Requires improvement

Leeds Community Healthcare NHS Trust

Child and adolescent mental health wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RY632	Little Woodhouse Hall	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 the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the child and adolescent mental health inpatient unit as requires improvement because:

- Systems and processes were not operating effectively and sufficiently embedded to ensure the quality and safety of the unit. Issues identified included a lack of staff understanding in reporting safeguarding alerts and notifications to the Local Authority and the Care Quality Commission, protocols to support staff in the roll-out and the use of restraint new methodology were not in place, and procedures were not in place to monitor the use of prescription pads. Also actions identified in action plans and reviews for example the ligature risk assessment and the assessment of the lift were not completed in the identified timescales. Staff were unclear about key performance indicators and quality targets, and were unable to provide these relating directly to this service at the time of inspection. The systems for recording the training of temporary staff were unclear.
- Staffing during evenings and weekends was almost entirely reliant on bank or agency staff. Some relatives and carers raised concerns that they had difficulty in communicating with the unit and in having questions answered by temporary staff. Not all temporary bank or agency staff, had completed the required mandatory training. The trust did not always recognise the needs of mental health practitioners, for example, the lack of specialist training and induction in the line with the national quality standards for this service, and policies and procedures relating to mental health services not being in place. Unit staff told us that at times they felt isolated from the main oversight of the trust.
- There was a lack of regular therapeutic intervention for young people. At the time of the inspection, family therapy, art therapy and dialectical support therapy were not available, and the drama therapist was only able to hold one patient group session per week.

However:

- Young people had updated risk assessments in place, which staff discussed at daily handover meetings. Support of young people with physical healthcare needs was accessible and of a high standard. Staff updated young peoples' care plans and staff planned discharge from the point of admission. These were personalised, and holistic, young people were involved in the development of the care plans and discharge plans along with their family where appropriate. The service worked with partner organisations in the community to facilitate successful recovery and discharge. Young people had access to advocacy and were encouraged to get involved with the service via weekly community meetings and by involvement in activities such as the recruitment of staff.
- The staff team were positive about their role and spoke about young people positively in meetings and discussions about their care. They were passionate about caring for the young people using the service and were kind, respectful and treated young people with dignity. Young people and their families were positive about the way staff treated them when they were admitted to the unit. Staff were positive about being part of the multi-disciplinary team within the unit, where they felt listened to and supported in their work. Staff knew the trust vision and values and linked them to their work. Systems and processes were operating effectively in relation incidents, complaint and staff supervision and appraisals.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Although the trust had completed substantial work in relation to ligature points and blind spots in response to the previous inspections, actions identified on the trust's action plan and risk assessments in relation to ligatures and blind spots had not been completed according to the identified timescales, and not all ligature risks had been completely mitigated for example the lift.
- Young people were not always restrained by staff that were appropriately trained because the trust had not trained all agency and bank staff in restraint techniques. Temporary staff managed some shifts with only one permanent staff member, which meant that if required restraint could not take place safely. Young people often needed restraint for medical interventions.
- The service was transitioning to a new method of restraint, and this was ongoing at the time of inspection. Staff were confused about which method of restraint to use. The trust had not put a protocol into place to manage this in the interim until only one method was in use.
- Although staff were aware of their responsibility to safeguard young people, not all safeguarding incidents had been reported to the correct Local Authority, to ensure they were thoroughly investigated and reviewed, or to the Care Quality Commission where required.
- Staffing during evenings and weekends was almost entirely reliant on bank or agency staff.
- Although the service had recognised that preventing young people from leaving their bedrooms was seclusion (following our Mental Health Act Review visit in December 2016). The trust had not yet produced a seclusion policy for staff to follow.
- The unit did not have a procedure in place for monitoring the use of prescription pads. A lack of tracking meant that the service could not identify what prescriptions staff had used. Therefore, if prescription pads were missing or misused, any investigation would be difficult. This did not meet with NHS protect guidance.

However:

Summary of findings

- Incident reporting was thorough, and the trust had embedded a process of analysing and learning from incidents throughout the service. The service was routed in reflective practice and learnt from incidents.
- The unit and equipment were clean at the time of our visit and the unit manager audited cleanliness on a regular basis.
- Young people had updated risk assessments in place, which staff discussed at daily handover meetings.
- There had been no serious incidents in the last twelve months.

Are services effective?

Good

We rated effective as good because:

- Staff updated young peoples' care plans, they were personalised, and holistic, young people were involved in the development of the care plans along with their family where appropriate.
- Young people attended an education centre on the unit that met their individual learning needs, linked to their home school and supported their transition on discharge. This provision had received an 'outstanding' rating from Ofsted.
- There were good working arrangements in place with services in the community to facilitate transitions to and from the service. Support of young people with physical healthcare needs was accessible and of a high standard.
- The trust had recognised that staff team would benefit from additional clinical group supervision and had arranged an external supervisor to provide this every fortnight.

However:

- Staff did not receive specialist training and induction in relation to child and adolescent mental health in line with the national quality network standards for this service.
- There was no notice or information for young people to inform them of their rights as an informal patient. One young person was an informal patient during our visit who told us that they were unsure of their rights.

Are services caring?

Good

We rated caring as good because:

- Young people and their families were positive about the way staff treated them when they were admitted to the unit.

Summary of findings

- Staff were kind and respectful and treated young people with dignity. Staff spoke about young people positively in meetings and discussions about their care.
- The use of advocacy was good; all young people had access to advocacy on the unit.
- Young people were encouraged to get involved with the service via weekly community meetings and by involvement in activities such as the recruitment of staff.

However:

- Carers told us of difficulties in communicating with the unit. This raised their anxiety levels when staff were unable to answer their phone calls and temporary staff were unable to answer their questions.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Staff planned discharge from the point of admission and reviewed plans in formulation meetings and care programme approach review meetings. In all circumstances, staff updated relatives, and all professionals involved about future plans. The service worked with partner organisations in the community to facilitate successful recovery and discharge.
- The average bed occupancy was 85%, which is an optimum level to allow good care and treatment.
- The service had a range of relevant leaflets and posters on the unit, advising young people of their rights to complain, and seek advocacy. The materials were age appropriate and young people could access further relevant information on mental health treatment, diagnoses, medication.
- The service had received two complaints in the last twelve months, which were managed according to the trust's complaints policy. The service had also received 10 compliments from young people and their families.

However:

- There was a lack of regular therapeutic intervention for young people. At the time of the inspection, family therapy, art therapy and dialectical support therapy were not available, and the drama therapist was only able to hold one patient group session per week. The unit had recognised the need to provide additional therapies and told us that they were developing plans to offer new therapies such as yoga and mindfulness.

Summary of findings

Are services well-led?

Requires improvement 

We rated well-led as requires improvement because

- Systems and processes were not operating effectively and sufficiently embedded to ensure the quality and safety of the unit. Issues identified included a lack of staff understanding in reporting safeguarding alerts and notifications to the Local Authority and the Care Quality Commission, protocols to support staff in the roll-out and the use of restraint new methodology were not in place, mandatory training compliance, and with the completion of responses and actions in response to action plans and reviews for example the ligature risk assessment and the assessment of the lift.
- There were issues with governance of the service, which indicated that the leadership of the trust did not always recognise the needs of mental health practitioners. For example, the lack of specialist training, limited availability of therapies, lack of oversight of temporary staff training, and policy and procedures relating to mental health services were not in place. Unit staff told us that at times they felt isolated from the main oversight of the trust.
- Staff were unclear about key performance indicators and quality targets, and were unable to provide these relating directly to this service at the time of inspection. The trust advised that these were new targets and therefore not fully embedded at the time of inspection.

However:

- The staff team were positive about their role, and passionate about caring for the young people using the service. They were positive about being part of the multi-disciplinary team, where they felt listened to and supported in their work.
- Systems and processes were operating effectively in relation incidents, complaint and staff supervision and appraisals.
- Staff knew the trust vision and values and linked them to their work.

Summary of findings

Information about the service

Little Woodhouse Hall is a large three storey building situated in the centre of Leeds which houses an eight bedded mental health unit for children and young people. The unit provides facilities for male and female patients between the ages of 12 and 18 years old. The unit occupied the building's first floor and part of the ground floor.

Child and adolescent mental health services deliver services in line with a four-tier strategic framework, which is nationally accepted as the basis for planning, commissioning and delivering services. Little Woodhouse Hall provides a tier four service, which deliver services for children and young people with the most significant mental health problems, such as day units, highly specialised outpatient teams and in-patient units.

Little Woodhouse Hall is managed by Leeds Community Healthcare NHS Trust, which is responsible for providing some healthcare services in the Yorkshire and the 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.

Little Woodhouse Hall has been inspected twice previously in the last two years: a comprehensive inspection in November 2014 as part of the comprehensive Leeds Community NHS Trust inspection, and a responsive inspection in June 2016.

In November 2014, following the comprehensive inspection we rated the service overall as 'good', 'requires improvement' for safe, 'good' for effective, 'good' for caring, 'good' for responsive and 'good' for well-led. We were concerned that staff had not identified all the potential risks to patients from fixtures on the unit that patients could use to self-harm by hanging, and there were no clear timescales for moving premises or improving the current premises. The trust had breached a regulation and we issued the trust with one requirement notice for the inpatient unit for children and young people with mental health problems. This related to the following regulation:

- Regulation 15 Health and Social Care Act (Regulated Activities) Regulations 2014 Premises and equipment.

In June 2016 we carried out a responsive inspection of the safe domain due to being notified of delays in the implementation of the trust's action plan, and concerns with regard to incidents that had occurred at the service.

Following this inspection, we rated the safe domain as 'requires improvement' as we found that the trust had breached regulations. We remained concerned that the trust had not identified all ligature points on the unit. We also had concerns about the cleanliness of the unit and that it did not meet the Department of Health 'eliminating mixed sex accommodation' guidance. We issued the trust with two requirement notices for the inpatient unit for children and young people with mental health problems. These related to the following regulations:

- Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014 Safe care and Treatment
- Regulation 10 Health and Social Care Act (Regulated Activities) Regulations 2014 Dignity and Respect.

The trust had not entirely met the requirements of the breaches of regulation from the comprehensive inspection in November 2014 and the responsive inspection in June 2016 at this most recent inspection. This was because the trust had not entirely mitigated the risks to young and there remained outstanding actions on the trust's own action plans.

Our Mental Health Act Reviewer visited Little Woodhouse Hall on 15 December 2016. This visit raised a number of concerns about the service. This included the processes for searching, the availability of a female only lounge, clarity around the use of a shower room for different genders, staff understanding of seclusion, cleanliness and food provision, and the documentation and recording required under the Mental Health Act, for example Section 132 patient rights, Section 17 leave and medication certificates.

The trust was asked to complete and return a provider action statement to address these issues.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Director of Nursing

Team Leader: Amanda Stanford, Head of Hospital Inspection Care Quality Commission

The team that inspected the core service comprised of one Care Quality Commission inspector, one assistant inspector, a pharmacy inspector, one specialist advisor who was a mental health nurse and one specialist advisor who was a psychologist (both with experience of child and adolescent inpatient services).

Why we carried out this inspection

We undertook this inspection as part of our comprehensive inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations for information.

During the inspection, the inspection team:

- looked at the quality of the unit environment and observed how staff were caring for patients during mealtimes and education sessions
- spoke with five patients who were using the service
- spoke with six parents of patients using the service
- interviewed the interim service manager and the interim team manager
- met with four service leads from the Trust
- held focus groups with the multi-disciplinary team
- spoke with nine other staff members including the drama therapist, occupational therapist psychiatrist, psychologist, nurses, support workers and the social worker
- completed a detailed review of five patient records
- attended and observed three meetings relating to patient care
- carried out a specific check of the medicine management
- looked at a range of policy and procedures and other documents relating to the running of the service
- spoke to the lead teacher and the education manager of the medical needs teaching service

What people who use the provider's services say

During the inspection, we spoke with five young people using the service and six of their relatives.

The young people we spoke with were mostly positive about their experience. They said staff were very caring, knew their needs, listened to them, and were respectful.

They also told us that staff respected their privacy, for example, they knocked before entering their rooms. They told us they liked the unit and felt safe, and were pleased they had their own room.

All the young people knew who their key workers were and were set individual goals each week. They had access to education and spoke of having choice about activities and groups.

Summary of findings

However, young people we spoke with were unhappy about the food available through the catering system at the unit.

Five out of the six relatives had concerns about the service. One carer commented on the significant use of bank and agency staff on the unit, and questioned how well these staff could know the young peoples' care plans. One stated that the qualified staff tended to be in the office rather than with the young people. Four of the six relatives told us that communication with the unit was not good and that staff did not always respond in a timely way. They said they often struggled to get telephone contact with the right person. Two relatives told us that staff had not given them information or leaflets when their relative was admitted and they found this added to their anxiety at a difficult time. Two parents were concerned that therapeutic interventions such as family therapy were not taking place. Two relatives and carers believed that whilst using the service, their relative had been exposed to, and learned, new behaviours. They felt risk; particularly relating to self-harm had increased since the patients' admission. Whilst relatives were confident that young people received individualised care and had access to positive links with their home education provider, three relatives and carers expressed concerns about the lack of regular activity available and offered by the service, as well as how much the young people were encouraged to engage.

However, there was some positive feedback, relatives told us that they knew who the young person's key worker was, and they were invited to regular meetings with the multi-disciplinary team. Relatives felt that what they saw of the building was clean, and they felt that staff kept property and belongings safe. Two relatives and carers commented on the recent improvements to the decor on the unit.

Good practice

Education in the unit was of a consistently high quality. Educational staff tracked progress against school targets and current grades. Staff maintained links with the young peoples' home education provider throughout their admission and following discharge. The last Ofsted inspection of the service in 2012 was rated 'outstanding'. All carers we spoke with spoke highly of the education service provided.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all temporary bank or agency staff, complete the required mandatory training and that this is recorded and monitored appropriately.
- The trust must ensure that systems and processes are operating effectively and are sufficiently embedded to ensure the quality and safety of the unit. This includes safeguarding alerts and notifications to the Local Authority and the Care Quality Commission, an appropriate seclusion policy, protocols to support staff in the roll-out and the use of new restraint methodology, a clear mandatory training system for temporary staff, and that responses and actions are completed in response to action plans and reviews, for example the ligature risk assessment and the assessment of the lift, in a timely manner.

Action the provider SHOULD take to improve

- The trust should ensure that young people are able to access therapies whilst admitted to the unit.
- The trust should ensure that staff receive specialist training and induction in relation to child and adolescent mental health in line with the quality network standards for inpatient child and adolescent mental health.
- The trust should ensure that all informal patients are aware of their rights as outlined by Mental Health Code of Practice.
- The trust should ensure that it has clear processes in place for communication with carers and ensures it responds to their concerns in a timely manner.

Summary of findings

- The trust should ensure that the use of temporary staff does not impact on the safety and quality of patient care.
- The trust should ensure that it follows guidance in relation to the monitoring of the use of prescriptions.

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

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.

Specific Mental Health Act training was mandatory for staff working on the unit, but not mandatory from a whole trust perspective. 96% of staff had completed training. Staff told us that the trust delivered bespoke training regarding the Act as it relates to adolescents and children in conjunction with a mental health specialist trust in the local area.

Staff practice complied with the requirements of the Mental Health Act. The patients detained under the Act understood how it related to them and were empowered to exercise their rights. We saw good practice in relation to accurate and timely completion of Mental Health Act documentation.

An independent advocate was available for patients. They visited the unit twice a week, attending the community meeting on one of these visits, at other times they saw patients individually. We saw contact details displayed and young people could request additional meetings or support from the advocate.

We did not see a notice on the unit, which explained the rights of informal patients. We spoke with one informal patient who told us that they did not understand their rights.

The provider had not returned their action statement relating to care and treatment under the Act following a Mental Health Act review visit in December 2016.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards do 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 are considered such as those under section 25 of the Children Act, or by use of the Mental Health Act.

The Mental Capacity Act applies to all people over the age of 16. 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. Staff were aware of the need to make specific decisions with young people in line with assessments of Gillick competence. We saw that staff discussed this in multi-disciplinary team meetings where all young peoples' ability for informed consent was discussed weekly, as well as during the admission process. Staff received training in Gillick competence as part of their Mental Health Act training.

Staff received bespoke training regarding the application of the Mental Capacity Act in relation to their work with young people. 96% of staff on the unit had completed the training.

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

Our findings

Safe and clean environment

Little Woodhouse Hall is a three storey building situated in Leeds which has an eight bedded inpatient unit for male and female patients between the ages of 12 and 18 years. The ground floor area housed the main reception, a kitchen, therapeutic kitchen, dining room, laundry and access to the garden. The educational classroom, an activity room, visitor's lounge, art room, separate male and female lounges, bedrooms and bathrooms were on the first floor of the building. All of the bedrooms were on one corridor and the unit segregated these by locating male and female patient bedrooms at either end of the corridor. Patients also accessed the drama therapy room on the second floor of the building.

Little Woodhouse Hall was not specially designed as an inpatient unit for young people. It had an architecturally listed status, which meant that there were limitations attached to making changes and adaptations to the building. Therefore it was a challenge for the trust to achieve an entirely safe physical environment in that building. The corridor leading to the education and family rooms on the first floor had two blind spots (places where staff could not see patients). The trust had not mitigated this with the use of mirrors to aid observation, but told us that the observation of patients and awareness of staff of these blind spots reduced risk to patients. We did not see that there had been any incidents specifically relating to these areas. The trust held a monthly environmental risk meeting at Little Woodhouse Hall. The meeting included the unit manager, health and safety, estates lead, security lead, fire officer, risk manager and the children's quality lead. This meeting discussed new and current environmental risks and notes and actions from this meeting were shared with the senior management team.

The unit contained a number of ligature points (areas in which patients could tie something in order to strangle themselves). The service had completed an environmental risk assessment, which had highlighted all of the risks on the unit, and held monthly environmental risk meetings to continuously measure and reduce risk. To mitigate risk, staff completed patient risk assessments and increased observation of patients at risk of using ligatures. Communal areas, which had potential ligature points, staff locked when not in use.

Whilst the trust had carried out substantial work since our last inspection to make the unit safer for patients, outstanding actions remained on the unit's environmental risk assessment when we reviewed it at this inspection. Actions were not complete according to the trust's own timescale on the unit action plan dated January 2017 in relation to; the replacement of smoke alarms (October 2016) and all bedroom furniture (December 2016). The trust notes on their action plan that all actions must be completed prior to our inspection on 31 January 2017, however they remained outstanding. The trust said that the delay in completing this work was caused by on-going discussions with the buildings landlord.

In August 2016, the trust had commissioned an external report into the safety of the unit environment. This stated that the 'wheelchair lift' (used by staff and patients) was a 'high risk hazard' and should be removed or re-designed to prevent access by patients. This remained an outstanding action but the trust had attempted to mitigate the risk posed by the lift. They had done this by raising the lift (when not in use) to its highest position, as the lift contained several ligature points and had a platform from which a young person could jump to harm themselves. Although this minimised the drop from within the lift it had a strong rail that patients could still use as a ligature point. The lift also had a covered side obscuring vision. Staff told us that to mitigate risk, patients at risk of self-harm would be on higher levels of staff observation and the area (which was near the main staircase and nursing office); saw a regular throughput of people. The trust also told us that all staff had received an email reminding them to keep the lift in the elevated position to help reduce risks.

However, during this inspection, we observed the area for 20 minutes and saw that only one staff member walked past this area, and they did not look towards the lift area. It was our understanding that this area was used by patients who may or may not be accompanied by staff. This meant that the trust had not followed the advice of the external risk assessment commissioned. When we asked the unit

Requires improvement

Are services safe?

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

manager why the lift was still in place, they said that the matter had been discussed at an internal meeting, where a decision had been made not to remove the lift. We asked for minutes of this meeting but the trust did not make them available to us.

Little Woodhouse Hall provides care and treatment for both male and female patients. At our last inspection in June 2016, the trust was not compliant with eliminating same sex accommodation guidance written by the Department of Health, which gives clear guidance on providing accommodation within a hospital setting for mixed-genders. Since this inspection, the trust had made changes and was now compliant with this guidance. Every young person had their own bedroom, these were not ensuite, but shared bathrooms were gender specific and located at separate sides of the corridor. There were both female and male only lounges and a large shared lounge available for all to use.

At the responsive inspection in June 2016, we had concerns about the cleanliness of the environment and told the trust that it must make sure the unit was clean. At this inspection, the unit was clean, well maintained and well furnished. Cleaning records were up to date. The trust had a contract with a private provider who cleaned the building. The unit manager checked the monthly audit and joined the housekeeper undertaking this process when possible. The manager told us that staff logged any direct concerns about cleanliness through a helpdesk system and that the provider responded to them in a timely way. Cleaning staff were visible on the unit during both inspection days and the majority of young people told us that the cleaners were always on the unit. However, one young person reported a dirty lounge and another said that the shower room was often dirty. One carer told us that they had found soiled sheets on their relative's bed on two occasions.

The patient led assessments of the care environment for Little Woodhouse Hall in 2016 reviewed cleanliness, appearance and maintenance, and disability access on the unit. Teams of NHS and private health care providers undertake these assessments, and teams include at least 50% members of the public (known as patient assessors). Little Woodhouse Hall scored 94% for cleanliness, below the national average of 99%. However, the unit was two percent above the national average for appearance and maintenance scoring 94%. For disability access, the unit met the national average of 87%.

The clinic was also clean and tidy. Staff placed items in designated areas of the clinic. A green sticker system was in place identify when cleaning of equipment was done, by who and at which time. Night staff completed audits of the cleanliness of the clinic room. The room contained a physical examination bed with disposable covering. The unit had a resuscitation bag, which staff checked daily.

The unit had an alarm system; all staff carried a personal alarm, which linked to panels in the staff office from each floor. Staff gave visitors to the unit an alarm. The trust environmental risk assessment stated that these were regularly tested and maintained on a six monthly basis. The unit continued to await an update of this system to ensure the mapping of the alarm was linked to the correct areas of the ward. The trust had identified this as a risk on the trust corporate risk register.

Safe staffing

The trust had allocated the following whole time equivalent staff to support the young people admitted to the unit; a unit manager (0.8), consultant psychiatrist (1), specialist trainee doctor (1), clinical psychologist (0.6), band 7 nurse (1.6), staff nurses (11.6) paediatric nurse (1) and healthcare support workers (9.6). In addition, the unit was supported by the following whole time equivalent staff; an occupational therapist (0.5), a family therapist (0.5) (currently vacant post), a dietician (0.2), a teacher (1), administration support (1), a drama therapist (0.2) an activities co-ordinator (0.6) and a paediatric nurse (0.1). However, there were some vacancies within the above staffing numbers at the time of the inspection. The trust submitted data which showed that at the time of the inspection in January 2017, there were three vacant posts, 1.4 whole time equivalent vacancy for a band seven nurse, 0.8 for a band five nurse, and 0.88 for a band three healthcare support worker. This was 12.6% vacancy rate within nursing and healthcare support worker posts, which was above the trust average of 8%. However we saw that this was an improving picture with ongoing recruitment and a reduction in vacancies since September 2016.

The service had a staff turnover rate of 10% in the 12 months prior to 1 December 2016; this was for three staff leavers in the last twelve months. However, this was a small number of staff in a small staff team. Some permanent staff had left to work on the trust bank to provide more flexibility in their working life. Four staff had left the service for career

progression. Sickness rates at the time of the inspection were 8%, higher than the 6% trust average. The trust told us that this was due to episodes of long term sickness and that the rate is not usually high for the service.

The service had three shifts each day. Each shift had a minimum of three staff, of which one staff member was always a qualified nurse. The manager told us that the service aimed for two qualified staff on each shift. In addition, the unit manager and the team manager were present Monday to Friday 9am to 5pm. We asked the trust if the service used a specific tool to estimate the number and skill level of staff required on the unit. The trust stated that they did not use a staffing tool, but had a staffing plan about minimum staffing levels. The trust told us that a staffing tool was being developed. We reviewed staffing rotas, which indicated the manager had requested additional staff to meet the needs of the unit. There were no shifts that the manager had not filled, meaning that the unit did not work with less staff than was required by the staffing establishment.

Where there was not enough permanent staff to meet the needs of the unit, the unit manager brought in additional agency and bank staff to cover the shifts required. In August 2016, 63% of staff used were temporary staff; this was 43% in September 2016, 23% in October 2016 and 29% in November 2016. We reviewed staff rotas from 30 January 2017 to 12 February 2017, and saw that there was a high proportion of bank and agency staff on some evening and weekend shifts. One weekend (Friday late shift to Sunday night shift) consisted of 18 bank or agency staff and 13 permanent staff. One occasion in this same month, there were no permanent staff on shift on the unit for three hours. On one Saturday, there was one permanent staff member and six temporary staff. The unit manager confirmed that this was the case. The trust told us that temporary staff were known to the young people on the unit and that some of them had previously been permanent staff members. The manager said that handovers were detailed to ensure that temporary staff were aware of the needs of the patients. However, relatives told us that they felt that temporary staff did not know the young people well enough to share information with them when needed. Staff were not always visible to carers visiting the ward. One staff member and one young person told us of occasions when staff had cancelled activities, planned leave and 1:1 time due to low staffing on the unit. We observed that there was not a nurse available in communal areas at all times, but they were accessible to patients and other staff in the staff office. The Royal College of Psychiatry quality network standards for inpatient child and adolescent mental health services states that units should be staffed by permanent staff, and bank and agency staff used only in exceptional circumstances for example, in response to additional clinical need. The trust told us that the majority of bank staff were experienced and had worked on the unit previously.

Young people had access to a full time consultant child psychiatrist and two doctors as part of the staff team on the unit. There was additional cross cover from the community outreach team. There were nine child psychiatrists employed by the trust as a whole, who provided cover on an on-call basis at evenings and weekends.

The provider had mandatory training requirements for all staff working on the unit. The trust told us that this included; safeguarding children, information governance, health and safety, moving and handling, mental capacity act, fire safety, equality and diversity, safeguarding adults, infection control, conflict resolution and cardiopulmonary resuscitation. The units overall training compliance was 91%, which was above the provider's target of 90%, other than infection control (78%) and conflict resolution (68%). The trust advised that conflict resolution was not mandatory training as it was included within restraint training methods. In addition, the trust advised that 15 registered nursing staff had completed immediate life support training. Mandatory training did not include specialist training for working with this service group.

The trust stated that all staff employed through their own bank system were up to date with all relevant mandatory training prior to being able to work on the unit. However, the trusts systems for recording this were unclear. The trust originally provided data prior to the inspection which stated that two of ten bank staff had undertaken training in 'team teach' restraint. The trust then submitted further information following the inspection that eight of 19 bank staff had completed training in 'conflict resolution' and three of these had also completed prevention and management of aggression and violence. The trust recorded that all six agency staff working on the unit had no training in team-teach or in the prevention and management of violence and aggression. The trust provided us with data, which showed that in the same time (September to December 2016) 25 restraints had taken

place with young people. When we reviewed the rotas for this period of time untrained bank and agency staff were working on the unit when these incidents had taken place. We were concerned that temporary staff would need to restrain young people with the correct training.

Assessing and managing risk to patients and staff

The unit had not recorded any episodes of seclusion between 1 December 2015 and 30 November 2016. However, at the CQC Mental Health Act monitoring visit in December 2016, the reviewer identified that staff had prevented young people from leaving their room if staff thought that they presented a risk to themselves and others. The unit had not recognised this as seclusion and therefore did not record it as such and did not have a seclusion policy in place. Seclusion in patient bedrooms does not meet with criteria for a seclusion space as outlined by quality network standards. The trust was in the process of creating a seclusion policy but this was not in place at the time of our inspection. The trust told us they would complete this by May 2017 and that staff had been given briefing sheets. Five months was an inappropriate timescale for a matter of this importance.

Between 1 December 2015 and 30 November 2016, staff had used restraint with young people on 150 occasions. The unit recorded all levels of restraint, including when this was low-level restraint to site or use feeding tubes. Restraint figures reduced significantly when no young people admitted to the unit needed this assistance. None of the episodes of restraint were prone restraint (in a face down position), and one resulted in the use of rapid tranquilisation. Rapid tranquilisation is a process where staff give a young person medication to manage their mental health needs and this is given in restraint due to the urgency of these needs being met.

Staff told us that the use of restraint was low because they managed complex or challenging behaviour with de-escalation techniques such as distraction or talking therapies. Not all permanent staff (78%) were trained in conflict resolution. However the trust told us that this was not mandatory training as this is included within prevention and management of aggression and violence and team teach training. Staff received yearly updates on trust approved control and restraint procedure. However, bank and agency staff had not received training in , prevention and management of aggression and violence and team teach which meant that their skills to de-escalate an incident were reduced.

Nurses and nursing assistants undertook advanced training (five days) in restraint techniques called 'team teach', other staff completed basic training. In October 2016, the team had changed to using a new method of restraint 'prevention and management of aggression and violence'. However, we saw that not all staff were trained in the same method and were concerned that this meant there would be confusion at the point of restraint. The trust provided information, which showed that 18 permanent staff were trained in 'prevention and management of aggression and violence'. Six remaining staff were trained in team teach not prevention and management of aggression and violence. We were concerned about how this could cause confusion between staff during an incident of restraint. We asked which method would be used should a young person require restraint on the day of inspection, and after some initial confusion were told that the new methodology would be followed with a trained staff member taking the lead. There was no specific protocol in place for all staff to follow to support the use of restraint and the use of the new methodology.

The unit used the 'risk assessment and risk management guideline for clinicians assessing child and adolescent mental health service patients.' Staff completed risk assessments with every young person within 24 hours of admittance to the service. We reviewed five risk assessments and found that staff updated them, and reviewed risk management plans in daily handover meetings including the need for increased observations where necessary for young people who may self-harm. Following incidents the multi-disciplinary team used formulation meetings and the multi-disciplinary team meetings to reflect on what had happened, why and what changes could be made to prevent or mange an incident more effectively. Young people and sometimes their relatives were involved in this process.

The unit had some blanket restrictions in place, however these were appropriate and managed sensitively. A blanket restriction is something, which is in place on a unit, which applies to everyone admitted regardless of his or her risk level. For example, the unit had a search policy, which stated that staff searched young peoples' belongings when

Requires improvement

Are services safe?

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

they were first admitted to the unit. However, staff did this by supporting young people to unpack their belongings and explaining why specific items could not be kept on the unit, rather than searching their belongings. If a young person at risk of self-harm refused a search, staff would increase observations rather than complete a more forceful search. Staff also removed certain items from young people at night, such as mobile phones, which staff put on charge in a night nursing office. Staff set meal times, snack times and bedtimes and the young persons' welcome leaflet stated that they were 'expected to come on time'. We found this welcome pack used restrictive language such as 'you will be expected to ask when you wish to leave the table'. However, staff explained that these restrictions were reasonable to ensure good patterns of eating and sleeping for young people, which in turn encouraged their engagement with routines, therapies and education.

All staff had completed training in safeguarding children. Staff we spoke with knew about the importance of safeguarding, it was high on their agenda for care, and they told us that they understood their responsibility to report it. However, staff had only reported four safeguarding concerns to the local authority between 1 December 2015 and 30 November 2016. We saw a safeguarding flowchart in use. This chart did not identify Leeds local authority (who held statutory responsibility for the young people whilst on the unit) as the key point of contact to report a concern. Whilst staff reported safeguarding concerns to individual patient's social workers, the process in place did not meet statutory requirements. We discussed this with the service manager, social worker and the senior management team who agreed to amend the flowchart as a matter of urgency.

Neither staff nor managers seemed aware of their responsibility to inform the Care Quality Commission of notifiable incidents, for example, a young person absconding from the unit with police involvement. We raised this with senior managers during the inspection who assured us they would look at these requirements.

We reviewed the arrangements for managing medicines at the service. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely with access restricted to authorised staff. Staff maintained accurate records and performed balance checks regularly. Blank prescriptions were stored securely but there was no system in place to track the use of the prescriptions, which is not in line with NHS Protect national guidance. When a service does not track prescription use, they cannot identify errors or misuse. The trust told us that prescribers were responsible for their own prescription pads. However this was not a robust system as individual prescribers did not track and record their use to provide an audit trail.

We checked medicines and equipment for use in a medical emergency and found they were fit for use and a system of checks was in place to ensure this. Medicines cupboards were temperature monitored and staff knew whom to contact if temperatures exceeded the recommended range. Medicines requiring refrigeration were stored securely and staff recorded temperatures daily in accordance with national guidance. There was a robust system in place to ensure medicines were reconciled upon admission and in accordance with consent to treatment. Allergies were recorded and appropriate routine monitoring was documented

Staff were aware of young people admitted to the unit who had additional physical health needs. Staff completed daily monitoring of physical health needs, and sought specialist advice from community children's nurses where required.

Track record on safety

The service had not reported any serious incidents or adverse events between 1 December 2015 and 30 November 2016.

Reporting incidents and learning from when things go wrong

Staff we spoke with had a good knowledge of how to report incidents. Staff recorded incidents electronically. The unit manager told us that the service had an open culture of reporting incidents. In the period 31st July 2016 to 31 December 2016, the service had reported 126 incidents. We found that most incidents reported were self-harm on the unit (57% of incidents).

The team had guidance around debriefs following incidents. The manager told us that the team offered debriefing to patients and staff after every incident. One member of staff told us that this did not always happen in incidents which had involved them.

Senior managers told us that incidents that are not serious, but where significant learning was needed for staff, lead

Requires improvement

Are services safe?

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nurses within the service used root cause analysis to review these. We saw evidence of two such analyses which had been completed with actions and learning disseminated to the staff team.

The trust also had a quality lead (children's services), who worked with the team manager to review every incident recorded. This allowed them to see an overview of shared or repeated themes to reduce reoccurrence. The unit manager (as part of the children business unit) attended meetings where sharing and learning from incidents was a standing agenda item. Senior nurses who had the role of feeding learning back into the team attended this group. Significant learning following incidents or changes to practice would also be discussed at the 'support and development group'. Learning from incidents was also captured within the director of nursing's report and shared at Quality Committees.

However, during the inspection, we reviewed 15 incidents in detail and found that in 10 of these incidents staff had not recorded any lessons learned from the incident. One staff member told us that they could not always identify how lessons learnt were cascaded down and felt that at times, if they were not directly involved in the incident they may not be offered learning feedback.

Staff were aware of their duty of candour and were open and honest in discussing incidents with young people and their families. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of notifiable safety incidents and provide reasonable support to that person. We heard evidence from staff that they were open and honest with patients when things had gone wrong, and carers told us that they received phone calls to discuss incidents.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

We reviewed the care records of five patients, all of which had detailed care plans in place, which staff had reviewed and updated. They were all personalised, however the care plans lacked focus regarding the young person's strength, resilience, future aims, goals and aspirations.

All care plans were stored securely on the trust's electronic recording system.

Nurses and a medic undertook initial assessments and physical health assessments within 24 hours of admission to the unit. The team had a registered paediatric nurse who monitored ongoing physical health needs. All tubes required by young people for feeding were cited by the community children nurses (or in an emergency by the paediatric nurse at the children's hospital) this unit was closely located to the general hospital, and there were good contact and working relationships. The unit had ongoing support from community health staff such as physiotherapists.

Each young person we spoke with told us that they were included in the planning of their care and had copies of their care plans and activity schedules. All young people had a named nurse who was responsible for their care plan.

Best practice in treatment and care

The ward had made attempts to follow National Institute for Health and Care Excellence guidance when delivering care, for example by stating that it offered a range of therapies to support recovery such as; cognitive behavioural therapy, drama therapy, eating disorder therapy and dialectical behavioural therapy in both one to one sessions and in group work. However, young people and their carers told us that there was limited availability of therapies. One young person had only received two dialectical behavioural therapy sessions in two months. The trust told us that other staff were trained in cognitive behaviour therapy and other staff could work with patients on the core principles of dialectical behaviour therapy. However the therapy provided was not sufficient and not recorded as therapy sessions. The family therapist post had been vacant since December 2016, and therefore this therapy was not available. There was one occupational therapist employed who worked on a part time basis and art therapy had ceased several years ago. The drama therapist was only able to hold one session per week. However, access to psychology support was available via formulation, and one to one sessions where appropriate. The unit had recognised the need to provide additional therapies and told us that plans were being developed to offer new therapies such as yoga and mindfulness. Although the unit was aware of the types of therapies that would benefit young people, availability of trained staff limited the opportunity for access to this.

Young people and their families spoke highly of the service provided by the education facility on the ward. The education service had received an 'Outstanding' rating at the last inspection by Ofsted. In addition to treatment of their mental health needs, young people require access and support to maintain their education whilst in hospital. We observed the interactions between a young person and a teacher on the unit, it was highly individualised and focussed on the student's need, and it was positive and encouraging with entirely collaborative interaction with the young person. Access to education through the on-site school was individualised. A teacher linked with the young person's home education establishment to make sure that work given was appropriate for the young person and matched what they were learning in school or college. They also provided individual support to young people making a transition back into school or college at a pace the young person could manage. The teaching staff were proud of the progress young people on the unit made in reaching education targets.

Staff used recognised clinical outcome measures such as the health of the nation outcome scale for Child and Adolescent Mental Health, and the children's global assessment scale to record patient outcomes within two weeks of admission.

Staff followed guidance in relation to prescribing medicines and we did not see that any young person was being medication above recommended limits. However, the unit did not monitor or audit the use of prescription pads, which was not in line with national guidance.

Child and adolescent mental health units had completed one audit in May 2016 in relation to 'Controlled Drugs'. There were some actions for staff following this audit:

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- An old order book that has latest entries from 2009 can be destroyed.
- As the team would record different formulations and routes of all medicines separately on a prescription chart this requirement is already standard practice. The team's existing standard is also to prescribe any 'when required doses' (not only CDs) with maximum daily dose or stated interval frequency.
- Little Woodhouse Hall undertakes regular in house prescribing standards audits to monitor these.
- As schedule 2 and 3 CDs are rarely used on the unit it is important that staff have ready access to the SOPs as their value as reference documents for rarely undertaken activities is invaluable.

During this inspection, we saw that staff managed controlled drugs well and had no concerns that staff did not follow the audit recommendations.

Staff also undertook audits on the unit, such as audits of medication and storage, the clinic room, and emergency equipment, and we observed the outcomes of these. The provider told us they used these audit results to ensure that the unit ran safely and was in good order.

Skilled staff to deliver care

The unit had a compliment of staff from a range of disciplines that included mental health nurses, a psychologist, psychiatrist, occupational therapist, support workers, a cognitive behavioural therapist, a drama therapist, social worker, activity coordinator, and an education team. Staff were appropriately qualified and competent to carry out their work. However, the unit did not have a family therapist because the post was vacant, recruitment was in process since the post became vacant in December 2016. Carers and staff expressed that this had been a loss to the unit, because this therapy was no longer accessible and is an important part of the recovery and support process.

Staff received regular clinical supervision in relation to their professional practice as well as supervision with a manager or senior staff member. Staff also accessed supervision from group analyst external to the service. Supervision varied per staff group. Between 1 December 2015 and 1 December 2016 the clinical supervision rate for additional clinical services staff was an average of 64% (which was slightly below the trust target of 65%). In the same time, supervision of qualified staff was 80%.

Ninety-six percent of permanent non-medical staff had received an appraisal, which exceeded the trust's target of 92%.

The quality network for inpatient child and adolescent mental health standards state that 'all qualified staff receive at least five days training and continuing professional development activities per year in line with their professional body, in addition to mandatory training'. The trust did not offer additional specialist training to staff working in the service in relation to areas such as child and adolescent mental health and eating disorders. Staff received the trust induction. An induction checklist reviewed did not include specific training for the unit. One staff member who had not worked on a child and adolescent mental health unit before and felt that they needed more training before working on the unit.

Staff had on site bespoke Mental Health Act training. The trust told us that the unit is in negotiation with a local mental health trust to access on going mental health training.

Multi-disciplinary and inter-agency team work

Little Woodhouse Hall followed a multi-disciplinary collaborative approach to care and treatment. A multi-disciplinary team is a group of health care professionals who provide different services for people in a co-ordinated way. The weekly meeting of the group had input from nursing staff, the occupational therapist, social worker, doctors, and a teacher and was led by the psychologist. We also observed a formulation meeting attended by the same staff group, the content of the meeting focussed on for the needs of a young person. Formulation is a process whereby professionals create management strategies to support the young person and their staff team.

Staff undertook planning of care with a multi-disciplinary approach. The unit had weekly multidisciplinary meetings where staff discussed each patient. These reviews included the unit social worker who facilitated communication between health and social care agencies. Staff gave young people the opportunity to request leave away from the unit at these meetings, and were provided with a written response.

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.

Staff held handovers between each shift, where they discussed the current situation for each young person and any incidents. Healthcare support workers, psychiatrists, psychologists, and the occupational therapist attended handovers, and a nurse led the meeting. Within this meeting, staff reviewed the risks for each young person in order to identify changes and agree management plans. Staff could amend observation levels at this meeting according to the changing needs of each young person.

Adherence to the MHA and the MHA Code of Practice

Training in the Mental health Act was not mandatory for staff at Little Woodhouse Hall. However, 96% of staff had completed training. Staff told us that the trust delivered bespoke training regarding the Act as it relates to adolescents and children. This training also included Gillick competence to assess decision-making ability in young people. Staff had knowledge of the Mental Health Act.

Staff told us the Mental Health Act administrator was accessible and they would contact the administrator if they had any concerns. The Mental Health Act administrator was responsible for auditing adherence to the Act and supporting staff in its application.

At the time of the inspection six young people were detained under the act and two were admitted informally. We reviewed the documentation of all six patients detained under the Mental Health Act.

We found that the Mental Health Act documentation we reviewed was in order, including the accurate recording on 'T2' consent to medication forms, which we identified as an issue at the CQC Mental Health Act monitoring visit in December 2016. Staff confirmed that young people were informed of their rights under S132 of the Mental Health Act on admission to the unit and routinely thereafter. However one patient told us they were not clear on their rights as an informal patient, they said that they were unsure what their legal status was. We did not see a sign on the unit, which indicated to informal patients their rights.

All young people had access to advocacy. The unit had access to an Independent Mental Health Advocate. They visited the units several times a week and staff referred all young people who were detained to them.

The social worker from the unit was responsible for completing social circumstances report for young people attending hospital managers' hearings and tribunals, staff used these for information gathering purposes and discussed them in family sessions.

A number of issues were raised on the unit following a Mental Health Act Monitoring visit in December 2016. Not all of these issues had been resolved at the time of our inspection including the processes for searching, staff understanding of seclusion and a policy to support the use of seclusion, the cleanliness and the food provision.

Good practice in applying the MCA

Staff received bespoke training regarding the application of the Mental Capacity Act in relation to their work with young people. 96% of staff on the unit had completed the training.

The Mental Capacity Act applies to all people over the age of 16. 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. Staff were aware of the need to make specific decisions with young people in line with assessments of Gillick competence. We saw that staff discussed this is multi-disciplinary team meetings where all young peoples' ability for informed consent was discussed weekly, as well as during the admission process. Staff received training in Gillick competence as part of their Mental Health Act training.

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 are considered such as those under section 25 of the Children Act, or by use of the Mental Health Act.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed staff interacting with young people with humour and warmth. Staff aimed to communicate with the young people in ways that could build positive relationships. We observed respectful and age appropriate language used by staff. At the daily handover meeting and the multi-disciplinary team meeting we observed the language used and the description of the young people's behaviour was respectful at all times.

Patients spoke highly of the staff, and told us that staff treated them with respect, and that they felt involved in their care and treatment plans. Carers told us that staff did speak to them with respect but five of them spoke of erratic communication when trying to contact the ward to enquire about their relative.

Patient led assessments of the care environment are assessments undertaken by NHS and independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services. In relation to privacy, dignity and wellbeing, Little Woodhouse Hall exceeded the England average by four percentage points at 87%.

The involvement of people in the care they receive

The unit had a thorough admission process; this included an initial engagement meeting with young person and their family to discuss their individual needs where possible.

Young people were orientated to the unit and given a welcome pack. However, we spoke with three carers who told us that staff did not offer them any information about the service, or in relation to detention under the Mental Health Act when their relative was admitted, they told us that this increased their anxiety.

Each week every young person had an individual timetable with information about his or her individual sessions, meetings, groups and activities. Some parents received copies of these timetables, which helped them understand what was happening and when would be an appropriate time to visit or telephone. This was an individualised approach, which allowed the young person to take an active role in their care. Young people we spoke with said they were involved in developing and signing their care plans. We spoke with one patient who told us that their relatives were included throughout their care and treatment plan, and involved in all meetings and decision-making.

One patient had taken part in an interview panel to recruit new staff.

The unit held a weekly community meeting attended by advocacy services, where patients helped to make decisions about the running of the unit such as activities. During the inspection, we observed a community meeting and we saw efforts were made to enable ownership and support positive engagement. A young person took responsibility to minute the meeting, and we saw that staff followed up from concerns about food, which was raised at a previous meeting and had created feedback sheets.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

Between 1 December 2015 and 30 November 2016, the service had an average bed occupancy rate of 85%. However, during one month, it had reached 99%, the Royal College of Psychiatry state that the optimum bed occupancy for a unit is 85%.

The unit admitted young people from a wide regional area, which at the time of the inspection included the four counties of Yorkshire and Derbyshire. Two of the patients were from the immediate locality, which meant that it was easier to maintain strong links with their family, friends and education.

The average length of stay of discharged patients was 69 days. Some local patients were placed in units outside of their local area. However, this was because the unit could not meet the high level of risk they presented following initial assessment of their care needs.

The trust reported in the same period that there were no readmissions within 90 days of patients who they had discharged. The service had discharged 26 young people in the last 12 months. These young people had experienced a total of 97 days of delay to their discharge from the unit; the trust told us that these delays were due to finding appropriate next stage placements for young people. In order to manage delays to discharges, the unit manager maintained a relationship with the commissioner for the service and attended a weekly report management meeting.

We saw that the service was discharge focussed, staff planned discharge from the point of admission and reviewed plans in formulation meetings and care programme approach review meetings. In all circumstances, staff updated relatives, and all professionals involved about future plans, and follow up care was organised with community teams.

Young people, staff and carers told us that access to therapy was limited due to a lack of availability of staff to provide it. The unit did not record waiting times for therapies taking place on the unit. We saw that there was only one drama therapy session per week, art therapy had ceased and there was no longer a family therapist available. One nurse providing cognitive behavioural therapy was undertaking another role and unable to provide sessions as required.

Carers told us that the trust could improve the access process when young people are admitted to the ward. Carers said that staff did not provide them with information or leaflets and that this increased their anxiety.

The facilities promote recovery, comfort, dignity and confidentiality

Young people had access to a wide range of rooms and equipment to support treatment and care. These included activity rooms, a clinic room and a range of same sex and mixed lounges for relaxation. The unit also had an education room, which had a breadth of facilities that allowed access to a range of subjects, these included computer bases, bright displays of information, books in different languages, and on core subjects such as sciences, information technology, art and design.

Staff gave young people an activity schedule for the week, which included meetings, therapies, and school. Activities were listed from 9.00am until 10.00pm but no activities were planned for young people at the weekends. However, young people were happy with this because they had arrangements for family contacts at weekends. One part time occupational therapist and one activity coordinator (working three evenings and one day at the weekend each week) supported the unit.

Young people had access to outside space, although this was not directly accessible from the ward and was only accessible with the support of staff.

Young people had access to their bedrooms throughout the day but were encouraged to access and engage with planned sessions to aid recovery. Young people personalised their bedrooms and the unit corridors with posters and artwork. Young people and their carers told us that their possessions were secure and that they had somewhere safe to keep them.

Young people had access to a visitor's room where they could meet with their families.

Young people described the food as poor when they spoke with us, and repeated this in the community meeting we observed. Feedback sheets regarding the food had recently

Are services responsive to people's needs?

Good

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

been re-introduced and could be found in the dining area. Patients were encouraged to complete these to offer direct feedback to the sub-contracted catering company; however the trust had not yet made changes to the food.

Young people had open access to cold drinks, however hot drinks were only accessible through a locked door, and young people needed to seek out staff if they wanted to make a hot drink. Snacks and meals were only available at specific times during the day.

Meeting the needs of all people who use the service

The trust had made adaptations to the unit to allow the admission of young people with mobility needs. There was one adapted bathroom, and the service had a lift to access the unit area and the top lounge, however, the size of some of the doorways and corridors would mean should it be required, wheelchair access would not be available. The service was limited in what changes it could make due to the listed status of the building.

We saw a large amount of relevant leaflets and posters on the unit, advising young people of their rights to complain, and seek advocacy. The materials were age appropriate and young people could access further relevant information on mental health treatment, diagnoses, medication. Staff said that the information leaflets were available in different languages.

The unit was able to meet the individual dietary needs of all patients, which included those with eating disorders those on specialist diets such as a vegetarian or a halal diet, however choices from the catering service were limited. Staff were able to buy additional food from the local shops to supplement the menu.

We reviewed a daily menu that showed that staff offered young people a choice of food and each meal was colour coded to encourage healthy choices. There was a dietician attached to the unit for one day per week, who ensured supplements were in place for young people on special diets.

When undertaking assessment with young people admitted to the unit, the staff considered individual spiritual, cultural and religious needs and encompassed these into the planning of treatment and care. The service had access to a translation and interpretation service with which the trust had a contract. The unit did not have a specific faith or spiritual room; however staff said that a room could be allocated if required.

Listening to and learning from concerns and complaints

The service received two complaints between 1 December 2015 and 30 November 2016. One complaint was in relation to clinical treatment and the other in regards to lack of resources available. Both complaints were upheld by the trust but neither referred to the Ombudsman. These had been managed according to the trusts' complaints policy.

In addition to formal complaints, staff logged lower level concerns from carers or young people on an electronic system. All recordings from staff showed their status in the investigation process and any response or outcome. The team lead co-ordinated investigations into concerns raised, with the aim to deal with these with oversight from service manager. Staff confirmed that this process works and feedback was given to them regarding concerns raised. We saw evidence that immediate learning was cascaded through the team at handover. We saw that following an incident that had taken place recently on the unit, the team had reviewed their search policy and criteria to reduce the risk of reoccurrence.

Young people and carers could also make complaints and compliments via an advocacy service. There were details of how to make complaints in the young people's welcome pack. However, one patient told us that they had logged a complaint about the treatment they received from the unit but they had not received any formal response.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

The trust works to a vision that states 'we provide the best possible care in every community'. This vision was supported by the values of the trust which were;

- We are open and honest and do what we say we will
- We treat everyone as an individual
- We are continuously listening, learning and improving

The trust also had seven core behaviours for all staff which supported the vision and values. Staff knew the vision and values and behaviours as 'our eleven'.

We saw that the vision and values were embedded throughout the service. Posters outlining the behaviours were on display throughout the trust and referred to in weekly messages from the Chief Executive. Values were also embedded in recruitment practices, supervision and staff appraisal. All staff we spoke with where aware of the vision and values of the trust.

The senior management team had visited the service prior to our inspection and staff where aware of who they were. Concerns around the environment had meant that there had been an increased contact for the service with members of the trust board and the service manager felt that strong links had been formed.

Good governance

There were some effective governance systems within the service. The percentage of permanent staff who had received mandatory training was above the trust target. Staff received regular supervision and appraisal and shifts were not left uncovered. Managers embedded reflective practice and learning from incidents throughout the service, and staff reviewed risks on a daily basis. Staff followed some policy and procedure in relation to the Mental Health Act, and Mental Capacity Act. The unit manager and the staff team had access to administration support in the form of a full time administration staff member who worked on the unit.

Whilst it was clear much work had been done by the trust board in relation to the in patient child and adolescent mental health service the staff felt that they and the service would benefit from more oversight at trust level, for example in relation to the focus of the mandatory training, and increase in support via policy and procedures.

We found a lack of effective governance systems within the service. The trust had not yet completed a seclusion policy for the inpatient service. At the time of inspection, there was no procedure for staff to follow in relation to secluding young people in a crisis.

The trust's recording of mandatory training for temporary staff lacked clarity and it was difficult to find evidence that staff had been appropriately trained.

The process for staff to report safeguarding alerts was unclear. Staff and senior leaders were not aware of which Local Authority to report concerns to. The trust agreed that the guidance was unclear and that there had been an over reliance on the social worker within the service to report all incidents. Staff were not aware of their responsibility to report some incidents to us, and notifications had not been made.

Staff were unclear about key performance indicators and quality targets, and were unable to provide these relating directly to this service at the time of the inspection. However, the trust told us that work had been undertaken in respect of performance indicators and some staff may not be familiar with the changes at the time of the inspection.

There were issues with training that the trust had not mitigated. The unit used a high proportion of bank and agency staff. Although young people did not appear to be concerned about this, we were concerned about their lack of training in methods of conflict resolution and restraint. The staff team were concerned that trust did not offer specialist training in relation to child and adolescent mental health. The induction to the service was not thorough and did not include specialist training for staff who had not worked in this type of service previously.

The trust had not replaced key members of staff to ensure that therapies were available to young people. For example, the family therapist post had been vacant since December 2016, art therapy had ceased, and there was reduced availability of 1:1 psychology support and dialectical behaviour support therapy. Young people and carers told us that this was a concern for them.

Are services well-led?

Requires improvement

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.

Although action plans were in place and senior managers reviewed these, actions regarding the ligature points and the 'high risk hazard' lift at Little Woodhouse Hall remained outstanding. The trust had not addressed these within their own timescale. Oversight of this was limited because the service had not included them on the corporate risk register we reviewed at the time of inspection.

There was no process in place to monitor the use of prescription pads. This meant that the trust did not have oversight of how and when staff used these, and this did not follow NHS protect guidance.

Leadership, morale and staff engagement

The trust had undertaken a trust wide staff survey in 2015 where the majority of the results were less than the national average in areas such as staff satisfaction, support from immediate managers and staff experiencing bullying and harassment from patients or carers.

The service had not undertaken an individual staff survey with the staff team working on the unit. Staff we spoke with told us of good team morale and that they worked well together. They felt supported by the unit manager and other senior staff. Staff told us the psychiatrist and psychologist where very inclusive and keen on feedback and involvement from staff of all levels.

Staff told us that senior managers were accessible; they spoke highly of the unit manager and felt well supported. The lead consultant was accessible, approachable and committed. Staff told us there was a good local leadership and morale. However, staff told us that the team sometimes feel disconnected from the rest of the trust because they were the only mental health specialist inpatient service. They said they felt isolated from the main oversight of the trust.

Staff said they knew how to raise concerns and where aware of the whistleblowing policy, and felt comfortable in doing this. They had reflective practice sessions with an external supervisor and this was described as a meeting where they could discuss issues openly and address any areas of conflict.

Commitment to quality improvement and innovation

The service was not part of any national quality improvement networks, and was not currently involved in any research. However, they used internal processes to measure patient outcomes to monitor the success of the treatment and care offered to young people. The service also worked closely with commissioners to ensure access and discharge was continually monitored.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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 18 HSCA (RA) Regulations 2014 Staffing 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part; (2) Persons employed by the service provider in the provision of a regulated activity must – (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. **How the regulation was not being met:** Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet the requirements of the regulation. Staff employed by the provider did not receive such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

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 17 HSCA (RA) Regulations 2014 Good governance 17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 17 (2) (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

This section is primarily information for the provider

Requirement notices

17 (2) (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

How the regulation was not being met:

The provider did not ensure systems or processes were established and operated effectively to ensure compliance with the regulation.

The provider did not have systems in place that were of sufficient quality to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

The provider did not have systems in place that were of a sufficient quality to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.