

Good



Nottinghamshire Healthcare NHS Trust

Child and adolescent mental health services

Quality Report

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Date of inspection visit: 29 April – 1 May 2014

Date of publication: 24/07/2014

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Thorneywood Unit Porchester Road Mapperley Nottingham Nottinghamshire	RHANP	Inpatient unit, Child and Adolescent Mental Health Services	NG3 6AA
Duncan Macmillan House Porchester Road Mapperley Nottingham Nottinghamshire	RHA03	Child and Adolescent Mental Health Community Services	NG3 6AA

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare NHS 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.

Summary of findings

Where applicable, we have reported on each core service provided by Nottinghamshire Healthcare NHS Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare NHS 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 Services

Good



Are Child and Adolescent Mental Health Services safe?

Requires Improvement



Are Child and Adolescent Mental Health Services caring?

Good



Are Child and Adolescent Mental Health Services effective?

Good



Are Child and Adolescent Mental Health Services responsive?

Good



Are Child and Adolescent Mental Health 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

Nottinghamshire Healthcare Trust provides a specialist Child and Adolescent Mental Health Service (CAMHS). The service consists of community and inpatient care for young people with mental health needs. There is a 12-bedded ward for inpatient treatment, but only 10 beds were being used on the day of our inspection. The inpatient service was commissioned through NHS England.

We found that the CAMHS services were delivered in a safe and caring environment. However, the trust needs to make improvements to ensure that risks to people using the service are fully reviewed, understood and managed.

The trust provides an effective service. We saw some good examples of care, and teams working together, both in the inpatient unit and community services.

The services provided were caring. We saw good examples of individualised and person-centred care in the inpatient unit and within community services.

The services provided by the trust were responsive. We found that individual needs and wishes were met when assessing, planning and delivering care and treatment, and there was an emphasis on avoiding admission wherever possible.

These services were well-led by the trust. Most staff we spoke with felt well supported by their immediate line manager and were aware of the senior leaders within the trust. They also felt that communication from 'board to ward and community' was effective.

Summary of findings

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

Are services safe?

The service had a proven track record on safety and was developing some service-based learning from incidents. The trust effectively anticipated and managed most of the potential risks to the service.

Only 10 beds were being used on the day of our inspection due to a lack of staff. We saw that beds for male and female were not kept, and a female-only lounge was not provided on the unit.

The safety of, and clinical risks to, some community teams were not well documented and were not available to all staff.

Requires Improvement



Are services effective?

Teams in both inpatient and community services worked well together to deliver effective care. However, some community teams did not have staff from a wide range of disciplines. There were some good examples people using the service being involved in creating personalised care plans.

Physical healthcare needs were assessed and met in the inpatient unit.

Community staff's caseloads varied in size and complexity. This could affect the delivery of care and treatment for some young people.

Good



Are services caring?

Young people who used services were treated with kindness, dignity, respect, compassion and empathy. We saw that they were given information about, and involved in, the planning of their care and treatment.

Good



Are services responsive to people's needs?

We found that individual needs and wishes were met when assessing, planning and delivering care and treatment, and that there was an emphasis on avoiding admission wherever possible. Young people and their families were encouraged to provide feedback on their care, and were told how to raise concerns.

Records showed that some people referred to specific CAMHS community services were not seen quickly enough for initial assessment and treatment. However, senior staff confirmed that the trust was working with commissioners to address these delays.

Good



Summary of findings

Are services well-led?

Most staff we spoke to felt well supported by their immediate line manager. They also knew who the senior leaders within the trust were, and felt that communication from 'board to ward and community' was effective. Weekly ward meetings were used to help junior staff learn and develop.

The inpatient service worked with local organisations to proactively manage the clinical risks to the people who used this service. Local leadership was good, but monitoring of some of the community CAMHS services could be improved to ensure referrals and assessments are acted on quickly.

Good



Summary of findings

Background to the service

Nottinghamshire Healthcare Trust provides a specialist Child and Adolescent Mental Health Service (CAMHS). We last inspected the inpatient unit in September and October 2013, and reported that the service was compliant with the seven outcomes inspected. We reviewed the findings from the previous report as part of this inspection.

We looked at the report from the last Mental Health Act monitoring visit, dated December 2013, and the subsequent action plan by the trust. In addition, we saw a draft copy of the Royal College of Psychiatrists' report on the quality network for inpatient CAMHS. The trust confirmed that they were addressing the issues identified in this report.

Before this inspection, neither we nor the Mental Health Act Commission had inspected the community CAMHS.

The service consists of community and inpatient care for young people with mental health needs. There is a 12-bedded ward for inpatient treatment, but only 10 beds were being used on the day of our inspection. Staff informed us that this was due to a lack of staff. The inpatient service was commissioned through NHS England.

We saw evidence that community services were working with other stakeholders, including the local authorities and the criminal justice system.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott – Deputy Chief Inspector for Hospitals (Mental Health) Care Quality Commission

Team Leader: Jenny Wilkes, Care Quality Commission

The team that inspected the trust included CQC inspectors, consultant psychiatrists, nurses and a variety of specialist advisors and Experts by Experience.

The team that inspected this service was a CQC inspector, a child and adolescent mental health services (CAMHS) consultant psychiatrist, a senior CAMHS nurse, consultant and a social worker.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot 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 provider:

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

We visited the Child and Adolescent Mental Health Services of Nottinghamshire Healthcare NHS Trust between 29 April and 2 May. Before visiting the service, we reviewed information from the provider and looked at feedback from local organisations, including Healthwatch and advocacy services, as well as from focus groups of people who used the service.

Summary of findings

During our visit, we spoke with staff on the wards and in the community, and with people who used the services, both on the inpatient unit and in the community. We also met with some of the families of young people using the services.

We observed how people were treated on the inpatient unit, and took part in one of the multidisciplinary weekly

ward rounds. We also observed some consultations in the community and spoke with senior community and ward based staff, including doctors, nurse leaders, front line and support staff. In addition, we reviewed treatment plans as well as the trust's systems for obtaining feedback from other people who had used this service.

What people who use the provider's services say

We met nine young people who used this service as an inpatient or in the community, and also some family members. In addition, we reviewed the trust's quality monitoring systems and feedback from people who had used the service.

Some of the young people on the inpatient unit were concerned about the number of staff and the care that they received. However, they also spoke highly of some staff members and confirmed that they listened to them

and their concerns. We saw that some young people and their families were involved in their individual care and treatment, and that they had the opportunity to discuss these with their key worker and other staff.

The trust's quality monitoring systems showed that young people and their families were complimentary about their individual key nurse and their community care coordinator. They also appreciated the support from community based staff. In addition, we saw compliments and thank you cards from some young people and their families, which demonstrated that the service was responding to and meeting the needs of individuals.

Good practice

The school adjacent to the Thorneywood inpatient unit, which is provided in partnership with the local authority, had been rated as 'Outstanding' by Ofsted at their last inspection in May 2013.

The community 'Head to Head' service was a good example of different organisations working together. It supports the mental health needs of young people known to the criminal justice system, who are a 'difficult to reach' and challenging group.

The paediatric liaison service based at the Queens Medical Centre was an innovative and excellent service. It provided and promoted a joined-up approach to physical and mental health care for young people and their families.

Innovative and outstanding practice was also seen within some community services, for example through the piloting of the 'digi pen' care recording system and the 'patient feedback challenge'. The latter used independent volunteers to gather feedback from the young person without a staff member being present following each treatment episode.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action we have told the trust it should take:

- The trust should ensure that all the core bank and agency nursing staff who work on the Thorneywood inpatient unit receive their level 3 safeguarding children training.

Summary of findings

- The trust should consider the provision of a CAMHS ward based local policy to provide guidance on gender segregation for front line staff.
- The trust should ensure that all their CAMHS community care and treatment records are reviewed for consistency and completeness.
- The trust should continue to work with commissioners to ensure that all the beds on the Thorneywood inpatient ward are fully available for young people who need these.
- The trust should ensure that young people on the Thorneywood inpatient unit meet their responsible clinician weekly in order to review their care and treatment needs.
- The trust should review their current systems for the effective monitoring and management of individual community CAMHS team caseloads.
- The trust should continue to work with commissioners to ensure that every young person who had been referred to the community CAMHS team received prompt initial assessment and treatment.
- The trust should ensure that a review takes place of the multi-disciplinary input into some community CAMHS teams and into the Thorneywood inpatient unit.
- The trust should ensure that young people on the Thorneywood inpatient ward get a formal response to any complaints made about their care and treatment.
- The trust should ensure that steps are taken to permanently fill those CAMHS managerial positions that are currently interim or acting roles.

Nottinghamshire Healthcare NHS Trust

Child and adolescent mental health services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Thorneywood Unit – inpatients CAMHS service	Thorneywood Unit Porchester Road Mapperley Nottingham Nottinghamshire NG3 6AA
Child and Adolescent Mental Health Community Services	Duncan Macmillan House (Trust Headquarters) Porchester Road Mapperley Nottingham Nottinghamshire NG3 6AA

Mental Health Act responsibilities

We reviewed six care records in the inpatient unit of those young people who were detained under the Mental Health Act 1983. The required legal documentation was completed

appropriately and there was evidence that capacity assessments were being completed. Young people were being granted Section 17 leave. We saw that Section 132 rights were being read and regularly reviewed.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff spoken with were aware of the Mental Capacity Act and the implications that this had for their clinical and professional practice. Those training records seen showed us that staff were receiving training on the Act.

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

The service had a proven track record on safety and was developing some service-based learning from incidents. The trust effectively anticipated and managed most of the potential risks to the service.

Only 10 beds were being used on the day of our inspection due to a lack of staff. We saw that beds for male and female were not kept, and a female-only lounge was not provided on the unit.

The safety of, and clinical risks to, some community teams were not well documented and were not available to all staff.

within their specific team and disseminated through the trust. This was supported by the minutes of the trust's accountability review report for this service dated April 2014.

We saw that individual treatment records identified young people's previous risks and behaviours as well as current assessed concerns and risks. These were evaluated based on a weekly review of each young person. However, the trust may find it useful to note that these reviews did not always include a weekly meeting with the young person's consultant psychiatrist.

The evidence seen demonstrated to us that the service had a proven track record on safety and was developing some ward based learning from incidents that had happened. We saw that trust wide learning had been recorded and disseminated via the 'Risky Times' trust wide publication.

Our findings

Thorneywood inpatient unit

Track record on safety

Staff told us that there had been an increase of incidents of self-harm on this unit for March and April 2014. This appeared to be due to a change in assessed clinical need. Staff confirmed that these incidents were being managed effectively.

The figures shown to us by the trust indicated that there had been a recent downwards trend of incidents over the previous six months. Staff confirmed that clinical and other incidents were reviewed and monitored by the service and this was reflected in some of those care and treatment records seen. Senior staff confirmed that the unit's specific risk register was updated and reviewed by managers as required.

The trust's National Reporting Learning System (NRLS) data showed us that 34 moderate incidents had been reported from this speciality by the trust between February 2013 and January 2014. These figures obtained from the National Reporting and Learning Service (NRLS) showed us that the trust was reporting incidents within the expectations for a trust of this size and configuration. Staff told us that the lessons learnt from these incidents had been discussed

Learning from incidents and Improving safety standards

Staff confirmed that the trust had an on-line reporting system to report and record incidents and near misses. We saw that staff had access to this system via 'password' protected computer systems.

Staff confirmed that individual concerns were discussed at their weekly team meetings. They confirmed that they were encouraged to report incidents and 'near misses'. Some young people told us that they were comfortable in raising their concerns with staff. However, the trust may find it useful to note that they also informed us that they were 'unsure' about the outcome of these expressed concerns.

Systems were in place to review incidents and near misses. This included a formal debrief for staff and discussion during clinical and managerial supervisions for front line staff. Staff confirmed that they had received mandatory safety training and that they felt well supported by their line manager following any incidents or near misses.

Wider trust learning was evidenced through the bi-monthly newsletter issued by the trust's risk and governance committee. This included updates and 'key messages' for staff. Staff were aware of the availability of this publication.

The evidence seen showed us that the trust had effective systems in place to learn from untoward incidents and had improved safety standards as a result.

Are services safe?

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

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

There were two males and eight females using the service when we visited. Previously, the ward had been female only due to the lack of demand from young men for this service. However, staff informed us that this had changed over the past year and more young men had been admitted.

The trust had an identified safeguarding children lead and staff told us that they were aware of their role within this service. Staff were aware of the trust's safeguarding and other policies. The records seen showed us that staff had received their mandatory safeguarding children training. However, senior staff confirmed that 50% of qualified staff had not received their level three enhanced safeguarding children's training.

Staff told us they knew how to raise any safeguarding concerns and reported close links and partnership working with the Local Authority's safeguarding team. Staff were aware of the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager.

This was demonstrated by those individual care and treatment records seen. These showed us that any potential identified safeguarding concerns had been reported appropriately and pro-actively by staff. The young people spoken with told us that they usually felt safe in the service and this was supported by our discussions with front line staff.

During our tour of the ward, we noted that it was clean and well maintained. Staff reported some delays in getting repairs done but confirmed that repairs classified as 'urgent' were addressed promptly by the trust. The trust may find it useful to note that whilst environmental risk assessments were in place. Some of these had not been reviewed as scheduled in March 2014.

The young people spoken with did not express any concerns about the gender mix and staff confirmed that if there was a young person with any concerns these would be identified in their care plan. None of the care plans that we saw identified this as a concern to the individual concerned.

Staff had arranged the young peoples' bedrooms into generalised male and female areas. None of these bedrooms were en-suite but there were gender specific

toilets and bathing facilities available. We saw that ligature risks were being managed effectively on the unit through a mixture of relational security and environmental risk assessments.

There was no physical segregation of male and female sleeping arrangements and no provision of a female only lounge on the unit. There were no call bells in people's rooms should they need these. There was no ward based local policy available in order to provide guidance on gender segregation for front line staff.

The trust is looking to re-provide these services in a purpose built unit but we noted that this was a medium term plan and subject to discussions with the commissioners of this service.

Assessing and monitoring safety and risk

Staff told us that they were kept informed of developments on the ward through comprehensive handovers between each shift and through their participation on weekly clinical reviews and 'step ahead' meetings with young people and their families. The care and treatment records seen showed us that staff were aware of each young person's assessed clinical needs and subsequent re-assessed associated risk. Staff told us that they had received induction and training to prepare them for their specific role and felt well supported by their line manager.

We noted that the trust was using 10 beds on the day of our inspection. Senior staff told us this was due to current staffing constraints. We reviewed the unit's staffing rotas from February 2014 and these showed us that the trust's long term staffing levels were sufficient for the 10 young people being cared for. The trust was using a number of bank staff to cover for absences within the core unit staffing. However, we noted that these staff already worked for the trust and were familiar with the service and the young people who used this service.

Our review of the staffing rotas was supported by our observations of staffing levels on the day of our inspection. We noted that these were safe to meet the needs of the 10 young people who used the service. We noted that recruitment plans were in place to address current staff vacancies.

Staff attended weekly team meetings during which any concerns were highlighted and shared by the team. We saw

Are services safe?

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

that monthly clinical supervisions took place. The trust provided evidence to demonstrate that where concerns were identified about individual staff practice, prompt action had been taken to address these concerns.

The evidence seen meant that the trust was effectively assessing potential risks to people who used this service and monitoring the safety of their own staff.

Understanding and management of foreseeable risks

We saw that the trust had a contingency plan in place for this service and staff told us that they were aware of this. For example we saw evidence of preventative maintenance and of emergency contact numbers. The trust may find it useful to note that some staff expressed concerns about this being a 'stand-alone unit' and separate from the wider support systems that were available to larger services within the trust.

The evidence seen showed us that the trust effectively anticipated and managed any potential risks to the service.

Community child and adolescent mental health services

Track record on safety

Staff reported a positive and inclusive culture within this service and that any previously identified concerns had been appropriately addressed. Evidence showed us that identified risks for particular services had been identified and escalated appropriately through individual line managers. Staff told us that the lessons learnt from these incidents had been discussed within their specific team and disseminated through the trust.

We saw that some community treatment records, including all the electronic records maintained by the trust, clearly identified previous risks and behaviours as well as current assessed concerns and risks. However, the trust may find it useful to note that we saw some gaps in the recording of information within a number of those community treatment paper-based records reviewed.

The evidence seen demonstrated to us the overall community service had a proven track record on safety and had learnt from incidents that had happened. However, some improvements were required to ensure that previous clinical risks and behaviours were documented thoroughly and were available for all staff including those without immediate access to a computer.

Learning from incidents and Improving safety standards

Staff confirmed that the trust had an on-line reporting system to report and record incidents and near misses. We saw that staff had access to this system via 'password' protected computer systems.

Staff confirmed that individual concerns were discussed at their team meetings. They confirmed that they were encouraged to report incidents and 'near misses'. Family members told us if they had any concerns they knew who to contact within their community team.

Systems were in place to review incidents and near misses. This included a formal debrief for community staff and discussion during clinical supervisions for front line staff. Staff confirmed that they felt well supported by their line manager following any incidents or near misses.

Wider trust learning was evidenced through the bi-monthly newsletter issued by the trust's risk and governance committee. This included updates and 'key messages' for staff.

The evidence seen showed us that the trust had effective systems in place to learn from untoward incidents that had happened in the community and had improved safety standards as a result.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

The trust had identified safeguarding children leads and staff were aware of their roles within the trust. Front line staff told us that they had received their 'level three safeguarding children training'.

Staff told us they knew how to raise any safeguarding concerns and reported close links and partnership working with the relevant Local Authority's safeguarding team. Staff knew the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager.

This was demonstrated by those individual treatment records seen. These showed us that any potential identified safeguarding concerns had been reported appropriately and pro-actively by staff. Family members told us that they felt safe in the service and knew who to contact if they felt unsafe.

Are services safe?

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

The evidence seen demonstrated to us that the trust had reliable systems, processes, and practices in place to keep people safe and safeguarded from abuse.

Assessing and monitoring safety and risk

The evidence seen showed us that staff were aware of the risks associated with their specific role and that any concerns were discussed within the weekly staff meetings. Evidence was seen of staff taking proactive risk management strategies – for example, when planning initial assessments and subsequent treatment appointments. Examples seen were the use of open access computer based diaries and the use of mobile phones to keep in touch with colleagues and management. Some staff gave us examples of joint visits where specific concerns had been identified. Staff told us that they had received induction and training to prepare them for their specific role and felt well supported by their line manager.

Some of the care and treatment records seen showed us that robust risk assessments were carried out on initial assessment and that these were reviewed at each appointment by the clinician and the person using the service. However, the trust may find it useful to note that we saw some gaps in the recording of safety and risk information within a number of those community treatment paper-based records reviewed.

We noted that staffing levels were satisfactory and arrangements were in place to provide short term cover from within the core community staff group. Longer term absences were covered from within the trust by the use of trust employed bank staff. Some staff raised concerns

about the impact upon capacity of a recent rise in ‘self-harm’ incidents reporting to the local NHS acute trust. Senior managers provided us with examples of the actions taken by the trust to manage some of these concerns.

Some staff told us they were concerned there were no facilities for young people under the age of 18 who needed a place of safety under the 1983 Mental Health Act. This meant young people were sometimes reviewed by the team in police cells when they required a place of safety, although staff told us they sought alternatives, such as residential units or the accident and emergency department wherever possible.

Staff attended weekly team meetings and clinical discussions during which any concerns were highlighted and shared by the team. We saw that monthly clinical supervisions took place.

The evidence seen meant that improvements were required by the trust to ensure that clear assessments of safety and risks were recorded fully in individual care and treatment records.

Understanding and management of foreseeable risks

We saw that the trust had a contingency plan in place and a lone worker policy. Staff told us that they were aware of these. Staff told us that good communication systems were in place and these were used to inform people of any delays or changes in appointment times. The trust had robust systems and processes in place to manage any foreseeable risks to continued service provision.

The evidence seen showed us that the trust effectively anticipated and managed any potential risks to the service.

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

Teams in both inpatient and community services worked well together to deliver effective care. However, some community teams did not have staff from a wide range of disciplines. There were some good examples people using the service being involved in creating personalised care plans.

Physical healthcare needs were assessed and met in the inpatient unit.

Community staff's caseloads varied in size and complexity. This could affect the delivery of care and treatment for some young people.

Our findings

Thorneywood inpatient unit

Assessment and delivery of care and treatment

From the evidence seen and discussions with managers and front line staff, we saw the trust was able to demonstrate that people who used this service received care and treatment in line with the current best practice guidance.

We saw that young people who required admission to an inpatient bed were assessed by their own specialist CAMHS psychiatrist in conjunction with the CAMHS consultant responsible for the inpatient beds. We noted that bed management meetings took place between the trust and NHS England specialist commissioners on a monthly basis to ensure the effective use of this service.

The evidence seen and discussed with staff showed us that they were aware of national guidance, policies, enquiries and clinical guidance. We saw examples of care plans that referenced NICE (National Institute of Clinical Excellence) guidelines. We observed part of a multi-disciplinary review meeting with the permission of those involved and noted that these were focused on the recovery of the young person.

We saw that individual care and treatment records reflected the assessed needs of young people who used

this service and how they were being met. However, the trust may find it useful to note that we found the recording of specific key worker sessions with people was sporadic. Staff told us that this would be addressed immediately.

The records seen showed us that people's specialist physical healthcare needs were being addressed by the service and that assessment of their physical health status was recorded.

The records showed us that each young person had a named nurse. Most young people were aware of their named nurse and told us that they met with them for discussions around their care and treatment.

Evidence was seen of some local based audits. For example a NICE audit was carried out in November 2013 and the service scored 91% and a cleanliness audit dated January 2014 scored 92.1%. These findings were recorded in the unit's accountability review report dated April 2014 and were available to front line staff.

Evidence was seen of actions being taken by the trust when concerns had been identified with clinical practice. For example, following a number of medication errors staff had attended a specific training session with the trust's pharmacist. This had led to improved clinical practice and fewer identified medication errors.

Senior staff confirmed that trust wide audits were also carried out. These findings were disseminated by the trust's risk and governance committee through specific trust management cascade information and via the 'risky times' publication.

Outcomes for people using services

The records and other evidence seen showed us that the trust were involved in the monitoring and measurements of quality and outcomes for people. For example, we saw that the unit's 'survey monkey' results were 100 per cent apart from information on prescribed medication which scored 66%

Evidence was seen of other person reported outcome measures (Proms) in individual care and treatment records as part of the evaluation of the care being provided by this service. We noted that the service measured outcomes for people by using the Health of the Nation Outcome Score (HoNOS).

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.

Some young people told us that they did not feel that they were making progress. However, we saw evidence within individual care records of staff recorded individual progress and evidence of increased self-esteem and improvements in mood reported by the young person concerned.

Staff, equipment and facilities

The records and evidence seen showed us that the trust ensured that adequate staffing and equipment were available to promote the effective delivery of care and treatment for the people who used this service. Staff told us that there were not enough locally commissioned beds to meet the needs of each young person who required admission to an inpatient bed. This was supported by trust evidence that showed a number of young people admitted to adult services or to 'out of county' provision. Senior staff confirmed that the trust was engaging actively with the commissioners of the service to address these potential concerns.

The training records seen showed us that staff had attended their mandatory training and other extended professional skills training. Senior staff told us that training attendance was monitored and non-attendance reviewed through the trust's training department.

We saw examples of professional skills training being undertaken by staff in order to provide them with the necessary clinical expertise to meet the needs of the young people who used the service. Staff told us they had received an initial induction to the service. Evidence was seen of weekly staff meetings and of personal appraisal development (PAD) delivery. Figures supplied by the trust showed a current personal appraisal development rate of 93.75% as at April 2014.

We saw records that demonstrated to us that the trust had completed the required risk assessments and maintenance on the equipment used by the service. Adjustments had been made to meet the access needs of young people with mobility difficulties and those with a potential sensory impairment.

The trust confirmed that the current ward environment was not ideal and that there were future plans to provide a purpose built unit for this service. We noted that the premises were clean and that the young people were supported to keep their bedrooms tidy. Adequate privacy

curtains were in place in those two bedrooms that were shared. We saw that there was number of private rooms available for meetings and individual consultations and meetings.

Multi-disciplinary working

We saw that the trust worked effectively with other providers and partners in the provision of this service. For example, we saw evidence of close and collaborative working with the community CAMHS service and with the relevant local authorities where any safeguarding concerns had been identified. This included the sharing of information and the provision of planned admissions and supportive discharge to and from the ward.

The records reviewed showed us that young people and where applicable their families had been actively involved in care and treatment planning. We saw some good examples of individual involvement in the drawing up of personalised care plans.

Evidence was seen of close working relations with the adult mental health service. This included the provision of advice and the reviewing of young people being cared for on an adult acute admission ward.

Community child and adolescent mental health services

Assessment and delivery of care and treatment

We saw some good examples of effective care and treatment being provided by this service. For example we observed a comprehensive family focused initial assessment within the community learning disability CAMHS service. Good examples of positive and collaborative work were noted within the Looked After Children (LAC) and the Head to Head services.

Good relations were reported by staff between the outpatient service and the inpatient unit. For example, via the provision of advice and support regarding potential new admissions. The evidence seen and discussed with staff showed us that they were aware of national guidance, policies, enquiries and clinical guidance. We saw examples of community treatment plans that reflected current NICE (National Institute of Clinical Excellence) guidelines.

Some good examples were seen of joint care assessments based on the needs of the young person and their family. For example the paediatric liaison service based at the local acute hospital provided us with good examples of community linked assessments.

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.

Evidence was seen of some locally based audits. For example we saw that incidents are recorded and monitored through the trust reporting system. The results of any investigation were audited by senior staff and reviewed at staff meetings and disseminated through the trust as required. A monthly care plan audit was carried out of a sample of care documentation within some of the community services visited and any concerns identified to individual staff as part of their monthly clinical supervision with their line manager.

Senior staff confirmed that trust wide audits were also carried out. These findings were disseminated by the trust's risk and governance committee through specific trust management cascade information and via the 'risky times' publication.

Outcomes for people using services

The records and other evidence seen showed us that the trust was involved in the monitoring and measurements of quality and outcomes for people. Evidence was seen of other person reported outcome measures (Proms) in individual community care and treatment records as part of the evaluation of the care being provided by this service. We noted that the service measured outcomes for people by using the Health of the Nation Outcome Score (HoNOS).

Evidence was noted of some positive outcomes as reported by people using the SUCE (Service User Care Experience) forms. We saw evidence that some community services were piloting the 'patient feedback challenge'. This involved the use of independent volunteers to gain feedback from people following each treatment episode and without the staff member being present.

Staff, equipment and facilities

The records and evidence seen showed us that the trust tried to ensure that adequate staffing equipment and facilities were available to promote the effective delivery of community care and treatment for the people who used this service. Some staff raised concerns about their individual work load. The trust may find it useful to note the managerial monitoring of these varied within those community teams visited. This meant that some staff had caseloads that varied in size and complexity.

The training records seen showed us that staff had attended their mandatory training and other extended professional skills training. Staff confirmed the trust

provided support to enable them to attend this additional training. Senior staff told us that training attendance was monitored and non-attendance reviewed through the trust's training department.

We saw current examples of professional skills training being undertaken by staff in order to provide them with the necessary clinical expertise to meet the needs of the people who used the service. Staff told us they had received an initial induction to the service. Evidence was seen of weekly staff meetings and monthly clinical and managerial supervision sessions throughout those community services inspected.

Some concerns were identified by the looked after children service regarding the availability of clinical areas and consultation rooms to enable the effective and confidential working of this service.

Those community staff spoken with confirmed that they were equipped with mobile phones. Some staff was piloting a new system of recording care and treatment episodes via the use of a 'digi pen'. This enabled the effective recording of assessments, care plans and treatment episodes onto the trust's electronic record system and meant that young people received a paper copy immediately after assessment.

Multi-disciplinary working

We saw that the trust worked effectively with other providers and partners in the provision of this service. For example, we saw evidence of close and collaborative working with local authorities, schools, General Practitioners (GP) and local Youth Offending Teams (YOT). This included the sharing of information and regular meetings where specific concerns had been identified.

However, the trust may find it useful to note that senior staff informed us of a lack of multi-disciplinary involvement in some of the community teams. For example within the CAMHS community learning disability team there was no speech and language, occupational therapy or psychology input.

The records reviewed showed us that people and, where applicable, their families had been actively involved in their care. We saw good examples of individual involvement in the drawing up of community treatment plans.

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 noted close links with the local acute NHS trust. This included providing support and advice to staff caring for people who presented with 'self-harm' episodes via the accident and emergency department. This included the following up of each referral within 14 days.

Are services caring?

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

Summary of findings

Young people who used services were treated with kindness, dignity, respect, compassion and empathy. We saw that they were given information about, and involved in, the planning of their care and treatment.

Our findings

Thorneywood inpatient unit

Kindness, dignity and respect

The trust provided good evidence to demonstrate to us that the young people who used this service were being treated with kindness, dignity, respect, compassion and empathy. This was supported by our observations of the care provided during our inspection.

We met with some young people during our visit and their individual concerns about care and treatment were shared with the clinical team during our inspection of the unit. However, we also noted that some of these concerns were already being pro-actively addressed by staff.

We noted positive engagement between staff and young people and the development of therapeutic relationships within the named nurse framework. Guidelines were in place for responding to self-harm episodes on the unit and these included front line staff spending time with the young person listening to their concerns.

The young people spoken with were complimentary about the food provided and some aspects of the education provision.

We saw that staff were actively engaged with the young people who used the service and where applicable their families or main carers. Those treatment records seen showed us that the service had adopted a holistic approach towards the assessed needs of the young people. Evidence was seen of a recently commenced activity programme and a designated spiritual room.

Private consultation rooms were available if required within the unit and front line staff spoken with were aware of the need to protect the privacy and dignity of people.

People using services involvement

The evidence reviewed during the inspection showed us that the young people who used this service were involved as far as possible in their own care and treatments.

We saw good examples of individual involvement in those records reviewed and of active participation by people in their treatment plans. Young people spoke highly of the unit based advocacy service and of the education re-integration worker and accessed these services accordingly. This demonstrated to us that people received person centred treatment according to their individual needs.

Information provision was good within the service. We saw a number of noticeboards and these included helpful information for young people and their families. We saw that the service had an age appropriate and accessible welcome pack to the unit. Some young people confirmed that they had received a copy of this on their admission. Staff confirmed that where required they had access to interpreters and information in different formats for people who used the service.

Emotional support for care and treatment

The records and other evidence reviewed showed us that people received the correct level of care and treatment required. Staff informed us that they would advocate on behalf of people where this was appropriate.

Some young people were positive about the education service provided by the unit. We saw that they attended this service four days a week based upon individual risk assessments. We saw a wide variety of educational activities being provided. This included music, core curriculum subjects and art and design. We noted that this educational establishment had been rated 'Outstanding' by OFSTED at their last inspection in May 2013.

Community child and adolescent mental health services

Kindness, dignity and respect

The trust provided good evidence to demonstrate to us that people were treated with kindness, dignity, respect, compassion and empathy. This was supported by our discussions with front line staff and the family members of people who used the service. We noted that the feedback about the services received from people via the trust SUCE (Service User Care Experience) forms was generally

Are services caring?

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

positive. Any concerns identified through these forms had been addressed by senior staff and managed through weekly clinical discussion and monthly supervision meetings.

We observed an initial assessment meeting with the permission of all of those involved and noted a family and young person centred approach by staff. Those treatment records seen showed us that services had adopted a holistic approach towards the assessed needs of young people.

We observed an appointment at the CAMHS paediatric liaison service in-reach to acute hospital paediatric services. We saw that staff treated the young person and their family with kindness dignity and respect.

Private consultation rooms within community clinics were used wherever possible for consultations and we noted that staff took steps to ensure the confidentiality of any discussions held with young people and their families.

People using services involvement

The evidence reviewed and our discussions with staff and the feedback seen from the people who used this service showed us that people were involved as far as possible in their own care and treatments.

We saw good examples of individual involvement in those records reviewed and of active participation, wherever possible, by the young person in their care and treatment. This demonstrated to us that people received person centred treatment according to their individual needs.

Information provision was good across those locations visited. We saw examples of useful information for carers and families and about local 'self-help' groups. Information around any identified complaints was available. For example in the form of the trust's 'Patient Advice Liaison Service' (PALS) and service user care experience (SUCE) leaflets and other contact information. Staff confirmed that where required they had access to interpreters and information in different formats for people who used the service.

Emotional support for care and treatment

The records and other evidence reviewed showed us that people received the correct level of care and treatment required. Community staff informed us that they would advocate on behalf of people where this was appropriate.

Young people and their families told us that they felt well supported by the services provided. They told us that they felt well supported by their care co-ordinator and other staff. This was supported by those individual treatment feed-back forms reviewed.

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 found that individual needs and wishes were met when assessing, planning and delivering care and treatment, and that there was an emphasis on avoiding admission wherever possible. Young people and their families were encouraged to provide feedback on their care, and were told how to raise concerns.

Records showed that some people referred to specific CAMHS community services were not seen quickly enough for initial assessment and treatment. However, senior staff confirmed that the trust was working with commissioners to address these delays.

Our findings

Thorneywood inpatient unit

Planning and delivering services

Evidence showed us that the trust was planning and delivering the inpatient services in partnership with the commissioner of these services. For example we saw that the trust held monthly bed management meetings with the regional case manager from NHS England. These meetings included discussions around bed availability and young people accommodated in adult wards and with other providers, both NHS and private, elsewhere in the country.

Evidence was seen of collaborative working by the inpatient unit with schools, local authorities throughout Nottingham and community based staff including outpatients.

Those care and treatment records seen showed us that staff from this service had provided support and information where appropriate to other stakeholders. For example through the work of the education reintegration worker. This helped to ensure that young people in education maintained some continuity with their education whilst an inpatient in this unit.

Right care at the right time

We saw records and other evidence that demonstrated to us that the trust was making efforts to meet the needs of young people and their families who required admission

into an inpatient facility. Senior staff confirmed that this was an issue with CAMHS provision across the country and that NHS England was aware of the local difficulties that the trust was encountering.

The inpatient unit had clear admission criteria in place and this included exclusion on the grounds of the assessed need for some young people for a secure environment. Evidence was seen of close working relationships between community based CAMHS psychiatrists and the inpatient bed CAMHS psychiatrist.

An emphasis was seen on admission avoidance wherever possible. For example, via enhanced community support and intensive home treatment programmes. Evidence was seen of discharge planning commencing when the young person was admitted.

Care Pathway

The care and treatment records reviewed showed us that the inpatient unit took account of individual needs and wishes whenever possible and when care and treatment were being planned and delivered to the young people who used this service.

Clear records were seen that showed us that people and their families were involved in multi-disciplinary reviews. For example following each review young people and their families were involved in 'step ahead' meetings. These were facilitated by their key worker and were focused upon the young person and their recovery. Making choices where ever possible. We noted that other stakeholders had been invited to attend. The trust may find it useful to note that some ward based staff reported non-attendance by some community trust staff at these review meetings.

We saw evidence that the unit had taken prompt action in response to any proven concerns raised by the young people who used the service.

Learning from concerns and complaints

There was plenty of information available to young people and their families at those locations visited regarding how to report on their experiences of the care received and how to raise any concerns that they may have. Staff gave us some examples of changes made following feedback received from young people. For example, we saw changes to how night time observations were carried out.

Are services responsive to people's needs?

Good 

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

Some young people spoke highly of the local advocacy service and of the support that they received from this service. The trust may find it useful to note that some young people told us that they had raised concerns but hadn't received a formal response to these.

Community child and adolescent mental health services

Planning and delivering services

Evidence was seen that showed us that the trust was planning and delivering these services in partnership with the local commissioners of these services. The trust may find it useful to note that some senior staff raised concerns about dealing with a number of local clinical commissioning groups within Nottinghamshire. For example, in getting agreement from all the local commissioners for new service provision.

We saw some specific examples of good collaborative working within the 'looked after children' service and the 'head to head' services visited. Here, the trust worked effectively with other stakeholders to meet the needs of these 'hard to reach' and vulnerable groups of young people.

Some of the care and treatment records seen showed us that community based staff had attended stakeholder and other meetings to participate in multi team reviews of the young person concerned.

Right care at the right time

We saw some evidence provided by the trust that demonstrated recent improvements with access times and subsequent treatment. The records seen during our inspection showed us that was a historic variation between how some young people were being assessed and allocated for treatment by the community CAMHS teams.

A sample caseload for one service showed us that there was a minimum of two and a maximum of 12 months between initial referral and allocation date. This meant that

there was a delay between initial referral and allocation/treatment for some young people. Senior staff confirmed that they prioritised urgent referrals and were working hard to address the identified concerns.

However, we saw some good examples of weekly allocation meetings in some services and a prompt response to the assessed needs of the young person by trust staff. This included collaborative working with the young person's GP or with the local Youth Offending Team (YOT).

Care Pathway

Some of the care and treatment records examined showed us that the service took account of individual needs and wishes when assessing, planning and delivering care and treatment to people who used this service. However, there were some gaps identified in those paper-based records reviewed during our inspection and these were brought to the attention of senior staff during our visit.

Evidence was seen that showed us that individual young people were involved in making choices about their care and treatment where ever possible. For example in the location of meetings with their care co-ordinator and the extent of family involvement. This was supported by the feedback seen to the trust from young people and their families.

Learning from concerns and complaints

Evidence was seen of the leaflets given to young people and their families by trust staff regarding the service being provided and how to raise any concerns. For example we saw that SUCE (Service User Care Experience) leaflets were given to young people and subsequently completed by them and returned to the service. Staff gave us some examples of changes made following feedback received from young people. For example, we saw changes to how text reminders of appointments were sent.

We were given examples of when trust staff had acted as an advocate for young people. For example within the criminal justice system and education services.

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

Most staff we spoke to felt well supported by their immediate line manager. They also knew who the senior leaders within the trust were, and felt that communication from 'board to ward and community' was effective. Weekly ward meetings were used to help junior staff learn and develop.

The inpatient service worked with local organisations to proactively manage the clinical risks to the people who used this service. Local leadership was good, but monitoring of some of the community CAMHS services could be improved to ensure referrals and assessments are acted on quickly.

Our findings

Thorneywood inpatient unit

Vision and strategy

Staff spoken with confirmed that they were aware of the trust's vision and strategy. They confirmed that they were aware of trust wide communication strategies such as the 'Positive' trust wide magazine and 'Risky Times'. They reported that they generally felt listened to by senior trust management.

Weekly ward meetings were held and senior nurses reported that they used these as learning and developmental opportunities for junior staff. Staff meetings and personal appraisal developments (PAD) were also used to communicate trust wide messages to front line staff.

Responsible governance

We saw clear clinical governance arrangements in place at a local level. For example we saw the trust's accountability review report for this service dated April 2014. We saw an emphasis on the young person's care and treatment and front line staff understood the importance of their role in direct care delivery.

The training records reviewed showed us that staff had received mandatory and job specific additional training to prepare them for their role.

The evidence reviewed on the ward showed us that the service managed the clinical risks to the people who used this service proactively and in partnership with local stakeholders where appropriate.

Leadership and culture

Staff told us that they were well supported by their line manager and could approach them if they had any concerns or questions about their case load or other professional concerns. We saw evidence of monthly clinical and managerial supervisions for staff. Staff told us that the culture upon the ward had 'improved' recently. We saw that bank staff who knew the ward well provided cover for long term absences from within the core ward team. Evidence was seen of local recruitment initiatives to address vacancies. However, we noted that some senior roles within the ward were defined as 'interim' and staff themselves could not confirm when these roles would become permanent.

Staff were aware of the trust's whistleblowing policy and told us that they knew how to raise any issues through this process. They were aware of senior trust leaders and their role in the organisation. They confirmed that visits had been carried out to the service by senior managers.

The care and treatment records seen were well completed and individual risk assessments had been reviewed and updated appropriately. Evidence was seen that treatment outcomes were being monitored through the weekly multi-disciplinary team and 'step ahead meetings'.

Engagement

All of the young people spoken with confirmed that they had access to a ward based independent advocate and spoke highly of this service. They were also supported to make complaints where applicable. This was further evidenced by the provision of locally based information seen during the inspection.

Senior staff confirmed that any complaints made were dealt with appropriately via local resolution and the trust's NHS complaints procedures. However, the trust may find it useful to note that some young people reported that they had not been notified of the outcome of their complaint.

Performance Improvement

Staff told us that they were aware of their own professional objectives and that these were reviewed as part of their monthly clinical and managerial supervision opportunities.

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.

These were also being monitored through their performance appraisal development. We saw that performance monitoring of the service took place and that local audits happened.

Community child and adolescent mental health services

Vision and strategy

The community based staff spoken confirmed that they were aware of the trust-wide vision and strategy. They confirmed that they were aware of trust wide communication strategies such as the 'Positive' trust wide magazine and 'Risky times'. They told us that they felt listened to by senior trust management.

Weekly team meetings were held and staff felt that these were useful and supportive for staff who often worked alone.

Responsible governance

We saw clear governance arrangements in place at a local level and an emphasis on person centred care delivery within each of the community teams visited. Staff were clear about their clinical role and responsibilities and understood the importance of their role in direct care delivery.

The training records reviewed showed us that staff had received mandatory and job specific additional training to prepare them for their role.

Most of the community care and treatment records reviewed demonstrated to us that the service managed the clinical risks to the people who used this service in partnership with local stakeholders.

Leadership and culture

Staff told us that they were well supported by their line manager and could approach them if they had any concerns or questions about their case load or other professional concerns. We saw evidence of monthly clinical

and managerial supervisions for staff. Some staff told us that there was a good team spirit within their particular community team and that short term staff absences were covered from within the team.

Staff were aware of the trust's whistleblowing policy and told us that they knew how to raise any issues through this process. They were aware of senior trust leaders and their role in the organisation. They confirmed that visits had been carried out to some community services by senior managers and non-executive directors (NED).

Most of the community care and treatment records seen were well completed and where applicable individual risk assessments had been reviewed and updated appropriately. Evidence was seen that treatment outcomes were being monitored through team meetings and in multi-disciplinary reviews.

Engagement

Staff told us that young people receiving care and treatment in the community and their families received information about the service being provided. We saw examples of some information leaflets that were being used.

Senior staff confirmed that any concerns were dealt with appropriately via local resolution and the trust's NHS complaints procedures.

Performance Improvement

Whilst we saw evidence of the monitoring of individual staff objectives and appraisals, we had some concerns about some of the community service's prompt responsiveness to referrals and assessments and noted that there appeared to be concerns about the effective monitoring of the size and complexity of some individual staff members' caseloads compared to that of other similar staff within the same community teams.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

The trust had not made arrangements for gender segregated living accommodation or 'female only' communal areas within Thorneywood inpatient ward.

Regulation 10 (1)(b)