

governance decisions. Our discussions with staff and our observations of care being delivered assured us that the vision and values were embedded in the service and in individual practice.

Staff commented that managers were extremely approachable and operated an 'open door' policy for staff to raise any issues or concerns. They knew who the senior managers were and throughout our inspection they acknowledged and spoke with each other. Staff told us about a particularly difficult period on the ward when the senior managers regularly attended the ward to support staff. The patients we spoke with told us that staff were approachable and caring.

Good governance

Staff told us they had regular contact with the senior management team. They explained the leadership and management structures in their service and they knew who the senior managers were. The model of leadership encouraged and supported staff to be involved in the governance process.

We found all the staff were well managed locally. Managers had the experience, capacity and capability to ensure that the vision and values could be delivered. Staff were clear about their roles and they understood the management structure. They received appropriate training and were appraised and supervised, complaints were investigated, incidents were reported and investigated, changes were made where needed and safeguarding and Mental Health Act procedures were followed.

On every ward, staff completed regular audits. Assessments, care plans and risk management plans were audited to ensure they were completed and reviewed regularly. There were also environmental audits that included ligature risk audits, and audits of infection control systems, equipment and medicines. Other audits included looking at the quality of discharge summaries and record keeping. Audit findings were addressed quickly.

Staff used a number of quality tools and assessments to measure patient safety. These ranged from being conducted monthly to quarterly and annually. Examples included ward inclusion quality mark reports, the Royal College of Psychiatrists' quality network for inpatient child and adolescent mental health inspection, patient led assessments of the care environment, infection control audits and the monthly key themes reports.

Are services well-led?

Outstanding ☆

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.

Across both teams, staff understood their responsibilities relating to the duty of candour. They knew what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Performance information was used to hold management and staff to account. Staff supervision was carried out at least every month. Staff told us they had been supervised and appraised by their line managers and that they were supported by them as well as by their peers. However, the records we reviewed were not all up to date.

Staff were responsible for ensuring their training was up to date but their managers also monitored compliance. Staff compliance with mandatory training requirements at 31 May 2016 was 86%. Throughout our inspection we discussed various issues with staff, such as safeguarding, mental capacity and dealing with violence and aggression, and we reviewed care records and supervision notes. We were assured that staff were competent and had the skills necessary for them to carry out their roles.

There was a good governance structure to oversee the operation of the service. There was a handover meeting every morning. Both wards held monthly business meetings where performance and wider service issues were discussed. This included information from patient community meetings. We found the meetings we attended or saw minutes of to be well structured, informative and productive, addressing quality issues clearly. Staff also used innovative approaches to encourage patients to provide feedback, such as using iPads.

The service used the commissioning for quality and innovation framework as quality indicators. Currently these included delayed discharges, supervision, safeguarding training and reduction in restrictive interventions. There were clear targets and action plans that were regularly reviewed.

Ward managers told us they had sufficient autonomy to carry out their role and they felt supported by the senior managers. Staff shortages had been recognised and an action plan was being implemented to resolve the issues.

Leadership, morale and staff engagement

Managers prioritised safe, high quality, compassionate care and promoted equality and diversity. They made every effort to deliver and motivated staff to succeed. They actively shaped the culture of the service through effective engagement with staff, patients and their representatives and stakeholders.

Staff told us they felt well supported by their local managers, peers and more senior management. Many commented on the positive relationship they had with their managers. Examples of strong local leadership from the managers were clear, such as implementing initiatives to meet the diverse needs of patients and ensuring the vision and values were embedded into individual practice and service delivery.

Staff had opportunities for career progression. Some health care support staff had been supported through training to become registered nurses.

Sickness and absence rates were worse than the national average at 6% on Hope unit and 8% on Horizon unit.

Leaders encouraged cooperative, supportive relationships among staff. Staff were proud of the service as a place to work and they spoke highly of the culture. They felt respected, valued and supported, and were positive about their jobs. They reported good multidisciplinary team working. Staff were supportive and caring towards each other. We observed all staff interacting as a cohesive team, with a clear understanding of each other's roles. They told us they enjoyed their work and were proud of the culture of care. They showed a clear commitment to providing the quality care that patients needed. There was strong collaboration and support across the teams and a common focus on improving patients' experiences.

Candour, openness, honesty and transparency and challenges to poor practice were encouraged. Managers encouraged staff to be open and honest when things went wrong. The duty of candour was discussed at business meetings so that staff had a good understanding of the duty. Staff we spoke with understood what a notifiable safety incident was and explained what they were expected to do. They were clear that they would explain and apologise to patients and their families in any event.

Staff understood the whistleblowing process and said they would use it to escalate concerns. They told us they felt able to raise concerns without fear of victimisation, to promote service development and improvement.

Are services well-led?

Outstanding ☆

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.

Staff were encouraged to discuss issues and ideas for service development within supervision, business meetings and with senior managers. Records we reviewed confirmed this. There were regular staff surveys with action plans for improvements based on the findings.

The wards had recently held away days as part of service development and team building. Staff views were requested in advance so that the day could be structured appropriately around their values and aspirations within the service philosophy. The questionnaire identified a number of areas for improvement, such as communication, decision making and continuous improvement. All staff were also invited to evaluate the day.

Commitment to quality improvement and innovation

Both wards participated in the inclusion quality mark. The most recent reports from January 2016 outlined areas of good practice including systems to ensure that consent and best interest processes are followed, physical health monitoring, patient involvement, safeguarding and collaborative care delivery.

In 2015, both wards had been reviewed by the Royal College of Psychiatrists as part of the quality network for inpatient child and adolescent mental health services. Hope unit was accredited and Horizon unit was accredited as excellent.

As part of the Royal College of Psychiatrists' ongoing accreditation process, Hope had undergone peer review in April 2016. The unit had fully met 98% of child and adolescent mental health services standards. The report outlined key achievements including effective discharge summaries, the response to data gathered following incidents and the wide range of therapies provided.

Horizon had also recently undergone peer review but the report was not available at the time we inspected.

Psychology staff were undertaking a joint project with the University of Manchester to develop a new outcome measure for tier four child and adolescent mental health services that encompassed a more subjective, user defined perception of recovery. An article had been published in the quality network for inpatient child and adolescent mental health services newsletter.

There was also ongoing work with the University of Manchester to develop a fidelity tool to assess the quality of team formulations.

A proposal had been submitted to NHS England to consider a limited day provision for patients with eating disorder, in response to clinical need. This would enhance the service further in developing pathways for patients on the eating disorder programme.