Good

Leeds Community Healthcare NHS Trust

Child and adolescent mental health wards

Quality Report

Little Woodhouse Hall
LS2 9NT
Tel: 0113 220 8500
Website: www.leedscommunityhealthcare.nhs.uk/

Date of inspection visit: 24-27 November 2014
Date of publication: 22/04/2015

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Little Woodhouse Hall	RY632	Little Woodhouse Hall	LS2 9NT

This report describes our judgement of the quality of care provided within this core service by Leeds Community 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.

Where applicable, we have reported on each core service provided by Leeds Community Healthcare NHS Trust and these are brought together to inform our overall judgement of Leeds Community 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 wards	**Good**
Are Child and adolescent mental health wards safe?	**Requires Improvement**
Are Child and adolescent mental health wards effective?	**Good**
Are Child and adolescent mental health wards caring?	**Good**
Are Child and adolescent mental health wards responsive?	**Good**
Are Child and adolescent mental health wards well-led?	**Good**

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

There were some good practices in place, for example reporting and responding to incidents, the management of medicines, safeguarding children and adolescents and ensuring the staffing levels and skill mix were appropriate.

Improvements were needed to ensure patients were protected from avoidable harm. For example:

- The trust was a tenant at Little Woodhouse Hall and therefore could not make changes to the fabric of the building. They had identified that the design and layout of the ward, where patients were cared for was not safe or suitable and they were looking for other premises. However there was no agreed timescale for any move to happen.
- The local environmental health and safety register did not include any potential risks to patients from objects which could be used by patients to self-harm by hanging. This meant staff may not have been aware of all of the potential environmental risks to patients or have considered ways to remove them.
- Staff were specially trained to use the least form of restraint possible. Staff recorded the incidents of restraint in the patient's notes. However, no-one collated the number, type and staff involved with a restraint incident to enable patterns or triggers to be identified and to reduce risks to patients.
- The hospital had an arrangement that Leeds General Infirmary security guards would assist on an evening if a patient became violent. However, we found the agreement was not clear whether security staff had completed the appropriate training to restrain a young person or child.

We found Little Woodhouse Hall provided patients with the care, treatment and support they need based on the best available evidence.

Information about patients' care and treatment and their outcomes, was routinely collected and monitored. Staff had the supervision and training they needed to carry out their roles effectively, although this was not always recorded on the computer data system used for recording training. All of the multi-disciplinary staff team were involved in the assessment and planning of patients' care. Staff had followed the Mental Health Act 1983 code of practice.

We observed how patients were cared for and found patients were spoken to in a dignified and caring manner. Patients spoke positively about those who cared for them. Patients and relatives were informed about and involved in decisions about care and treatment. External agencies had been accessed by the service to support patients' needs and where patients chose, access to an advocacy service.

The needs of the different patients was taken into account when planning and delivering services. Care and treatment was co-ordinated with other services. Patients could make a complaint or raise a concern. There was evidence these were taken and responded to in a timely way and listened to. Improvements had been made to the quality of care as a result of a complaint.

Little Woodhouse Hall local management team were knowledgeable about quality issues and priorities, they understood what the challenges were and took action to address them. Performance information was used to hold management and staff to account.

Summary of findings

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

Are services safe?

Requires Improvement

At the time of the inspection we judged the safety of services required improvement. Staff had not identified all the potential risks to patients from fixtures on the ward that could be used by them to self-harm by hanging.

The trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or how the present premises could be improved upon whilst they waited for the move.

Staffing establishments (levels and skill mix) were set and actively reviewed to keep patients safe and meet their needs across all services and at all times of day and night.

The staff followed the local safeguarding procedures for children and incidents were reported.

Staff were specially trained to use the least form of restraint possible. Staff recorded the incidents of restraint in the patients' notes. However, no-one collated the number, type and staff involved with the restraint to enable patterns or triggers to be identified to reduce risks patients.

The hospital had an arrangement that Leeds General Infirmary security guards would assist on an evening if a patient became violent. However, we found the agreement was not clear whether security staff had completed the appropriate training to restrain a young person or child.

Are services effective?

Good

At the time of the inspection we judged the effectiveness of services as good. Little Woodhouse Hall provided patients with the care, treatment and support they need based on the best available evidence.

Information about patient care and treatment and their outcomes, was routinely collected and monitored.

Staff had the supervision and training they needed to carry out their roles effectively, although this was not always recorded on the computer data system.

All of the multi-disciplinary staff team were involved in the assessment and planning of patients' care.

Staff followed the Mental Health Act 1983 code of practice.

Summary of findings

Are services caring?

Good

At the time of the inspection we rated caring as good. We observed how patients were cared for and found patients were spoken to in a dignified and caring manner. Patients spoke positively about those who cared for them.

Patients and relatives were informed about and involved in decisions about care and treatment. External agencies had been accessed by the service to support people with their needs and where patients chose they had access to an advocacy service.

Are services responsive to people's needs?

Good

At the time of the inspection we rated the responsiveness of the service as good. The needs of the different patients was taken into account when planning and delivering services. Care and treatment was co-ordinated with other services.

Although the premises were not suitable, the trust had begun the process to find new premises.

Patients could make a complaint or raise a concern. There was evidence these were taken and responded to in a timely way and listened to. Improvements had been made to the quality of care as a result of a complaint.

Are services well-led?

Good

At the time of the inspection we rated how well led the service was as good. Little Woodhouse Hall local management team were knowledgeable about quality issues and priorities, they understood what the challenges were and took action to address them. Performance information was used to hold management and staff to account.

Staff told us there was good local leadership and morale was good

Summary of findings

Background to the service

Child and adolescent mental health services (CAMHS) deliver services in line with a four-tier strategic framework which is nationally accepted as the basis for planning, commissioning and delivering services.

Tier 1 - Consists of practitioners who are not mental health specialists, for example GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. Practitioners offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development and refer to more specialist services.

Tier 2 – Consists of CAMHS specialists working in community and primary care settings. Practitioners offer consultations to identify severe or complex needs which require more specialist interventions and assessment.

Tier 3 –Consists of a community mental health team or clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders.

Tier 4 –Consists of services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units.

Leeds Community Healthcare NHS Trust is responsible for providing healthcare services in the Leeds and Humber region. The trust provides a range of community services for adults and children including community nursing, health visiting, physiotherapy, community dentistry, primary care mental health, Child and Adolescent Mental Health Services, smoking cessation and sexual health services. It has 3,000 staff that delivers a service to approximately 800,000 people a year.

Little Woodhouse Hall is part of the Child and Adolescent Mental Health Services, tier 4 service. The unit provides up to eight beds for young people from the age of 13 up to the age of 18. Leeds Child and Adolescent Mental Health Service (CAMHS) offer assessment and help to children and young people with significant emotional and behavioural difficulties (e.g. anxiety, depression, eating disorders) and their families. The most recent Care Quality Commission (CQC) inspection on the 29 July 2013 found Little Woodhouse Hall compliant with the essential standards of quality and safety.

Our inspection team

Our inspection team was led by

Chair: Fiona Stephens**,** Clinical Quality Director, Medway Community Healthcare

Team Leader: Adam Brown, Head of Hospital Inspections, Care Quality Commission

The team who inspected child and adolescent mental health services (CAMHS) consisted of one CQC inspector, a nurse specialist and two Mental Health Act Commissioners.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive community health services inspection programme.

Summary of findings

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?

Before visiting and following the inspection, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 25 and 26 November 2014. During the visit we talked with three patients. We observed how patients' were being cared for. We spoke with nine members of staff, including the outreach team, service manager, ward manager, nurses, the consultant psychiatrist, support workers and ward administrators. We reviewed two electronic care records and two Mental Health Act records of people who use services.

What people who use the provider's services say

Feedback from three patients was positive; they said staff cared for them and were interested in their well-being.

However, two said sometimes they did not feel listened to and thought this was because they had complained about not being able to use a DVD in their rooms on an evening.

Good practice

An outreach team sat between the community CAMHS teams and the inpatient facilities. This operated as the gatekeeping function for inpatient beds for Leeds residents. They focus exclusively on the very acute end of the spectrum, i.e. preventing inpatient care and facilitating early discharge.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must make sure that patients are protected against the risks associated with unsafe or unsuitable premises. Staff had not identified all the potential risks to patients from fixtures on the ward that could be used by them to self-harm by hanging. The trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or how the present premises could be improved upon whilst they waited for the move.
- The staff should collate the number, type and staff involved with the restraint to enable patterns or triggers to be identified to reduce risks to patients.
- The trust should make sure Leeds General Infirmary Security Guards, who assist on an evening if a patient becomes violent, are suitably trained to carry out the restraint of a child.
- The trust should make sure mandatory training is recorded on the computer data system.

Leeds Community Healthcare NHS Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Little Woodhouse Hall	Little Woodhouse Hall

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.

Two patients were detained under the Mental Health Act 1983 (MHA). We found staff practice complied with the requirements of the Mental Health Act. The patients detained under the MHA understood and were empowered to exercise their rights under the Act. For example applications to review detention to the Mental Health Tribunal and hospital manager.

Staff at Little Woodhouse Hall told us they adhered to and had bespoke training regarding the MHA for adolescents and children. This was confirmed in the records we reviewed.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards does not apply to people under the age of 18 years. If the issue of depriving a person, under the age of 18, of their liberty arises other safeguards must be considered. Such as the existing powers of the court, particularly those under s25 Children Act, or use of the Mental Health Act.

The Mental Capacity Act does apply to young people aged 16 and 17. Where mental capacity assessments should be carried out to make sure the patient has the capacity to give consent.

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 some decisions

themselves. As a consequence, when working with children staff should be assessing whether a child has a sufficient level of understanding to make decisions regarding their care.

Staff at Little Woodhouse Hall told us they adhered to and had bespoke training regarding the MHA and MCA for adolescents. This was confirmed in the records we reviewed.

Requires improvement

Are services safe?

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

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

Summary of findings

At the time of the inspection we judged the safety of services required improvement. Staff had not identified all the potential risks to patients from fixtures on the ward that could be used by them to self-harm by hanging.

The trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or how the present premises could be improved upon whilst they waited for the move.

Staffing establishments (levels and skill mix) were set and actively reviewed to keep patients safe and meet their needs across all services and at all times of day and night.

The staff followed the local safeguarding procedures for children and incidents were reported.

Staff were specially trained to use the least form of restraint possible. Staff recorded the incidents of restraint in the patients' notes. However, no-one collated the number, type and staff involved with the restraint to enable patterns or triggers to be identified to reduce risks patients.

The hospital had an arrangement that Leeds General Infirmary security guards would assist on an evening if a patient became violent. However, we found the agreement was not clear whether security staff had completed the appropriate training to restrain a young person or child.

Our findings

Are child and adolescent mental health wards 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**

At the time of the inspection we judged the safety of services required improvement. Staff had not identified all the potential risks to patients from fixtures on the ward that could be used by them to self-harm by hanging.

The trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or how the present premises could be improved upon whilst they waited for the move.

Staffing establishments (levels and skill mix) were set and actively reviewed to keep patients safe and meet their needs across all services and at all times of day and night.

The staff followed the local safeguarding procedures for children and incidents were reported.

Staff were specially trained to use the least form of restraint possible. Staff recorded the incidents of restraint in the patients' notes. However, no-one collated the number, type and staff involved with the restraint to enable patterns or triggers to be identified to reduce risks patients.

The hospital had an arrangement that Leeds General Infirmary security guards would assist on an evening if a patient became violent. However, we found the agreement was not clear whether security staff had completed the appropriate training to restrain a young person or child.

Safe and clean ward environment

The trust did not own Little Woodhouse Hall and so were unable to make changes to the building without the landlord's permission. Little Woodhouse Hall occupied the first floor of a three-story building. It had a games room and dining room on the ground floor. The ward accommodated eight patients of either gender. The bedrooms were single and did not have en-suite facilities. Although male and female bedrooms were normally segregated, at the time of our inspection one of the female bedrooms was being used for a male.

We looked at the design layout of the ward where patients were cared for and found the environment was not safe or suitable. For example;

Requires improvement

Are services safe?

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

- The corridors were narrow and only allowed for enough room for patients to pass two abreast, which would have presented a problem when assisting patients who had mobility difficulties.
- The security and safety of the patients was compromised due to unclear lines of sight and patients being able to get to other areas of the building. The trust had informed us two patients absconded from the ward area between September 2013 and September 2014.
- At night the staff told us the doors at either end of the bedroom corridor were locked from 8.30 pm to 7 am to ensure patient safety.
- We identified issues with regards to potential risks where patients could use objects to harm themselves for example ligature points in bathrooms and bedrooms. During the inspection we asked the ward manager to review the ward environment for any potential risks to the patient's. The ward manager provided us with information following our inspection to show this had been carried out.

We found risks to patients were managed locally by closer observation when they were at risk of self-harm. The trust had recognised the need for new premises and a working party had started to look at the ward moving to new premises. However the local environmental health and safety register did not include any potential risks to patients from objects which could be used by patients to self-harm by hanging. This meant staff may not have been aware of all of the potential environmental risks to patients or have considered ways of removing the risks.

We looked at the cleanliness and found the environment was safe and suitable. The building was clean throughout and there was good practice in the control and prevention of infection. Practice was supported by staff training.

We saw that staff checked the clinical room regularly. It was clean, tidy and equipped with appropriate resuscitation equipment and emergency drugs.

Safe staffing

We reviewed the staffing levels on the ward to ensure they met the needs of patients. The information we gathered from staff and records demonstrated staffing establishments (levels and skill mix) were set and actively reviewed to keep patients safe and meet their needs across all services and at all times of day and night. A recent recruitment drive had reduced the use of agency and bank staff on the ward.

We spoke with a consultant psychiatrist during our visit who confirmed the arrangements in place to deal with medical emergencies were satisfactory.

Assessing and managing risk to patients and staff

The ward complied with the Local Safeguarding Children Board (LSCB). We found safeguarding vulnerable adults, children and young people was a priority to staff. Information provided by the trust and staff demonstrated they were suitably trained, followed appropriate systems and responded to any signs or allegations of abuse.

Risks to individuals were effectively assessed and managed, including clinical and health risks and risks of harm. We reviewed two patient records and found patients' had been involved in risk assessments and the assessments were proportionate although one had not been reviewed regularly.

We looked at the arrangements in place for the use of restraint by staff from the trust and found them appropriate. Staff followed the CAMHS positive handling policy that considered the consent of and involvement of the patient's and the use of least restrictions and had special training. They recorded the incidents of restraint in the patients' notes. However, the staff did not collate the number, type and staff involved with the restraint to enable patterns or triggers to be identified to reduce risks patients.

The hospital had an arrangement that Leeds General Infirmary security guards would assist on an evening if a patient became violent. However, we found the agreement was not clear whether security staff had completed the appropriate training to carry out the restraint of a child.

Staff told us that patients were searched on their return from unescorted leave; this included young people who were not detained under the Mental Health Act 1983 but was dependent upon the risk to themselves of self-harm.

There were good systems in place to manage medicines and ensure that patient's medicines were provided in a safe and timely way.

Reporting incidents and learning from when things go wrong

Requires improvement

Are services safe?

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

We found incident recording and reporting was effective and embedded across all the service. Staff told us they were supported and treated fairly when they raised concerns.

The records demonstrated and staff confirmed that when things went wrong incidents were investigated, learning was communicated and action was taken to improve. The staff team had learnt from an external event.

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

At the time of the inspection we judged the effectiveness of services as good. Little Woodhouse Hall provided patients with the care, treatment and support they need based on the best available evidence.

Information about patient care and treatment and their outcomes, was routinely collected and monitored.

Staff had the supervision and training they needed to carry out their roles effectively, although this was not always recorded on the computer data system.

All of the multi-disciplinary staff team were involved in the assessment and planning of patients' care.

Staff followed the Mental Health Act 1983 code of practice.

Our findings

Are Child and adolescent mental health wards effective?

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.

At the time of the inspection we judged the effectiveness of services as good. Little Woodhouse Hall provided patients with the care, treatment and support they need based on the best available evidence.

Information about patient care and treatment and their outcomes, was routinely collected and monitored.

Staff had the supervision and training they needed to carry out their roles effectively, although this was not always recorded on the computer data system.

All of the multi-disciplinary staff team were involved in the assessment and planning of patients' care.

Staff followed the Mental Health Act 1983 code of practice.

Assessment of needs and planning of care

We looked at the care records of two patients and found they were personalised, holistic and recovery focused. The care records showed that a physical examination had been undertaken and that there was ongoing monitoring of physical health problems. Patients we spoke with told us they were aware of their plan and its contents and understood what it was for but two told us that any 'physical illnesses were always blamed on their eating disorder'.

Information provided to us by the trust following the inspection showed us that between July and September 2014, 100% of patients who passed through the unit had evidence of weekly goal-planning (weekly review meetings) with their named nurse towards recovery and collaborative involvement in care planning.

We found there was a range of professionals involved in patient care such as psychologists, occupational therapists, psychiatrists and also nursing and support staff that were responsible for the day to day delivery of care.

Information provided to us demonstrated that all patients admitted to the ward were assessed for substance misuse and evidence of withdrawal symptoms at the point of admission.

There were also robust arrangements for collecting information from all agencies involved with the young person and their family.

Best practice in treatment and care

Patients received care, treatment and support that achieved good outcomes and was based on the best available evidence. The service followed evidence-based best practice and professional standards, which were appropriately tailored to meet the needs of patients. For example the eating disorder pathway was underpinned by guidance from the National Institute of Health and Care Excellence (NICE) and The Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN).

The ward reported regularly to NHS England commissioners using national patient outcome measures from Public Health England such as the Child Global Assessment tool and the National Outcome Scales for Children and Adolescents (HoNOSCA). This ensured the best possible quality of therapeutic interventions for patients. The ward manager and the commissioner told us they always achieved good outcomes for patients.

Are services effective?

Good

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

The ward monitored its overall performance using the Royal College of Psychiatrists, Quality Network For Inpatient CAMHS, accreditation tools and visits. The last report was for March 2014.

We found the ward had a range of activities available to patients throughout the day and weekend which included independent living skills, recreational meaningful activities and also educational skills by way of teaching up to advanced level (A Level). Patients up to the age of 16 were required to have appropriate teaching sessions.

Skilled staff to deliver care

The team operated within a multi-disciplinary team framework. There was good evidence of effective working within the service which included the consultant psychiatrist, nursing staff, health care support workers, occupational therapists and teachers.

We concluded staff were appropriately qualified and competent at the right level to carry out their work, based on the information provided by the trust and what staff told us. For example, staff had training to meet the specific patient needs, such as the positive handling of children and young people and eating disorders. Staff told us they were supported by their managers to access a range of training to meet the needs of the patients. However the information provided to us by the trust indicated some areas of training were outside of the target range for compliance, such as 76% cardiopulmonary resuscitation (CPR).

We found there was effective supervision, and appraisal. Both group and individual clinical supervision was available to staff.

Although the information provided by the trust for mandatory training and clinical supervision showed lower levels of compliance on a computer database (ESR) at about 75%. The ward manager told us the clinical supervision policy had on the 20 October issued the requirement to record clinical supervision on ESR). They said they were on track to becoming fully compliant with supervision and appraisal but the information on the ESR was not up to date and may show lower rates of compliance.

Multi-disciplinary and inter-agency team work

A multi-disciplinary team meeting (MDT) is a group of health care and social care professionals who provide different services for patients in a coordinated way. Members of the team may vary and will depend on the patients' needs and the condition or disease being treated.

We found there was a multi-disciplinary collaborative approach to care and treatment. Nursing staff, occupational therapists, teachers, a consultant psychiatrist, specialist doctor, social workers and a psychologist attended the weekly team meetings. Patients could raise points for the meetings but did not attend. Following the meetings two members of the MDT team would meet with the patient to gain agreement and explain what had occurred. Staff told us this was because the patients would find it easy to speak in a small group.

Adherence to the MHA and the MHA Code of Practice

Two patients were detained under the Mental Health Act 1983 (MHA). We found staff practice complied with the requirements of the MHA. The patients detained under the MHA understood and were empowered to exercise their rights under the Act. Such as application to cease detention to the Mental Health Tribunal and hospital manager.

The Deprivation of Liberty Safeguards (DoLS) does not apply to people under the age of 18 years. If the issue of depriving a person, under the age of 18, of their liberty arises other safeguards must be considered. Such as the existing powers of the court, particularly those under s25 Children Act, or use of the Mental Health Act.

The Mental Capacity Act does apply to young people aged 16 and 17. Where mental capacity assessments should be carried out to make sure the patient has the capacity to give consent.

For children under the age of 16, decision making ability is governed by Gillick competence. This concept of competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. As a consequence, when working with children staff should be assessing whether a child has a sufficient level of understanding to make decisions regarding their care.

Staff at Little Woodhouse Hall told us they adhered to and had bespoke training regarding the MHA and MCA for children and adolescents. This was confirmed in the records we reviewed.

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.

Are Child and adolescent mental health wards effective?

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.

At the time of the inspection we judged the effectiveness of services as good. Little Woodhouse Hall provided patients with the care, treatment and support they need based on the best available evidence.

Information about patient care and treatment and their outcomes, was routinely collected and monitored.

Staff had the supervision and training they needed to carry out their roles effectively, although this was not always recorded on the computer data system.

All of the multi-disciplinary staff team were involved in the assessment and planning of patients' care.

Staff followed the Mental Health Act 1983 code of practice.

Assessment of needs and planning of care

We looked at the care records of two patients and found they were personalised, holistic and recovery focused. The care records showed that a physical examination had been undertaken and that there was ongoing monitoring of physical health problems. Patients we spoke with told us they were aware of their plan and its contents and understood what it was for but two told us that any 'physical illnesses were always blamed on their eating disorder'.

Information provided to us by the trust following the inspection showed us that between July and September 2014, 100% of patients who passed through the unit had evidence of weekly goal-planning (weekly review meetings) with their named nurse towards recovery and collaborative involvement in care planning.

We found there was a range of professionals involved in patient care such as psychologists, occupational therapists, psychiatrists and also nursing and support staff that were responsible for the day to day delivery of care.

Information provided to us demonstrated that all patients admitted to the ward were assessed for substance misuse and evidence of withdrawal symptoms at the point of admission.

There were also robust arrangements for collecting information from all agencies involved with the young person and their family.

Best practice in treatment and care

Patients received care, treatment and support that achieved good outcomes and was based on the best available evidence. The service followed evidence-based best practice and professional standards, which were appropriately tailored to meet the needs of patients. For example the eating disorder pathway was underpinned by guidance from the National Institute of Health and Care Excellence (NICE) and The Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN).

The ward reported regularly to NHS England commissioners using national patient outcome measures from Public Health England such as the Child Global Assessment tool and the National Outcome Scales for Children and Adolescents (HoNOSCA). This ensured the best possible quality of therapeutic interventions for patients. The ward manager and the commissioner told us they always achieved good outcomes for patients.

The ward monitored its overall performance using the Royal College of Psychiatrists, Quality Network For Inpatient CAMHS, accreditation tools and visits. The last report was for March 2014.

We found the ward had a range of activities available to patients throughout the day and weekend which included independent living skills, recreational meaningful activities and also educational skills by way of teaching up to advanced level (A Level). Patients up to the age of 16 were required to have appropriate teaching sessions.

Skilled staff to deliver care

The team operated within a multi-disciplinary team framework. There was good evidence of effective working within the service which included the consultant psychiatrist, nursing staff, health care support workers, occupational therapists and teachers.

We concluded staff were appropriately qualified and competent at the right level to carry out their work, based on the information provided by the trust and what staff told us. For example, staff had training to meet the specific patient needs, such as the positive handling of children and young people and eating disorders. Staff told us they were supported by their managers to access a range of

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.

training to meet the needs of the patients. However the information provided to us by the trust indicated some areas of training were outside of the target range for compliance, such as 76% cardiopulmonary resuscitation (CPR).

We found there was effective supervision, and appraisal. Both group and individual clinical supervision was available to staff.

Although the information provided by the trust for mandatory training and clinical supervision showed lower levels of compliance on a computer database (ESR) at about 75%. The ward manager told us the clinical supervision policy had on the 20 October issued the requirement to record clinical supervision on ESR). They said they were on track to becoming fully compliant with supervision and appraisal but the information on the ESR was not up to date and may show lower rates of compliance.

Multi-disciplinary and inter-agency team work

A multi-disciplinary team meeting (MDT) is a group of health care and social care professionals who provide different services for patients in a coordinated way. Members of the team may vary and will depend on the patients' needs and the condition or disease being treated.

We found there was a multi-disciplinary collaborative approach to care and treatment. Nursing staff, occupational therapists, teachers, a consultant psychiatrist, specialist doctor, social workers and a psychologist attended the weekly team meetings. Patients could raise points for the meetings but did not attend. Following the meetings two members of the MDT team would meet with the patient to gain agreement and explain what had occurred. Staff told us this was because the patients would find it easy to speak in a small group.

Adherence to the MHA and the MHA Code of Practice

Two patients were detained under the Mental Health Act 1983 (MHA). We found staff practice complied with the requirements of the MHA. The patients detained under the MHA understood and were empowered to exercise their rights under the Act. Such as application to cease detention to the Mental Health Tribunal and hospital manager.

The Deprivation of Liberty Safeguards (DoLS) does not apply to people under the age of 18 years. If the issue of depriving a person, under the age of 18, of their liberty arises other safeguards must be considered. Such as the existing powers of the court, particularly those under s25 Children Act, or use of the Mental Health Act.

The Mental Capacity Act does apply to young people aged 16 and 17. Where mental capacity assessments should be carried out to make sure the patient has the capacity to give consent.

For children under the age of 16, decision making ability is governed by Gillick competence. This concept of competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. As a consequence, when working with children staff should be assessing whether a child has a sufficient level of understanding to make decisions regarding their care.

Staff at Little Woodhouse Hall told us they adhered to and had bespoke training regarding the MHA and MCA for children and adolescents. This was confirmed in the records we reviewed.

Good

Are services caring?

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

Summary of findings

At the time of the inspection we rated caring as good. We observed how patients were cared for and found patients were spoken to in a dignified and caring manner. Patients spoke positively about those who cared for them.

Patients and relatives were informed about and involved in decisions about care and treatment. External agencies had been accessed by the service to support people with their needs and where patients chose they had access to an advocacy service.

Our findings

Are child and adolescent mental health wards caring?

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

At the time of the inspection we rated caring as good. We observed how patients were cared for and found patients were spoken to in a dignified and caring manner. Patients spoke positively about those who cared for them.

Patients and relatives were informed about and involved in decisions about care and treatment. External agencies had been accessed by the service to support people with their needs and where patients chose they had access to an advocacy service.

Kindness, dignity, respect and support

We observed how people were cared for on the ward we visited and found people were treated with dignity and respect.

Nursing and supporting staff showed interest in the young people they cared for and a willingness to ensure that each person was able to have a meaningful and fulfilling life. Three patients told us they felt supported and well-cared for as a result.

Feedback from three patients was positive; they said staff were caring and interested in their well-being.

The involvement of people in the care they receive

We found the records demonstrated patients were involved and received copies of their risk assessments and care plans. The ward manager explained two members of the MDT team would speak with the patient immediately following their MDT to explain what had happened. They said generally patients did not attend the meetings because they may find it too intimidating and be unable to make their views known.

Information about how to give details of the patients' experience was also available on the trust website. This informed the public that they could speak directly with the CAMHS practitioner or their manager, complete a feedback form, fill in an experience of the service questionnaire or email the service or join a have your say forum.

Advocacy services visited the ward twice a week to offer patients support and advice.

The ward held daily community meetings where patients could make their views known about the ward.

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

At the time of the inspection we rated the responsiveness of the service as good. The needs of the different patients was taken into account when planning and delivering services. Care and treatment was co-ordinated with other services.

Although the premises were not suitable, the trust had begun the process to find new premises.

Patients could make a complaint or raise a concern. There was evidence these were taken and responded to in a timely way and listened to. Improvements had been made to the quality of care as a result of a complaint.

Our findings

Are child and adolescent mental health wards responsive to people's needs?

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

At the time of the inspection we rated the responsiveness of the service as good. The needs of the different patients was taken into account when planning and delivering services. Care and treatment was co-ordinated with other services.

Although the premises were not suitable, the trust had begun the process to find new premises.

Patients could make a complaint or raise a concern. There was evidence these were taken and responded to in a timely way and listened to. Improvements had been made to the quality of care as a result of a complaint.

Access, discharge and bed management

The ward had an urgent 48 hour referral and admission protocol with Leeds CAMHS outreach and therapy Service. This included an on-going management plan across the two teams and the plans being shared with the young person and parents/carers. The aim of admission was to enable the risks to be reduced enough for a young person to be managed by their family/carers with support from their local assertive outreach and/or community CAMHS team.

A team sat between the community CAMHS teams and the inpatient beds. This operated as the gatekeeping function for inpatient beds for Leeds residents. They focused exclusively on the very acute end of the spectrum, i.e. preventing inpatient care and facilitating early discharge. Also they had input from other therapists as well via a city wide therapy service. The team worked closely with the community CAMHS teams, providing additional support and input where intensity had increased above that which the CAMHS teams could handle. They also worked closely with the transition team, who worked with people from 17½ to ease the transition into adult services where this was necessary.

The ward had recently commenced using the new national access assessment form for tier four services. Referral to the inpatient wards was mostly by the Leeds CAMHS outreach and therapy services. Access to the Leeds CAMHS outreach and therapy services was by any lead professional after completing a family common assessment framework form. The assessment provided a method for assessing needs for children and young people to support earlier intervention and to improve joint working and communication between practitioners. Professionals who could refer included GPs, health visitors, school nurses, educational psychologists and social care services. The CAMHS services provided professionals with a leaflet which explained the referral process.

The ward manager told us that the ward took referrals from the Yorkshire and Humberside region, and were able to accommodate most of the referrals. Patients were only accommodated in other hospitals outside of the region when they required single sex accommodation.

The child global assessment tool (C-GAS) showed between July and September 2014, that there had been eight patients who had been admitted and discharged. The C-GAS assessments carried out on admission and on discharge showed an improvement in seven cases.

On discharge patients, if appropriate, could be offered both increased support from community CAMHS and help to transition back to mainstream school. Discharge plans were shared with the patients, GP, Parents and other professionals involved in the care of the young person

The ward environment optimises recovery, comfort and dignity

Are services responsive to people's needs?

Good

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

The ward environment did not optimise recovery, comfort and dignity. The ward was located on the second floor of a three storey building, with a classroom, lounge and dining room on the ground floor. The other areas were used for office space. To protect the patients during the night the bedroom corridor doors were locked from 8 pm. This meant the patients did not have access to the second lounge, dining room and classrooms. Three patients told us they did not like this and found it very restricting.

The ward did not have direct outside space and patients had to be escorted to the gardens.

The trust had recognised the need for new premises and this was included on the children's services risk register. This showed a working party had started to look at the ward moving to new premises. The first meeting took place on the 25 October 2014.

Ward policies and procedures minimise restrictions

The ward manager explained that access to electronic equipment and mobile phones was dependent upon the potential risk to the individual patient. We found patients had access to mobile phones following school (3 pm) and before bedtime (10 pm). DVD players were not allowed in the patients' bedrooms at night. Three patients told us they were unhappy about this restriction.

Meeting the needs of all people who use the service

The assessment form included details about patients' family, religion and other cultural needs, as well as their medical and nursing needs. Their care and treatment was planned and delivered to reflect these needs, as appropriate.

The staff attempted to make all documentation 'young person friendly' and use plain English and avoid the use of jargon. Leaflets about the CAMHS services was available to the public on the trust website.

The ward manager told us that patients had access to both advocacy and interpreters.

Listening to and learning from concerns and complaints

We concluded that the staff were listening to the concerns and complaints of patients and families This was because information about how to complain was part of the welcome pack given to patients on admission to the ward. There was also a post box where patients could make written complaints or compliments anonymously. All the patients told us they were aware of how to make a complaint, but two told us they did not feel listened to All were aware of the advocate and their role.

The trust had a complaints procedure the guidance of which was summarised and advertised on the ward. Information about the Patient Advice and Liaison Service (PALS), which supported patients to raise concerns, was also displayed. Staff said most concerns were resolved locally at ward level. If unresolved they would be escalated to the modern matron and would be investigated by a member of staff independent to the ward. We found evidence that complaints had been responded to and lessons had been learnt from complaints.

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

At the time of the inspection we rated how well led the service was as good. Little Woodhouse Hall local management team were knowledgeable about quality issues and priorities, they understood what the challenges were and took action to address them. Performance information was used to hold management and staff to account.

Staff told us there was good local leadership and morale was good

Our findings

Are child and adolescent mental health wards well-led?

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.

At the time of the inspection we rated how well led the service was as good. Little Woodhouse Hall local management team were knowledgeable about quality issues and priorities, they understood what the challenges were and took action to address them. Performance information was used to hold management and staff to account.

Staff told us there was good local leadership and morale was good.

Vision and values

There was evidence of vision and values which has been developed with input from key stakeholders. Such as the quality network for inpatient CAMHS.

Staff and management we spoke with told us they were aware of the organisations vision and values. They said they were often visited by members of the management team and trust board because many were very "interested" in the service.

Good governance

We found the ward was well managed and had good governance. We concluded this because the ward had a clear role that was explicitly set in the context of a four-tier CAMHS strategy. Staff had received the training and support they needed to carry out their role. The ward was covered by a sufficient number of staff of the right grades and experience. Incidents were reported and there was evidence of staff learning from incidents. The MHA had been adhered to. There were robust systems in place to monitor the quality and performance of the services provided.

Leadership, morale and staff engagement

Staff we spoke with said they felt supported by their direct line managers, they felt they could raise issues of concerns at their supervisions. All the staff we spoke with were aware of what they were responsible for and the limits of their authority. They said their morale was good. The ward manager we spoke with told us that there was generally a low level of sickness on the ward and where there had been or was sickness this was generally due to long term health conditions that were unavoidable.

Staff were encouraged to engage with the trust. For example the staff and family test questionnaire for June 2014. This showed that out of 19 young people and families only five would not recommend the service and this was mainly because of the environment.

Commitment to quality improvement and innovation

The staff monitored the quality of the service they provided and were innovative. We concluded this because the ward followed the protocol set down by their commissioner, NHS England. These included;

- Eating Difficulties Questionnaire (EDE-Q)
- The child global assessment tool (C-GAS)
- The National Outcome Scales for Children and Adolescents (HoNOSCA).

The ward had achieved accreditation from The Royal College of Psychiatrists, Quality Network For Inpatient CAMHS. The last report was for March 2014.

Information on patient experience was reported was collated using the CHi- Experience of Service Questionnaire (CHi-ESQ).

The MHA group ensured robust governance, risk management, quality improvement and performance mechanisms were in place to provide assurance to the

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.

quality governance and risk committee that statutory duties were being met in relation to the care provided to patients who were subject to a Section of the MHA.to make sure they were legally detained.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises We found that the registered person had not protected people against the risk of unsafe or unsuitable premises at Little Woodhouse Hall. This was in breach of regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must make sure that patients are protected against the risks associated with unsafe or unsuitable premises at Little Woodhouse Hall. Staff had not identified all the potential risks to patients from fixtures on the ward that could be used by them to self-harm by hanging. The trust had identified the premises were not suitable, but did not have a clear timescale for moving to new premises or how the present premises could be improved upon whilst they waited for the move.