

Outstanding**North East London NHS Foundation Trust**

Child and adolescent mental health wards

Quality Report

Brookside Unit
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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)
RATRK	Brookside unit	Brookside Unit	IG3 8XQ

This report describes our judgement of the quality of care provided within this core service by North East London Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by North East London Foundation Trust and these are brought together to inform our overall judgement of North East London Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Outstanding 

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 children and adolescent mental health wards as **outstanding** overall because:

- There was strong and inspirational leadership at a trust and service level that had transformed this service and over an 18 month period the ratings moved from inadequate to outstanding.
 - During this most recent inspection, both staff teams were fully committed to ensuring that they provided quality services and continued to improve through innovation. Staff from both teams were involved in a number of quality improvement projects and accreditation. Young people receiving care were encouraged to become actively involved in these quality improvement projects and their input was valued.
 - Staff treated young people and their families as partners in their care. They understood the importance of being kind and respectful. There was genuine empathy and understanding of individual needs and wishes, which was reflected in the work undertaken with young people and their families. There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Staff morale was high and commented that this had steadily improved since the ward had re-opened in September 2016.
 - The leadership, governance and culture of the service drove improvement and underpinned the delivery of high quality person-centred care. Staff were accountable for delivering change. Leaders had an inspiring shared purpose and motivated staff to succeed. There were high levels of staff satisfaction and staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to raise concerns. Managers made themselves available and were actively involved in ward based activities.
 - There were robust and effective governance procedures. Managers and senior members of the multi-disciplinary team met regularly to discuss issues relating to the running of both services. There was a good flow of information from these meetings to the trust leadership team and back to the frontline staff.
- The trust's development and implementation of the YPHTT demonstrated a clear proactive approach to seeking out and embedding new and more sustainable models of care. The service was seeking accreditation and beginning the process of identifying a research model to formally evaluate outcomes for patients accessing the YPHTT.
- Young people said that they received excellent care, staff were amazing and that they felt safe on the ward.
 - Although the ward had staffing vacancies, the managers had planned for this and ensured that there were sufficient staff on duty. Existing staff members or a small group of regular bank and agency staff filled vacant shifts. The trust monitored safe staffing levels against admission numbers. The Young Peoples' Home Treatment team was adequately staffed and staff turnover was low.
 - The building was modern and there were various outside spaces, which all young people could access. Families could stay in a family suite on site if needed. The building was visibly clean and well furnished. Young people could personalise their bedrooms. The environment was well maintained and potential ligature anchor points were appropriately managed.
 - Staff had a good understanding of risk. Both teams had regular risk meetings, which were attended by a broad range of disciplines. All staff had the opportunity to contribute to the risk identification and formulation of risk management plans. Risk assessments were frequently updated. Both teams had clear time frames to assess new referrals and formulate the young person's care plan, which meant that there was no delay to care and treatment commencing. Both teams liaised with the trust's safeguarding team and other external organisations appropriately and in a timely manner when risks were identified. There were clear processes in place to safeguard young people and staff knew about these. Incident reporting and shared learning from incidents was evident in these services. Teams considered the review of incidents to be an opportunity for learning.
 - Planning and delivery of care was holistic, personalised and recovery focussed. Planning and

Summary of findings

delivery of care placed children and young people at its centre and staff ensured that patients, their families and carers had appropriate information so they could make informed decisions. Staff from both teams ensured that they monitored all aspects of the young person's well-being including their physical health. There were mechanisms to identify when a young person's physical health was deteriorating. Where young people had additional physical health needs, staff escorted them to their hospital appointments. Since the previous inspection in October 2016, there had been improvements in how patients' physical health checks were recorded.

However:

- We identified a number of minor procedural lapses in governance systems. A fire evacuation drill was overdue. Staff arranged for this to take place shortly after the inspection. Fire alarm checks and staff radio checks were not completed as frequently as required by the trust.
- Whilst the majority of equipment used to monitor patients' physical health was maintained, a blood glucose monitoring machine had not been calibrated. This was escalated and addressed by ward staff during the inspection.
- The majority of frontline staff were not aware of the name of the trust's Freedom to Speak up Guardian and their role. However, all of these staff stated that they could get these details from the trust's intranet.
- At a previous inspection in October 2016, we found that some meal choices were not available in sufficient quantities. During this inspection this had improved, however, patients said that the quality of food was poor. Managers and staff were actively working to address this and had organised meeting with the catering provider.

Summary of findings

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

Are services safe?

We rated safe as good because:

- The ward environment was safe as well as being a welcoming environment for young people. Young people had been involved in the redesign of the unit.
- Staff had a good understanding of safeguarding processes. Staff embedded these processes in all the work that was undertaken. Both teams had strong relationships with the trust safeguarding leads. The trust's safeguarding specialists had undertaken an audit of child sexual exploitation. Staff had undertaken additional training to recognise child sexual exploitation. Staff in both teams were knowledgeable regarding the range of risks that could impact negatively on a young person.
- There was good use of crisis planning in both teams. Staff supported young people to help them recognise and take appropriate steps when their mental health was deteriorating.
- Safe staffing levels were maintained and there was an ongoing recruitment programme to fill vacant posts. Both teams re-assessed staff caseloads on a regular basis and made sure they could be safely managed. Both the inpatient unit and YPHTT services monitored risks to patients and ensured appropriate plans to mitigate and manage risk were in place.
- The completion rate for staff mandatory training across both teams had improved since the last inspection and was above 75%.

However:

- A fire evacuation drill which was due in July 2017 had not taken place and was overdue by five weeks. This was brought to the attention of managers who said they would organise a drill within 48 hours. All other previous fire drills had been held in line with the trust's policy. Some weekly fire alarm tests had not been documented as being completed.
- The unit was equipped with separate call alarm systems and staff had access to these. Additionally all staff were expected to carry radios. These radios were part of the inpatient security system. We found that the radios were not checked daily, in accordance with trust policy and procedure.

Good



Summary of findings

- Whilst the majority of equipment used to monitor patients' physical health was maintained, blood glucose monitoring equipment had not been calibrated. However, this was not required for the care and treatment of patients at the time of the inspection and appropriate action was taken to calibrate the equipment during the inspection.

Are services effective?

We rated effective as good because:

- Staff in both teams carried out comprehensive assessments of patients' needs. Members of the MDT contributed to these assessments. Care records were up to date and comprehensive. The managers of both teams were undertaking regular audits to monitor the quality of the plans.
- Staff discussed medicines with young people. Staff provided information leaflets and went through it with parents. This was done prior to these medicines being started. The inpatient unit and YPHTT worked collaboratively and staff from the MDT worked across both teams, which ensured continuity of care for young people.
- Staff had access to specialist training. Staff participated in clinical audits, which led to service improvements.
- The services offered a broad range of psychological therapies including those recommended by NICE. For example, cognitive behavioural therapy and family work. Staff monitored care and treatment outcomes for patients and used this to improve the care and treatment offered to patients.

Good



Are services caring?

We rated caring as outstanding because:

- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring and supportive. Staff in both teams were very caring and understood the needs of the young people and their families.
- Reports from patients and families were very positive about the service, they said they received excellent care and that staff were 'amazing'.
- Young people were supported to express their views and realise their potential. Young people were encouraged to contribute their ideas regarding how to improve the unit. Staff supported

Outstanding



Summary of findings

young people to become engaged with schooling and other available opportunities. Community meetings took place regularly Staff attended these meetings and they were recorded. Staff encouraged and supported young people to become involved in the recruitment of new staff.

- There was a strong client centred approach for people using the service and their carers. Staff explained each person's diagnosis and treatment in a way that was age appropriate and could be understood by the young person. Clinicians were committed to ensuring that young people overcame their difficulties. For example, clinicians could attend school with young people to provide support so they could continue their education. There was family suite available for parents/carers to stay in when they visited young people so that young people could maintain close contact with those close to them during their inpatient stay.
- Children and young people's needs and preferences were reflected in how care was delivered. Planning and delivery of care took into account patient's personal, cultural and social needs into account. The home treatment booklet helped to break down barriers. It contained information about the service including biographies of the staff that were in the team.

Are services responsive to people's needs?

We rated responsive as good because:

- Teams worked in collaboration with young people and their families. Services used feedback from young people and their families to improve the service.
- The premises were child and young people friendly. The services displayed information about local services
- There were clear criteria in respect of who could access the services. Services were responsive and had specified time frames to assess and offer treatment to young people. The YPHTT could see young people within 24 hours of referral. Young people had the opportunity to visit the inpatient unit before they were admitted.
- Staff were able to respond promptly to emergencies. They could offer urgent appointments to young people who required them. The YPHTT could offer young people up to three appointments a day. Both teams had effective handovers on a daily basis. The discussions of these handovers were recorded in patient progress notes

Good



Summary of findings

- Both teams made an effort to understand and respect the diversity of the young people who accessed the service. At the previous inspection in October 2016, we found that information in other languages was not always displayed. During this inspection, we saw that information could be provided in other languages. The team were working in collaboration with another organisation to ensure they were able to respond appropriately to transgender young people. The inpatient unit had made careful plans to transfer a young person to a hospital, which was abroad. The unit was providing an escort to ensure the safety of the young person.
- At a previous inspection in October 2016, we found that some meal choices were not available in sufficient quantities. During this inspection this had improved, however, patients said that the quality of food was poor. The inpatient unit had responded to complaints by the young people regarding the food and were reviewing the catering provision.

Are services well-led?

We rated well-led as outstanding because:

- The trust leadership team had transformed this service in an 18 month period so the rating had changed from inadequate to outstanding. This was a very significant achievement.
- Local leadership was strong and strove to deliver and motivate staff to succeed. Successful leadership strategies were in place to ensure delivery of quality services and to ensure a positive culture across both teams. Senior managers were highly visible in both teams. Managers undertook shifts on the ward.
- Staff understood and implemented the vision and values of the trust. Teams were supportive of each other and modelled the trust's visions and values. They knew the goals for the service and were committed to ensuring that these were implemented to a high standard.
- Staff were proud to work in these teams. The morale of both teams was extremely high. They celebrated their success and were committed to the work they undertook. Colleagues were complimentary of each other and felt well supported. After the last inspection, the team had organised a meal to celebrate their improved rating.
- All managers felt they had sufficient authority to undertake the tasks required to manage the service. One manager was newly appointed and was clear about the role they were required to

Outstanding



Summary of findings

undertake and the processes in place to support them. The two teams worked in close collaboration. There was a focus on working closely with other stakeholders and using their feedback. There was a common focus on improving care for people who used services.

- Governance and performance management arrangements were robust and underpinned the delivery of high quality services that aimed to continuously improve. Teams had key performance indicators, which were monitored through regular meetings. There were a range of quality assurance meetings that reviewed the activity of both teams. These incorporated and used the feedback from the young people and carers.
- Both teams were becoming involved in quality improvement projects. The inpatient unit was seeking QNIC accreditation. The staff were fully involving young people in the QNIC process.

However:

- We identified a number of minor procedural lapses in governance systems. These were escalated during the inspection and addressed by managers.
- Staff were not aware of the name of the Freedom to Speak up Guardian. This was brought to the attention of the managers who emailed the Freedom to Speak up Guardian the day of the inspection and invited them to attend a team meeting.

Summary of findings

Information about the service

The Brookside unit is a new and innovative model of care. It is divided into two services the CAMHS inpatient unit and the young people's home treatment team (YPHTT). The two services work together to support young people with complex needs to receive support in their own homes but where needed to be admitted for inpatient care. Both are commissioned as Tier 4 services.

The care pathway lead and modern matron are based at Brookside. Both these individuals have overall managerial responsibility for the inpatient service and crisis team. Each team has its own team/ward manager. Some staff from the unit work across both teams.

The Brookside inpatient ward is a 15-bedded mixed gender inpatient mental health unit for young people. The service can take referrals from across the country. However, the majority of the young people admitted to the unit live in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest.

When the inpatient unit was last inspected in October 2016, it received an overall rating of good. That inspection took place shortly after the inpatient unit had re-opened.

The YPHTT has been fully operational since September 2016 and was not inspected during the October 2016 inspection. The service is commissioned to work with up to 17 young people and their families. The YPHTT provides a rapid response and helps to avoid admission to the mental health inpatient ward by supporting young people in acute mental health crisis in their homes. The team also help young people who have been discharged from hospital as they make the transition back into the community.

The Brookside Unit is the only inpatient child and adolescent facility managed by trust. Both services provide specialist psychiatric care for young people who are experiencing an acute mental health crisis, whose presentations are complex and require treatment. Both teams have doctors, nurses, psychologists, occupational therapists and support workers who are available to support young people and their families.

The inpatient unit has an on-site school. The school is registered with the office for standards in education, children's services and skills (Ofsted). The school has not yet been inspected by Ofsted.

Our inspection team

The team that inspected this core service comprised two CQC inspectors, one inspection manager, one specialist advisor who was a psychiatrist with a background in the mental health of young people, a nurse specialist advisor who had a background in the mental health of young

people and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, mental health services.

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.

During the inspection visit, the inspection team:

- visited the Brookside unit
- spoke with nine young people who were using the service
- spoke with five parents/carers who shared their views and experiences of the services

Summary of findings

- spoke with the managers or acting managers for the ward and the Young People's Home Treatment team (YPHTT)
- spoke with other staff members of the inpatient unit and YPHTT; including doctors and nurses
- interviewed the care pathway lead and the modern matron with responsibility for these services
- attended and observed two hand-over meetings, two risk meetings and one governance meeting
- attended and observed an occupational therapy cooking session and the ward based community meeting
- accompanied staff on a home visit
- spoke to the advocacy service
- interviewed staff working in the Tier 3 community CAMHS service
- collected feedback from 10 young people and parents/carers using comment cards
- looked at nine treatment records of patients
- carried out a specific check of the medication management on the unit
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke with 14 young people and their families. They said that the care they received from clinicians was excellent, supportive and well organised. They also said that staff were caring, polite and interested in the well-being of young people. Parents and carers told us that staff were interested in their well-being. They also told us staff supported them in their parenting role and this helped to allay their fears.

Young people said that the staff were amazing, young people felt well informed about the care they received and could make their own choices. Teams gathered the views of young people and families using surveys, community meetings and in focus groups. Young people knew how to make a complaint and understood their rights.

All of the young people on the ward we spoke with said they were happy with the environment and the facilities on offer. The young people said that when other young people displayed aggressive behaviour that the ward staff were good at managing this and keeping everyone safe.

All the young people we spoke to said that the food served on the ward was not of a good quality and needed to be improved. They had shared their views with the managers. The managers were working with the young people and the catering team to make improvements.

Good practice

- The teams based at Brookside services were in the process of identifying internal quality improvement projects.
- Managers were gathering data regarding the work undertaken by the YPHTT to begin the process of evaluating the effectiveness of the model.
- Managers were reviewing the work undertaken by their services and identifying whether there was a gap in provision for young people who had emerging personality disorder.

Areas for improvement

Action the provider **SHOULD** take to improve

Summary of findings

- The provider should ensure that fire evacuation drills take place when scheduled. The provider should also ensure that fire alarm checks take place in accordance with trust policy.
- The provider should ensure that radio checks take place in accordance with trust policy and that records of these checks are appropriately maintained.
- The provider should ensure that all equipment that may be required to monitor patients' physical health is regularly calibrated.
- The provider should ensure that the quality of food provided on the inpatient unit is improved.
- The provider should ensure that staff are aware of the trust Freedom to Speak Up Guardian and their role.

North East London NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Brookside Unit	Brookside Unit

Mental Health Act responsibilities

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

At the time of our inspection, there were six young people detained under the MHA and five young people who were informal patients on the inpatient unit. Records indicated that staff had informed young people of their rights.

Staff had been trained in the Mental Health Act, 86% of staff had completed this training at the time of our inspection. If staff were unsure about aspects of the Act they were able to get support from MHA office. Advocacy services were available at the unit and staff regularly referred young people to these services. MHA paperwork was in order, accessible and available on the ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) applies to young people aged 16 and over. For children under the age of 16, staff applied the Gillick competency test. This recognised that some children might have a sufficient level of maturity to make some decisions themselves.

Doctors on the unit took the lead on issues of capacity. Ninety-three per cent of staff had MCA, including Gillick competency, training. The understanding of Gillick competency amongst the staff group was good. Staff

described how to apply the guidance when a young person had decided they did not want their family to be involved. Where a patient's capacity to make a specific decision had been assessed, this was documented appropriately in their care records. Since the previous inspection in October 2016, there had been improvement. During this inspection, we saw that issues of capacity were promptly assessed.

Detailed findings

This meant that staff always sought consent for care and treatment young people and their families where appropriate.

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

Safety of the ward layout

- Both the inpatient unit and the offices for Young People's Home Treatment Team (YPHTT) were located in the Brookside unit. The unit was located separately from adult inpatient services. The unit was a purpose built single storey building. Staff working at the unit ensured that they only admitted authorised individuals to the building. Access to the building was via an intercom and an airlock door system. Visitors to the unit were required to sign in which meant that staff were aware of who was onsite. Young people who were under the care of the YPHTT did not routinely visit the Brookside unit.
- During this inspection, we were told staff undertook environmental checks of the unit. The purpose of the walk round was to identify any safety concerns within the unit. At the October 2016 inspection, we found that records relating to environmental checks were not being completed. During this inspection, we saw that this had improved, as records were available. These showed that when rooms were being checked this was done thoroughly. However, further work was needed to ensure records of environmental checks were well organised and stored in date order.
- The ward layout did not allow staff to view all areas of the ward. The nursing office overlooked the communal lounge and part of the corridor. There were restricted areas for patients and these could only be accessed via pre-programmed key fobs. For example, young people could only access the laundry accompanied by a member of staff for reasons of safety. To mitigate the risks associated with the ward layout staff carried out regular observations, used increased observations including one to one for patients identified as being at increased risk and ensured that staff were present in communal areas at all times.
- The ward appropriately identified potential ligature risks and took action to mitigate and manage the risks associated with these. The unit completed a yearly ligature audit. The trust also had a ligature risk flow chart, which gave guidance to staff regarding the daily checks to be undertaken to ensure that potential ligatures on the ward were managed. The trust had also taken pictures of potential ligature anchor points and had circulated these to the staff group. A ligature anchor point is an environmental feature or structure, which patients may fix a ligature with the intention of harming themselves. The trust had completed a ligature risk assessment in April 2017 and had updated it in August 2017 following an incident on the ward. The ligature risk assessment was kept in the nursing office, which meant that staff, including agency staff that might be less familiar with the ward could have access to it. Where patients were identified as being at risk of fixing ligatures, these risks were appropriately mitigated by accommodating patients in bedrooms located near the nursing office and the use of increased observations.
- The in-patient unit was open plan and compliant with Department of Health guidance on same sex accommodation with separate bedroom and bathroom areas for male and female patients. Staff gave young people key fobs to their own rooms. There was also a female only lounge which female patients could access using their key fobs.
- Ward based staff had appropriate access to alarms, which worked throughout the ward. All members of staff had a personal alarm and the ward had been refurbished to include a security identification panel. Staff were also provided with radios. The radios should be checked on a daily basis but we found there were gaps in the records. Between 1 May 2017 and 12 August 2017, the radios should have been checked on 104 occasions but they had been checked on 11 occasions. Although staff had access to personal panic alarms which still allowed them to summon assistance in an emergency, they could not be sure that the radios which were also part of the security arrangements for the unit worked properly.
- The unit was assessed for fire risk on an annual basis. Access to the ward, was through magnetically locked doors. These external doors opened automatically in the event of a fire or fire drill. The fire risk assessment was dated September 2016. This assessment listed a

Are services safe?

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number of remedial actions that were required. For example, fixing seals around doors, and upgrading two doors to a greater fire proof standard. Completion dates for these remedial works were not included in the available records. Staff assured us that these works had been completed but the assessment document had not been updated to reflect this.

- Fire alarm tests should take place on a weekly basis, however, these tests were not taking place in line with local policy. The fire alarm logbook documented that tests had taken place nine times between February 2017 and July 2017. Fire evacuation drills were due to take place on a six monthly basis. The unit had undertaken a fire evacuation drill in January 2017. A subsequent scheduled drill in July 2017 had not taken place. The management team were made aware of this. They said they would arrange for an evacuation drill to take place within 24 hours.

• **Maintenance, cleanliness and infection control**

- The premises were visibly clean and tidy. None of the young people, carers or staff raised concerns regarding the cleanliness of the building. Copies of the cleaning schedule were displayed on the walls and updated when cleaning tasks were completed. The ward was comfortably furnished. The ward had participated in the patient led assessment of care environment. It had scored highly with a score of 100% for cleanliness and 95% for condition, appearance and maintenance.
- The ward had a designated infection control lead and staff were aware of and put into practice, the trust's infection control procedures. Staff followed the guidance when washing their hands. Staff that undertook cleaning duties wore appropriate personal protection including aprons and gloves, which was in accordance with infection control guidance. The ward based staff undertook infection control audits.

• **Seclusion room**

- There were no facilities to nurse patients in seclusion. The ward had a de-escalation room but it was not in use at the time of this inspection, as the operational policy had not been agreed.

• **Clinic room and equipment**

- Staff had access to a treatment room and a medication room. Both rooms and the equipment were visibly clean and tidy with hand washing facilities available. The equipment in the room had "clean" stickers visible and in date.
- The treatment and medication rooms had emergency equipment available, which included a full and in date oxygen cylinder and an emergency grab bag (containing adrenaline pens, a defibrillator, defibrillator pads, ligature cutters, razors, gloves, face masks of varying sizes, and a suction machine) for use during immediate life support. Staff checked the emergency grab bag every day.
- Medical devices (blood pressure machine and weighing scales) were available and portable appliance tested appropriately. The clinic room had weighing scales, blood pressure monitoring equipment and two blood glucose monitoring machines. Neither of the blood glucose machines had been calibrated within the last 12 months. Staff said that they had ordered the solutions required for calibration and were waiting for it to be delivered. At the time of the inspection, none of the young people on the ward needed regular blood glucose monitoring. The issue with the blood glucose monitoring machine was brought to the attention of the modern matron on the day of the inspection. The modern matron took immediate action to address this and to ensure that the ward had the means to monitor the blood glucose of the young people.
- The ward had an electrocardiogram machine and nurses were trained to use it. Staff had undertaken training in basic life support and were aware of the locations of ligature cutters on the wards.

Safe staffing

Nursing staff

- Although the ward had staffing vacancies, managers planned for this and ensured that there were sufficient staff on duty to safely deliver care. The trust used a safe staffing tool to calculate the numbers of staff required on shift to safely meet the needs of patients. There were nursing vacancies. The ward had recently increased nursing establishment, which had led to an increased vacancy rate of 33%. The trust had recruited 11 nurses but they had not started at the time of the inspection. When these nurses came into post, the ward would be

Are services safe?

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fully staffed. The trust had an ongoing programme of recruitment. There were plans for a further recruitment campaign, which was due to take place in September 2017.

- The YPHTT had vacancies for two band 6 nurses and two band nurses 5. The trust were interviewing for these posts in August 2017. When these posts were filled, the team would be fully staffed. In the interim, the trust were using bank and agency nurses to cover the vacancies in both teams and maintain safe staffing levels. There were no unfilled shifts. This was an improvement on what we found at our previous inspection in October 2016, when although safe staffing levels were maintained, not all shifts were filled.
- The managers had calculated the number and grade of nurses required for all shifts across both teams. For example, the ward had three shifts. The shift pattern was morning, afternoon and nights. The morning shift had three qualified nurses and three health care assistants. The afternoon shift had three nurses and four healthcare assistants and the night shift had two nurses and three health care assistants.
- The ward manager had authority to increase staffing levels based on the acuity of patients and their needs. For example, if a patient was identified through risk assessment as requiring enhanced observations to ensure their safety or the safety of others. The ward manager kept a list of bank and agency staff whom had worked on the ward previously and were familiar with the patient group. They had a proactive approach to booking bank and agency staff and had set up a text group so that bank and agency staff could be made quickly aware of upcoming shifts. The ward manager stated that this arrangement was useful in ensuring that all shifts were covered.
- The YPHTT regularly reviewed staff caseloads to ensure they could be safely managed.
- The ward and YPHTT had low levels of sickness. None of the staff or the young people who were on the ward identified high levels of sickness as an issue. The average sickness rate between January 2017 and June 2017 for the inpatient unit was 2%. The trust was able to supply sickness data for March 2017 to June 2017 for the YPHTT. The average rate of sickness for this team was 1.8%.
- The YPHTT had not had any staff leave since it had opened. The inpatient unit had an average of 9% staff turnover since October 2016.
- The managers from both teams provided all staff including bank and agency with an induction to the unit. The staff were introduced to the patients when they first came on shift. This ensured that they were familiar with ward and the young people.
- Patients had a named nurse on every shift. Staff informed patients of this on admission and let them know who their named nurse and healthcare assistant would be. No escorted leave or activities had been cancelled as a result of staff shortages. Staff stated that the only reason activities would be cancelled was if the young people did not want to participate.
- Each young person had regular one to one time with their named nurse. Staff working in the YPHTT visited young people at home up to three times a day. Different workers undertook these visits, however, it was a small team and young people and their parent/carers were familiar with all members of the team.
- There were enough staff to carry out physical interventions (for example, observations, and restraint) safely and staff had received training to do so

Medical staff

- Medical staff were routinely available during the day on the ward. Doctors working in the CAMHS unit could provide emergency appointments to young people who were being treated by the YPHTT. For example, during the inspection we saw a doctor responding to an emergency involving a young person.
- The inpatient unit had procedures in place if there was a medical emergency out of hours. Doctors who were located at the local acute hospital could attend the unit in an emergency. The staff said that they had not experienced any difficulties or delays in getting a doctor out of hours and doctors always attended quickly when contacted. Out of hours, a CAMHS consultant psychiatrist was also on call.

Mandatory training

- When the inpatient unit was inspected in October 2016, we found that the overall mandatory training compliance rate was 82%, which was below the trust's

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

target of 85%. During this inspection, we found that the training compliance rate had improved and overall mandatory training compliance rate had exceeded the trust target in all areas except information governance. The completion rate for this course was 79%, the manager stated that they expected the completion rate to improve in the near future as more courses were being run. In the absence of all staff having completed this training, we saw evidence in minutes of meetings that managers reminded staff of the importance of handling patient's personal information appropriately, in line with trust policy.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We reviewed nine patient care and treatment records. These showed that staff completed a risk assessment for each young person when they were admitted and reviewed and updated this regularly.
- Staff from both teams regularly reviewed and formulated plans to manage risk behaviours of patients and risks to staff through the handover and risk meetings. There were clear terms of reference for the handover and risk meetings. Staff from the multi-disciplinary teams attended these meetings. Both teams had been involved in piloting the trust's risk assessment template. The template was stored on the young person's care records, which meant that it was accessible to all staff. There was an expectation that the risk meeting would take place Monday to Friday. The meeting was used to discuss issues of risk, plan for discharge, document changes to medication and generally update all attendees regarding the young person's presentation. Staff used this meeting to update records. In the records we reviewed, we saw that risk information was comprehensive and updated regularly and after every incident.
- Staff reviewed risk using a standard risk screening and assessment tool. The risk tool was in line with the Department of Health Guidance, Best Practice in Managing Risk (DOH 2007). The risk assessment tool was structured and ensured that risk assessments were evidence based.

Management of patient risk

- Where potential risks were identified, management plans were in place to mitigate these. Staff identified

and responded to changes in risk. Both teams had regular risk management meetings. We attended the YPHTT meeting and observed the staff group discussing all the young people on the caseload. The staff used this meeting to identify what risks existed and what needed to be done to manage these risks. For example during that meeting, staff identified that there were particular concerns regarding one young person whose physical health had begun to decline and required urgent follow up. Staff updated the risk documents on the care records after meetings.

- Staff were visible throughout the ward environment. The YPHTT offices were located off the ward. Staff from this team were visible and interacted with the patient group. A number YPHTT staff also worked with the young people on the ward. Where patients were subject to enhanced observations, staff did this with sensitivity and in a non-intrusive way.
- There were very few restrictions. The trust had restrictions regarding smoking which was in line with their smoking policy. The trust was smoke-free and had been so since October 2015. Prior to being admitted young people were advised that smoking was not permitted in the unit or in the grounds. None of the staff we spoke to said that it was difficult to enforce this policy. Young people who smoked could be offered support to stop smoking. Young people's care plans emphasised the importance of having a healthy lifestyle. The trust asked young people not to bring tobacco, plastic bags, cigarettes, lighters or matches with them to hospital. Where other restrictions were applied this was individually assessed and managed. Patients were able to use their mobile phones.
- Young people who had been admitted to the ward as informal patients were made aware of their right to leave the unit. They were able to do so after staff had considered the young person's risk and if necessary, their parents had consented.
- Staff working in the YPHTT undertook home visits. The team had lone working protocols to ensure their safety whilst in the community. For example, in handover meetings staff confirmed what visits they would be undertaking that day. The trust had provided the YPHTT

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with mobile phones. All the staff we spoke to were aware of what action they should take should they have to contact the team base in an emergency whilst out on a visit.

Use of restrictive interventions

- The trust was committed to reducing the number of face down restraints (prone). They had a Reducing Restrictive Interventions Strategic Action Plan. Restraints had dropped from 400 to 85 restraints in the last 12 months. From February 2017 to 31 July 2017, there were 52 restraints recorded for the inpatient unit. These incidents of restraint involved 17 patients.
- Between February 2017 and to 31 July, there had been 11 prone restraints involving three patients. Staff said that there had been episodes of high patient acuity on the ward during this period. One of the restraints had been care planned with consultation with the young person. For two months during this period (May 2017 and June 2017), there had been no prone restraints.
- The trust had trained staff in supine restraint techniques in February and March 2017. Since staff had received training in the new restraint techniques, the number of prone restraints on the ward had decreased. Staff said they used restraint as a last resort and whenever possible tried to de-escalate the situation first. The ward had a de-escalation suite that was not in use at the time of our inspection.
- No restraints had occurred within the YPHTT.
- We looked at incident records for episodes of restraint. These clearly detailed what had taken place and those involved in the restraint. Managers on the inpatient unit had good oversight of all incidents of restraint.
- Between February 2017 and July 2017, there had been 11 incidents of rapid tranquilisation on the inpatient unit. However, at the time of our inspection none of the patients had received intramuscular rapid tranquilisation medicines. Staff had attached the rapid tranquilisation policy to the door of the medicine room and this helped to remind staff what steps they should take when administering rapid tranquilisation.

Safeguarding

- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. Staff knew how to identify adults and children at risk of, or suffering, significant harm and took appropriate action to protect them.
- Training in safeguarding was mandatory. Staff in both teams had been trained in safeguarding both adults and young people. One hundred per cent of all staff had been trained in safeguarding children level 1, 92% of staff had completed safeguarding children level 2 and 88% of staff had completed safeguarding children level 3. Ninety four per cent of staff had been trained in safeguarding adults.
- Both teams embedded safeguarding protocols and processes in their daily work with young people. Staff knew how to make alerts when safeguarding issues arose. Staff discussed safeguarding daily as part of their risk meetings. Staff we spoke with told us they had good links with the safeguarding lead at the trust who supported them with guidance. Staff could consult with the specialist safeguarding lead Monday to Friday during office hours. The specialist safeguarding advisors provided a monthly drop in service at the Brookside unit.
- YPHTT staff raised safeguarding issues during appointments and agreed plans with the young person to manage and reduce their risk.
- Staff were knowledgeable regarding the range of risks that could impact negatively on a young person. Staff had undertaken additional training to recognise child sexual exploitation and patient records showed that staff from both teams had liaised with other agencies to protect the young person. For example, the inpatient unit had admitted some young people with gang affiliations onto the ward. The staff had discussed this with the trust's safeguarding team and had liaised with police for advice.
- Staff recorded safeguarding alerts in a tracker that described the alert and what the outcome was. Safeguarding information was also recorded in the young people's care records. The teams had access to multi-agency safeguarding hubs that included police officers, local authority staff and teachers.

Staff access to essential information

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

- All information needed to deliver patient care was available to all staff when they needed it and was in an accessible form. The patients' electronic records contained the care records, risk management plan and daily progress notes. Staff used paper records to record the young people's vital signs. The staff then transferred the readings to the young people's care records. The staff were aware where the information on patient care and treatment was located. Staff said they could locate information easily. This had improved since the previous inspection in October 2016, when we found that there were inconsistencies in where this information was recorded.
- Whenever possible the ward used bank and agency staff that were familiar with the patient group, the protocols and the records systems. The ward ensured that bank and agency staff could access electronic records.

Medicines management

- Good medicines management processes were in place and followed by all staff. Staff had access to medicines disposal facilities, including sharps bins and pharmaceutical waste bins, which were all dated appropriately. Consumables such as dressings, needles, syringes, and blood bottles were in date. Medicines were stored securely in locked cupboards and a locked fridge within a locked clinic room. Emergency medicines (naloxone, flumazenil, and glucagon) were stored in the clinic room and there were signs to show staff exactly where to find them.
- Staff recorded minimum, current and maximum fridge temperatures daily. When the readings were out of the required range we saw that appropriate action was taken. Staff recorded ambient temperature readings each day. When the clinic room was too hot (above 25°C), we saw that appropriate action was taken. The trust had a policy to reduce the expiry date for medicines affected by temperature rises.
- Staff ensured that patients received medicines for short term leave in a timely manner. Staff working in the YPHTT were able to administer medicines up to three times a day for patients (and their families) that were unable to do this independently. Staff from the YPHTT transported medicines in secure bags.
- Staff were able to access medicines information via the trust intranet. The Lead pharmacist for CAMHS attended

quality and safety meetings. We saw that a pharmacist had screened all the prescription charts, and had made appropriate clinical interventions. Prescription charts did not have the patient weight recorded on them. However, staff told us that these were recorded in a separate folder on admission and checked weekly.

- The ward kept one controlled drug (CD) which was handled in accordance with legislation. Suspected illicit substances were recorded in the CD register and reported to the police. We saw that all medicines were in date. All but one opened liquid medicine had an expiry date sticker attached and completed. Ward staff completed a monthly expiry date check in line with trust policy.
- The management team at the unit had taken the decision to have a separate medication room as a result of learning from reported medicines incidents. Medication errors had reduced as a result of having two separate rooms. Staff ensured that young people had their medicines administered in private in the medication room. Staff checked the name and dose of medication with the young person and it was signed off on the drug chart. Drug charts had the allergies noted and a photograph of the young person attached to it. If young person refused to have their photograph taken, the staff member administering the medication checked the young person's date of birth. To minimise the risk of young people receiving the wrong medication bank/agency did not administer medication.
- Ward based staff monitored medicine incidences. Between April 2017 and June 2017, there had been six medicine incidents on the ward. Two of these incidents related to the patient or carer administering the medicine incorrectly. One incident related to missing medication, two incidents related to the medicine process not being followed or the authorisation being incorrect, and the sixth incident related to a patient refusing their medication.

Track record on safety

- There had been no serious incidents on the ward or in the YPHTT between 1 January 2017 and 30 June 2017. Staff across both teams were able to describe recent

Are services safe?

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serious incidents that had occurred in other parts of the trust. Staff outlined how they had used the learning from these incidents to improve safety in their respective teams.

- The trust also used the learning from national reports and provided guidance and policy documentation to staff. For example, the National Guidance on Learning from Deaths identified that there was a lack of documentation of the assessment of the patient in care records. In all the care records we reviewed during the inspection from both teams, we found that staff ensured that the assessments were holistic, detailed and updated on a regular basis. Staff had embedded the learning from the guidance into their day to day practice.
- In comparison to the previous year, there had been a decrease in incidents. The majority of incidents were self-harm and related to a small number of high risk patients. There were 167 incidents of violence and aggression towards staff and patients since the ward had reopened. There were 22 incidents of violence and aggression towards staff in the YPHTT. The trust monitored all incidents of violence and aggression. Between 1 January 2017 and 30 June 2017, there had been a decrease in incidents of violence and aggression. For example, in January 2017 there had been nine incidents of patient to patient violence. In June 2017, there had been four incidents. With regards to incidents of patient to staff violence, there had been 20 incidents in January 2017, this had decreased and in June 2017, there were eight incidents of violence.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and what should be reported. Staff reviewed incidents that occurred within the previous 24 hours. Staff discussed these incidents in handover meetings and risk meetings. Staff used these meetings to agree management plans and update care plans, crisis relapse plans and discuss how to mitigate the young person's risk. The managers in both teams reviewed incident forms to ensure staff completed incident reports in an appropriate manner. Staff said they felt supported by their colleagues and managers when incidents occurred. Managers made themselves available to staff to provide a debrief. The trust was able to provide staff with counselling if this was required.
- The trust shared information from other parts of the organisation regarding serious incidents. For example, the trust had circulated an infographic regarding the dangers of black bin bags because of an incident of self-harm. The infographic detailed what had happened, why it had happened, human factors which included failures and what needed to happen to minimise the risk of a similar incident re-occurring. Staff working in both teams made sure that black bin bags and other plastic bags were not brought onto the ward environment.
- All staff had a good understanding of the duty of candour. This duty was introduced in April 2015. It requires staff to provide people who use services with reasonable support, truthful information and an apology when things go wrong. There was evidence that staff from both teams had adhered to this duty in the work they undertook with young people and their families.

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 nine patient care and treatment records. These demonstrated that staff from both teams completed a comprehensive assessment of the patient at, or soon after, admission. When the inpatient unit was inspected in October 2016, we found that the initial assessments did not cover all the areas relevant to young people. During this inspection, we found that the assessments were comprehensive, person centred, recovery orientated and relevant to the needs of young people. For example, we found evidence of staff assessing the possible risks of sexual exploitation, substance misuse as well as other vulnerabilities. Staff updated care plans on a regular basis in collaboration with the young person. This ensured that the care plans remained focused on the young person's needs and supported their recovery.
- Staff completed baseline physical health checks when young people were admitted. We saw that recording of physical health checks had improved since the last inspection and that this information was consistently recorded. Staff undertook vital sign monitoring where indicated. We saw one example of a patient who was given an intramuscular olanzapine depot injection for the first time. Baseline physical observations were completed. In addition, we found that post dose observations were also completed. For another patient, we found that the staff had administered an ECG and screened the young person for illegal drugs and alcohol. All the records we reviewed showed that staff undertook regular reviews of the patient's physical health and responded appropriately when there were changes in the young person's health. Where young people refused to have their vital signs, the staff ensured that they recorded this on the young person's care records.
- Outcome measures were integral to clinical practice. A number of assessment tools were used. Staff used Health of the Nation Outcome Scales Child and Adolescent Mental Health (HoNOSCA). The assessment focused on the young person's general health and social functioning. Staff used it to assess the severity of each problem at the beginning of treatment and at the end to measure whether there had been any improvement as a result of treatment. There were also other outcome measures used throughout the young person's treatment journey. These included strength and difficulty questionnaires, post traumatic stress disorder questionnaires and inventories to measure levels of depression. Staff reviewed and discussed treatment outcomes with the young person and their families on a regular basis to measure the progress that the young person had made. They also used the treatment outcome measures to inform future care planning.
- A wide range of therapies were available, including family work, psychology, occupational therapy and cognitive behaviour therapy. The psychology team matched interventions offered to the needs of the patient group and took a holistic approach. For example, the staff offered parents and carers individual psychological support. The psychology team offered three psychology groups per week on the ward, and those who were being supported by the YPHTT could access 1-1 support. At the time of the inspection, the team had adjusted their inpatient provision and were running a hearing voices group and a therapeutic arts and crafts group during the school holidays.
- The occupational therapy (OT) department were able to offer a full programme to young people who were being cared for by both teams. For example, OT staff completed sensory profiles with young people to assess how the child responded to a range of sensory inputs. Ward based OT activities supported the young people to develop life skills. During the inspection, we attended an OT cooking session where young people were cooking food that they had grown in the gardens at the Brookside unit.
- The trust had a no smoking policy on all its sites. The policy sought to support a healthy working environment and facilitate the current and future health of employees, patients and visitors. Nicotine Replacement Therapy was offered to young people to support them in

Best practice in treatment and care

- Clinicians considered national institute for health and care excellence (NICE) guidelines when prescribing medication and used them to inform treatment pathways, particularly the use of psychological therapies. We saw that the weight of patients had been taken into account when prescribing medicines

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managing their smoking whilst they were admitted to the inpatient unit. Where young people had issues with drugs or alcohol, both staff groups liaised with the local young people's drug and alcohol teams.

- Staff were committed to improving the work they undertook to support young people. Staff participated in clinical audits. For example, staff had undertaken an audit of how staff had responded to safeguarding concerns in the inpatient unit. The audit identified that staff did not always recognise issues of child sexual exploitation. The managers working in the unit were implementing plans to ensure that staff confidence and competence in this area was improved. Staff had also undertaken an audit of missed medication doses. The audit showed 100% compliance with regards to recording missed doses. The staff group from both teams were beginning to identify quality improvement projects that were relevant to the work they were undertaking.

Skilled staff to deliver care

- Both teams had a wide range of disciplines. This included doctors, psychologists, nurses, occupational therapists, teachers and a pharmacist along with other visitors such as the fitness instructor. The service was in the process of recruiting a social worker.
- Staff had the qualifications and skills they needed to carry out their roles effectively. Newly qualified nurses had a year-long preceptorship. This meant that nurses had support from a more experienced nurse to make the transition from student to develop their practice further. This process also supported nurses to develop their knowledge and skills in delivering patient-centred care. Staff also had opportunities to attend leadership conferences and encouraged nursing assistants to undertake registered nurse training. Nursing assistants had also received training in phlebotomy and how to administer an electrocardiogram.
- Some staff members in both teams had received specialist training in addition to mandatory training. This included training in child sexual exploitation, domestic abuse and Prevent. In conjunction with the safeguarding specialist, staff were expanding their knowledge regarding harmful sexual behaviours based

on the Barnardo's report "Now I know it's wrong". This was because the report had identified that children and young people with mental health problems were at risk of engaging in harmful sexual behaviours.

- The modern matron and care pathway lead recognised the importance of continued professional development and ensuring that staff were involved in identifying ongoing training, to enhance the skillset of the staff group. For example in the unit business meeting in May 2017, they had encouraged staff to identify training that would be beneficial.
- Staff received regular supervision to discuss case management, to reflect on and learn from practice, and for personal support and professional development. In addition, staff were offered specialist safeguarding supervision. There was an expectation that staff from both teams would attend a minimum of four safeguarding supervisions per year. The compliance with safeguarding supervision at the time of the inspection was 100% across both teams.
- The appraisal completion rate was 85%. Both teams had staff that had been in post less than 12 months whose performance had not yet been appraised.

Multi-disciplinary and inter-agency team work

- Staff from both teams had daily team handovers between shift changes and discussed the needs of current patients. In YPHTT handover, the primary nurse and named doctor for each patient provided the update. The discussion was comprehensive and individualised. Staff identified what support was required for the young person. For example for one young person, the team made a decision that they should only be visited by male members of staff.
- The YPHTT used handover meetings to review and discuss the young people on their caseloads. At the point of the inspection there were eight young people being supported by the YPHTT.
- There were weekly business meetings, which was attended by a range of staff including members of the administration staff and education. These meetings were minuted and tasks were allocated to individual team members to action. We reviewed three sets of minutes and there was evidence that actions were followed through and it was noted on the minutes when the actions had been completed.

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.

- Both teams worked well with other teams within and external to the trust. Staff invited colleagues from the local CAMHS community teams to CPA review meetings along with local school representatives and social care. Staff liaised with social care where necessary.

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

- Eighty-six per cent of staff had been trained in the Mental Health Act (MHA). All the staff we spoke to had good working knowledge of the Act.
- In the records we scrutinised there was evidence that young people were informed of their rights on admission. There was evidence of staff regularly revisiting rights with the young people.
- If staff were unsure about aspects of the act they were able to get support from the trust MHA office. Advocacy services were available at the unit and staff could link patients into these.
- The MHA paperwork was accessible and available on the ward.

Good practice in applying the Mental Capacity Act

- The Mental Capacity Act (MCA) applies to young people aged 16 and over. For children under the age of 16, staff applied the Gillick competency test. This recognised that some children might have a sufficient level of maturity to make some decisions themselves. Ninety-three per cent of staff had been trained in the MCA. Doctors on the unit took the lead on issues of capacity. Since the previous inspection in October 2016 there had been improvement. During this inspection, we saw that issues of capacity were promptly assessed. Where a patient's capacity to make a specific decision had been assessed, this was documented appropriately in their care records.
- The trust's rapid tranquilisation policy contained information for staff regarding consent, it directed staff to the 'consent to examination and treatment policy' as children were subject to special rules. This meant that staff were made aware which was the correct legislation they should be using when working with this patient group.

Are services caring?

Outstanding



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

Our findings

Kindness, privacy, dignity, respect, compassion and support

- Staff were highly motivated to provide care that was kind and promoted patient's dignity. We observed strong, positive interactions between staff and young people. Staff showed compassion for the young people that they worked with. Staff discussed young people with respect and concern at handover meetings and were knowledgeable regarding patient needs. For example, one particular patient became distressed when they heard loud noises, staff ensured that when the fire alarms were being tested that they took this young person into the gardens to ensure that the loud noises did not upset them.
- Staff recognised the need to deal with the 'whole person' and took into account their personal, cultural, social and religious needs into account. The young people and their parents came from a diverse range of backgrounds and a variety of needs. All the staff we spoke to stated that a culture of openness and acceptance was encouraged. They stated that would be confident in raising any concerns about disrespectful or discriminatory behaviour without fear of the consequences. They stated that if there were concerns within the patient group that they could raise concerns in the community meeting or during patient 1-1's. Similarly, if the concerns were within the staff group they would raise concerns directly with the colleague or use forums like the business meetings or reflective practice.
- Staff were fully committed to working in partnership with patients and making this a reality for each person. The staff group ensured that young people were supported both on the ward and whilst receiving care and treatment from the YPHTT. For example, staff and young people on the ward met on a daily basis in the morning for a mutual help meeting. The meeting gave both staff and patients the opportunity to thank individuals for anything they had done for them since the last meeting. In addition, staff used this meeting to explain things that might have happened recently on the ward that might be confusing or distressing. This

mutual help meeting assisted the ward community to understand each other's behaviour. The times and dates of the mutual help meeting was advertised on the ward timetable and it was voluntary.

- Young people, parents and carers said that the staff from the YPHTT were responsive to their needs. They said that when in difficulty, staff responded swiftly and provided them with the support they required in a crisis.
- The young people we spoke with felt that that the service had exceeded their expectations. They were highly complimentary about staff, they said they received excellent care and that staff were 'amazing'. All the young people we spoke with stated that they felt safe and that the ward environment was nice. Young people also said there were plenty of activities.
- The service had an admission pack and admission suite at the front of the building. Staff had worked in collaboration with the young people at the unit in developing this handbook. Staff had recognised that any further amendments to the book should be done in collaboration with the young people. For example, in the May 2017 business meeting, staff noted that the booklet had been amended and this should be discussed with the young people in the next community meeting.
- The PLACE assessment had scored the ward 86% for privacy, dignity and well-being.

The involvement in receive

Involvement of patients

- People's individual preferences and needs were reflected in how care was delivered. Prior to agreeing to admission young people could visit the ward with their parent/carers. This visit allowed young people and their parents/carers to meet with the staff and see the ward environment. The inpatient ward had an admission pack and admission suite at the front of the building. Staff would go through admission issues and give new patients a tour of the ward.
- Young people who were being cared for by the home treatment team were provided with biographies and photos of the team that would be coming to visit them. This helped to break down potential barriers as the young people could recognise the team and their differing roles.



Are services caring?

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

- When the service was inspected in October 2016, we found that although staff recorded the views of young people it was brief with limited information. During this recent inspection in August 2017, we found that the recording on care plans had improved. The care records for both teams were comprehensive and detailed. The records we reviewed showed that staff had in depth discussions with young people. Staff recorded the views of the young people in the words of the young person. Staff reviewed care plans on a weekly basis with the young people. Staff gave young people copies of their care plans. Where appropriate, staff discussed the contents of the care plan with the young person's parent/carer.
- Young people could become involved in the recruitment of staff for example by sitting on interview panels. Staff from the trust's patient experience partnership supported young people who wanted to become involved in recruitment.
- The staff at the unit had given thought to the needs of the young people and how best to ensure that they could become involved, feel empowered and express their views. The ward used a parity model for their community meetings. This demonstrated that staff had thought about the possible power imbalance during community meetings and ensured that the number of staff who attended the community meeting matched the number of young people who attended. The young people on the ward held a community meeting once a week. The meeting allowed the young people to discuss issues that were relevant to them and provide some input into the running of the unit. For example, the issue of the food was raised and its poor quality was raised consistently in meetings. The community meeting minutes did not always clearly identify who was responsible for completing the actions identified in the meeting. As a result, it was not always clear whether the issues raised by the patients in these meetings had been resolved. In addition, the inpatient unit had a suggestion box for young people on the ward.
- Young people on the ward had access to an independent advocacy service, which provided support in relation to their care and treatment whilst in hospital. Staff working in the YPHTT also ensured that young people using that service received information

regarding the advocacy service. Once a month, the advocate attended the unit and held an advocate forum. The advocate facilitated and fed back comments, questions and concerns.

Involvement of families and carers

- Young people, their families and carers were active partners in their care. Patients and their families routinely attended CPA meetings to plan for their discharge from the inpatient ward and YPHTT.
- Staff working in the YPHTT undertook home visits in pairs. This meant that one member of staff could spend time with the family/carers giving them individual support whilst the other member of staff spent time with the young person. Six carers provided feedback as part of the inspection. Five carers were very complimentary about the care and support that was being provided. These carers felt that they were fully involved in the care that their child was receiving and could speak to the staff about any concerns they had. One carer was dissatisfied with the service and felt they had not received the support they needed. This carer had raised their concerns directly with Brookside management.
- When the service was inspected in October 2016, we found that the inpatient unit was in the process of developing a survey for families and carers to give feedback on the service. During this inspection, we found that both the inpatient unit and YPHTT were using the trust's feedback survey. Each month a senior member of staff from each service contacted a minimum of five randomly selected service users or carers by telephone to ask them five key questions about their experience of care. In August 2017, 67% parents and carers who were being supported by the inpatient unit said that they were likely to recommend the service and 33% of parents and carers using the YPHTT said they were extremely likely to recommend that service. None of the respondents said they were unlikely or extremely unlikely to recommend the service. One hundred per cent of parents and carers said that they found it easy to get care, treatment and support from the inpatient unit. Sixty-seven per cent of parents and carers who were being supported by the YPHTT said they found it easy to get care and treatment from that team.

Are services caring?

Outstanding



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

- Twenty one compliments had been received by the Brookside team between 1 January 2017 and 30 June 2017.
- Both the ward staff and YPHTT were considering how to provide additional support for carers, for example through a carers forum, however, they had not set date for the forum to start.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

Bed management

- Brookside unit and the YPHTT were commissioned as Tier 4 services, to provide specialist in-patient care or 'hospital at home' to children who were suffering from severe and/or complex mental health conditions that cannot be adequately treated by community CAMH services. The YPHTT was commissioned to provide acute home treatment for young people whose mental health crisis was so severe that they would otherwise have been admitted to a hospital. The YPHTT helped to prevent inpatient admission for young people. The YPHTT offered care and treatment in the least restrictive setting.
- Brookside inpatient unit mainly admitted young people locally from CAMH services within the trust but were able to admit young people from outside of the local area if necessary. The Interact service which was part of the tier 3 community CAMH service was able to fast track referrals for young people who presented at A&E. The YPHTT worked solely with young people who lived in the four London boroughs covered by the trust.
- The YPHTT team had processes in place to ensure that young people in priority need were identified and offered an appointment as quickly as possible. Staff could see emergency or urgent cases on the same day if necessary. Young people waited no more than 48 hours to be seen once their referral was accepted. Staff in the YPHTT worked outside of the core hours of 9am to 5pm to ensure they could support young people and their families as much as possible and at times suitable for them. Staff in this team told us that they did not cancel appointments and in the event of staff sickness, another member of the team undertook the visit.
- The average bed occupancy on the inpatient unit was 55% since reopening in September 2016. When young people went on home leave, they were able to return to their own bedrooms upon return.
- Efficient systems were in place to plan and facilitate the admittance and discharge of patients. The staff from both teams held a bed management meeting on a weekly basis. This ensured that occupancy levels on the ward were regularly reviewed and that the young people

being supported by the home treatment team were discussed. Members of the multi-disciplinary team and managers attended the bed management meeting. During the meeting, staff reviewed new referrals, current inpatients and all the young people in the YPHTT and identified what additional interventions were required to facilitate discharge. If a young person was an inpatient and was deemed suitable for transfer to the YPHTT this was also discussed. Similarly, if young people who were being treated by the YPHTT needed an inpatient admission this was discussed and planned for.

- Managers for both teams felt confident that they could refuse an admission if it was believed that it would have a negative impact on the current patient group or the prospective new admission. For example, during the bed management meeting we observed the staff discussing the care and treatment required for a young person aged 12 years. Staff expressed some concern regarding the suitability of the inpatient unit for this young person, as the current patient group was much older. Staff identified another inpatient unit in another trust that had a young inpatient group, which might be more suitable. For patients who had obsessive compulsive disorder, staff recognised that an inpatient admission might be detrimental, ward based staff liaised with the YPHTT to plan how to support these young people within the home environment.

Discharge and transfers of care

- From June 2016 to June 2017, 22 patients experienced a delay of discharge. The total was 396 days. However, this included the period the trust had closed the unit between June 2016 and September 2016. At the time of this inspection, the average inpatient stay was 22 days. Where patients discharge was currently delayed, staff had oversight of this and actions were in place to progress these.
- Members of the multi-disciplinary team, managers from the inpatient unit and YPHTT in addition to the matron and care pathway lead attended the weekly bed management meeting. The staff group discussed delayed transfers of care at this meeting. Where staff identified delayed transfers of care, the blockages for discharge were discussed and plans made to engage with external stakeholders to support these young people. Staff worked in collaboration with these stakeholders to make plans for transfers of care to

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Good 

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appropriate placements. For example, a young person was being transferred to adolescent mental health unit abroad. Staff had liaised with that unit to ensure that they were fully aware of the needs of the young person. A member of staff was travelling abroad with the young person to provide support and facilitate the transfer from Brookside to the hospital abroad.

- Staff reported and there was evidence in the care records of both teams that plans for discharge were made as soon as the young person was admitted. Staff discussed discharge planning in ward rounds and 1-1 meetings with patients. The staff clearly documented details of planned discharge. Young people told us they were aware of and involved in discharge planning. Staff prioritised the ongoing care needs of young people when making plans for discharge. These plans included ensuring that young people were discharged to the right place and the right time to support their continued recovery. Staff were working with the recommendations of "Future in Mind" and working jointly with other services, sharing good practice and consistently involving the young people and their carers.
- If a young person was ready for discharge but had not completed all aspects of their OT or psychology care plan the staff group continued to support them after discharge until those interventions were completed.
- Two external professionals told us they were impressed with the quality of care provided by the inpatient service and that staff were focussed on the needs of the young people. Staff from the young person's community mental health team said that both the inpatient service and the YPHTT were very responsive and staff provided information readily. They received regular invites to meetings from both teams regarding young people who were being transferred to their service.

The facilities promote comfort, dignity and privacy

- Recovery was a key priority for both teams. In the ward, area there was a notice board with patient quotes. The quotes were intended to inspire the young people and their parents and carers. The quotes emphasised the importance of recovery and wellness.
- Each young person had their own bedroom, which they could personalise if they wished with posters, plants and their own bedding. The trust had decorated some

of the bedrooms with murals that were soothing. If a young person had sensory difficulties, staff ensured that they were given a bedroom without a mural that was minimally decorated.

- Young people had displayed information about themselves on their bedroom doors. This included how they would like to be woken up in the morning. Each bedroom had somewhere that young people could store their possessions.
- The unit had a range of rooms that both staff and patients could access. These included therapy rooms, activity rooms and a clinic room to examine patients. There was a gymnasium on the unit. Young people had access to outdoor exercise facilities, for example tennis courts, which were located within the gardens of unit. Staff could accompany young people on walks. There was a well-equipped sensory room, which offered a space where young people could go if they were feeling stressed. The OT team were planning to plant a sensory garden. There was a large lounge and dining area, which was bright and young person friendly. This area had comfortable soft furnishings, a pool table, a television and other activities. The ward had a laundry. Staff supported young people to do their laundry because young people were not allowed to be in the laundry room unsupervised.
- There were quiet areas on the ward and a room where patients could meet visitors. There was a visitor room located in the reception area. The room offered a private space for visitors to the unit.
- The unit had a family suite for families who wished to stay at the unit overnight. This was particularly helpful for visitors who had to travel some distance to visit their loved ones. The family accommodation was adjacent to the ward but was self-contained. Visiting families accessed the unit via separate entrance. The accommodation was comfortable and well furnished. At the previous inspection in October 2016, we found that young people did not have facilities to hang their towels when using the bathroom. During this inspection, we saw that this had improved and no patients raised this as an issue.
- Young people were allowed to have mobile phones subject to an individual risk assessment. This meant that they could make phone calls in private. Young

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people and staff had collaborated to identify rules should be put in place regarding the use of phones, for example not using the phone to film others. Chargers were kept in the nursing office due to issues of risk. The ward area also had two computer tablets, which young people could use.

- At a previous inspection in October 2016, we found that some meal choices were not available in sufficient quantities. During this inspection this had improved, however, patients said that the quality of food was poor. Whilst the PLACE assessment scored food highly at 98%, this was not reflective of the feedback we received from young people. We spoke to five young people all of whom stated that the food was poor. All the comment cards received from young people highlighted that the food was of poor quality. The young people on the ward had spoken to staff regarding the quality of the food. Managers and staff were working to improve the quality of meals.
- When the ward had re-opened in September 2016, the staff had consulted with the young people regarding the menu. When we inspected the ward in October 2016, the young people said that the food was satisfactory.
- The kitchens on the wards were kept locked. Young people had access to bowls of fresh fruit and hot and cold drinks.

Patients' engagement with the wider community

- Staff supported young people who were admitted to the ward to maintain contact with their family and friends. Young people under 18 were not allowed to visit the ward without an adult. Young people were encouraged to identify individuals who were important to them and their details were added to a list of visitors. Care records showed that staff regularly communicated with families and encouraged them to visit the ward often as possible. Parents and carers told us staff were very welcoming when they visited the ward.
- The trust recognised the importance of ensuring that young people did not miss out on their education. The inpatient unit had a school based on site and the education staff were fully integrated into the multi-disciplinary team. Young people were encouraged to participate in education as much as possible. The school was well-resourced and had permanent staff. The teaching staff offered educational activities tailored

to the individual needs of the young person. Staff ensured that there was a range of age appropriate educational activities, which were offered during term times.

- In July 2017, the school in conjunction with the trust and with agreement from the ward had extended the length of the school day. If a young person who was on the ward was not well-enough to attend the school, teachers were able to provide them with work for them to complete outside the school environment. For young people who were being supported by the YPHTT, staff were able to accompany these young people to school and provide them with support during the school day. This helped to allay any anxieties these young people may experience in the school environment and provided the member of staff with the opportunity to assess how the young person was able to cope in the school environment. We saw evidence of this in care records. For example, a staff member had recommended that a specific young person would benefit from transferring to another school, which could offer a more supportive environment.

Meeting the needs of all people who use the service

- Staff considered the comprehensive range of needs of young people and their families at all times and made every effort to meet these needs. Eighty-eight per cent of staff had completed training in equality and diversity. This training formed part of the trust's mandatory programme of training.
- The Brookside building was accessible to people with physical disabilities. Individuals with impaired mobility could use ramps and the building was single storey. The doors to the ward were wide enough for wheelchairs and there was non-slip flooring throughout the building. The family suite was equipped with ramps to the front door.
- At the previous inspection in October 2016, we found that information in other languages was not displayed. During this inspection, we saw that for patients and their carers whose first language was not English, staff provided information in different accessible formats. Staff used interpreting services for young people and parents/ carers whose first language was not English. Staff could organise interpreters quickly. When

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appropriate staff would organise separate interpreters for young people and their parents/ carers for joint meetings to ensure impartiality and to ensure that each party had their own voice.

- When the inpatient service was inspected in October 2016, we found that there was also a lack of information relevant to young people on display on the ward. During this recent inspection, we found that the staff group had ensured that there was ample information available relevant to young people. For example, there was information specifically aimed at young people regarding mental health.
- Staff promoted not only mental well-being but also recognised the importance of physical well-being. There a range of sports facilities on the Brookside site and there had been a sports day held at the unit in July to celebrate health and well-being day. Both staff and young people had participated in the event.
- Teams demonstrated an awareness of religious and cultural needs. The inpatient unit had a contemplation room with a prayer mat and religious texts.
- Transgender young people were well supported and placed in areas of the ward that reflected their gender identity. Staff working in both teams had accessed training and had undertaken a continued professional development session on gender identity. A member of the clinical psychology team had completed a thesis on gender identity. Staff had worked with a young person to formulate a list of preferred pronouns. Staff had circulated the list amongst the staff group including those who worked on the bank. Some staff from the ward had supported a patient to attend PRIDE and there was information on the ward for young people who were lesbian, gay, bisexual or transgender.

- Staff on the ward sought to promote positive images of women and their achievements. The ward had celebrated international women's day in March 2017. There was visual display on the ward of women who had achieved success in the arts, sports etc.
- A choice of foods to meet patients' cultural or spiritual needs was available, which included halal and kosher foods.

Listening to and learning from concerns and complaints

- Parents and young people said they knew how to make a complaint and felt comfortable speaking to staff about any concerns they might have. All staff were committed to ensuring that young people and their parents and carers had a positive experience of using services. Staff ensured that trust complaints leaflets were available in the reception area of the Brookside unit.
- Staff we spoke with from both teams were aware of the process for dealing with complaints. They told us that they aimed to resolve complaints quickly through informal processes but would use formal complaints processes should this approach prove unsuccessful.
- There had been two formal complaints raised regarding the inpatient unit and no complaints raised regarding the YPHTT. Both complaints related to patient on patient abuse. Neither complaint was upheld.
- The young people on the ward had made a number of informal complaints regarding the food on the ward. The ward manager and modern matron had acted upon this and were working with the young people and the catering team to improve the food that was offered.
- Staff received feedback on complaints in MDT meetings.

Are services well-led?

Outstanding



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Our findings

Leadership

- The local leadership was strong and strove to deliver and motivate staff to succeed. Leaders of the service had a shared purpose, which inspired and motivated them and other staff to deliver the highest quality care. The managers of both teams, the modern matron and the clinical pathway lead were based at the Brookside building. Staff from both teams said these managers were visible and approachable. Leaders had appropriate knowledge, skills and experience of working with young people with mental health difficulties. A number of the managers had long standing experience of the service and had been key in redeveloping the service, making the improvements identified at the October 2016 inspection and driving further improvement.
- The trust's senior management team were visible and visited the unit. The clinical pathway lead, modern matron, team leader and ward manager ensured that they made themselves available for patients. For example, they participated in ward activities and the ward manager undertook nursing shifts on regular basis. All the managers we spoke with were knowledgeable regarding the work of both the inpatient unit and the YPHTT. They were able to describe clearly how the work of both teams complimented each other and how they ensured that they offered quality care to young people.
- The leadership drove continuous improvement that staff delivered. Staff in both teams felt supported and said that the trust had invested time and provided quality training to them in order to improve the quality of services.

Vision and strategy

- Trust values were on display in services and staff were able to describe how these values were embedded in the work they undertook with young people and their families. We observed staff at all levels behave in ways that reflected the trust vision, purpose and commitments. For example, one of the trust's values was to put people first. In the meetings we attended for both teams, staff ensured that all discussions focused on patient need.

- Staff from both teams demonstrated a strong commitment to supporting the young people they were working with. Staff supported each other and had a culture of openness in which they could discuss challenges in their work with colleagues.
- Both teams worked collaboratively to deliver high quality care within the budgets available. Staff from the MDT worked across both teams and members of the nursing staff could work in either team dependant on patient need. This meant that there was continuity of care for young people who transitioned between the two teams.

Culture

- Strong leadership had supported and nurtured the development and embedding of a positive culture on the ward that reflected trust values and placed young people and their carer's at the centre of their care. The culture over both teams was one that strove to provide excellent care.
- The morale of both teams was extremely high. Staff commented positively regarding their colleagues and stated that they felt motivated and enthusiastic about the work they undertook. Some staff who had worked on the inpatient ward previously, said that the changes that had taken place since April 2016 had brought about real improvements for both the young people and the staff. There were high levels of staff satisfaction, many commented that they were proud of their team.
- Staff at all levels felt able to raise concerns and thought this was encouraged by leaders and the culture of the team. Staff were aware of the whistleblowing process. The trust had a Freedom to speak up Guardian. This new role was one of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS. None of the staff other than the managers were aware of the Freedom to Speak Up Guardian. This was brought to the attention of managers who said they would invite the Guardian to a staff meeting.
- Managers addressed poor performance promptly and had a process to follow if performance did not improve. Managers in both teams felt supported by other departments in the trust to deal with human resource issues.

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- Staff reported that their managers and the trust respected their individual needs and supported them in terms of career progression. The trust had won an award for taking steps to promote equality and diversity for black and ethnic minority staff with the implementation of its ethnic minority staff network strategy.
- The trust had celebrated the re-opening of the unit and findings of the last inspection. The trust had an official re-opening of the unit in March 2017 and the deputy mayor of London had attended the ceremony. At a local level, the teams had also celebrated their success.

Good governance

- There were systems and processes in place to ensure that the quality and safety of both the inpatient unit and YPHTT was assessed, monitored and improved. Staff from both teams attended the Brookside quality governance meeting each week (BPQSG) which fed into a directorate level quality assurance meeting. The BPQSG reviewed issues relevant to both the inpatient unit and the YPHTT. For example, in August 2017, the managers reviewed compliance rate for safeguarding supervision. Managers ensured that relevant information from governance meetings was shared with the staff group. We identified a number of minor procedural lapses in governance systems, which were escalated and addressed by managers.
- The service lead and modern matron for the Brookside unit produced six monthly quality risk profile reports. The reports triangulated information from the trust's systems to provide the service with a profile to drive up quality. The report was used to make recommendations for improvement across both the ward and the YPHTT. For example, the most recent report dated 1 August 2017, recommended that staff look at the trends in self-harm incidents to identify patterns.
- Both quality assurance groups had a presence from the executive team. Managers discussed significant issues pertaining to both teams during board meetings. For example, in February 2017 the board had discussed increasing the numbers of young people who could be admitted to YPHTT from 15 to 17 and incidents that had taken place on the ward. In March 2017, the board had discussed safer staffing on the ward. Managers shared information from these governance meetings with staff in local teams.
- Managers at all levels used the governance meetings to review the range of audits that were taking place and to identify where there were areas for improvement. The managers for both teams were planning to meet with the trust safeguarding specialists in August 2017 to discuss the findings of the safeguarding audit. They were in the process of finalising a timetable of training for staff on the CSE toolkit. Additionally the managers were looking at the quality of care plans as the audit had identified that 85% compliance for the inpatient unit and 87% for the YPHTT in May 2017. They had noted that the care records did not always record whether the young person had been offered a copy of the care and this was an area of practice that required improvement. Both teams had a target of 90%. Managers had looked at the obstacles to achieving the target and what was required to overcome these obstacles. For example, they had noted that YPHTT had difficulty in achieving the target because the care plans did not change as frequently as on the ward. The managers were going to adjust the audit documentation to reflect this difference between the inpatient unit and the YPHTT.
- Both teams used learning from deaths, incidents and complaints to improve the service. For example, because of serious incident on an adult ward the inpatient unit had reviewed the list of contraband items allowed on the ward. As a result of the review, plastic bags were not allowed on the wards, because they were a ligature and asphyxiation risk.
- The inpatient team and YPHTT had a strong collaborative focus, which extended to their relationships with other stakeholders. Leaders liaised with external bodies. Managers regularly met with commissioners to discuss both services and ensured that there was clear communication. Managers from both teams worked closely with their colleagues in community CAMHS. These colleagues attended some of the meetings, including the BPQSG.

Management of risk, issues and performance

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- Staff said they could escalate issues of concern. There were a range of options for this including business meetings, supervision or approaching the manager outside of these formal meetings. All the staff we spoke to said they would raise issues without delay.
- The Brookside unit had a comprehensive business continuity plan. This was dated January 2017 and was due to be reviewed annually. It identified what action the trust should take in the event of a disruptive event. For example, if the building became unusable, the plan gave details of alternative site and the arrangements for transporting patients to this site. The emergency contact details of key staff were noted on the plan.

Information Management

- Both teams had systems to gather data, which could be used to gauge performance. None of the staff said that data collection was an onerous task. Staff had access to equipment and technology to assist them in undertaking day to day tasks. Staff from both teams could access information easily. Managers used data collection to provide quarterly reports to commissioners. The data provided covered incidents, safeguarding, complaints, restraints, staff training and serious untoward incidents. The managers reviewed data on a monthly basis in the trust's monthly governance meetings.
- The trust provided staff with information governance training. To ensure that staff kept patient information confidential, electronic case records were password protected. There was a clear desk policy in operation and whiteboards with patient information could be covered so that it could not be seen by patients or visitors to the building.

Engagement

- The trust provided staff with information through the intranet and bulletins. The trust made good use of social media to keep the public informed of the work they were undertaking to support patients. For example, the trust had used social media to advertise an event on how digital technology could be used to support young people involved in CAMHS. In addition, the trust had a short film regarding the inpatient unit on YouTube.
- Innovative approaches were used to gather feedback from people who use services. NHSE had recognised

that the 5x5 feedback survey (Friends and Family test) was an innovative method to gather feedback. The trust had begun piloting this in 2013. Brookside staff gathered feedback from parents and young people in a variety of ways including using the 5x5 survey. There was also a suggestion box in the reception area of the Brookside building.

- Leaders understood the importance of consistently engaging and involving staff in decision making regarding improvements. In addition to regular team meetings, managers had organised an away day for both teams in July 2017. The day had been used to strengthen the team through activities and reflect on the work that the staff group undertook to support the young people.
- The trust were also committed to improving quality and were having a trust improvement week in September 2017. As part of this they were inviting staff to think about what things could be changed to improve the experience of patients using the trust's services.

Learning, continuous improvement and innovation

- The staff group were committed to wanting to improve through innovation and continuous learning. The inpatient unit was in the process of applying for accreditation from the Royal College of Psychiatrists. To achieve accreditation the unit would have to demonstrate a number of quality indicators had been met. For example, that the environment was appropriate for young people, that staffing levels were sufficient, they were well trained and that young people and their families were fully involved in decisions regarding care and treatment.
- As well as seeking external accreditation, the unit was also looking at improving quality through quality improvement projects. The unit were planning to undertake a project to improve the young person's experience of care planning. A member of the nursing staff and a young person were working together on the quality improvement project. The project was focused on ensuring that young people felt more involved in the development of their care plans.

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- The trust were discussing the evaluation of the YPHTT model and were waiting for 12 months data before they could start this process. Staff were looking at which research model to use. The trust aimed to publish their research once completed.
- The care pathway lead was working with staff on the unit to identify if there was a gap in service provision for young people with emerging personality disorder.