Good

Affinity Healthcare Limited

Child and adolescent mental health wards

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Cheadle Royal Hospital	1-127893060	Orchard	SK8 3DG
Cheadle Royal Hospital	1-127893060	Woodlands	SK8 3DG
Cheadle Royal Hospital	1-127893060	Meadows	SK8 3DG

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

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?	Good 
Are child and adolescent mental health wards effective?	Requires Improvement 
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

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Summary of findings

Overall summary

Overall, on the child and adolescent mental health inpatient wards we found that:-

Wards provided safe environments for patients.

Staffing levels were sufficient to meet patient needs and keep them safe.

The service analysed incidents to identify themes and trends to look at ways to reduce the use of physical intervention.

Patients had access to psychological therapies as part of their treatment and psychologists were part of the multi-disciplinary team (MDT).

Staff worked collaboratively with the patient, families and local agencies to understand and meet the range and complexity of patients' needs.

Where patients were detained under the Mental Health Act 1983, their rights were protected and staff complied with the MHA code of practice.

Most patients spoke positively the service. The service included the views of patients and relatives in decisions about care and treatment.

Patients could make a complaint or raise a concern and these were responded to.

Staff felt supported by the organisation and their line managers. Staff morale was good.

The service ensured that learning from serious incidents was always shared and improvements made.

The service had been innovative by developing its own approaches to managing self harming behaviours.

However; staff were not appropriately qualified and competent in providing treatment and care to patients with autism .

Summary of findings

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

Are services safe?

Good

We rated the service as 'Good' because;

- Staff undertook a risk assessment of every patient on admission and updated this regularly and after any changes to the patient's needs.
- Wards provided safe environments for patients. Risk assessments were in place to mitigate any risks the environment posed.
- Staffing levels were sufficient to meet patient needs and keep them safe.
- The service monitored incidents and learned when things went wrong.
- There were regular audits carried out to ensure the safe management of medication.
- The service responded with an immediate action plan when the seclusion rooms were identified as being unsuitable.

Are services effective?

Requires Improvement

We rated the service as 'Requires Improvement' because;

- Staff were not appropriately qualified and competent in providing treatment and care to patients with autism. Staff told us they were well supported and supervised in their roles although written evidence did not reflect this. However the service should ensure staff receive adequate training in autism.
- Patients had access to psychological therapies as part of their treatment and psychologists were part of the multi- disciplinary team (MDT).
- Staff worked collaboratively with the patient, families and local agencies to understand and meet the range and complexity of patients' needs.
- Where patients were detained under the Mental Health Act 1983, their rights were protected and staff complied with the MHA code of practice.

Are services caring?

Good

We rated the service as 'Good' because;

- We observed how patients were cared for and found patients were spoken to in a dignified and caring manner.
- Most patients spoke positively about those who cared for them.
- Patients and relatives were informed about and involved in decisions about care and treatment.

Summary of findings

- External agencies had been accessed by the service to support patients with their needs.

Are services responsive to people's needs?

Good

We rated the service as 'Good' because;

- The service liaised with other services and professionals to ensure admission and discharge was managed effectively to ensure good outcomes for patients.
- The ward environments did optimise recovery, comfort and dignity and kept patients safe. Where shortfalls were identified the service had an action plan in place to make improvements.
- 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

We rated the service as 'Good' because;

- Staff felt supported by the service and their line managers.
- Staff morale was good.
- Systems were in place for staff to raise issues or concerns.
- Staff were informed of lessons learnt from incidents.
- The service implemented new approaches to managing self harm behaviours.
- The service participated in the Royal College of Psychiatrists, Quality Network for Inpatient CAMHS.
- Woodlands ward had developed, 'The safe intervention for ligaturing assessment score' (SILAS) following analysis of the unit's intervention techniques in the management of young patients who used ligatures to self harm.

Summary of findings

Background to the service

Affinity Healthcare Cheadle Royal provides inpatient mental health services for young people and adults.

These services are provided for patients who are admitted informally and patients compulsorily detained under the Mental Health Act. This report looks at the Child and Adolescent Mental Health Service and the Psychiatric Intensive Care Units (PICU) provided by the organisation.

A significant number of patients' admitted to Cheadle Royal have a diagnosis or suspected diagnosis of autism. The service does not provide care and treatment to patients' who have a learning disability. The wards were mixed sex with the exception of Woodlands which provides care and treatment to young females. All of the patients' within the service were between the ages of 12 and 18 years and were generally not within the demographic region of Cheshire. The hospital accepted admissions from all over the country including Wales and Scotland.

Since their registration with the Care Quality Commission Cheadle Royal Hospital has been inspected six times and each of the wards and PICUs have received a visit from a Mental Health Act Reviewer. Visits by Mental Health Act Reviewers have previously highlighted issues with the environment and seclusion facilities on the PICUs.

Our inspection team

Team Leader: Sharon Marston, Inspection Manager, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: a consultant psychiatrist a pharmacist and a mental health act reviewer.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of the experience of people who use services, we always ask the following five questions ofevery service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before commencing the inspection visit we reviewed the information we held about these services and engaged with other stakeholders to gather further information.

During the inspection the inspection team:

• Visited all Child and Adolescent wards and the psychiatric intensive care units (PICUs).

• Spoke with the managers of each of these wards.

• Spoke with 12 other staff including doctors, nurses, healthcare assistants, OTs and independent mental health advocates.

• Spoke with nine patients who were using the service and two relatives.

• Collected comment cards from 11 patients.

• Reviewed 14 care records and nine prescribing charts.

.• Looked at a range of policies, procedures and other documentation related to the provision of care.

Summary of findings

What people who use the provider's services say

Patients and their relatives were mostly positive about their experience. Six out of nine patients said they were treated with kindness and dignity and most patients and families were involved in decisions about their care.

At the end of the inspection we collected three comment cards that were not positive. Comments from Meadows were patient's said staff were sometimes unkind, did not listen to people and told us the care was not good.

Good practice

Woodlands ward had developed, 'The safe intervention for ligaturing assessment score' (SILAS) following analysis of the unit's intervention techniques in the management of young patients who used ligatures to self harm. This approach considers three domains; the monitoring of the physical health of the young person, engagement and co-operation to ensure physical safety of the staff team and to empower responsibility of the young person and time limits to give support whilst encouraging the young person to regain control for themselves.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider should ensure that all patients have a person-centred holistic care plan in place to meet their needs.
- The provider should ensure there is a clear autism pathway in place and takes into consideration autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum guidance as published by National Institute Health and Care Excellence.
- The provider should ensure the plans to refurbish Meadows ward are completed.

Affinity Healthcare Limited

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Orchard	Cheadle Royal Hospital
Woodlands	Cheadle Royal Hospital
Meadows	Cheadle Royal Hospital

Mental Health Act responsibilities

Child and Adolescent wards and PICU had effective systems in place to ensure adherence to the Mental Health Act 1983 (MHA) and the Code of Practice (CoP).

Staff were trained in the MHA, the CoP guiding principles and were able to seek administrative support and legal advice from a central team.

Documentation in respect of the MHA was generally good. Patient files were in good order with each containing relevant detention documents including a full Approved Mental Health Professional (AMHP) report. There was evidence that documentation relating to the detention of patients were scrutinised and correctable errors were amended within the specified period and in accordance with the MHA and CoP.

Patients were informed of their rights in accordance with section 132 on admission. Where patients lacked capacity to understand, we found evidence that repeated attempts were made to ensure that patients continued to be given this information until they could understand it.

Patients were treated under the appropriate authority in line with section 58.

Mental Capacity Act and Deprivation of Liberty Safeguards

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 section 25 Children Act, or use of the Mental Health Act.

The Mental Capacity Act applies to young people aged 16 and 17. 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 or not a child has a sufficient level of understanding to make decisions regarding their care.

We saw some comprehensive assessments of capacity in relation to treatment for a mental disorder on all wards.

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

Summary of findings

Our findings

Safe and clean ward environment

Wards were clean throughout with the exception of Meadows where there was food on the dining floor from the previous night before. Staff acknowledged this was not acceptable and cleaned the areas immediately. There were daily cleaning schedules and audits in place to ensure the risk of infection was minimised.

Fixtures, fittings and furniture on Meadows ward were in need of replacement and repair. The ward had a full refurbishment plan in place which identified a new layout of the ward. This contained details of the proposed plans which included moving the bedrooms which were located on the corridor at the entrance to the ward. Patients and staff told us they had been involved in the plans to make improvements to the ward. The ward had been placed on the service risk register and had clear actions and timescales to ensure improvements.

Not all wards had clear lines of sight but where this had been identified staff were situated in areas to ensure close observation which minimised any risk of harm occurring.

Each ward had a ligature risk assessment which had been completed by senior managers in the service with contribution by ward managers. Where ligatures had been identified these were managed through risk assessment of patients and the use of observations where necessary to reduce the risk of harm occurring. Staff knew where ligature equipment was kept and how to use it should.

Clinic rooms were clean and tidy with appropriate resuscitation equipment and emergency drugs. Most staff had training in life support techniques. Staff carried personal alarms which could be used in an emergency and knew how to respond if the alarms were activated.

Safe staffing

Establishment levels: qualified nurses (WTE) 29

Establishment levels: nursing assistants (WTE) 60

Number of vacancies: qualified nurses (WTE) 0

Number of vacancies: nursing assistants (WTE) 0

Full hospital staff sickness rate site (%) in 12 month period 5.4%

The service carried out reviews of staffing levels and had set minimum staffing. We had requested information prior to our visit to establish staffing levels for the months prior to our visit. We observed staffing levels on each ward and confirmed the numbers with ward managers. We found Woodlands had a high use of bank and agency staff with 146 shifts being covered between November 2014 and January 2014. We were told this was to manage the complex needs of some patients'.

Both staff and patients' reported levels of staffing were adequate.

Agency staff were provided a comprehensive induction to the service prior to commencing work. There was an induction handbook and staff were able to access policies and procedures relating to the service as well as been given sufficient time to read patient records.

Wards had arrangements in place to deal with medical emergencies. The service was nurse led but in the event of an emergency the service accessed local community resources such as on call doctors and emergency services. Staff were aware of what to do in the event of a medical emergency.

Assessing and managing risk to patients and staff

Risks to patients were appropriately assessed on admission and these were updated on a weekly basis or where there had been a change in the patient's risks. Risk assessments included clinical, health and risks of harm to themselves and others, where possible staff involved patients and their carers.

Risk assessments were person-centred and reviewed regularly. Staff used a risk based approach; this included a comprehensive system to indicate the level of risk. Comprehensive risk assessments and associated intervention plans were in place for each patient.

Good

Are services safe?

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

Staff followed a risk based approach when to assess the need for closer observation of patients. On Woodlands ward many patients were in continuous sight of a member of staff to ensure their safety and safety of others.

Appropriate arrangements were in place for the use of restraint. Each incident of restraint was documented giving clear details of the staff involved in the restraint the techniques used and length of time the restraint lasted for. The service was therefore able to collate data to inform the number of times restraint was occurring but also look at methods to reduce incidents occurring. The physical environment of Meadows was identified on the risk register as not been therapeutic and could have potentially contributed to the number of incidents that involved the use of restraint. Ward staff told us they did not use prone restraint (face down) and this was consisted with the records we reviewed.

In the six months prior to our visit, there had been 71 incidents involving the use of restraint on Orchard ward, 142 on Woodlands ward and 176 on Meadows ward. None of these episodes of restraint had involved the use of 'prone' restraint.

The service had commenced a physical restraint reduction plan for 2014/2015 which included the eradication of prone restraint. Staff had received training in the management of violence and aggression.

The seclusion unit was based on Meadows and Woodlands. In the six months prior to our visit, there had been 93 incidents of seclusion on Meadows ward, nine on Woodlands ward and one from Orchard ward.

Staff told us that patients were restricted or searched on their return from leave dependent upon the risk of self-harm. However where this had been identified as a risk there was information provided which demonstrated patients consented to the searches prior to them being carried out. They were equally carried out by an appropriate gender of staff.

Medicines were stored securely and safely administered by trained staff. Where patients had been administered medication in an emergency the NICE guidelines had been followed. Where patients received medication out side recommended guidelines there was appropriate documentation and authority in place for the use of the drugs.

Staff responded appropriately to allegations of abuse. Safeguarding was discussed at multi-disciplinary team (MDT) meetings where a representative of the local authority attended meetings. All staff were aware of the safeguarding leads in the service and how to report incidents. Training records demonstrate all staff had completed safeguarding training.

Track Record on Safety

Information about any adverse events had been cascaded to staff within the service. The service was able to demonstrate where lessons had been learnt and practices changed following an incident on one ward. For example staff had identified between the hours of 4pm and 7pm there was an increased period of risk because patients often were bored and had limited activities to participate in.

The service had recently appointed an activities co-ordinator during this period and although there was no quantitate data to support there was a reduction in risk staff told us there had been.

Reporting incidents and learning from when things go wrong

Incident recording and reporting was effective and embedded across all wards. All incidents were reviewed by the ward managers and forwarded to the services clinical governance team and reviewed at quality assurance groups who maintained an oversight.

Staff were able to tell us about feedback they had received following incidents and changes which had been made. Debrief occurred dependent on the seriousness of the incident within a team meeting or supervision as well as staff handovers. Staff were involved in the learning process.

When things go wrong there was open and transparent culture, incidents were investigated, learning was communicated and action was taken to improve. This was demonstrated by a serious incident which had occurred.

Are services effective?

Requires Improvement

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

Summary of findings

Our findings

Assessment of needs and planning of care

Arrangements were in place for collecting information about the patient's care needs before admission where possible to ensure the service was able to meet the patients' needs.

We looked at the care records of 14 patients and found they were not always personalised, holistic or recovery focused. The care records showed that a physical examination had been undertaken and that there was on-going monitoring of mental health.

There was a range of professionals involved in patient care such as occupational therapists, psychologists, psychiatrists. However the specialist CAMHS nurses had not received specialist training in autism and there were no speech and language therapists. Patients did have access to a range of psychological therapies such as cognitive behavioural therapy and family therapy but the quality of therapy did not always reflect published research and guidance.

For example the service provided care and treatment to 50% of patients who had a diagnosis or unconfirmed diagnosis of autistic spectrum disorder. Some patients received as part of their treatment cognitive behavioural therapy but the learning styles of the patients and cognitive functioning had not been considered when designing treatment.

The service had also not carried out any sensory integration assessments of any patients' who had a diagnosis or suspected diagnosis of autistic spectrum conditions. Not completing such assessment can lead to potentially challenging and disturbed behaviour if appropriate assessments and care plans are not in place to manage sensory needs of individuals.

We looked at the model of care for patients who had a diagnosis of autism and the service lacked a clear pathway for individuals and did not use any recognised learning methods to enhance skills acquisition that would support the reduction of behaviours which challenge. The service did not use positive behaviour support, active support, applied behaviour analysis or alternative methods of communication and personalised support plans to support patients' with autism.

The service did have a GP visited the ward weekly to respond to any physical health needs.

Best practice in treatment and care

Patients had access to psychological therapies as part of their treatment and psychologists were part of the multi-disciplinary team. Examples of therapies available were cognitive behavioural therapy (CBT), family therapy and dialectical behaviour therapy (DBT).

Formulation meetings were held, where all the staff involved in a patient's care focused on their care and treatment and developed a plan of future care.

The use of high dose antipsychotic treatment was monitored. We saw information which demonstrated pharmacists alerted the clinical team when monitoring tests or medication reviews were due to reduce the risk of any adverse effects. The clinical pharmacist told us that they actively sought to engage with patients about their medicines and provided medicine information leaflets where appropriate. We saw examples of medication descriptions and found they were child friendly.

The wards reported regularly to NHS England commissioners. Wards monitored their overall performance using the Royal College of Psychiatrists, Quality Network for Inpatient CAMHS, accreditation tools and visits.

We were told there had been changes to the education department and that the education department was in the process of being registered with Ofsted. Patients were supported in their education and encouraged to learn through an appropriate curriculum.

Skilled staff to deliver care

Staff were not appropriately qualified and competent in providing treatment and care to patients with autism. Staff we spoke with were not able to demonstrate a good understanding of the condition and how it could effect individuals. They were unable to inform us or discuss any recognised best practice treatment approaches. We

Are services effective?

Requires Improvement

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.

were informed by staff that a psychology led programme was being rolled out across the teams which focussed on developing staff knowledge and understanding in the care of patients with autism.

Staff had received training to meet the specific patient needs, such as DBT and security training. Staff told us they were supported by their managers to access training to meet the needs of the patients. Staff had regular access to e-learning which was a database referred to as "foundations for growth". Most staff had completed mandatory training such as safeguarding, management of violence and aggression, and basic life support. We were provided information to demonstrate staff had also received training in autism but staff were unable to demonstrate good knowledge and awareness of the condition.

Ward managers told us supervision was carried out monthly and staff were appraised yearly. Ward managers were able to describe monthly clinical supervision and group supervision. The information we were provided demonstrated the service was up to date in the majority of cases with supervision.

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 patient's needs and the condition or disease being treated.

Wards followed a multi-disciplinary team collaborative approach to care and treatment. Nursing staff, occupational therapists, teachers, a consultant psychiatrist, social workers and a psychologist attended weekly meetings to discuss progress and treatment options for each patient.

For those patients detained under the MHA 1983, staff supported the involvement of the local care managers in the care programme approach process (CPA). Where they were unable to attend in person, due to the geographical distance, information was shared by phone or reports. A CPA is a way that all inpatient and community services are assessed, planned, coordinated and reviewed at least six monthly, for someone with mental health problems or a range of related complex needs.

Care records we examined demonstrated, families and care co-ordinators were informed of the patients' care and support needs and where they were in their treatment. This ensured planning for their transition back to the local community. We were told by relatives they had the opportunity to meet with clinical staff in evenings and weekends in addition to telephone and video calls to ensure they were involved in care and treatment of the young person.

Staff held daily handover meetings to discuss the previous 24 hours on the ward. Within this meeting they reviewed patients' potential risks to identify changes and agree management plans.

Adherence to the MHA and MHA Code of Practice

We reviewed the Mental Health Act documentation on all wards and found staff practice complied with the requirements of the MHA code of practice (CoP). The patients detained under the MHA understood and were empowered to exercise their rights under the Act. Examples were an application to cease detention under the Mental Health Act Tribunal and hospital managers hearing. Where a patient had not understood their rights staff had returned to explain them more often.

Good practice in applying the MCA

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 section 25 Children Act, or use of the Mental Health Act.

The Mental Capacity Act applies to young people aged 16 and 17. For children under the age of 16, decision making ability is governed by Fraser 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 or not a child has a sufficient level of understanding to make decisions regarding their care.

We saw some comprehensive assessments of capacity in relation to treatment for a mental disorder on all wards.

Are services caring?

Good

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

Summary of findings

Our findings

Kindness, dignity, respect and support

We found in most situations staff treated patients with kindness, dignity, respect and support. However we did find the privacy and dignity of patient's on Meadows was not always maintained. We brought this to the immediate attention of managers who provided us with an action plan detailing how immediate improvements would be made.

On all wards we observed patients and staff together and saw staff treated patients with respect. We saw staff engaging in activities wih patient's such as playing cards, watching TV, and having general conversations. Patient's spoke positively about staff.

However feedback we received from patient's on Meadows was not positive. We received a number of comment cards where we were told staff were not kind or caring and they felt they were treated often in a degrading manner. We examined records relating to concerns raised and brought the comments made to the attention of managers who provided us with an immediate action plan to engage patients further and address their concerns. We returned to the service to ensure improvements had been made. We found the service had taken action to engage with patients and evidence to show they had acted on feedback they had received.

The involvement of people in the care they receive

We found patients and their families were mostly involved in their care. An independent parent support group had been set up by a relative of one patient who had previously stayed at the hospital. The purpose of the group was to allow parents/carers to raise any concerns confidentially and have an independent discussion regarding their own care and support needs. We attended one of the meetings and found they offered a substantial amount of support to relatives/carers .

Where relatives could not attend MDT meeting arrangements were made to enable them to listen and take part in the meeting using a telephone and video system.

Staff were aware of how patients could access the advocacy service, patients were offered this service on all wards and the advocacy services attended wards each week so they could build relationships with patients and have an opportunity to listen to their complaints or concerns.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access, discharge and bed management

The service admitted patients aged 12 to 18 years old. The service had a psychiatric intensive care unit (PICU) for child and adolescents as well as three other wards which provided care and treatment. Many patients using the service had been referred to the service from long distances from their homes. The staff reviewed the admissions, ensured the service was appropriate. Ward managers were able to tell us about the admissions process and told us they were able to refuse admissions if it was not within the interests of the patient or where they were unable to meet their needs.

Discharge was planned for from admission, and reviewed as part of the CPA or MDT. Each patient had a discharge plans in place with details of the services they would require additional support from when they left hospital. Where appropriate, referrals were made for 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 service had arrangements in place to ensure patients moving from CAMHS services to adult services had identified placements.

The ward environment optimises recovery, comfort and dignity

The ward environments did optimise recovery, comfort and dignity and kept patients safe with the exception of Meadows where a full refurbishment plan had been implemented to ensure better therapeutic outcomes for patients.

Bedrooms were en-suite and could be personalised in the way in which the patient chose There were sufficient rooms to enable patients to engage in education and activities.

Patients had access to outside space, although due to environment constraints this was difficult to facilitate. The service did have a plan in place to address the identified needs of patients to have suitable access to outside.

There were a range of activities available to patients throughout the day and weekend which included independent living skills, recreational meaningful activities and also educational skills. Patients also had access to a kitchen to make drinks and snacks. On all wards patients had access to telephones and where risk assessments had been completed were also able o use the internet.

Meeting the needs of all people who use the service

Patients had access to interpreters and we saw examples of staff awareness when providing care and treatment for patients from all cultures.

Where patient's required support with sexual identity the service accessed local services to support people where required as well as utilising the skills of the psychologists within the team.

Listening to and learning from concerns and complaints

Concerns and complaints of patients and families were listened to. There was information displayed on the wards informing patients and their families how to complain and other agencies which provided advice and support. All the patients we spoke with told us they were aware of how to make a complaint. The service had also age appropriate welcome packs for the patient's which contained details of how to make complaints. The welcome pack had been produced by patient's using the service with support from staff.

The service had a complaints procedure, the guidance of which was summarised and advertised on the ward.

Complaints had been responded to and lessons had been learnt from complaints, when concerns had been raised. The service had also developed ways of analysing complaints to examine themes and trends so they could be addressed.

Are services well-led?

Good

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

Summary of findings

Our findings

Vision and values

Staff were aware of the vision and values of the organisation and the senior management team. All staff said they felt were well supported and listened too.

Ward managers reported regular contact with their senior managers, they said they could raise concerns and felt they would be listened to.

Good governance

The services was well managed and had good governance. Staff had clear roles and responsibilities and the effectiveness and capability of staff was scrutinised through supervisions, peer support and training. All staff reported that they liked working at the service and had done for many years.

Staffing levels were reviewed by the ward managers and increased should the need arise. we were repeatedly told the needs of patients came first and was the focus of all treatment and care.

There was evidence of audits being carried out in relation to infection control, medication management, care plan review and staff training and supervision. It was equally clear where concerns had been identified there were clear actions in place to address any shortfalls.

Leadership, morale and staff engagement

Staff we spoke with said they worked well as a team and felt supported by their direct line managers. They said they felt involved in the service and were able to give examples of projects they had been involved in such as ward refurbishment.

Staff reported they had regular staff meetings and felt they were informed about developments in the organisation. we were able to review the minutes of staff meetings which confirmed what we had been told.

The service carried out surveys which showed a majority of people felt happy with the care and treatment provided. where patients had expressed dissatisfaction and action plan was in place to address the issues raised.

Commitment to quality improvement and innovation

The staff monitored the quality of the service they provided and were innovative.

The service participated in the Royal College of Psychiatrists, Quality Network for Inpatient CAMHS.

Clinical audits had been carried out regarding the use of seclusion and self-harm in younger people.

Woodlands ward had developed, 'The safe intervention for ligaturing assessment score' (SILAS) following analysis of the unit's intervention techniques in the management of young patients who used ligatures to self harm. This approach considers three domains; the monitoring of the physical health of the young person, engagement and co-operation to ensure physical safety of the staff team and to empower responsibility of the young person and time limits to give support whilst encouraging the young person to regain control for themselves. Staff told us they were presenting their experiences of implementing SILAS and outcome measures at a national conference the week after our visit. Since the introduction of SILAS in 2010, staff told us that the incidence of restraints and harm to staff and patients had reduced.