Good

Norfolk and Suffolk NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

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Date of inspection visit: 12 - 22 July 2016
Date of publication: 14/10/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RMYNP	Lothingland	5 Airey Close	NR32 3JQ

This report describes our judgement of the quality of care provided within this core service by Norfolk and Suffolk 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 Norfolk and Suffolk NHS Foundation Trust and these are brought together to inform our overall judgement of Norfolk and Suffolk 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?	Good
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 rated the ward for children and adolescents with mental health problems as good overall because:

- Staff assessed and reported any safeguarding concerns in order to protect young people from harm.
- Staff updated the risk assessments of young people following incidents. Debriefs were held where possible following incidents on the ward. This enabled staff reflection and learning.
- We saw that professionals worked together to ensure that they met the needs of young people who used the service.
- Staff provided care and treatment that was informed by national evidence and research.
- Young people were encouraged to make choices and decisions about their care and treatment.
- Staff had effective communications with families and carers with appropriate involvement encouraged.
- The ward offered a wide range of information and leaflets around health promotion, how to complain and the rights of being an inpatient, whether informal or detained.
- Young people were supported through their care pathway. There was evidence of active discharge planning.
- The ward offered a structured therapeutic programme, which consisted of leisure activities, therapeutic activities and educational sessions.
- Young people knew how to give feedback about the service and how to complain. There were systems for reviewing complaints in order to improve the service.
- Staff were able to give feedback on the service and also input into future service development.

However:

- There had been use of physical restraint which resulted in young people being in the prone (face down) position. However, there were practices in place to minimise the length of time and to de-escalate situations where this might be used.
- There were some areas where ligatures could be tied, but staff had mitigated these risks as much as possible.
- Not all vacant shifts had been filled with bank or agency staff. This meant that the ward had to work below usual numbers on occasions.
- Staff across young person services in the trust reported a lack of inpatient beds for young people during crisis. This meant that on occasions young people were admitted to a hospital a long way from their home.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Staff understood the need to assess and report safeguarding concerns and how to keep young people safe. If a young person remained on the ward for a consecutive period of three months, staff notified the local authority. Most staff had received mandatory training around the safeguarding of children.
- The ward held resuscitation equipment and emergency drugs which were accessible and could be easily accessed in the event of a medical emergency.
- Environmental risk assessments were undertaken regularly.
- Staff completed a risk assessment for each young person admitted and updated this regularly to reflect progress and incidents.
- Staff knew what incidents to report and how to do this. Debriefs were undertaken following incidents on the ward and there was evidence of reflection and learning.

However:

- There had been use of physical restraint which resulted in young people being in the prone (face down) position. However, there were practices in place to minimise the length of time and to de-escalate situations where this might be used.
- There were some areas where ligatures could be tied, but staff had mitigated these risks as much as possible.
- Not all vacant shifts had been filled with bank or agency staff. This meant that the ward had to work below usual numbers on occasions.

Are services effective?

Good

We rated effective as good because:

- There were regular and effective multi-disciplinary meetings whereby professionals worked together to ensure that the needs of young people were met.
- The ward utilised the skills of the wider multi-disciplinary team members to lead training when needs were identified at ward level.
- Young people received care and treatment that was informed by national evidence and research.
- The staff maintained good working relationships with teams outside of the organisation when planning and delivering care.

Summary of findings

- Staff received regular clinical and management supervision.
- Overall, 86% of staff had received training on the Mental Health Act and the Mental Capacity Act.

Are services caring?

Good

We rated caring as good because:

- Young people told us that staff were caring and treated them with respect.
- Staff had a good understanding of the needs of young people.
- Young people were encouraged to make choices and decisions relating to their care and treatment.
- We saw there was good communication systems and appropriate involvement of families and carers.
- Young people were able to give feedback and felt listened too.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Young people were supported through their care pathway. There was evidence of active discharge planning.
- The ward offered a structured therapeutic programme, which consisted of leisure activities, therapeutic activities and educational sessions.
- Information leaflets around appropriate health promotion, how to complain and the rights of being an inpatient were available to young people.
- Young people knew how to give feedback and how to complain. There were systems for reviewing complaints in order to improve the service.
- Food was freshly prepared on site and young people were actively involved in the meal planning.

However:

- Staff who worked with young people reported a lack of inpatient beds for young people during crisis. This meant that on occasions young people were admitted to a hospital a long way from their home. However, a new build is planned and will increase beds.

Are services well-led?

Good

We rated well led as good because:

- Staff had access to information about the trust's vision and values and agreed with these. The trust values were incorporated into staff appraisals.

Summary of findings

- Staff told us they felt well supported by the service manager.
- Staff were aware of, and knew how to use the trusts whistle-blowing policy.
- We saw effective team working and opportunities for peer support during group supervision and reflective practice meetings.
- Staff were able to give feedback and input into future service development.

Summary of findings

Information about the service

5 Airey Close is the trust's only inpatient ward for children and young people, providing seven beds in total. It is a bungalow and is set in a residential area of the community, among other bungalows providing trust services for other patient groups.

We last inspected 5 Airey Close in October 2014. We asked the trust to take actions regarding disseminating the learning of lessons following incidents, and recruiting a unit manager. At the inspection we found that the actions had been completed.

Our inspection team

Chair: Paul Lelliott, Deputy Chief Inspector (Lead for mental health), CQC

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

Inspection Manager: Lyn Critchley, Inspection Manager (mental health), CQC

The team that inspected the child and adolescent mental health ward comprised of one CQC Inspector and one specialist advisor (nurse).

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Spoke with three young people who were using the service
- Spoke with the service manager
- Spoke with seven other staff members; including the doctor, nurses, an occupational therapist, support worker and housekeeper
- Attended and observed a handover meeting
- Looked at seven care and treatment records of young people
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

- Young people we spoke with were positive about the ward and felt safe, as it was a small unit and said staff were caring and had good relationships with them.
- We were told that usually there was a good range of activities on offer.
- Two out of three young people spoke highly of the food that was prepared on site.
- Young people attended weekly multi-disciplinary meetings and felt involved in these.
- Young people we spoke with felt that the environment was comfortable, and liked the available community blankets. These were blankets, which young people used for security to wrap themselves in.
- Young people were able to personalise their bedrooms.
- Young people said staff treated them with respect.

Good practice

- There was good multi-disciplinary team working within the ward which helped to promote positive outcomes for the young people who used this service.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that when staff use physical restraint, there is minimal use of the prone position.
- The trust should ensure that ligature risk assessments are thorough, updated regularly, and be sure that all staff are aware of risks and how they are mitigating these.
- The trust should ensure that there are enough staff on each shift.

Norfolk and Suffolk 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
5 Airey Close	Lothingland

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.

- We found that detention paperwork was up to date and stored appropriately.
- Staff routinely explained to young people what their rights were under the Mental Health Act (MHA), upon admission, and again as appropriate thereafter.
- Ward staff confirmed that they contact the mental health act administrator if they needed specific guidance or advice.
- The doctor sought consent to treatment and recorded in the clinical notes.
- Staff training for the Mental Health Act was 86%, which fell below the trust target of 90%.

Mental Capacity Act and Deprivation of Liberty Safeguards

People under the age of 18 are not subject to the Deprivation of Liberty Safeguards. Young people's consent was sought and mental capacity tested where appropriate.

- Overall, 87% of staff had completed Mental Capacity Act (MCA) training.
- The trust had a policy on the MCA, which staff were aware of and could refer to. There was a Mental Capacity Act lead within the trust who staff could contact for advice.
- Staff encouraged young people to make decisions independently as much as possible. Staff assumed that

all young people had capacity, and would meet with the multidisciplinary team and discuss if staff felt a young person did not have the capacity to make a specific decision.

- Qualified staff had knowledge around Gillick competence when determining a young person's capacity to consent. Gillick competence is the principle used to judge capacity in children to consent to medical treatment. Qualified staff were also aware of the Fraser competence, which relates to a child under 16 who is deemed competent to receive contraceptive advice without parental knowledge.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- The ward was originally used as a domestic dwelling, so was not a purpose built ward. Lines of sight were not clear, which meant patients could not be easily observed in all areas. The environment was not completely ligature free. However, there was a ligature risk assessment that identified risks and how staff managed these. Staff were aware of blind spots and formulated care plans or used increased observations where necessary to promote the safety of young people.
- The ward was girls only and so complied with the Department of Health guidelines around eliminating mixed sex accommodation. Boys were currently placed out of area. However, a new unit was commissioned and in the process of being built which will remedy this.
- There was a small clinic room, which was adequate for dispensing and storing medications including controlled drugs. There was no room for an examination couch. Staff told us that physical examinations could be completed in the nearby bungalows if required, or a young person's bedroom used with consent.The resuscitation equipment was stored in a separate locked cupboard on the ward. We saw that staff had signed a form to indicate they had checked the equipment and emergency drugs regularly. All staff had keys to the locked cupboard to access resuscitation equipment in the event of a medical emergency.
- The ward did not have a seclusion room. There was a room, which staff described as a de-escalation room, which had soft, strong seating to enable a distressed young person to sit with support from staff. Staff told us they would try to de-escalate a young person if they saw they were upset and would only use physical restraint as a last resort.
- The ward had adequate furnishings which were well maintained. Young people told us that the sofas and chairs were comfortable. Some areas of the ward would benefit from redecoration due to scuffmarks and general wear and tear.
- Staff adhered to infection control principles. There was adequate hand washing facilities and hand gel available.
- There were cleaning schedules in place, which showed that staff regularly cleaned the ward.
- Regular environmental risk assessments took place and we saw that staff reported maintenance issues in a timely manner.
- Staff and visitors had access to alarms, which were checked regularly by staff to ensure they were in working order.

Safe staffing

- The ward had a total establishment of 14 qualified nurses. At the time of inspection, there were three vacancies. The ward establishment for support workers was 11, and there were no vacancies.The trust continued to recruit and had formed relationships with the local university with a view to recruit newly qualified nurses as they graduated.
- The ward did use bank and agency staff to cover absence, sickness and vacancies. Staff tried to use regular bank staff for continuity of care for patients. Between January and March 2016, the ward had requested 553 shifts to be covered. Of these, 263 were filled by bank staff and 24 were filled with agency staff. This left 266 shifts unfilled.
- From March 2015 to March 2016, three staff members left the ward. This represented a 10% turnover of staff. Staff told us people had left to work elsewhere within the trust, within community teams. The trust reported a staff sickness rate of four percent for this ward.
- The number of staff on shift matched the ward rota and was in line with the levels and skill mix determined by the trust as safe.
- The service manager was able to adjust staffing levels on a daily basis to reflect the needs of the young people.
- A member of staff was present in communal areas of the ward when young people were using them.

Good

Are services safe?

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

- Young people had regular one to one time with allocated staff. We saw that young people were offered individual time at least once a day. This was planned in advance, according to the rota and re-visited on a shift to shift basis to ensure that this could be facilitated.
- Staff told us that it was unusual that leave would be cancelled due to staff shortages. We saw that young people went out with staff or family members on a regular basis.
- There was enough staff to carry out physical interventions if necessary. However, staff told us that any form of physical restraint would be a last resort and they would use distraction and de-escalation techniques in the first instance. Staff planned rotas to ensure there was a safe mixture of staff to carry out physical interventions.
- The ward had a dedicated doctor who was available between the hours of nine to five during the week. Outside of these hours, there was an on-call rota whereby doctors within the trust provided support.
- As of April 2016, 73% of staff on the ward had completed and were up to date with their mandatory training. This was lower than the trust target of 90%. Staff reported there would often be a wait to get onto the mandatory courses, in particular the manual handling course.

Assessing and managing risk to patients and staff

- There had been no reported incidents of seclusion or segregation over the last 12 months. The ward did not have a seclusion room. Staff explained what seclusion was and knew how to report.
- Between the 01 October 2015 and 31 March 2016 there had been 62 incidents of restraint reported. The restraints involved five young people. Of the restraints, 20 resulted in the young person in prone position (face down). Staff told us that if a young person was in the prone position they would try to turn them over at the earliest opportunity. Of these prone restraints two young people were administered rapid tranquilisation. Staff told us they would only use physical restraint after de-escalation had failed. If staff had to physically intervene, taught techniques would be used and recorded. Staff used prevention of management and aggression (PMA) techniques.
- Staff told us the de-escalation room on the ward had proved beneficial on occasions when young people had become distressed, as it provided a quiet space away from others, and allowed staff and patients to hold discussions around emotions and concerns in private. Risk management plans detailed actions that were required to minimise the risk to young people, and any triggers or risk behaviours that staff needed to be aware of. Suggested strategies were included within the plan.
- We looked at seven care and treatment records. We saw that staff had assessed the potential risks young people presented to themselves and others. The multi-disciplinary team reviewed these at least weekly to ensure people received appropriate support.During the handover current risks were discussed.
- The ward had a contraband and prohibited items list in order to keep young people safe. To promote least restrictive practice, staff would individually risk assess items. At the time of inspection, young people were not permitted to have mobile phones on the ward. However, the staff were preparing for a trial so that young people could have mobile phones, which would enable contact that is more frequent with family and friends. The ward did have expected bed times for the young people, to encourage a good night's rest and establish a routine that supported treatment and education.
- There were notices clearly displayed on the ward telling informal patients of their right to leave the ward. Young people were encouraged to speak to a member of staff if they felt they wanted to leave.
- There were policies and procedures in place for staff to follow when observing or searching young people. These were in paper and electronic format. Staff told us they would try to offer more support to individuals as opposed to resorting to enhanced observations. The searching of young people would only be undertaken when necessary for risk items, and would always be carried out in private and with a qualified nurse being present.
- Staff had completed safeguarding training for adults and children as part of the trust mandatory training. All of the staff we spoke with had a clear understanding of safeguarding and their responsibilities in relation to identifying and reporting allegations of abuse. Qualified

Good

Are services safe?

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nurses knew who the safeguarding lead was for their area and felt able to contact them for advice when needed. All staff had received training at level one, and 94% had received the level three training.

- There was effective medication management and a visiting pharmacist was available to offer support and advice. A pharmacy technician visited the ward every week. Medicines were stored securely on the ward. Staff recorded daily temperatures of the medicines fridge and clinic room in which medicines were stored. This meant that medicines were stored appropriately. There were regular audits in place for medication charts.
- Staff provided young people with information about their medication. The doctor and nurses would discuss medication with the young person initially, or could refer them to the pharmacist to speak to if required. Leaflets were available to young people on request.

Track record on safety

- There were no serious incidents reported by the trust between January 2015 and March 2016. There were no reported adverse events specific to this ward.
- Staff reported incidents at ward level. Examples of incidents included violence or destructive behaviour and deliberate self-harm. There was an electronic programme which enabled the service managers to review all incidents which could then be analysed. We saw staff learned from these incidents, and as a result of one incident, a twilight shift was introduced (working from 15:00 – 23:00 hours) to try and minimise the risk of incidents occurring between these times.

Reporting incidents and learning from when things go wrong

- Staff had not reported any serious incidents on the ward over the last year. Staff were able to describe how they reported incidents and accidents and what would be deemed reportable. The internal reporting system ensured that senior managers were alerted so that they could monitor and investigate where appropriate.
- Staff received bulletins via email with trust updates and alerts following learning from incidents. The manager attended a “5 lessons learnt” monthly meeting. At ward level the manager used staff meetings and multidisciplinary meetings to cascade information. Staff said they tried to hold a debrief after an incident on the ward to discuss and reflect on potential learning.
- Staff told us that they were open and transparent with young people and their families if things went wrong.

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

- All young people had a comprehensive and timely assessment completed following admission to the ward. Care records showed that a doctor completed an initial physical health assessment. Records showed that risks to physical health were identified and managed effectively. Assessments included a review of the individual's physical health on a weekly basis; this took place more frequently if a need was identified. We saw young people were being weighed regularly and had regular physical observations, including blood tests if they had an eating disorder. Staff formulated care plans to capture this.
- Care plans addressed the young person's holistic needs. We saw that they were personalised and recovery orientated with goals meaningful to the individual. Staff reviewed these regularly following the weekly multidisciplinary team meeting and updated or discontinued as appropriate.
- Most records were held electronically. This meant that they were secure and would be accessible to other teams if a young person was transferred or discharged.

Best practice in treatment and care

- We looked at seven medication records. The doctor followed guidance from the national institute for clinical health and excellence (NICE) when prescribing medications. The doctor communicated with the pharmacist to discuss treatment options or to obtain advice when necessary. Medications were discussed in the weekly multidisciplinary meeting (MDT). We saw examples of this in young people's records.
- The ward offered a range of psychological therapies for young people including cognitive behavioural therapy (CBT); cognitive analytic therapy (CAT) and family therapy. Psycho educational groups also took place.
- The ward had a lead staff member for physical health who attended the weekly MDT meetings. The staff member kept an overview of the physical health needs of young people and ensured that physical health care plans were kept up to date. We saw that regular physical healthcare checks were taking place as required. There was access to other specialists, such as the dietician on a referral basis.
- Staff assessed young people's nutrition and hydration needs using the STAMP (screening tool for the assessment of malnutrition in paediatrics). This is a national tool for the use of people between two and 16 years. Young people were weighed when necessary and assessments reviewed according to individual need.
- Staff used nationally recognised assessment and outcome tools as part of their work with young people. For example, the Health of the Nation Outcome Scales Child and Adolescent Mental Health (HONOS-CA), the children's Global Assessment Scale (CGAS) which measures children's general functioning and the Strengths and Difficulties Questionnaire (SDQ).
- Staff participated in regular clinical audit on a weekly or monthly basis. Examples of audits included physical health audits, nutrition audits and infection control.

Skilled staff to deliver care

- Staff working on the ward came from a range of professional backgrounds including nursing, medical, occupational therapy and psychology.
- Staff received appropriate training, supervision and had opportunities for ongoing professional development. Some support workers had been trained to take bloods and undertake electrocardiograms (ECG's). Staff told us that the ward induction included information around key policies such as observation levels. We saw that there was folder in the nursing office which had paper copies of ten different policies considered as essential information for new staff. Staff said the trust induction offered minimal training around children and young people. However, we saw that there was an internal training arrangement whereby healthcare professionals went to the ward to give training sessions around specific issues related to young people. Example of this included training in eating disorders and autism spectrum disorder (ASD). The sessions offered would be dependent upon staff need and the young people on the ward.

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.

- Staff told us they received clinical and management supervision monthly, where they were able to reflect upon their practice and incidents that had occurred on the ward. Trust data showed that 87% of staff had received regular supervision.
- There were regular team meetings and staff felt supported by their manager and colleagues. Staff told us that the team worked well together to meet the needs of young people.
- Trust data showed that 79% of non-medical staff had received an appraisal over the last year, as of the 31 January 2016. An appraisal is an opportunity to discuss job role, expectations, progress and development. It is an opportunity for staff to plan ahead with their managers. The trust target for supervision is 95%.
- Senior staff addressed poor staff performance through supervision or the disciplinary process with support from human resources if appropriate.

Multi-disciplinary and inter-agency team work

- The ward held weekly multidisciplinary team (MDT) meetings where the care and treatment of young people were discussed. Young people attended these meetings and received written information on what was discussed and what was agreed.
- Staff reported effective handovers. We observed a handover between shifts which included communicating decisions made at the weekly MDT meeting. The handover was effective in sharing information about young people and their progress.
- Staff invited healthcare professionals from external agencies to meetings as and when felt necessary. Staff reported that good communication could be problematic due to geographical distance on occasions. Staff tried to improve communication by sending letters and emails, or making telephone contact.
- The ward had established links with a local general hospital. This improved support for young people admitted to the ward who required nasogastric (NG) tube feeding. We saw that staff contacted and worked with the local authority as and when needed.

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

- Staff told us they had received training on the Mental Health Act and the code of practice. Overall, 86% of staff had completed this training.
- There were three young people detained under the Mental Health Act during inspection. Staff told us that completed consent to treatment forms were usually attached to the medication charts of young people detained. Initially we did not see these attached to medication charts, but when we asked staff about this they said they were with the doctor. When we reviewed this later in the day, we saw the appropriate forms had been attached to the medication charts.
- We saw that young people had their rights under the Mental Health Act explained to them on admission and routinely thereafter.
- Ward staff said they contacted the Mental Health Act administrative team if they needed any specific guidance about people detained under the Mental Health Act.
- Staff completed detention paperwork correctly and these were held securely.

Good practice in applying the Mental Capacity Act

- Overall, 87% of staff had completed Mental Capacity Act (MCA) training.
- The trust had a policy on the MCA, which staff were aware of and could refer to. There was a Mental Capacity Act lead within the trust who staff could contact for advice.
- Staff encouraged young people to make decisions independently as much as possible. Staff assumed that all young people had capacity, and would meet with the multidisciplinary team and discuss if staff felt a young person did not have the capacity to make a specific decision.
- Qualified staff had knowledge around Gillick competence when determining a young person's capacity to consent. Gillick competence is the principle used to judge capacity in children to consent to medical

Are services effective?

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treatment. Qualified staff were also aware of the Fraser competence, which relates to a child under 16 who is deemed competent to receive contraceptive advice without parental knowledge.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed staff interacting with young people in a caring and compassionate way. We saw staff members address a young person who was upset in a calm, discreet and appropriate manner.
- Young people told us that staff were kind and felt they could trust them. We were told that staff would knock before entering a young person's room.
- During interviews, staff spoke with compassion and respect about young people. Staff were clearly passionate about their roles and had a good understanding of the needs of young people being cared for on the ward.

The involvement of people in the care that they receive

- When young people were admitted to the ward they were shown around and introduced to other young people and staff who were on duty. A welcome pack was given to young people which contained information about the ward and what to expect during the stay.
- Young people were involved in developing their care plans. Staff had written most care plans in the first person as the staff relayed the young people's words. Nursing staff discussed care plans with young people and then typed them up, printed it off and gave this to the young person to ensure they agreed with what was written. The young person signed the plan to indicate their agreement, and was given a copy if they wanted to have one.
- Young people had the opportunity to attend the multidisciplinary meeting once a week so they could discuss their care and treatment. Young people had told staff that they sometimes forgot what was said during the meeting. Therefore, a staff member attending wrote this information down for the young person so that they could take away and discuss with families or friends, as appropriate.
- Young people could access advocacy. Staff ensured that there were contact details visible on the ward.
- We saw that with consent from the young person, a nurse updated families and carers via telephone after the MDT meeting each week. We saw that families and carers had appropriate involvement in the young person's care, this included being invited to care programme approach meetings.
- We saw there were opportunities for families and carers to visit, cook and eat with young people as part of their care plan.
- Daily community meetings were held to discuss relevant information. This included any concerns or queries for the staff to address, as well as general news and goals for the day. The meetings were minuted.A further meeting was held in the evening to reflect upon the day, and to see if concerns or queries had been addressed.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Bed occupancy between October 2015 and March 2016 was reported by the trust to be 98%.
- We were initially told that there had been no out of area placements within the 12 months prior to inspection. However, data received from the trust on the 21 July stated that there were 11 out of area placements. This meant that young people were placed away from home. A new building is planned and will increase bed numbers.
- We were told that there was not a waiting list of people to be admitted. However staff in the community youth teams told us that young people were placed out of area on occasions, particularly if they had complex needs or were male. Staff told us that young people had been to units in Manchester and Harrogate, due to no local bed availability, which made it difficult for family to visit. This ward was the only one within the trust for young people.
- Ward staff worked with community services such as the intensive support team to ensure that young people were in hospital for the least amount of time possible. Data provided by the trust showed that between July 2015 and March 2016, the average length of stay was 83 days.
- All discharges were planned and occurred at an appropriate time of day, with families and other healthcare professionals being informed of plans.
- The trust reported no delayed discharges for the 12 months prior to inspection.
- There were no re-admissions of young people back into hospital within 60 days of being discharged from this service.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a range of rooms and equipment to support treatment and therapy. There was direct access to outdoor space, therapy rooms and a relaxation room. There was a clinic room, but this was too small for an examination couch to fit in.
- There were rooms on the ward where young people could meet with visitors. However, where possible staff encouraged young people to go out during visits.
- Young people were able to make a telephone call in private. Young people told us they were looking forward to the trial of the use of mobile phones on the ward so they could keep in touch with friends and families more often.
- The ward had a good sized garden with a lawn to the back. There was also access to a courtyard.
- The housekeeper prepared all meals from fresh produce on site on a daily basis. Young people were involved in their menu planning. Staff told us that generally the food was well received by young people who use the service.
- Young people could access cold drinks 24 hours a day as there was a water dispenser in the dining area with available juice and cups. Hot drinks were available during the day on request. There were set snack times twice daily when young people could choose to eat their own snacks. Snacks were stored individually in named boxes.
- Young people were able to personalise their bedrooms. Two young people showed us their bedrooms and both had posters on the walls, timetables for the week and other personal items around the room.
- The ward provided a secure place to store individual possessions.
- We saw an activities timetable which covered every day of the week, including weekends.. The timetable included leisure activities, therapeutic activities, education and free time.

Meeting the needs of all people who use the service

- The ward was a bungalow so all accommodation was on one level. It was suitable for young people with mobility difficulties or who required disabled access.
- The ward had access to leaflets and information in different languages spoken by people who use the service. This was not a need at the time of inspection, but could be accessed as required.

Are services responsive to people's needs?

Good

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

- There was a range of leaflets and information displayed on the ward. We saw information about the Mental Health Act and rights, how to complain, information about accessing advocates and details of a carers group. We also saw numerous leaflets for young people around physical health, sexual health and mental health.
- The ward had access to interpreting services, which were offered through the trust as and when necessary.
- As the housekeeper prepared food freshly on the premises, the food was purchased regularly from local supermarkets. We saw that there was a range of foods which met different dietary requirements.
- Young people had access to a range of spiritual support if required, and were encouraged to attend places of worship with family or friends if desired. Ward staff could arrange a visit on the ward from a chaplain.

Listening to and learning from concerns and complaints

- There had been two reported formal complaints raised between March 2015 and March 2016. Of the two complaints, one was not upheld, and one was partially upheld. The complaint that was partially upheld was around care and treatment. Neither complaint was referred to the Ombudsman.
- Young people we spoke with knew how to make a complaint. There were posters on the ward informing of what to do. We saw that young people tended to take minor complaints during the daily community meeting. This seemed an effective forum as concerns were discussed with and dealt with on the ward, or escalated to the service manager if felt necessary. Staff knew how to handle any complaints and was able to relay the process in terms of documentation and escalation.
- Staff received feedback on the outcome of investigations following complaints. This would be discussed at the staff team meetings, or during supervision sessions if felt appropriate.

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.

Our findings

Vision and values

- Staff were aware of the trust's values and told us that they agreed with them. We saw trust vision and value posters displayed on the ward.
- Team objectives reflected the trust's values.
- Managers used the values during the appraisal process. This meant that values were revisited regularly.
- The values had recently been introduced with the selection and recruitment process. Staff felt this was positive.
- Staff were aware of who the senior managers within the trust were, although could not be sure if they had visited the ward over the last 12 months.

Good governance

- Data was captured for service managers to enable then to monitor quality and effectiveness of the service. This included audits such as care programme approach; Mental Health Act and reading of rights audits and anti-psychotic audits.
- Staff felt that they learnt from incidents and complaints through feedback received. For example, during a discussion around incidents of deliberate self-harm, staff identified this tended to occur during handover. This meant that the nurse would be called out of handover to dress wounds. To prevent the disruption, the staff put together a box of basic first aid equipment to clean and dress wounds which was available to healthcare support workers. This meant they could address patient need without having to disrupt handover.
- Staff adhered to policies and protocols around safeguarding, the Mental Health Act and the Mental Capacity Act.
- The service manager felt they had sufficient authority and administrative support to carry out their role, and had been involved in the planning and redesign of the new service.
- Staff could submit items to the risk register.
- Staff told us that the service manager was supportive and focused upon developing staff.

Leadership, morale and staff engagement

- All staff within the trust were able to complete the annual staff survey.
- The service manager stated that at the time of inspection they had one staff member on long term sick due to a fractured bone. Other sickness was short term.
- At the time of inspection there were no grievance procedures being pursued within the service, and there had been no allegations of bullying or harassment. Staff were aware of the whistle blowing policy and how to use this. Staff felt able to raise concerns without the fear of victimisation from other colleagues.
- Staff reported there had been many changes within the trust over the past two years and morale had been low. However, they felt that it was improving and there had been an improvement with communication from board to ward level. Staff we spoke with appeared happy in their roles and proud of the service they worked in.
- Staff told us there were opportunities within the trust for people working within different roles for leadership development.
- We observed a good team working and mutual support throughout the inspection.
- Staff gave feedback to the trust through the staff survey. We saw that some of the ward staff had been involved with the upcoming service development.
- Staff told us they were open and honest with young people and their families if things went wrong. We saw evidence of this, when there was a reported medication error. There was emphasis upon joint and honest working with young people and their families.

Commitment to quality improvement and innovation

- The ward was a member of the quality network for inpatient CAMHS QNIC, which is a national quality improvement programme.