Good

Northamptonshire Healthcare NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
The Sett	RP1V6	The Sett	NN5 6UH
Berrywood Hospital	RP1V4	The Burrows	NN5 6UD

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

Summary of findings

Ratings

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

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

Contents

Summary of findings

Overall summary

We rated the child and adolescent mental health wards overall as 'good' because:

- Each patient had an individualised risk assessment**.** These had been reviewed by the multi-disciplinary team.
- Staff received training in how to safeguard patients from harm and showed us that they knew how to do this effectively in practice.
- Staff had received training on the use of restraint and seclusion records were well maintained.
- We saw that the trust had systems to report incidents, manage emergency situations and investigate any serious untoward incidents.
- Assessments and care planning were completed to meet patient's needs with systems for ensuring these were updated as these changed.
- Treatment and care best practice was supported through the use of nationally recognised assessment tools and a range of therapeutic interventions in line with the National Institute for Health and Care Excellence (NICE) guidelines.
- Staff reported effective team working and joint working across units and other services.
- Most patients reported they were treated with dignity and respect and gave positive feedback about staff.
- Both units had an education department which had been rated as "outstanding" by OFSTED.
- Staff could access specialist support and services if patients required specific help.
- Units had 'you said we did' boards which showed how they were responding to issues raised by patients.
- Staff knew who the most senior managers in the trust were.
- Managers had access to governance systems that enabled them to monitor the quality of care provided.

However:

- We found areas across both units where patient safety may be at risk. For example, staff had not identified some ligature risks and some were not being managed effectively.
- The Burrows had a seclusion room which was partially non compliant with the Mental Health Act 1983 Code of Practice (2015).
- At the Burrows, we found issues regarding food safety which could pose a risk to patients.
- Both units had staff vacancies and staff and patients said this impacted on the service delivery.
- Trust procedures for recording mental capacity and consent to treatment assessments of patients were not robust.
- Records did not always detail when detained and informal patients had been informed of their legal rights.
- Records seen did not always capture the involvement of patients in the treatment they received.
- Minutes of patient engagement groups (PEG) did not always detail actions taken to issues raised.
- Staff told us that patients sometimes had to be placed in other hospitals a long way from their home area which made it difficult for family and staff to keep contact.
- Ward managers did not have access to any complaints' themes and analysis and it was unclear how staff were learning from these to plan and develop services.
- Managers had access to trust data such as incident reporting to gauge the performance of the unit. However managers' access to this information differed across units and it was not evident how they were using this to improve the overall quality of the service.

Summary of findings

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

Are services safe?

Requires Improvement

We rated the child and adolescent mental health wards as 'requires improvement' for safety because:

- We found ligature points in both units which had not been assessed and managed.
- The Burrows had a seclusion room which was partially non-compliant with the Mental Health Act 1983 Code of Practice (2015).
- At the Burrows, we found issues regarding food safety which could pose a risk to patients.
- Both units had staff vacancies and staff and patients said this impacted on the service delivery.
- Staff said they used prone restraint with patients in line with trust policy with reference to national guidance; which was for the least amount of time required.

However:

- There were systems for the safe administration and storage of medicines.
- There were designated male and female bedrooms with en-suite showers.
- Each patient had an individualised risk assessment**.** These had been reviewed by the multi-disciplinary team.
- Staff received training in how to safeguard patients from harm and showed us that they knew how to do this effectively in practice.
- Staff had received training on the use of restraint and seclusion records were well maintained.
- Staff knew how to report any incidents on the trust's electronic reporting system.
- We saw that the trust had systems to manage emergency situations and investigate any serious untoward incidents.

Are services effective?

Good

We rated the child and adolescent mental health wards as 'good' for effective because:

- Assessments and care planning were completed to meet patient need with systems for ensuring these were updated as these changed.
- Goal setting meetings took place with patients in addition to CPA reviews.
- Manager's had systems to track when staff had completed mandatory training. There were no identified shortfalls.

Summary of findings

- Treatment and care best practice was supported through the use of nationally recognised assessment tools and a range of therapeutic interventions in line with the National Institute for Health and Care Excellence (NICE) guidelines.
- Staff told us that they felt supported by colleagues.
- Staff reported effective team working and joint working across units and other trust services.

However:

- We saw that two out of four staff had not received appraisals within 12 months as per trust policy.
- Two staff reported limited opportunities for additional training such as on The Children Act.
- Trust procedures for recording mental capacity and consent to treatment assessments of patients were not robust.
  - Records did not always detail when detained and informal patients had been informed of their legal rights.

Are services caring?

Good

We rated the child and adolescent mental health wards as 'good' for caring because:

- Most patients reported they were treated with dignity and respect and gave positive feedback about staff.
- We found that staff communicated in a calm and professional way.
- Staff showed an understanding of individual needs of patients.
- Daily meetings took place on each unit for patients to give feedback on the service and encourage goal setting.
- Staff supported parents to 'tell their story' as part of a trust board presentation about their family's experience of these services.

However:

- Records seen did not always capture the involvement of patients in the treatment they received.

Are services responsive to people's needs?

Good

We rated the child and adolescent mental health wards as 'good' for responsive because:

- We found that discharge planning started from admission considering the next step for the patient.
- Ward managers showed us 'wish lists' and bids made for additional funding to respond to requests for young people regarding improving the ward.

Summary of findings

- Teachers attended the wards so that patients could continue their education. Some patients had attended the Prince's Trust for voluntary work.
- Both units had an education department which had been rated as "outstanding" by OFSTED.
- Staff could access specialist support and services if people using the service required specific help.
- Units had 'you said we did' boards which showed how they were responding to issues raised by patients.

However:

- Community staff told us that often patients were placed out of area if they need a more intensive support or needed a specialist placement to treat an eating disorder.
- Some patients had to be placed at times a long way from their home area which made it difficult for family and staff to keep contact and to aid transition to one of their units.
- The Sett was purpose built but since local housing had been developed, their garden and some rooms were overlooked by neighbours. Staff had identified steps to manage patient privacy.
- Ward managers did not have access to any complaints themes and analysis and it was unclear how staff were learning from these to plan and develop services.
- Minutes of patient engagement groups (PEG) did not always detail how any concerns raised were being addressed or escalated appropriately.

Are services well-led?

Good

We rated the child and adolescent mental health wards as 'good' for well led because:

- Staff knew who the most senior managers in the trust were.
- Staff attended governance meetings to review the prevention and management of violence and aggression incidents across services.
- Managers had access to governance systems that enabled them to monitor the quality of care provided.
- The service had undergone a transformation that included how services would be delivered to patients through an integrated service with staff and public consultations and patients and their families were given the opportunity to have a say in the way the services were designed.
- Staff spoke positively about the supportive culture in their teams.

Summary of findings

- The sett unit is registered with 'The Quality Network for Inpatient CAMHS', (QNIC) and both units were members of the Prescribing Observatory for Mental Health (POMH-UK) which aims to help improve prescribing practice.

However:

- Team minutes did not fully capture how the learning or actions were to be taken after feedback at governance meetings.
- Managers had access to trust data such as incident reporting to gauge the performance of the unit. However managers' access to this information differed across the units and it was not evident how they were using this to improve the overall quality of the service.

Summary of findings

Background to the service

- The trust had two children and adolescent mental health service (CAMHS) inpatient units, the Burrows and the Sett, for patients aged between 13 and 18 years with a range of complex mental health conditions.
- The Burrows was a ten bed step-down unit offering rehabilitation services to help patients who have had stays in psychiatric intensive care units or low secure units integrate back into the community. It serves the East Midlands and surrounding counties. The Sett was a ten bed unit which provides assessment, treatment and management of patients whose mental health problems cannot be managed in the community. It was a regional unit that serves Northamptonshire, Leicestershire, Milton Keynes, Derbyshire and Lincolnshire. Both units occasionally admitted patients from other areas.
- Patients could be admitted to the wards either informally or detained under the Mental Health Act 1983.
- Both units have a multi-disciplinary team including education staff, a medical team, psychologist, nursing team, occupational therapist, activities coordinator, family therapist and housekeeping staff.
- This core service is managed under the children and ambulatory services directorate.
- The CQC had not inspected these units previously.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett - Consultant Psychiatrist Oxleas NHS Foundation Trust

Team Leader: James Mullins - Head of Hospital Inspection (mental health) CQC

The team included CQC managers, inspection managers, inspectors and support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected this service consisted of a CQC inspector, a Mental Health Act reviewer, and three specialist professional advisors. A consultant child and adolescent psychiatrist, a mental health nurse and a psychologist. All of whom had experience of working in child and adolescent mental health services.

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before visiting, we reviewed a range of information we hold about Northamptonshire Healthcare NHS Foundation Trust and asked other organisations to share what they knew.

Summary of findings

We carried out an announced visit between 03 and 05 February 2015.

During the inspection visit the inspection team:

- Visited both units.
- Held a focus group with patients at the Sett.
- Met with seven patients.
- Spoke with 23 specialist CAMHS staff plus three education staff members.
- Reviewed eight assessment and treatment records of people who used the service.
- Reviewed four staff training and appraisal/supervision records.
- Observed a care programme approach (CPA) appointment with patient and carers.
- Observed daily meetings at both units.
- Observed staff handovers at both units.
- Interviewed senior clinicians. This included two ward service managers and the head of specialist children's services and an associate medical director.
- Reviewed a range of policies, procedures and other records relating to the running of this service.
- Held focus groups with different staff groups.
- Reviewed information we had asked the trust to provide.

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

What people who use the provider's services say

- We spoke with seven patients through individual interviews.
- Most patients told us that they were treated with dignity and respect and received good care. They told us that there were opportunities for involving them and their carers in the service.
- Patients told us that they could give feedback on the service and were encouraged to goal set at the daily community meetings.
- Patients felt that staff listened to them and were responsive when concerns were identified.

Good practice

- Staff supported parents to 'tell their story' as part of a trust board presentation about their family's experience of these services.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust MUST take to improve

- The trust must ensure that the Burrows seclusion room is compliant with the Mental Health Act 1983 Code of Practice (2015).
- The trust must ensure that the ligature risks identified on both units are risk assessed and addressed.

Action the trust SHOULD take to improve

- The trust should review the effectiveness of their current staff recruitment and retention policy and procedures.
- The trust should review its procedures for recording mental capacity and consent to treatment assessments of patients.
- The trust should review its procedures for informing detained and informal patients of their legal rights.
- The trust should review its procedures for using the information gained by the trust and feedback from patients, staff and others to continuously improve and ensure the sustainability of its services.

Northamptonshire Healthcare 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
The Sett	The Sett
The Burrows	Berrywood Hospital

Mental Health Act responsibilities

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

- Staff would contact the Mental Health Act administrative team if they needed any specific guidance about their roles and responsibilities under the Mental Health Act (MHA). Staff could contact the approved mental health professionals (AMHP) service to co-ordinate assessments under the Act. A Mental Health Commissioner last visited the Sett in January 2014 and the Burrows in March 2014. Following their report the trust sent us an action plan with details of how they planned to ensure people were regularly reminded of their legal rights and that a record of their consent to treatment was available. We found these areas still needed further action. We reviewed five records where a patient had been detained. For one person, it was not evident that they had been assessed to consider if their detention under section 2 MHA could be discharged before it expired. Section 17 forms relating to authorised leave held limited information. There was limited information for informal patients and visitors on how to enter and leave the Burrows. We found staff responded to requests to assess and admit patients to the units, where required, following detention by the police under Section 136 MHA.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- This service caters for people under 18 years of age so the Deprivation of Liberty Safeguards do not apply. We saw use of a standardised consent form for recording the consent of patients and carers. The recording of discussions and mental capacity assessments with patients regarding consent to treatment varied across both units.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

The Sett and The Burrows

Safe and clean ward environment

- The Burrows was a non-purpose built ward/unit.
- There were not clear lines of sight with clear observation of all areas in both units.
- We found some ligature points in both units which had not been assessed and managed effectively we brought this to managers' attention.
- There were designated male and female bedrooms with ensuite showers. Staff told us there was flexibility to use beds across the unit dependent on need.
- Single sex day rooms were available. Consideration was given towards the needs of transgender patients.
- Emergency equipment was in place and checked regularly to ensure that it was fit for purpose and could be used in an emergency.
- Staff carried personal alarms in order to summon assistance if required. At the Burrows in two areas they did not work and staff had contingency plans. Patients did not have access to an alarm in their bedroom to raise concern.
- The units were locked. There were systems for monitoring staff keys.
- There were systems for the safe administration and storage of medicines.
- Each unit had a low stimulus de-escalation room.
- The Burrows had a seclusion room which was partially non-compliant with the Mental Health Act 1983 Code of Practice (2015). It did not offer clear observation; the viewing panel had to be manually operated to be kept open to provide the only vision into the room. The digital clock was difficult to see. The bed was not secured to the floor. Staff had difficulties opening the toilet door. Three staff told us they could not ever remember anyone in seclusion requesting the toilet.
- Both units were clean.
- The Burrows manager told us that maintenance requests were not always promptly addressed and they had raised this issue with their manager for action.
- At the Burrows, we found issues regarding food safety which could pose a risk to patients. Patient fridge temperatures had exceeded five degrees Celsius for eight days with no staff actions taken to reduce the temperature. Some sauces which required refrigeration were not kept in the fridge. We raised this with staff who took action to address the matter.

Safe staffing

- The trust had identified staffing levels for teams although were not using a recognised tool.
- The staff rota was difficult to understand at the Burrows.
- Managers reported safer staffing levels through governance structures.
- Between September and November 2014 trust safer staffing levels showed appropriate, staffing levels.
- The Burrows had two staff whole time equivalent (wte) vacancies. The Sett had 5.4 wte vacancies. Managers reported recruitment plans were in place and some staff had been appointed.
- Staff told us that they were able to book additional staff directly in order to maintain standards of quality and safety.
- From October to December 2014, 2,342 hours of booked agency and bank staff were used for the Sett and 1,825 hours of booked agency and bank staff at the Burrows.
- Staff sickness from October to December 2014 was above 5% for both units.
- Staff had received appropriate recruitment checks to ensure they had the correct skills and were suitable to work with vulnerable children.
- Patients at the Sett told us activities including leave could be cancelled due to staffing shortages.
- There were no trust systems of how much community leave patients had. This meant that it was difficult to monitor when this was cancelled.

Assessing and managing risk to patients and staff

- Each patient had an individualised risk assessment**.** These had been reviewed by the multi-disciplinary

Requires improvement

Are services safe?

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

team. Risk assessments took into account historic risks and identified where additional support was required. However, one risk assessment carried out before a patient went on leave had minimal information.
- When appropriate staff created and made use of crisis plans.
- Staff received training in how to safeguard patients who used the service from harm and showed us that they knew how to do this effectively in practice. Managers were unable to give details of the number of safeguarding referrals and any identified themes stating this was held by the trust safeguarding team. A senior manager said no concerns had been raised regarding CAMHS staff. There was a staff safeguarding lead in the service.
- Staff had received training on the use of restraint and seclusion and records were well maintained.
- From October 2014 to January 2015 there were eight restraints of patients, two in the prone position at the Sett. The Burrows had 26 seclusion incidents, 88 restraints of patients and six in the prone position.
- Staff said they used prone restraint with patients in line with trust policy. Examples given by staff related to part of the process to safely exit a seclusion room.
- Minutes from the monthly trust 'PMVA' meetings showed the trust was monitoring the use of prone restraint; however, these did not detail actions taken to reduce the use. The October and November 2014 minutes showed that a document for the trust board was being developed outlining the rationale for deviating from the Department of Health guidance and following NICE guidance.
- Patients were risk assessed according to what they could keep in their rooms.
- Staff hand overs were comprehensive and included updates on potential risk factors.

Track record on safety

- An electrical fire had occurred in the Sett in 2014. We saw that the trust had systems to manage emergency situations. The incident had been investigated and actions taken to minimise future risk. The trust had reported the notifiable incident appropriately to the Care Quality Commission.
- The trust had risk registers and safety thermometers at service line and team level regarding risks for their area with identified actions.

Reporting incidents and learning from when things go wrong

- Staff knew how to report any incidents on the trust's electronic reporting system.
- Staff received email bulletins with trust updates and alerts following learning from incidents and to communicate issues for an example after an incident at an inpatient unit.
- Staff told us incidents were discussed at staff team meetings or at debriefs. However meeting minutes did not always detail this.
- Staff told us that they received feedback about the outcome of serious untoward incidents that had happened and gave some examples.

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

Our findings

The Sett and The Burrows

Assessment of needs and planning of care

- Assessments and care planning were completed to meet patient need with systems for ensuring these were updated as needs changed.
- Goal setting meetings took place with patients in addition to CPA reviews.
- Records showed that patient had physical examinations and support to meet any identified needs.

Best practice in treatment and care

- Assessments took place using nationally recognised assessment tools including the children's global assessment scale (CGAS) which measures children's general functioning; the health of the nation outcome scales child and adolescent mental health (HONOS-CA) and the Steve Morgan risk management tool.
- The malnutrition universal screening tool (MUST) was used in the ongoing monitoring of patient's weights and body mass index where they had an eating disorder.
- Staff provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence (NICE) such as cognitive behavioural therapy (CBT) and family therapy. NICE guidance was followed when prescribing medication for individual patient.
- Psychology staff were monitoring improvements to patients following treatment.
- Audits had identified actions for any areas of improvement.

Skilled staff to deliver care

- Managers had systems to track when staff had completed mandatory training. There were no identified shortfalls.
- Systems were in place for new or temporary staff to receive inductions to the trust and the service.
- Managers explained the staff appraisal and supervision systems in place. Staff said they received individual and peer supervisions and appraisals. Staff kept their own supervision records and there was no quality checking process. We saw that staff received appraisals; although there was evidence that this was not always every 12 months as per trust policy. One staff member told us they had not received an appraisal in 18 months.
- Staff had opportunities for specialist training for their role and had continuous professional development as part of maintaining their professional registration with examples given. Two staff reported limited opportunities for training such as on the Children Act.
- Staff told us that they felt supported by colleagues. .

Multi-disciplinary and inter-agency team work

- Staff teams were multi-disciplinary with a variety of skills and experience to meet the needs of patients. For example, education staff, a medical team, psychologist, nursing team, occupational therapist, activities coordinator and family therapist.
- Staff reported effective team working and joint working across units and other services.
- Additionally staff liaised with other agencies such as community teams, GP's, schools and out of area hospitals.
- Staff said they notified the local authority if a child was admitted for over three months.
- Staff reported attending interagency meetings.
- Care programme approach (CPA) meetings were scheduled and attendance was encouraged by all involved in the patient's care and treatment.
- Staff reported effective handovers. We observed handovers between staff shifts and saw that staff had verbal and written systems for communicating areas of improvement or risks.

Adherence to the MHA and the MHA Code of Practice

- During our visit there were six patients detained under the Act. Staff would contact the Mental Health Act administrative team if they needed any specific guidance about their roles and responsibilities under the Mental Health Act. Staff could contact the approved mental health professionals (AMHP) service to co-ordinate assessments. A mental health act commissioner last visited the Sett in January 2014 and the Burrows in March 2014. Following their report the trust sent us an action plan with details of how they planned to ensure people were regularly reminded of their legal rights and that a record of their consent to treatment was available. We found these areas still needed further action.

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.

- We reviewed five records where a patient had been detained. Copies of legal documentation were difficult to find on the electronic record system. We found inconsistent evidence of patients being informed of their legal rights at the Burrows and some information was not in an easy read format. It was not consistently documented that patients had understood their rights. In four patient's records consent to treatment assessments were either not fully completed or the discussion with the patient documented. A consent form was available but it was not specific to any form of treatment. For one person, it was not evident that they had been assessed to consider if their detention under section 2 of the MHA could be discharged before it expired. Section 17 forms relating to authorised leave held limited information. Staff at the Burrows told us that forms were not printed off and a copy was not given to the patient and escort. Therefore patients may not be fully aware of their leave conditions.
- There was limited information for informal patients and visitors on how to enter and leave the Burrows and patients did not appear fully aware of their rights. We found systems to assess and admit patients to the units where required following detention under Section 136 MHA.

Good practice in applying the MCA

- Staff told us that they had received training on the Mental Capacity Act 2005.
- Trust policy and staff considered the 'Gillick competency and Fraser' guidelines for patients under the age of 16 years. Patients told us staff asked for their consent regarding treatment.
- We saw a relative had signed their consent to admission for patient under 16 years.
- A leaflet, 'Can I choose whether to be admitted or not' was available at the Sett, outlining how consent was given for admission.

Good

Are services caring?

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

Summary of findings

Our findings

The Sett and The Burrows

Kindness, dignity, respect and support

- Most patients reported they were treated with dignity and respect and gave positive feedback about staff.
- Staff spoke about patients in a caring and compassionate manner.
- We observed therapeutic interactions and found that staff communicated in a calm and professional way.
- Staff showed an understanding of individual patient need.

The involvement of people in the care they receive

- Most patients said staff encouraged them to give their views and involved them in their care. However records seen did not always capture this.
- We saw two risk assessments where the patient was involved in creating strategies to help reduce risk in the future.
- We found staff supported parents to 'tell their story' as part of a trust board presentation about their experience.
- Daily meetings took place on each unit for patients to give feedback on the service and encourage goal setting.
- Patients were involved in choosing the décor of the units and taking part in staff interviews.
- There was information available on each ward about access to advocacy services.
- The trust had produced a 'welcome pack' for patient. The information was created in conjunction with PALS (patient advice and liaison service) and provided comprehensive information about what to expect from the service.

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

Our findings

The Sett and The Burrows

Access, discharge and bed management

- There were referral criteria for the units and details were held on the website.
- Admission to the units had to be agreed with NHS England commissioners before placement.
- There was not a waiting list for admission at the time we visited and we saw admission and discharges took place.
- Admission to the Burrows was usually planned as patients moved from a low secure unit or psychiatric intensive care unit as part of their transition back to living in the community.
- Community staff told us that often patients were placed out of area especially if they need a more intensive support or needed a specialist placement to treat an eating disorder. Trust information received stated that as CAMHS inpatients were NHS England commissioned as part of specialised services and were regionally procured and provided, the number was zero.
- Staff told us people had to be placed at times a long way from their home which made it difficult for family and staff to keep contact and to aid transition to one of their units.
- From October to December 2014 highest bed occupancy at the Burrows was 86% and 99% at the Sett. When we visited the Sett was full and the Burrows had three vacancies.
- The average length of stay of patients for the Sett was 47 days. No information was available for the Burrows.
- We found that discharge planning started from admission considering the next step for the patient.
- There were systems in place to monitor and track discharge times and any delays. There were three delayed discharges at the Sett which the manager advised included delays in other agencies identifying appropriate community accommodation and local authority funding.

The ward optimises recovery, comfort and dignity

- Patients had access to an enclosed garden. The Sett was purpose built but since local housing had been developed, their garden and some rooms were overlooked by neighbours and staff had identified steps to manage patient's privacy.
- There were identified educational staff and patient could continue their education. Some patients had attended the Princes Trust for voluntary work. Both units had an education department which had been rated as "outstanding" by OFSTED. Each patient had an activity plan.
- We found age appropriate furnishings such as pictures on the ward. Family rooms were identified at each unit. Patients did not have key access to their rooms instead had identified room access times. Staff said patients could request additional time outside of that and this was usually granted.
- Ward managers showed us 'wish lists' and bids made for additional funding to respond to requests for patients regarding improving the ward. For example developing a pet area at the Burrows.

Meeting the needs of all people who use the service.

- Patients had opportunities to develop their daily living skills and had community leave as part of preparation for moving out of hospital.
- Staff told us that multi-faith services could be accessed as required. Staff told us they had access to interpreters and translation services that provide the welcome pack in other languages, as and when this service is required. A vegetarian meal choice was available at the Sett each day and staff had taken action to improve the choice offered.
- A range of leaflets and age appropriate service information for patients and carers was available across team sites and on the trust website. Self-help guides were available. Staff explained the systems in place for the transition of young people to adult services as required.
- Staff said there was access to specialist support and services if patients required specific help. For example, we found that staff had completed post-traumatic stress disorder training.
- Staff at the Sett had liaised with a specialist worker regarding being able to respond to the needs of transgender patients.

Are services responsive to people's needs?

Good

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

Listening to and learning from concerns and Complaints

- Information was displayed on the ward and trust website for patients to report any 'concerns, complaints, compliments' and there were systems for them to be investigated and complainants to be given a response.
- There had been six concerns, seven complaints and no compliments for these units from December 2013 to December 2014.
- Ward managers did not have access to any themes and analysis and it was unclear how staff were learning from these to plan and develop services.
- The welcome pack gave information about how to make a complaint.
- Information about the patient advisory liaison service (PALS) and advocacy services information were displayed on the ward.
- Units had weekly patient engagement groups (PEG) which were chaired by a patient. Patients were able to raise concerns and comments during this meeting. However, minutes did not always detail how any concerns raised were being addressed or escalated appropriately.
- The trust gained regular real time feedback from patient and carers through their 'I want great care' survey. In December 2014 the Sett was highly rated with 4.1 stars out of five and the Burrows had 4.2 stars showing patients and others were satisfied with the service.
- Units had, 'you said, we did' boards which showed how they were responding to issues raised by patients .Ward mobile telephones had been purchased at the Burrows in response to a request for greater telephone access.

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

Our findings

The Sett and The Burrows

Vision and values

- Information on the trust's vision, values and mission statement (PRIDE) were available at the Sett.
- Staff knew who the most senior managers in the trust were.

Good governance

- Staff attended governance meetings to review the prevention and management of violence and aggression incidents across services.
- Manager were required to report to senior management on a monthly basis on a variety of areas such as safer staffing and training.
- Managers at the unit and other staff such as a consultant psychiatrist who was an associate medical director attended governance meetings. They cascaded the learning or actions to be taken via team meetings. However minutes did not fully capture this
- Managers had access to governance systems that enabled them to monitor the quality of care provided. This included the trust's electronic incident reporting system, ward based audits and electronic staff training record.
- Staff received emails and newsletters from the trust giving updates on trust development.

Leadership, morale and staff engagement

- The service had undergone a recent transformation in order to provide an integrated service.
- Consultations with staff and the public had been undertaken to gain feedback. This meant people were given the opportunity to have a say in the way the services were designed.
- Staff said their manager/supervisor was accessible for advice and guidance as required.
- Managers had systems for monitoring sickness levels and conducted exit interviews to identify any themes for why people left the trust. They told us that most staff sickness was not work related and that there were no identifiable themes.
- The trust had a system for staff to raise any concerns confidentially. Staff spoke positively about the supportive culture in their teams. Managers across both units said they supported each other.
- Managers had systems to address poor performance with individual staff if needed.
- The trust had a human resources department and referred staff to occupational health services where applicable.
- A service manager for the service was on sickness leave and another was offering management support from CAMHS community services.

Commitment to quality improvement and Innovation

- Managers had access to trust data such as incident reporting to gauge the performance of the unit. However managers' access to this information differed across units and it was not evident how they were using this to improve the overall quality of the service.
- The Sett unit was registered with 'the quality network for inpatient CAMHS', (QNIC) and a peer review had taken place January 2014, with an identified action plan arising.
- Both units were members of the prescribing observatory for mental health (POMH-UK) which aimed to help improve prescribing practice.
- We saw internal CQC type audits were undertaken with action plans for any issues identified. An action plan for the Burrows included addressing issues with assessments, the involvement of people in care planning and updating risk assessments in a timely manner when risks changed.
- Regular bed management meetings took place with commissioners to review patient needs and identify areas for service improvement.
- Initially opened in November 2013, the Burrows had refined its admission criteria in April 2014 in liaison with commissioners to respond to the assessed needs of patients and to ensure that patients were admitted with similar needs.
- Patient-led assessments of the care environment (PLACE) were completed and we found that the Sett had

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scored the high scores for cleanliness, food and facilities but lowest for dignity and privacy and wellbeing. However, during our visit patients did not raise any concerns regarding these findings.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes **The Burrows had a seclusion room which was partially non compliant with the Mental Health Act 1983 Code of Practice (2015)and the ligature risks identified on both units had not been risk assessed and addressed by the trust.** The trust must ensure that patients having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of suitable design and layout. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation (15) (1) (a).