Good

Sussex Partnership NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

Sussex Partnership NHS Foundation Trust HQ
Swandean
Arundel Road
Worthing
West Sussex
BN13 3EP
Tel: 01444 472670
Website: www.sussexpartnership.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX2X4	Chalkhill		RH16 4EX

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

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

- Families, carers, and most young people spoke positively about those that cared for them. They told us that staff listened to them and informed and involved them in decisions about care and treatment. Care plans reflected this and were very holistic and personalised. Staff gave young people copies of their care plan. Carers told us that the consultant and other staff were accessible. They provided weekly updates and information to help the carer understand the current situation of the young person and their treatment. Staff made changes to the running of the unit in response to the views and opinions expressed by young people.
- The unit provided young people with a range of activities and therapies. Young people on the unit had access to occupational therapists and psychologists. Staff also worked collaboratively with local authorities and community services to better understand and meet the range and complexity of the needs of young people.
- Staff spoke enthusiastically about their roles and displayed a passion to meet young people's needs. Staff demonstrated an empathy and understanding about the young people's varying circumstances and a commitment to offering a professional, accountable service with a real desire to see young people move on in their lives.
- Managers supported staff to develop and improve. Staff had good access to specialised training and received regular supervision and a yearly appraisal.
- The unit was well-led. Staff felt supported by their managers and staff morale was good. Staff told us that managers were approachable and supported them to develop their role further. Carers spoke very highly of the leadership within the unit and felt this had an impact with the whole team. Carers told us that the unit had improved significantly over the past year.

However:

- There was not always regular staff members on shift during the night.
- There was a Mental Health Act Review visit in February 2016 that identified areas of improvement that needed to be addressed. An action plan for these improvements had been put in place.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Staff undertook a risk assessment on every patient on admission. These were then reviewed by the multi-disciplinary team and updated regularly.
- Staff we spoke with knew who the safeguarding lead was. Staff demonstrated clear knowledge of safeguarding procedures.
- The clinic room was clean and tidy and medication charts were audited weekly.
- Environmental risk assessments were undertaken regularly. Risk assessments were in place to mitigate any risks the environment posed.
- Young people and staff had access to appropriate alarm systems and security to maintain their safety.
- Chalkhill had systems in place to ensure safe staffing. Staff were appropriately qualified for their roles and attended relevant training.
- Chalkhill had good systems in place on reporting incidents and learning from them.

However:

- Young people told us having night staff they knew well had not been consistent at a time when they often felt most vulnerable. The young people and carers had raised the concern with staff and this had been discussed further by the inspection team with senior staff. Managers stated they were aware of the situation and equally concerned, they were keen to look at strategies to address this and would continue to work on this matter.

Are services effective?

Good

We rated effective as good because:

- Young people had comprehensive assessments of their needs, which included clinical needs, mental health and physical health.
- Staff worked together with the young person, families and local agencies to provide a care plan that responded to the person's individual needs.
- Care plans were comprehensive, holistic and personalised, Young people were actively involved in their care.
- All staff received regular supervision and appraisals. Staff told us they were well supported and supervised in their role.

Summary of findings

- If a young person required more intensive treatment for their eating disorder such as nasogastric feeding, Chalkhill referred them on to a more specialised unit.
- Young people and carers had access to a wide range of psychological therapies as part of their treatment. Psychologists were part of a multi-disciplinary team.
- Young people had a goal setting /care plan meeting within the first five days of admission, community teams and local authority are pre-booked into these meetings prior to admission.
- Staff had regular team meetings and development days.
- Staff demonstrated a strong commitment to work together as a multi-disciplinary team to offer an environment where effective and meaningful care can be given.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- We observed young people being well cared for by staff. Staff spoke to young people in a caring manner and with respect and dignity. The young people we spoke with were positive about the staff and the care they received.
- Some young people were exhibiting extreme anxiety during our inspection and we observed staff providing close one to one time. Staff were offering reassurance and appropriate de-escalation techniques and showed an awareness of managing any potential risks.
- On the day of our inspection, we observed staff responding to carers who were distressed giving them individual time using appropriate therapeutic interventions to provide support.
- Young people, families and carers were informed about and involved in decisions about care and treatment. Families had regular access to the staff team and consultant psychiatrist. Carers praised staff highly in their feedback for the good communication and care shown.
- Young people had weekly community meetings and the opportunity to give feedback and suggest change. We saw evidence of this during our inspection. They had a suggestion box where young people could post comments.
- Carers told us that they were being encouraged by the staff team to establish a carers forum for the unit.
- Chalkhill unit continued to develop ways of involving young people and carers in the running of the unit. Young people were actively involved in the recruitment of staff and were on interview panels. We watched a video designed by the young people on what to expect when admitted to Chalkhill.

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Young people had access to a wide range of activities to support their care and recovery.
- There was access for young people who were well enough to an on-site school where they could continue their education. The school was a recognised examination centre and young people could still sit their exams.
- Young people were able to personalise their bedrooms. Young people spoke about how important this was to them.
- At the community meetings young people's requests and suggestions were listened and responded to.
- Young people could make a complaint or raise a concern. Young people and staff received feedback on complaints to improve standards of care.
- The unit worked alongside the urgent help service to try and prevent admission and promote meaningful discharge plans. All members of the multi-disciplinary team worked with the service.

Are services well-led?

Good

We rated well-led as good because:

- Staff were informed of lessons learnt from incidents and spoke about incidents at team meetings.
- Staff were encouraged to develop within their role further.
- Staff felt supported by their managers and felt valued. Staff were supported further in reflective practice sessions once a week.
- Staff morale was good and staff felt supported by the ward manager. Staff knew and were familiar with senior staff.

Summary of findings

Information about the service

Chalkhill Unit is an inpatient child and adolescent mental health service provided by Sussex Partnership NHS Foundation Trust (SPFT). It provides mental health care and treatment for children and young people up to the age of 18, who are experiencing a range of emotional and mental health difficulties. There is also a registered education and examination centre inspected by the Office for Standards in Education, Children Services and Skills (OFSTED). On the two previous OFSTED inspections Chalkhill had been rated as outstanding. This is a government department that inspects and regulate services which provide education for children and young people.

Chalkhill is a 16-bed mixed sex facility situated on the Princess Royal Hospital site. At the time of the inspection, there were 13 young people at the unit.

This was the second time that the Care Quality Commission has inspected the child and adolescent mental health inpatient service. The last Inspection was in January 2015 when it had been rated as requires improvement. The actions that were identified for Chalkhill to address had been met. These actions related to, a lack of qualified staff and absences being covered by healthcare assistants, ligature risks that were not always appropriately managed, that staff did not receive annual updates for mandatory training. Other actions had been met on improving training in physical healthcare to address the needs of young people with eating disorders.

Our inspection team

The overall team that inspected the trust was led by:

Chair: Dr James Warner, consultant psychiatrist and national professional advisor for old age psychiatry.

Head of Inspection: Natasha Sloman, Head of Hospital Inspection (mental health) CQC

Inspection Manager: Louise Phillips, Inspection Manager (mental health) Hospitals CQC

The team that inspected this core service comprised one Care Quality Commission (CQC) inspector, a Mental Health Act reviewer and a nurse with expertise in working in inpatient child and adolescent mental health services (CAMHs).

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- Visited the ward, looked at the quality of the ward environment and observed how staff were caring for young people

Summary of findings

- visited the education centre and spoke with staff and young people briefly
- spoke with four young people who were using the service
- spoke with four carers
- spoke with the ward manager
- spoke with 13 other staff including nurses, occupational therapists, psychologist, support workers, doctor, psychiatrist and the head teacher of the education centre and occupational therapists.
- looked at 13 medication cards
- reviewed four care records
- looked at three comment cards
- carried out a specific check of the medication management.
- looked at a range of policies, procedures and other documents relating to the running of the service.

At the time of our inspection most of the young people were at school and not available until after 15:30. In addition, many of the young people were unwell and needing one to one time with staff.

What people who use the provider's services say

Young people, families and carers were mostly positive about their experience. They said staff were very caring and felt their needs were respected. Young people did comment about there not being enough staff at night and this was mentioned in the three comment cards collected. Young people did speak about having regular one to one sessions and that they knew who their identified nurse was. Carers spoke about there being very good communication and being informed and updated on a regular basis.

Young people spoke about staff responding well to their individual needs and the staff team responding to their views and ideas at the community meetings.

Good practice

- The consultant psychiatrist showed real commitment to including young people and carers fully in their care and treatment. This ethos and leadership had made a significant impact on the quality of care. Carers spoke of a significant improvement since last year and that the whole staff team showed real commitment and a desire to support this ethos.
- Chalkhill worked pro-actively with the urgent help service to prevent admission of young people and offered intensive care at home.
- Chalkhill was accredited as excellent by the quality network for inpatient CAMHS (QNIC). QNIC aims to improve the quality of inpatient child and adolescent psychiatric in-patient care through a system of review against certain standards. Chalkhill is also under NHS England as a national provider and is inspected separately by these organisations.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that there are familiar staff on shift at night time and at least one permanent member of the staff team.
- The provider should ensure work is carried out to ensure the action plan identified from the Mental Health Act Reviewer visit for the seclusion/s136 suite is implemented.

Sussex Partnership 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
Chalkhill Unit	

Mental Health Act responsibilities

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

Chalkhill had six young people detained under the Mental Health Act on the day of our inspection. Staff received training and had a good understanding of the Mental Health Act. Training of staff in the Mental Health Act was above the 60% compliance rate set by the trust. The unit had support from the Mental Health Act administration office for the trust. There were regular audits to ensure the Mental Health Act was being implemented correctly. There were copies of consent to treatment forms accompanying the medication charts.

Staff routinely explained to young people what their rights were under the Mental Health Act. This happened on admission to the unit and was repeated thereafter. We saw evidence of this in the clinical notes. Staff referred young people to the advocacy service. However, some young people did express that they did not feel staff encouraged this.

We looked at all the Mental Health Act documentation and found it had been completed correctly.

Mental Capacity Act and Deprivation of Liberty Safeguards

All Staff received specific training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with about the training stated it was valuable because it was specific to the work they did and about young people, their rights and the law. Compliance rate for training was above trust target of 60%. For children under the age of 16, decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some

children may have a sufficient level of maturity to make decisions themselves. Consequently when working with children staff should be assessing whether or not a child has a sufficient level of understanding to make decisions regarding their care. Qualified staff spoke confidently about Gillick competence and there was good evidence of knowledge about ' Gillick competence'.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- Young people could be observed in most areas of Chalkhill by staff. In areas that had specific risks, such as therapy rooms or classrooms, a member of staff would always be present when young people used the room. In the residential accommodation upstairs, there was closed circuit television for the communal areas. When young people were assessed as being at high risk they were managed by closer staff observation.
- The bedrooms all had en-suite facilities. The bathrooms and bedrooms had been changed following the Care Quality Commissions last inspection visit. Ligature points had then been identified with the bathroom taps and the wardrobes. All these had now been changed.
- The Mental Health Act codes of practice sets out and states a clear criteria about sleeping areas and accommodation within a hospital setting and Department of Health provides guidance on same sex accommodation. The Chalkhill unit admitted males and females.
- On the day of our inspection we were shown male and female accommodation which was in three separate corridors. All bedrooms were ensuite. Young people did not access the accommodation during the day. There was a nurse's station in the middle As much as possible these corridors were kept female and male only. We were told that there were occasions, due to demand and need, when males may have to be accommodated in the female corridor and vice versa. At these times, the risks were mitigated by close staff observation and a risk assessment completed in addition to this. The young person concerned would be put in a room nearest the nurse's station so they did not have to pass by bedrooms occupied by the opposite sex. The three corridors either side of the nurses station had close circuit television for observation. The unit had a separate space protocol which set out the procedure in the event of the corridors being mixed gender. In this protocol, it sets out that senior management must be alerted and an incident raised when this occurs and that all possible steps must be made to rectify the situation.
- The clinic rooms were clean and tidy. Clinic rooms were equipped with appropriate emergency drugs. The resuscitation equipment was generally well equipped and checked appropriately. However, the heart start machine did not work and needed a new battery. This was resolved when we were there on inspection. There were no life support grab bags for easy quick response to the S136/seclusion room and education centre. The fridge temperature had been below the required temperature for several days. However, the ward manager informed us he would be getting a new fridge.
- Chalkhill was a clean environment. The unit had just had a deep clean due to a recent outbreak of diarrhoea and vomiting. The unit had been closed to admissions and followed their infection control protocol. The data relating to cleanliness scored the unit at 94%.
- A hand hygiene nurse had been visiting the unit regularly and educating young people and staff on good practices for the control and prevention of infection and good hand hygiene.
- The unit had a seclusion room. Between a six month period December 2015 and May 2016 there were five incidents of seclusion .Young people called this room a 'quiet room'. It had its own toilet facilities. There was a seclusion policy, which staff followed. There was a Mental Health Act review visit in February 2016 that identified two areas of improvement for the room. An action plan for these improvements had been put in place.
- It is also a S136 place of safety specifically for young people under the age of eighteen, but we were told it is only used if no other facility for young people was available. We were shown a risk assessment for the reduction and prevention of violence and aggression at work completed on 31 August 2016. Prevention and management of violence and aggression (PMVA) training was completed on site and was specific around managing young people.
- Staff had personal alarms and knew how to respond if these were activated.

Safe staffing

- The staffing levels during the day were five staff on early and late shift, of those, two staff were qualified, and three were support workers. In addition, the ward

Good

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manager was present between Monday to Friday 9am-6pm. There was an extra staff member on shift on the day of the weekly ward round. There was access to medical cover day and night, Chalkhill was on the same site as a general hospital, which had an urgent treatment centre. In addition, there was a contract with the Royal Sussex for physical health support and physiotherapy. The occupational therapists work shifts and although not included in safe staffing numbers, they did support and work with the team to ensure young people could continue with their leave and activity plans.

- At night, there were four staff on shift, two qualified and two nursing assistants. On Sunday evening, there was an additional staff member on shift when the young people returned from leave.
- The nursing staff team consisted of a ward manager and 12 qualified and 11 unqualified nursing staff. We looked at the staff rotas. We saw bank and agency staff were used. Chalkhill used staff that were familiar with the unit. We were told that Chalkhill could request extra staff and this had had never been a problem. Review of staffing rotas showed that on average agency and bank staff were used once daily to cover the night shift.
- The occupational therapist team consisted of five qualified and one assistant. The team did shifts and although not included in the safe staffing numbers they did support the team when short staffed. In addition, there was a psychology team.
- Staff we spoke to said that activities and leave would always take priority and were rarely cancelled.
- There were vacancies for two support workers and interviews were scheduled for the week after our inspection. We were told a qualified registered mental health nurse would be starting in October and an additional senior nurse (Band 7) job share post was being recruited to.
- We observed staff presence in communal areas. Young people said that staff were easily accessible. There were several staff doing close one to one observations and we observed staff offering reassurance to the young people concerned, as well as demonstrating an awareness of that person's safety and that of others.
- Staff were up to date with their mandatory training and this was above the 75% compliance rate of the trust. The trust had a compliance target of 75% for all mandatory training and a compliance target of 60% for training in fire procedures at inpatient and non-inpatient services, Mental Capacity Act, Deprivation of Liberty Safeguards and the Mental Health Act. There were 12 mandatory training courses for example equality and diversity, which had 89% and infection prevention level one, had 100% compliance. The unit had specific training for staff around young people, the Mental Health Act, Mental Capacity Act and the Children Act. Training was provided by a solicitor.

Assessing and managing risk to patients and staff

- Risk assessments were carried out on every young person when admitted to the service. We were shown young people's risk assessments. These were reviewed in the daily handovers and updated following incidents and after the weekly multi-disciplinary meeting ward round meeting.
- The unit reviewed risks daily in handovers and observations from staff on young people were increased after incidents to minimize risks. These were recorded on the young person's care records.
- The unit had a search policy. Young people's belongings were searched when first admitted to the unit. Young people were not allowed plastic bags and aerosols in order to mitigate against risks. When young people return from leave we were told the staff team work alongside parents and carers to ensure the policy was followed.
- Staff told us that restraint was used rarely. For the six-month period from December 2015 to May 2016, there were 27 incidents of restraint for ten young people.
- None of the restraints had been in the prone restraint position. Staff used the quiet space and often this is at the request of the young people. Staff gave an example of using this the weekend prior to our inspection for a young person, a staff member stayed with the young person all the time and they were not locked in the room. Another recent incident of increased aggression from a young person resulted in that person moving to a more intensive unit following a risk assessment review from the staff team at Chalkhill. This had been so the young person received the appropriate management and care for their escalating behaviour. This ensured their safety, welfare and the protection of the remaining young people and staff on the unit.
- We reviewed all medicine charts for young people at the unit. They were regularly audited and all had photo identification attached to them. This was to ensure medicines are given to the correct person.

Good

Are services safe?

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- Young people were allowed their mobile phones after the school day ended. The phones were handed back at night time. This decision would be continually reviewed in their community meetings so to mitigate against risk, an example had been given of when someone had taken photographs in the unit on their phone.
- The unit was locked on the day of our inspection. We were told the unit was not always locked. The unit were responding to the needs and risks of the young people they were caring for. There were notices on the door written clearly by young people explaining what to do if they wanted to leave the unit.
- Staff had good knowledge on safeguarding. Staff knew how to make a safeguarding alert and spoke about the safeguarding lead who they liaise with if they have a question or query. Staff stated that there were very clear procedures in place, which were easily accessible in the office.
- A pharmacist attends ward round weekly and attends the unit twice weekly with a technician who completes a stock check of medicines. Medication management training was provided to nursing staff.

Track record on safety

- No serious incidents were recorded in the last twelve months. The team had a good safety culture and an awareness of how to manage risks posed.

Reporting incidents and learning from when things go wrong

- Staff we spoke with had a good knowledge of incidents and knew how to report them. Incidents were recorded, reported and then discussed in daily meetings. Staff were aware of their duty of candour and were open and honest in discussing incidents with young people and lessons learnt . The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.'
- We were told by staff that following incidents a debrief took place for staff and young people. Staff were open and honest with young people and took time to explain situations that had taken place and if there were any changes as a result and why.
- All Incidents go into a folder as well as on the electronic recording system. As part of these, there was a summary of what staff could have done better. There was an incident log with a section on what staff can do to learn from the incident.
- The team had reflective practice once a week led by a psychologist within the team where incidents were discussed and lessons learnt.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- On admission, a comprehensive assessment was completed young people then had a goal-setting meeting and a care planning approach meeting would be set within five working days of admission. Care co-ordinators were aware of this prior to admission. Following this there were weekly reviews. Discharge planning was part of this process. All young people had a primary nurse and associate and had regular one to one sessions where there care plan was reviewed. The young people we spoke with said that they felt that staff responded to their individual needs. We were shown care records, which were current, personalised, holistic, and recovery focused.
- All care records were logged on an electronic recording system. There were paper records kept in the office so bank staff could have access to this information. The office was locked at all times.
- The unit had good observation procedures. We looked at care records and were told by staff that young people's observations were reviewed and increased if required following incidents.
- We looked at four care plans. The care plans showed a physical assessment was carried out. Young people had ongoing physical health care reviews.
- Ward rounds were held weekly with all disciplines attending, community teams and a local authority social worker.
- The unit had several young people under local authority care and maintained good links with social workers.
- Staff had a reflective practice once a week supported by one of the psychologists in the team.

Best practice in treatment and care

- The unit used a specific assessment tool for young people with anorexia nervosa known as junior Marsipan (The Management of sick patients with Anorexia Nervosa). This was used for assessment prior to admission of a young person.
- Young people had access to psychology and had a session once a week. Carers told us they saw a systemic therapist as part of the family therapy.
- Paediatric Early Warning Score forms demonstrated daily observations were undertaken. These were a way of ensuring a young person's physical health was monitored.
- Staff used a recognised routine clinical outcome measure commissioned by the Department of Health, health of the nation outcome scale to measure and assess health.
- Young people had weekly sessions with a psychologist and families and carers had access to this and told us they attend for family therapy.

Skilled staff to deliver care

- The unit had a compliment of staff from a range of disciplines that included mental health nurses, a psychologist, pharmacist, doctors and occupational therapists. Staff were appropriately qualified and competent to carry out their work. Managers encouraged staff to develop within their role further by attending specialist training. Additional training was offered on the unit around specific areas by those with particular experience and qualifications for example the consultant did training with the staff team on eating disorders.
- Staff received regular clinical supervision in relation to their professional practice as well as supervision with a manager or senior staff member. Ward manager spoke about completing regular staff appraisals and staff we spoke with said they worked together with the manager about setting objectives and these being reviewed every six months.
- The consultant and junior doctor had specific child and adolescent mental health experience, particularly eating disorders. The trust had a family eating disorder service, which the unit referred into.
- The unit did not have a dietician. This post was vacant and the unit stated that they were having difficulties recruiting to this post. In the meantime, the unit could utilise the services at the general hospital.
- Staff had access to physical health care support, needs, physiotherapy via The Royal Alexandra hospital.
- Staff received specialist training from the consultant on the ward who has specific children's mental and eating disorder experience.

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.

- Staffs told us that they attend a professional group on eating disorders and were encouraged to develop further in this area.

Multi-disciplinary and inter-agency team work

- Chalkhill followed a multi-disciplinary collaborative approach to care and treatment. A Multi-disciplinary team meeting (MDT) is a group of health care professionals who provide different services for people in a co-ordinated way. The weekly ward round had input from nursing staff, occupational therapists, psychologists, a consultant psychiatrist, specialist doctor, pharmacist and teaching staff from the onsite school.
- There were daily multi-disciplinary meetings, in addition three handovers between nursing shifts. Staff held daily handovers to discuss the current situation with each young person and any incidents that had happened. Within this meeting, risks were reviewed in order to identify changes and agree management plans. Staff on the unit liaised with care co-ordinators, social works and carers.
- There were regular care plan reviews and a meeting organised within the first five days of admission where a young person's care co-ordinator and social worker would attend. Where they were unable to attend a teleconference would be set up.
- Prior to admission care co-ordinators and social workers were told of this meeting and the expectation to attend in order to provide a co-ordinated, caring and effective response to the young person.
- Primary nurses and the multi –disciplinary team kept in regular contact with the local authority for young people who are looked after and under their care. Local authorities were informed if a young person remained on the ward for longer than three months.

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

- Staff received specific training at the unit from a solicitor on the Mental Health Act. The unit had a 65% completion rate for Mental Health Act training. The trust compliance rate was 60%.
- We looked at Mental Health Act documentation. Staff told us young people were informed of their rights under S132 of the Mental Health Act on admission to the unit and routinely thereafter. Young people we spoke with confirmed they had their rights read to them.
- Appropriate information about young people's rights under the Mental Health Act were visible on the noticeboards. On the doors out of the unit, there were clear notices in easily understood language about why the doors were locked and what to do to leave the unit.
- All young people had access to advocacy. Young people who were detained were referred to an Independent Mental Health Advocate (IMHA). We were informed that advocates attended meetings with young people. However, some young people we spoke with stated they felt that at times staff delayed requesting an IMHA.

Good practice in applying the Mental Capacity Act

- Staff received training on the Mental Capacity Act. Staff showed a good understanding of the guiding principles of the Act. The staff had achieved 68% compliance. The trusts target had been set at 60%.
- No young people were under the Mental Capacity Act, does not apply to people under 18 years of age. We were told any application to deprive someone of their liberty between the ages of 16-17 years would be made directly to the Court of Protection.
- For children under the age of 16 decision making is governed by Gillick Competence. This competence recognises that some children may have a sufficient level of maturity to make some decisions about themselves. Staff should be assessing whether or not a child has a sufficient level of understanding to make decisions regarding their care. Staff we spoke with were able to demonstrate a good understanding of Gillick Competence. Admission forms addressed specifically Gillick competency for admission and treatment. For those treated under parental responsibility, young people who were assessed as not competent we saw this evidenced, documented within the care plan.

Outstanding ☆

Are services caring?

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

Our findings

Kindness, dignity, respect and support dignity and respect.

- All the young people we spoke with said that staff were very caring and they were treated with dignity and respect. On the day of our inspection, we observed staff responding to young people in a very caring and calm manner. We observed staff responding compassionately to young people and carers who were distressed.
- In the patient led assessments of the care environment known as PLACE assessment, the Chalkhill unit scored 91.24% for privacy, dignity and wellbeing. Place assessments are self-assessments undertaken by the NHS and independent/private healthcare providers of which the public take part in as assessors.
- Staff demonstrated an understanding and a real commitment to delivering good care and the importance of recognising young people as individuals all with different needs.

The involvement of people in the care they receive

- Young people were orientated to the ward and given a welcome pack. Young people had designed a DVD about what to expect when coming to Chalkhill in their own words. This was available on the unit's website.
- Care plans were developed in partnership with young people. A separate care plan was completed with occupational therapists. The occupational therapy staff did additional care plans with young people, which were holistic and individualised, looking at the activities of daily living, goals. Young people had copies of their care plan, and we saw copies of care plans signed. Young people told us that they were involved fully in their care plan and were given a signed copy.
- There were feedback forms for young people and families and carers to fill in prior to the ward round to give feedback if they so wish.
- Young people were regularly involved in the recruitment of staff. Young people were also involved in the interviewing of applicants.
- On admission, young people were referred to advocacy and there were posters on the ward displaying contact numbers. We were informed that advocates attend ward reviews when requested by young people.
- Young people had weekly community meetings where they could raise issues with staff and make recommendations about the running of the unit and the decoration of the unit. An example of this was the young people at the unit at our inspection time had decided that they did not want a female only lounge as they felt this discriminated against people who were transgender. In addition they wanted unisex toilet facilities. This facility could be re-instated as could a female only lounge at the young peoples request.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Bed occupancy levels for the unit over the six-month period from December 2015 to May 2016 were 94 %. Bed occupancy levels are the rate of available bed capacity. It indicates the percentage of beds occupied by patients.
- Although Chalkhill unit was under NHS England as a national resource, priority would be given to the local catchment area. We were informed that there was always a bed for young people when they returned from leave.
- The unit had a transition protocol for preparing young people for adult mental health services in response to evidence that proper planning will improve the mental health outcomes for young people.
- Discharge was planned from admission and reviewed in ward rounds and care planning approach (CPA) review meetings. Staff aimed to discharge early in the week to avoid weekend discharge.
- The Chalkhill unit worked alongside the urgent help service to look at preventing admissions and putting strategies in place that would do that. They were situated on the same site, took part in some of the multi-disciplinary meetings, supported discharge and transfers to other units and offered follow up.

The facilities promote recovery, comfort, dignity and confidentiality

- Chalkhill was a purpose built unit. There was access to outside space. Young people had good access to a range of activities and facilities. There were exercise classes such as Zumba which we were told were every popular, a gym on site and there were sufficient rooms to engage in activities and for quiet time. There were activities at weekends if young people had not gone home and access to a unit vehicle so young people could arrange outings with staff.
- There was a dedicated quiet space where young people could do their schoolwork. There were rooms where young people could go to meet with visitors privately.
- Young people had access to drinks and healthy snacks 24 hours a day.
- Young people were able to personalise their bedrooms and young peoples own art work had been displayed throughout the unit.
- Food was described as good by young people. Carers and families could eat together if they wanted and the unit was working towards being able to prepare food on site. It was felt this would improve quality and the ability to respond more quickly to individual needs.
- There was a dedicated education centre and when young people transferred, if this was at exam time this could still be organised, as the centre was also an examination centre.
- Young people had access to outside space. There was a larger garden that was not accessible at the time of our inspection to mitigate against the current risks they had with the young people at the unit .This was in response to a recently identified absconding risk where a young person had jumped over the large wall.
- Visiting times were flexible to meet the needs of families, carers and young people. There were separate rooms where visitors could meet with young people. Young people could have their families and carers join them and eat with them at meal times.

Meeting the needs of all people who use the service

- Chalkhill had a lift for use by young people who had mobility problems to access the upstairs accommodation area and education centre. They had bedrooms that were accessible for a young person with mobility difficulties and we were shown one on our inspection.
- Young people had access to interpreters and staff told us about arrangements to access this. We were told that the information leaflets were available in different languages.
- The young people had asked in a community meeting that the toilets in the communal areas were made unisex so as not to discriminate against any young people who may be transgender. This had been implemented on the unit. It was under constant review to continue to meet all people's needs and wishes.
- Staff said that they were able to meet dietary needs of the young people. For example, nut allergies or halal food.
- The unit had a spiritual room and a spiritual champion. The chaplain visited the unit regularly and was establishing a group.

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

- All staff and carers we spoke with stated they knew how to make a complaint and that these were listened to. The trust had a complaints team. Feedback from complaints would be discussed in staff meetings as well as the community meetings with the young people. During a 12 month period June 2015 to May 2016 the unit received eight complaints, two of these were fully upheld. These complaints were documented clearly and shared with staff at team meetings and the young people in their community meeting.
- Staff knew how to handle complaints appropriately. Staff said that they would try to resolve complaints locally at ward level in the first instance. If a complaint could not be resolved, they would be escalated to the ward manager and service manager. We saw evidence of complaints that had been responded to.

Are services well-led?

Good

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

Our findings

Vision and values

- The ward manager reported regular contact with senior managers and felt when concerns and issues were raised they were listened to. Staff spoke about and were familiar with the visions and values of the trust.
- Staff told us that senior managers were accessible. The staff spoke highly of the ward manager and they felt well supported. The lead consultant was accessible, approachable, and committed. They were dedicated to establishing good quality, effective care and introducing innovative ways of working

Good governance

- Staff received regular supervision and yearly appraisals, which were reviewed six monthly. The ward manager staff all found supportive and accessible, though the ward would benefit from additional administration support.
- Both nurses and occupational therapists do shifts and work together with other members of the multi-disciplinary team, psychologists to ensure they can prioritise direct care and adhere to the persons care plan goals. Extra staff were put on shift for ward round day and on a Sunday evening when young people were returning from leave.
- Staff received mandatory training on areas such as infection control, equality and diversity. All of these were above the trusts compliance target. Four of the training courses were onsite fire, Mental Capacity Act, Deprivation of Liberty (DOLS) and Mental Health Act. This was so they could be more specific about what to do in the event of a fire on the unit and in relation to the law, staff could have specific training in relation to children and young people.
- Staff spoke confidently about making safeguarding alerts and were able to talk about key people, safeguarding leads they go to in the trust and local authority for further advice if required. Staff demonstrated a good understanding and knowledge about the Mental Capacity Act and Mental Health Act.
- There was a senior leadership meeting every two weeks.
- Chalkhill completed key performance indicators (KPIs) monthly; these were used to measure the unit's performance on areas such as physical health care checks. Regular audits were undertaken and fed back to the trust and commissioners.

Leadership, morale and staff engagement

- Staff we spoke with spoke highly of team morale and that they worked well together as a team. They felt supported by the ward manager and other senior staff. Staff told us the consultant was very inclusive and keen on feedback and involvement from staff of all levels. Staff were encouraged to develop there role further and take on lead roles within the team.
- Staff said they knew how to raise concerns and felt comfortable in doing this. They had reflective practice co-ordinated by a psychologist in the team this was described as a meeting where they could discuss issues openly and address any areas of conflict.
- There were weekly community meetings on the unit when staff openly shared any concerns together with the young people and explained any changes needed and why.
- Staff were aware of whistleblowing and were confident to use the policy if required. In supervision managers checked with staff if they had any concerns regarding bullying or harassment.
- There were three staff currently sick long term, managers were following policy around sickness.
- Senior staff went to a trust wide leadership team meeting every two weeks and there was a local leadership team. The senior managers brought areas and feedback brought up by the staff team on the service as a whole to these meetings.

Commitment to quality improvement and innovation

- Chalkhill is accredited and under the quality network for inpatient CAMHS (QNIC). QNIC aims to improve the quality of inpatient child and adolescent psychiatric in-patient care through a system of review against certain standards. Chalkhill had been accredited as excellent by QNIC. Chalkhill is also under NHS England as a national provider and is inspected separately by these organisations.
- The consultant psychiatrist offered weekly one to one support to carers.

Are services well-led?

Good

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

- The MDT team were encouraging families to set up a parent forum on the unit.