

Good**Alder Hey Children's NHS Foundation Trust**

Child and adolescent mental health wards

Quality Report

Dewi Jones Unit
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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)
RBSX3	Dewi Jones Unit	Child and adolescent mental health ward	L22 3XE

This report describes our judgement of the quality of care provided within this core service by Alder Hey Children's 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 Alder Hey Children's NHS Foundation Trust and these are brought together to inform our overall judgement of Alder Hey Children's 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

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

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 gave an overall rating for child and adolescent mental health inpatient wards of good because:

- The ward and facilities were safe, clean and adequately maintained. Ligature points were managed adequately. Staff observed blind spots at all times.
- Multi-disciplinary team meetings were highly effective and included representation from a wide range of disciplines.
- There was a holistic approach to assessing, planning and delivering care and treatment to patients, which commenced prior to admission. The unit's pre-admission process included comprehensive assessments and structured education, therapy and activity plans.

- There was a team around the child approach with the patient being at the centre of the assessment, care planning and recovery process. There was a strong, visible person-centred culture. Staff were highly motivated and provided care that promoted people's dignity.
- There were effective staff training, supervision and appraisal structures in place to support staff at all levels. Staff were fully aware of their own service's objectives but felt disconnected from the main trust.

Although the facilities promoted recovery, comfort and dignity, there was insufficient outdoor space on the site for activities such as ball games and physical exercise. There were some poor medicines management practices and no pharmacy service provided to the unit.

Summary of findings

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

Are services safe?

We rated safe as good because:

- The ward and facilities were safe, clean and adequately maintained. There were some ligature points within the unit but the risks were managed adequately. For example, environmental risk assessments were undertaken for all patients on admission. There were blind spots on the ward. Staff managed this risk by observing these areas at all times.
- Staffing levels and skill mix were planned and reviewed to ensure patients received safe care and treatment.
- There were some good medicines practices in place such as recording of patients' allergies, daily checks on controlled drugs, and weekly checks on emergency equipment.

However, there were some poor medicines practices, for example, there was no pharmacy service provided to the unit, fridge temperatures were not always recorded and opening/discard dates were missing on some medicines.

Good



Are services effective?

We rated effective as good because:

- There was a holistic approach to assessing, planning and delivering care and treatment to patients. Care plans were personalised and recovery-oriented.
- Multi-disciplinary team meetings were highly effective and included representation from a wide range of disciplines. However, there was no access to occupational therapy, social work, pharmacy and speech and language therapy.
- Most staff had received training on the Mental Health Act 1983 (MHA) and Code of Practice.

However, as the use of the Mental Health Act was rare, some staff were unfamiliar with its requirements.

Good



Are services caring?

We rated caring as outstanding because:

- Patients were active partners in their care. Staff were fully committed to working in partnership with people and their families. There was a team around the child approach with the patient being at the centre of the assessment, care planning and recovery process.
- Care was always delivered in line with individuals' preferences and needs. There was a strong, visible person-centred culture.

Outstanding



Summary of findings

Staff were highly motivated and inspired to provide care that was kind and promoted people's dignity. Relationships between patients, their families and carers, and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by the unit's leadership team.

- Staff recognised and respected the totality of people's needs. They took people's personal, cultural, social and religious needs into account. For example, records showed numerous contacts with police, social services and advice agencies on matters such as domestic violence and legal aid.
- Staff were very aware of the young age range of their patient cohort and were committed to ensuring the environment was pleasant and child-friendly. During the move to the present building in 2012, staff brought patients' artwork, pictures, sculptures and other items with them to make the unit immediately welcoming and familiar.
- People's emotional and social needs were highly valued by staff and were embedded in their care and treatment.

Are services responsive to people's needs?

We rated responsive as good because:

- The pre-admission process was thorough including comprehensive assessments and the development of structured education, therapy and activity plans and timetables.
- The unit was flexible to the needs of young people who turned 14 years old while they were in hospital. This meant they could stay in the hospital until their care episode was completed.
- Catering was managed on-site and took into account special diets, patient preferences and brand preferences.
- Staff, patients and relatives knew how to raise concerns.
- The facilities promoted recovery, comfort and dignity.

However, there was insufficient outdoor space on the site for activities such as ball games and physical exercise.

Good



Are services well-led?

We rated well-led as good because:

- There were clear team and service objectives which reflected the provider's values and strategy.
- Staff knew who the unit's senior management team were as they were visible but felt disconnected from the main trust and its executive team.

Good



Summary of findings

- There was a good meeting structure in place to escalate and cascade information through all levels of staff. This included management review and improvements of risks, incidents and performance monitoring.
- Staff training, supervision and appraisal structures were set up to support staff at all levels.
- Staff understood their roles and responsibilities, including accountability. Staff felt respected, valued and supported by the management team and their peers.
- The unit had good relationships with commissioners. There was a monthly contract monitoring review meeting trust wide.

Summary of findings

Information about the service

Alder Hey Children's NHS Foundation Trust provided child and adolescent mental health inpatient services at the Dewi Jones Unit.

The Dewi Jones Unit was a nine-bedded stand-alone unit which provided inpatient and day patient treatment for children aged 5 to 13 years. The service was commissioned by NHS England Specialist Commissioning Services, and was one of six specialist units in England.

The unit supported children who were experiencing emotional or psychological difficulties. It provided treatment and support for a range of conditions including anxiety and emotional disorders, depression, eating disorders, autism, obsessive compulsive disorders and self-harm.

The trust was last inspected in May 2014. This did not include an inspection of the child and adolescent mental health wards. However, a Mental Health Act 1983 (MHA) monitoring visit was completed on 11 August 2014. The visit identified a number of issues including:-

- absence of processes for scrutiny of detention papers
- keeping staff up to date with the expectations of the Mental Health Act and Code of Practice
- no evidence of discussion with patients about their capacity to consent to treatment
- no evidence that rights were explained to a patient who had been detained under section 2 of the MHA in the past.

The provider submitted an action plan to address these issues. These issues were reviewed as part of this inspection.

Our inspection team

Our inspection team was led by: Ann Ford, Head of Hospital Inspections (Acute Hospitals)

Team Leader: Sarah Dunnett, Inspection Manager, Care Quality Commission

The team who inspected the child and adolescent mental health wards consisted of five people: one inspection manager, three inspectors and one psychiatrist.

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 patients' who used the services, we always ask the following five questions of every service and provider:

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

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

During the inspection visit, the inspection team:

- Visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients.
- Interviewed the manager for the ward.
- Interviewed two consultant psychiatrists.

Summary of findings

- Interviewed the service manager for the unit.
- Interviewed the general manager for integrated community services who had operational responsibility for the CAMHS.
- Spoke with other staff members including doctors, nurses, psychiatrists, psychologists, family therapists, and healthcare assistants.
- Spoke with one relative of a patient.
- Attended and observed one hand-over meeting, one referral meeting and multi-disciplinary team meeting for two patients.

- Held focus groups with staff to seek feedback on their experience of working for the trust.

We also:

- Looked at medication records for four patients.
- Carried out a specific check of the medication management on the ward.
- Looked at care records for three patients
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients' feedback and comments about the unit were very positive. The environment was described as welcoming and conducive to wellbeing and recovery. Staff were praised for their supportive, respectful manner and described as caring and approachable. The unit offered a range of therapies and activities based on patients' individual needs.
- Patients' surveys showed that the quality and choice of food was good.
- Relatives gave positive feedback about the unit. They said that the environment was welcoming and child-friendly. Relatives said staff worked in partnership with families. They were provided with a parents' information pack and copies of care plans. Staff kept them up to date on their child's progress, and they were included in activities and treatments.

Good practice

- Staff explained the holding approach (restraint) to relatives of a patient where restraint was going to be used and showed how it was used.
- The on-site caterer worked together with parents, staff and patients to obtain patients' food preferences and cultural requirements.
- The unit had developed a guide to Dewi Jones Unit to support new patients. This was an accessible, child-friendly document developed with patients. It included tips and advice from patients on how to adjust to the unit.
- The unit had developed a parents' information pack to support families of new patients. The pack included information about the unit, services provided and contact details.

Areas for improvement

Action the provider **SHOULD** take to improve

- The trust should ensure adequate medicines management oversight, and improve day to day medicines management practices, for example, recording dates of opening of medicines. The provider should ensure that a patient's medication is verified by a pharmacist or pharmacist technician upon admission. The provider should ensure that medicines management practices are audited frequently in line with the good practice/compliance.
- The trust should ensure full compliance with the Mental Health Act and Code of Practice including

Summary of findings

records management, treatment certificates, consideration of, and decisions around consent to treatment, and good and timely access to mental health act support.

- The trust should consider improving the identification of key information in care records such as whether the child is on the child protection register or whether the child is looked after.

Alder Hey Children's 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
Child and adolescent mental health ward	Dewi Jones Unit

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.

- There was evidence to demonstrate that the Mental Health Act (MHA) was being adhered to. Most staff had received training on the MHA and Code of Practice. Patients had their rights under the Mental Health Act explained to them but there was no record of this in patients' files. Mental Health Act administrative support was available from the main hospital.
- Patients could access advocacy services and detained patients were offered independent mental health advocates (IMHA).
- Staff discussed treatment and care, consent to medication, and side effects with patients.
- There was limited use of the Mental Health Act 1983 within the service and as such some staff were unfamiliar with the implications of the MHA in practice. There was no effective system to monitor when rights had been given to a patient and when they were due to be given again. Legal documentation in regard to detention had not been completed in full. There was no evidence of regular audits to assure the provider that the MHA had been applied correctly.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act and Deprivation of Liberty Safeguards did not apply as the service supported children and adolescents aged 5 to 13 years. However, staff applied the principles of the Gillick Test.

Are services safe?

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

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

Summary of findings

We rated safe as good because:

- The ward and facilities were safe, clean and adequately maintained. There were some ligature points within the unit but the risks were managed adequately. For example, environmental risk assessments were undertaken for all patients on admission. There were blind spots on the ward. Staff managed this risk by observing these areas at all times.
- Staffing levels and skill mix were planned and reviewed to ensure patients received safe care and treatment.
- There were some good medicines practices in place such as recording of patients' allergies, daily checks on controlled drugs, and weekly checks on emergency equipment.

However, there were some poor medicines practices, for example, there was no pharmacy service provided to the unit, fridge temperatures were not always recorded and opening/discard dates were missing on some medicines.

- Equipment and items such as games consoles were locked in a cupboard in the lounge but were available upon request. Staff kept all razor blades and aerosols in the staff office for health and safety reasons. Security cameras were installed at the entrance on the ground floor. There was a security lead for the unit based on site.
- Staff undertook environmental risk assessments for each individual patient upon admission and identified risks were mitigated. The on-site caretaker had recently started to conduct weekly environmental checks to highlight new risks or maintenance issues.
- There was an alarm response system for staff and all staff carried alarms. Patients did not have call buttons in their rooms. However, patients could request alarms if they felt unsafe, and this was advertised on the notice board.
- The ward complied with guidance on same-sex accommodation in that all patients had individual bedrooms with en suite facilities.
- There was a fully equipped clinic room on the ground floor with accessible resuscitation equipment and emergency drugs. An additional set of resuscitation equipment was held on the upper floor. There was no room thermometer in the clinic room to ensure compliance with safe storage of medication practices.
- The seclusion room bathroom wall was not clean on the first day of our inspection and we raised this. When we returned the next day, the bathroom had been thoroughly cleaned. The two way intercom was not working properly. Staff reported this the same day but explained that the trust might take some time to respond.
- There was writing on the top corner of the seclusion room saying "I hate life", which could upset patients.
- The observation room was a double window in the adjoining staff office, which had blinds to reduce distraction/stimuli. The clock was outside the seclusion room but there was a gap in the door window through which it could be seen. Staff used an egg timer with children who could not tell the time. The seclusion room was checked before use but there were no records of this practice. The seclusion room was used three or four times a month for minutes at a time but there was no

Our findings

Safe and clean environment

- Overall, the ward and facilities were safe, clean and adequately maintained. Risks were managed appropriately. The first floor windows had restrictors fitted this meant there was a limit on how far they would open to protect the safety of the patients.
- The staff kitchen and the life skills kitchen were kept locked when it was not in use to ensure patients were not unattended whilst having access to kitchen equipment. Patients could use the life skills kitchen with staff following an individual risk assessment. The kitchen hatch was only partly opened to discourage patients from accessing the kitchen from the dining room.

Are services safe?

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

seclusion log to corroborate this. However, individual seclusion records were completed, which showed how patients were monitored during the seclusion period. These records were placed on their care files. Records showed that the consultant and multi-disciplinary team were informed immediately when patients were placed in seclusion.

- Staff were not able to observe all parts of the ward owing to its layout. However, staff were routinely positioned at junctions to ensure observation of all areas at all times. In addition, several patients were on 1-1 observations level, which meant staff were also positioned outside bedrooms.
- There was a ligature point by the large heater in the large lounge. Bathroom doors in bedrooms were not ligature proof. However, risks were mitigated. Environmental risk assessments were undertaken for all patients on admission, and owing to the young age of the patient group and their needs, patients were commonly nursed on 1-1 observation levels.

Safe staffing

- The total number of posts allocated to Dewi Jones was 25.06 whole time equivalent (WTE), of which 16.8 WTE posts were for nursing staff. As at June 2015, the nursing staff complement comprised nine WTE qualified staff posts, and 7.8 WTE unqualified staff posts. The qualified staff complement comprised five Registered Mental Nurses (RMN) and four Registered Sick Children's Nurses (RSCN). The unqualified staff complement comprised three WTE support workers and 4.8 WTE healthcare assistants.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. The unit was normally staffed for seven patients which was the number of beds commissioned by NHS England. Additional staff were deployed if there were patients in the two additional beds in the unit or to support increased observations of patients.
- At the time of inspection, Dewi Jones had two vacancies for health care assistants and one vacancy for a qualified nurse. Dewi Jones Unit had long-serving staff members and a low turnover of staff. It also had staff in post who had been students at the unit in the past. Between May 14 and April 15, the staff turnover rate for the unit was 9.58%.

- Day shifts comprised a minimum of two qualified staff, one of which was an RMN, and three unqualified staff. Night shifts comprised of a minimum of two qualified staff, one of which was an RMN, and one unqualified staff.
- Any staff shortages were responded to quickly and adequately. There was very low use of agency staff. In the last 12 months there has been one shift covered by bank staff at the Dewi Jones unit. Dewi Jones Unit operated an internal bank system and used staff known to the service and patients, or staff managed shifts between themselves, to ensure continuity of care. All nursing staff were on annualised hours contracts and shifts were rostered and filled according to fluctuating needs of the service and patients. For example, staff did not work during the weekend at times when all patients returned home. There was a floating cover system which offered the option of calling staff in, if required. The unit was developing a six month fixed term contract for bank staff to ensure a staffing supply familiar with the unit.
- Staffing shortages occurred when there was sickness or when a patient had very complex needs and required high levels of observation and care such as 3:1 or 4:1 staff/patient ratio. At such times, outdoor activities were very occasionally cancelled because the number of staff required for outdoor activities was greater than when indoors. However, this was rare, and the staff tried to avoid any disruption to the children's structured timetables.
- There was adequate medical cover day and night and an out of hour's on-call system was in place for psychiatry. If the unit was closed at the weekend because patients had home leave, there was nursing on-call cover in place.
- Most staff had received and were up to date with mandatory training. The average mandatory training rate for medical and nursing staff was 94%. However, for administrative staff, the average mandatory training rate was 50%. The training rate for information governance training for nursing staff was 71%, and for safeguarding level three training, the rate for nursing staff was 57%. 90% of nursing and support workers had received training on restraint and breakaway techniques.

Assessing and managing risk to patients and staff

- We examined care records for three patients. Staff undertook a risk assessment for every patient prior to and upon admission and updated this regularly

Are services safe?

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

following changes or incidents. Staff also undertook environmental risk assessments individual to the patient on admission. In accordance with good practice, staff used the Galatean Risk Assessment Tool (GRiST), which offered a comprehensive assessment of risks presented by patients.

- There were no incidents of the use of long term segregation. There were no incidents of restraint in prone position. Staff rarely used sedation and rapid tranquillisation. In one case, we observed a full multi-disciplinary team discussion on whether to use sedation as a last resort with a highly complex patient presentation.
- Staff were trained in safeguarding and staff were confident in identifying and raising safeguarding concerns. The mandatory training level for safeguarding level 1 was 100% but for safeguarding level 3, it was 57%. Safeguarding referrals were made following a multi-disciplinary team discussion. We saw two examples in which staff had recognised and made urgent referrals to social services following concerns they had about the patients' home circumstances.
- Daily checks on emergency equipment were completed.
- Medicines were stored securely and generally safely managed and administered. Staff had recorded patients' allergies clearly on medication charts. Staff completed daily checks on controlled drugs. Pro re nata (PRN 'as needed') medication was recorded appropriately. Staff administered medicines safely, checking doses and patient identification. However, the management of medicines was not always carried out in line with trust policy. Fridge temperatures had not been recorded in compliance with safe storage and management of medicines. New patients' medication had not been verified by a pharmacist. On one occasion, there was no second signature to confirm administration. Opening dates were missing on four liquid medicines which

meant that there was a risk that the medicine could be used after it should be. There were no audits of medicines management. When we raised issues with staff, immediate action was taken. Undated liquid medicines were discarded and staff were reminded in a handover meeting to record dates of when medicines were opened.

- It was not easy to identify from patients' records if they were on the child protection register, or were Looked After Children.

Track record on safety

- There had been one serious incident reported by the Dewi Jones Unit in the last 12 months. This was a never event that took place in the unit. It was not mental health-related matter but a medical emergency. Staff had acted quickly and appropriately to respond to the incident. Learning from the incident had been applied to practice.

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew how to report incidents onto the trust's incident recording system (Ulysses). Where feasible, staff and managers made immediate changes following incidents, for example, purchasing protective clothing to prevent injury to staff.
- Serious incidents were investigated by the trust but staff did not always receive the outcome and so learning opportunities were lost.
- Staff were given time to reflect and discuss issues. A staff member could request an issue meeting at any time. Managers had started to hold staff debriefing meetings following incidents in line with a new trust policy.
- Injuries to staff were recorded in a separate incident book and added to the risk register.

Are services effective?

Good 

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

Summary of findings

We rated effective as good because:

- There was a holistic approach to assessing, planning and delivering care and treatment to patients. Care plans were personalised and recovery-oriented.
- Multi-disciplinary team meetings were highly effective and included representation from a wide range of disciplines. However, there was no access to occupational therapy, social work, pharmacy and speech and language therapy.
- Most staff had received training on the Mental Health Act 1983 (MHA) and Code of Practice.

However, as the use of the Mental Health Act was rare, some staff were unfamiliar with its requirements.

Our findings

Assessment of needs and planning of care

- We examined care records for three patients. There was a holistic approach to assessing, planning and delivering care and treatment to patients. Comprehensive and timely assessments were completed prior to and on admission. Assessment documentation included information on physical health, education and family background. Home and school integration were part of care planning. Care plans were personalised and recovery-oriented. Care plans showed the goals the child wished to achieve and how these would be supported. Care plans were reviewed weekly. Daily notes were detailed and up to date.
- All patients were allocated a named keyworker and a nursing team. The multi-disciplinary team received a presentation about the child's history and needs prior to admission. This meant staff were familiar with the patient and could better support their admission.
- There were good systems in place to record discussions about medicines with patients and relatives.
- Specialist staff provided education on site. Schooling was tailored to the individual child's stage of intellectual development and specific needs.
- There were individual eating programmes in place for patients with disordered eating.

- One patient had received recent reviews from physiotherapy, dietetic and paediatric services, but there were no corresponding entries in the patient's records.

Best practice in treatment and care

- Dewi Jones offered a range of therapies including systemic family therapy, cognitive behaviour therapy, child psychodynamic psychotherapy. Additional services included neuro-cognitive testing, and assessment of Autistic Spectrum Disorder.
- Access to the acute children's hospital's physical healthcare specialists, such as physiotherapy and dietician, was difficult. In some cases, the unit had escalated their requests for specialist support to senior management. The hospital offered appointments at their main site ten miles away even when this was not practicable owing to a patient's condition. There was no process in place to access speech and language therapy from the main hospital.
- Restrictive practices were used as a last resort. All holds (restraints) were documented in detail and kept on patients' files.
- The service offered day patient services to avoid unnecessary admissions of children.
- Patients' records showed the service was utilising the Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA). This is an outcome measurement tool that assesses the behaviours, impairments, symptoms and social functioning of a child or adolescent with mental health problems.
- Prescribing was in line with NICE guidance and trust policy. There was a pharmacy link at the main hospital, however, there were no audits of medicines taking place.
- Dewi Jones Unit was committed to achieving Quality Network for Inpatient CAMHS (QNIC) standards in service delivery. The service had submitted their application for accreditation, which had yet to be assessed. However, the unit's self-assessment documentation showed a number of gaps. For example, the staffing mix lacked social work and occupational therapy support; there was no overnight accommodation for families; and some policies were out of date.

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.

Skilled staff to deliver care

- The unit had access to psychiatry cover out of hours via a regional on call system with response times usually within an hour.
- Staff were given protected time for continuing professional development. Staff received the necessary training for their roles and were encouraged to learn and develop. One staff member told us she had been supported to train to NVQ level 3 and had recently submitted an application for nurse training. Staff were also supported to complete the CAMHS diploma. Qualified staff had access to leadership and mentorship courses.
- Staff received regular supervision on a 1 to 1, team and professional basis. Staff had access to regular team meetings and could call issue meetings at any time. All medical staff had received an appraisal in the last 12 months. Since 1 April 2015, 50% of nursing staff had received a performance development review (PDR) and 43% had PDRs planned to be completed by 31 July 2015. Consultants had access to peer support and supervised junior doctors.
- Staff received induction training at the main children's hospital site, which meant that staff were away from Dewi Jones for a period of time. The unit had developed local induction training to maximise staff availability. All nursing staff had received holding approach (restraint) training and all staff had received breakaway training. Two members of the staff team were restraint trainers.
- The unit had good access to stoma and tissue viability nurses from the acute children's hospital. However, there was poor access to a range of physical healthcare specialists from the acute hospital, including physiotherapy, dietician, paediatrician, pharmacy and speech and language therapy. This meant there were delays in responding to patients' needs. Staff made referrals for speech and language therapy to the patient's local community team, which could result in delays if there were waiting lists or if services were out of area.
- The unit did not have the staffing mix required for compliance with Quality Network for Inpatient CAMHS (QNIC) standards. Gaps included occupational therapy, dietetics and social work. The unit had identified funding for the social worker position and the vacancy had been advertised.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary team meetings were held weekly. We observed one multi-disciplinary team meeting, which was highly effective. There was open and detailed discussion about each patient. All disciplines contributed to the discussion and all staffs' opinions were taken into account. Staff knew each patient very well and applied a person-centred approach to care. There were in-depth discussions, including ethical considerations on specific issues such as the appropriateness of sedation for a specific patient.
- The multi-disciplinary team included psychiatry, psychology, nursing, family therapy and education. Community CAMHS team members and child protection social workers were invited to attend, as required. However, there was no access to occupational therapy and pharmacy input.
- We observed one handover. Staff gave a brief report on each patient highlighting progress, issues and risks. Staff discussed sensitive issues in a respectful and caring manner. Staff were given a summary of any new information or changes about a patient and told where to access full information. The handover included routine issues such as maintenance issues in the unit. Key messages from the handover were documented and passed to the incoming team leader.
- Staff made appropriate referrals to other agencies, as required. Patients' records showed referrals to health services, children's social services and the police.
- Liverpool Council provided schooling on-site and there were good links with the home school service and Sandfield Park, the local hospital school.

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

- Compliance with training on the Mental Health Act (MHA) and Code of Practice was 75%. Training on the Mental Capacity Act was not routinely available from the trust but was included in the training needs analysis for CAMHS staff going forward.
- There was limited use of the Mental Health Act in the unit, for example, one patient a year. As such, it was difficult for staff to keep their knowledge and practice up to date.
- An Independent Mental Health Advocate (IMHA) was sought immediately when a patient became subject to MHA.

Are services effective?

Good 

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

- The unit had developed an easy read MHA Code of Practice for patients and relatives.
- Patients had their rights under the Mental Health Act explained to them but this was not recorded in the patients' care records. There was no easily accessible system to record when rights had been repeated with patients.
- Staff were committed to least restrictive practices, which led to a minimal use of seclusion, medication and restraint. Staff used a holding approach when necessary. Staff preferred to use the soft play room or a patient's bedroom rather than the seclusion suite. If the seclusion suite was used, subject to risk, staff kept the door open and sat outside, or sat with the child in the seclusion room, or used holding position, if required. Seclusion records showed the duration of use, whether the door was open or closed, how many staff were involved, and whether the holding position was used. Records showed that the seclusion suite was used for minutes at a time. The maximum time we saw was 40 minutes.
- Official documentation in regard to detention and consent to medication had not been completed in full. The date and time of detention had been omitted on Form H3 (Mental Health Act 1983) yet the form had been accepted by the Mental Health Act administrator.
- Mental Health Act administrative support was available from the main hospital. However, there was no evidence of regular audits to ensure that the MHA was being applied correctly. Staff cited an example of difficulties they had experienced in obtaining advice, official forms, and an IMHA for a detained patient in the past. They said they had learnt from the experience and the process had since improved. Staff now knew who to contact for advice and how to request an IMHA.

Good practice in applying the Mental Capacity Act

The MCA is not applicable as the service supports children aged 5 to 13 years. However, we found strong evidence of the consideration of consent issues.

- Patients and relatives were asked for consent to some activities. Patients' records held signed and dated consent forms for photos, publicity, swimming and escorted travel.
- We found an example in which staff had considered a child's competence to make a specific decision and had determined that the child was capable of making that decision.



Are services caring?

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

Summary of findings

We rated caring as outstanding because:

- Patients were active partners in their care. Staff were fully committed to working in partnership with people and their families. There was a team around the child approach with the patient being at the centre of the assessment, care planning and recovery process.
- Care was always delivered in line with individuals' preferences and needs. There was a strong, visible person-centred culture. Staff were highly motivated and inspired to provide care that was kind and promoted people's dignity. Relationships between patients, their families and carers, and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by the unit's leadership team.
- Staff recognised and respected the totality of people's needs. They took people's personal, cultural, social and religious needs into account. For example, records showed numerous contacts with police, social services and advice agencies on matters such as domestic violence and legal aid.
- Staff were very aware of the young age range of their patient cohort and were committed to ensuring the environment was pleasant and child-friendly. During the move to the present building in 2012, staff brought patients' artwork, pictures, sculptures and other items with them to make the unit immediately welcoming and familiar.
- People's emotional and social needs were highly valued by staff and were embedded in their care and treatment.
- Comments on noticeboards, in artwork and publicity indicated that patients liked the staff and the way they were treated. One relative told us staff were excellent.
- Staff showed an excellent understanding of each child's needs and family circumstances. Staff showed a person-centred approach in their attitudes and behaviours towards patients. There was a team around the child approach which put the patient in the central role in their assessment, care planning and recovery.
- There were systems in place such as annualised hour's contracts and floating cover arrangements which helped ensure a supply of familiar staff on shifts. In the interests of patients and continuity of care, staff preferred to manage shifts themselves rather than use staff who were unfamiliar with the unit and the patients.
- Patients were given a welcome pack prior to admission. This was a child-friendly document that had been developed with former patients and included tips and advice on how to settle into the unit. Families were given a parents' information pack.
- Staff had good working partnerships with families and carers. Staff made frequent contact with relatives to update them on their child's progress, which was noted in the daily care records.
- Relatives were asked to observe visiting times to help support the child's structured therapy programme. Staff made exceptions to visiting times if the circumstances permitted.
- Staff were committed to supporting patients and families on a wide range of matters. For example, records showed numerous contacts with police, social services and advice agencies on matters such as domestic violence and legal aid.
- Staff were sensitive to individual needs such as the self-conscious nature of a child with disordered eating, and adapted practices to best promote recovery, for example, eating in the bedroom. Staff recognised how nervous a new patient was and asked the nursing team to be sensitive about this, and respond to the patient in a flexible manner.
- Staff were very aware of the young age range of their patient cohort and were committed to ensuring the environment was homely, warm and welcoming. On moving to the new unit three years earlier, staff had thought to bring pictures, artwork, sculptures and other items that patients had created. This made the unit welcoming from the outset.

Our findings

Kindness, dignity, respect and support

- We observed excellent interaction between staff and patients. Staff were responsive, supportive, and discreet, when necessary. Patients were free to express themselves. Staff dressed casually and did not present themselves as authoritative figures. Staff sat low down with a child in 1 to 1 or time-out situations.



Are services caring?

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- Reception and security staff informed nursing staff when patients were near the exit. They did so discreetly so as not to alarm the patient or escalate the situation.

The involvement of people in the care that they receive

- Assessments and care plans were undertaken with patients and families and carers. All assessment and care plan documentation was signed by patients and relatives. Staff offered copies to patients and relatives but this was not clearly recorded in patients' files.
- The planned admission process was very thorough and informative, and involved the patient and relatives. The admission process included family and child outpatient appointments, a tour of the site, and a gradual admission process. Where appropriate, the unit offered day patient care.
- Patient and relatives were actively involved in the whole care pathway from referral to discharge. Family therapy sessions were offered to relatives even when the patient did not wish to attend. One relative told us they found this supportive.
- Patients and family could access advocacy services, which were advertised on noticeboards. The unit arranged access to independent mental health advocates (IMHA) for detained patients.
- Communication between staff and families was very good. Relatives were encouraged to liaise with staff teams and raise any issues. Relatives said they were kept up to date on their child's care.
- Staff used an egg timer for children in seclusion who could not tell the time.
- The unit ran a weekly parents/carers group, which was held during evening hours to encourage attendance. This was led by a psychotherapist and a nurse.
- The trust hosted a children's and young people's forum. This group had visited the Dewi Jones Unit and participated in a range of activities. This was displayed on the trust's website.

Are services responsive to people's needs?

Good 

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

Summary of findings

We rated responsive as good because:

- The pre-admission process was thorough including comprehensive assessments and the development of structured education, therapy and activity plans and timetables.
- The unit was flexible to the needs of young people who turned 14 years old while they were in hospital. This meant they could stay in the hospital until their care episode was completed.
- Catering was managed on-site and took into account special diets, patient preferences and brand preferences.
- Staff, patients and relatives knew how to raise concerns.
- The facilities promoted recovery, comfort and dignity.

However, there was insufficient outdoor space on the site for activities such as ball games and physical exercise.

Our findings

Access and discharge

- Dewi Jones Unit contained nine beds. NHS England commissioned seven beds and the remaining two beds were available for individual purchases, for example, a commissioner from Wales who needed care for a patient could arrange for that care to be bought from the unit. The unit offered inpatient and day patient care. The unit was keen to avoid unnecessary inpatient admissions for young children. All admissions were planned. The unit did not accept urgent admissions but did respond to urgent requests for assessment. As all admissions were arranged by specialist commissioners, children and young people needing to be admitted urgently would be referred to other services which could accept them.
- There were five inpatients and three day patients at the time of inspection. There was no waiting list at that time but there were patients who were in the pre-admission assessment phase. The pre-admission process was thorough including comprehensive assessments and the development of structured education, therapy and

activity plans and timetables. The pre-admission process was supportive to patients and families. It included family and child outpatient appointments, a tour of the site, information and welcome packs, and up to three visits to the unit. Patients and families were well supported during the assessment period.

- All patients were referred into the service by community CAMHS teams (tier 3). As a nationally commissioned service, referrals could be received from anywhere in the country. Following admission, the unit operated an assessment period of six weeks (42 days) and a treatment period of 13 weeks (91 days). Occasionally, a patient stayed longer. Between December 2014 and May 2015, the unit discharged twelve patients to their usual residence. The average length of stay for these patients was 78 days. There were no readmissions in the last 6 months. Ten out of the twelve patients originated from the northwest region mostly from neighbouring clinical commissioning group (CCG) localities such as Liverpool, Southport, Sefton and Cheshire. Two patients were from Wales. In some cases, the unit continued to provide some aftercare services such as family therapy.
- Most patients were discharged home unless a placement away from home was required. In such cases, we saw that social services and CAMHS team were involved in the patient's care from the outset. Dewi Jones had flexibility in its contract to continue with patient care when a patient turned 14. The patient was not discharged until the care episode was completed, and patients were not transferred to other units.

The facilities promote recovery, comfort, dignity and confidentiality

- The unit was located on a site ten miles away from the main hospital site. The entrance and reception area to the unit was welcoming and contained a drinks machine. Noticeboards displayed useful local information, leaflets and travel timetables. The unit was well presented and child-friendly with bright colours, modern furnishings, good décor, and posters and artwork. The unit felt and looked homely, cosy, and safe. There was strong evidence of children's involvement in the environment.
- The building contained two floors. All bedrooms were located on the first floor. There were fully equipped school, activity and therapy rooms on the ground floor. There was also a life skills kitchen. There were quiet areas on each floor, and there was a separate room

Are services responsive to people's needs?

Good 

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where patients could make private phone calls. The unit contained a pleasant dining room which looked like a small café. There was child-friendly material on display about healthy eating. The unit employed a cook and managed its own catering. Patients and relatives gave positive feedback about the food.

- There was a soft play room, excellent classroom facilities, a large lounge and several multi-function rooms throughout the unit. There were two pleasant outdoor spaces including a herb garden/horticultural centre and a landscaped courtyard. There was insufficient outdoor space on the site for activities such as ball games and physical exercise.
- Patients had good access to local facilities including the cinema, beach, marina, tennis courts, park and swimming pool. Care records and activity plans showed that outdoor activities were planned and undertaken frequently.
- Children attended school (education classes on site) in the mornings and had structured activities in the afternoons. These included therapy sessions, leisure activities, and games/hobbies.
- Patients were encouraged to personalise their bedrooms, for example, with photos and posters and other personal items. Patients could bring televisions, phones and computers if they wished to do so. Staff stored valuable items in lockers near the staff office as bedrooms did not contain lockers or lockable cupboards. Patients could request their mobile phones, tablets, etc. at any time outside of structured therapy/activity time.
- While most patients were from the local area, the catchment area for the service covered a large area. Being a nationally commissioned service, the unit occasionally received patients from other parts of the country. There was no accommodation for families but the staff provided information on inexpensive hotels and guesthouses in the local area.

Meeting the needs of all people who use the service

- Catering was managed on-site and took into account special diets, patient preferences and brand preferences. In one case, the cook had worked closely with a relative to get the patient's food preferences right.
- The unit had a quiet room containing prayer mats and a number of religious texts. Directions (north, south, east and west) had been marked on the walls.
- The specific needs of a patient with visual impairment had been considered in assessment, care planning and risk management.
- The trust provided interpreting services upon request. Staff who had used the service described it as simple and effective.
- Patient surveys about food were pinned on the dining room wall and showed that patients were happy with the food they received.
- Activities were rarely affected by staffing levels.
- There was an absence of information on carers' assessments but the unit was in the process of developing a leaflet.
- The unit was developing a physical exercise programme for patients.

Listening to and learning from concerns and complaints

- The trust did not provide disaggregated data on the total number of complaints received for the Dewi Jones Unit.
- Staff were aware of how to raise concerns and felt comfortable doing so. Unqualified staff were confident about approaching their supervisors on any matter.
- Families and carers were confident in raising complaints with staff and were encouraged to do so.
- Patients were encouraged to express themselves. A survey in one care record showed a patient's views on the service.
- PALS and advocacy information was displayed on noticeboards.
- There was a 'you said, we did' board showing suggestions made by patients and the unit's responses.

Are services well-led?

Good 

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

Summary of findings

We rated well-led as good because:

- There were clear team and service objectives which reflected the provider's values and strategy.
- Staff knew who the unit's senior management team were as they were visible but felt disconnected from the main trust and its executive team.
- There was a good meeting structure in place to escalate and cascade information through all levels of staff. This included management review and improvements of risks, incidents and performance monitoring.
- Staff training, supervision and appraisal structures were set up to support staff at all levels.
- Staff understood their roles and responsibilities, including accountability. Staff felt respected, valued and supported by the management team and their peers.
- The unit had good relationships with commissioners. There was a monthly contract monitoring review meeting trust wide.

- Intervening early in children and young people's lives to prevent mental distress and raising the visibility of CAMHS.
- Mental health promotion, tackling stigma and self-care.
- The general manager told us that they were preparing a local service strategy to support the above priorities and was also working in conjunction with the commissioners on service developments.

Good governance

- CAMHS inpatient services formed part of the integrated community services clinical business unit. There was a clear governance structure in place that supported the safe delivery of the clinical business unit.
- Lines of communication from the senior managers to the frontline services were mostly effective and staff were aware of key messages, initiatives and priorities of the local service.
- The service had strong governance arrangements in place to monitor the quality of service delivery. There were monthly team meetings, a CAMHS clinical governance meeting and an integrated community service quality assurance meeting.
- At the CAMHS clinical governance meeting, discussions were about quality, safety and standards. We reviewed minutes of these meetings which showed that there was a standard template in place to report by exception on departmental governance, PDR compliance, mandatory training, complaints, clinical incidents, risk registers, morbidity and mortality, patient experience, research and audits. This included oversight of risks within the service. This helped ensure quality assurance systems were effective in identifying and managing risks to patients and staff.
- The CAMHS clinical governance meeting reported to the integrated community service quality assurance meeting on a monthly basis. This meeting also shared information from other corporate meetings attended by management, patient experience and customer care, safety, effectiveness, and NICE guidance.
- NICE guidance was reviewed on an individual basis taking into account the impact on the services and actions detailed to meet best practice. There was a national practice lead who led on the review of NICE guidance and supported service implementation and action plans.

Our findings

Vision and values

- The provider's visions and strategies for the services were communicated to staff, and staff understood the vision and direction of their service. The service used the Liverpool Clinical Commissioning Group's Strategy 2014-2017 to plan their service delivery priorities. The action plan outlined the key developments for the next three years based on the priority areas. Priority areas were:
 - Joint commissioning.
 - Outcome monitoring.
 - Neurodevelopment difficulties and complex needs.
 - Workforce development.
 - Whole family.
 - Participation and stakeholder engagement.
 - Integrated working.
 - Equalities through CAMHS and improving access.
 - Transition of young people to adult provisions.

Are services well-led?

Good 

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.

- The trust held weekly harm meetings, which the CAMHS inpatient service could attend.
- The unit had good relationships with commissioners. There was a monthly trust-wide contract monitoring review meeting, which was led by the trust's Head of Quality/Director of Nursing and included the five clinical commissioning groups.
- The contract for CAMHS inpatient services was a "block contract" or fixed funding. There were identified gaps within the provision of the service which were being reviewed by the trust and commissioners.
- Access to some training off-site was difficult as it left the unit understaffed. Some online and local training had been developed by the unit to address this.
- There were good systems in place for continuing professional development and supervision. These included one to one supervision, group supervision, team supervision and appraisals. Staff attended regularly and said they benefited from them.
- There were effective systems in place to ensure shifts were covered with staff familiar with the unit and patients. Systems included contracted annualised hours, floating cover arrangements, and an internal bank agency.
- Some policies were out of date, for example, the seclusion policy and the locked door policy. It was not clear what process the trust had in place to monitor policies specific to the Dewi Jones Unit. However, the unit had changed practice to comply with new legislation and guidance while these policies were awaiting ratification.
- The trust had not identified it was not complying with its own policies in regard to medicines management.
- Staff were enthusiastic about their work with the patients and their families. Staff were also very positive about their teams and colleagues, and described a healthy supportive working environment at the Dewi Jones Unit.
- The average sickness and absence rate for Dewi Jones Unit between June 2014 and May 2015 was 6%, which was higher than the average rate for all CAMHS, which was 3.75%. This was mainly owing to two staff members who were on long-term sickness.

Commitment to quality improvement and innovation

Leadership, morale and staff engagement

- There were a range of key performance indicators which were monitored for quality assurance. These were managed through the monthly CAMHS clinical governance meeting by the clinical service manager.
- Incidents and complaints, including reviewing lessons learnt and monitoring themes, were managed and monitored by the CAMHS clinical governance.
- There was a service action plan in place, which showed specific issues, actions required, responsible lead, expected completion date and updated position. The service was aware of the gaps within provision and had plans in place to address these.
- A safe room and seclusion report was produced by the Dewi Jones Unit on a monthly basis. This showed the number of incidents, type of safe room or seclusion required, frequency, duration, impact on the child or young person, impact on the staff or service provision and outcomes. During the months of 1 April to 31 May, there were four recorded safe room or seclusion incidents.
- Patient surveys were in place for some aspects of the service, for example, choice and quality of food, quality of care, likes and dislikes. Feedback was used to monitor the quality of the service delivery and make improvements..
- Staff had good access and opportunities for reflective practice, group and individual supervision.
- Young people had been involved in developing the welcome guide for new patients.
- The unit was working towards Quality Network for Inpatient CAMHS (QNIC) accreditation.
- Staff spoke of a strong culture of openness and honesty. Staff spoke of feeling valued and supported by the local management and their peers. Junior staff said they were listened to.
- The local senior management team was active within the unit and visited regularly. Staff found them approachable and were confident in raising concerns. However, staff described feeling disconnected from the wider trust.