Greater Manchester Mental Health NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

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Date of inspection visit: 17 18 and 24 January 2022
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Our findings

Child and adolescent mental health wards

Good 

We last inspected child and adolescent mental health wards at the trust in 2018. At this inspection we rated the service as good overall, with requires improvement in safe.

We visited Junction 17 and Gardener Unit.

The inspection was unannounced (the service did not know we were coming).

During the inspection the inspection team:

- Toured the wards
- Interviewed the ward managers and the senior leaders within the service
- Spoke with Children and Young People who were using the service
- Spoke with carers of Children and Young People using the service
- Spoke with other staff members including, nurses, doctors, junior doctors, psychologists, family therapist, art therapist, music therapist, domestic staff, support workers, occupational therapy staff, the headteacher of the school and the wellbeing lead
- Attended and observed a multidisciplinary meeting
- Looked at the care and treatment records of Children and Young People on the wards
- Carried out a check of medication management
- Reviewed prescription charts
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Attended and observed ward based activities.

Our rating of this service stayed the same. We rated it as good because:

- Patient feedback about the staff was universally positive. Children and Young People told us that the staff had changed their lives and that the level of support they received had gone above and beyond what was expected of them. Children and Young People felt that staff genuinely cared about their wellbeing, and took the extra time needed to get to know them individually. Children and Young People and their families/carers were involved in all decisions about their care and treatment, and the multi-disciplinary team spent time explaining different options available to Children and Young People.
- The service provided safe care. The environment was clean, safe, well maintained and fit for purpose. The environment was in keeping with the needs of young people and was decorated and furnished to suit their needs. Risks were well managed, and staff had a good understanding of the risks the patient group posed. Risk assessments were thorough and individualised. The wards had enough staff to safely manage the patient group and staff were well trained. Medicines were managed safely, and staff had a good understanding of safeguarding procedures.

Our findings

- Comprehensive assessments were made for each patient, most started prior to the patient's arrival. There was a range of treatments available for Children and Young People which were in line with best practice guidance. There was a vast multi-disciplinary team available to young people in the service. This included a full therapy team with access to a family therapist immediately. Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment.
- Staff planned discharge well and involved outside agencies that were relevant to the Children and Young People care. This meant that discharge was only ever delayed if there was a clinical need, or due to the time some more specialised placements took to secure. The involvement of Children and Young People in the local community was important. Children and Young People were involved in local groups, attended local attractions with staff and even attended local colleges on public transport. Children and Young People were actively encouraged to be part of the local community and staff supported them to do this.
- The service was well led. All staff and even Children and Young People told us that the senior team were visible and frequently spent time on the wards, not only for meetings but to meet Children and Young People and get to know them and support the staff team. The senior team were experienced in CAMHS and had worked in them for some time. The systems in place to support staff enabled them to do their work much more easily. The team had a clear vision about the future for the service and were working hard to ensure this materialised. The passion for the service shown by the senior leaders within the service was clear for all to see and staff remarked on how this leadership and support had impacted positively on the morale of the team. All staff we spoke to were extremely proud to work within CAMHS services and wanted to ensure that they did their best for the Children and Young People who were in their care. Both wards were accredited with the quality network for inpatient child and adolescent mental health services and were involved in research to improve the service.

Is the service safe?

Good 

Our rating of safe improved. We rated it as good because:

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified.

Staff could observe children and young people in all parts of the wards.

The wards complied with guidance around mixed sex accommodation. Gardener Unit was a male only ward. Phoenix and Pegasus wards were mixed sex, but all bedrooms were en-suite. There was a single gender lounge on each ward. Bedrooms were kept separate across the two corridors with one for males and one for females.

Our findings

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. The ligature audits for both wards were complete and available on the ward for staff to access when needed. All staff we spoke to were able to tell us where the potential ligature points were located on the wards. These were mitigated using observations and by risk assessing patient access to rooms where ligature risks were higher.

Staff had easy access to alarms. The response times to alarms were low and staff told us that they felt safe on the wards. The alarm system alerted all staff in the building that assistance was required and there was a large staff presence in the building. There were not alarms in every patient bedroom. However, we discussed this with the provider who told us that there were some bedrooms with alarms that patients who were higher risk could use. The provider was looking into options of implementing a patient alarm system for both wards, in the meantime they were planning to order portable alarms that could be given to patients in order to allow them to alert staff if they needed assistance. Patient risk was managed via regular observations, thorough risk assessments and a good knowledge of the patient group. Patients who were deemed as higher risk could also be moved to bedrooms nearer to the nurses station for observation purposes.

All staff were trained in the physical management of violence and aggression. Staff who responded were also trained in immediate life support. The alarm alerted all wards on the hospital site and a response was given from each of the wards (11) if an emergency alarm was triggered.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. The wards had been adapted to make them suitable for the patient group but also to maintain safety. For example, the privacy screens on bedroom doors had pictures on that staff were able to see through. This made them appear to be a piece of artwork on the door whilst maintaining privacy for the Children and Young People and allowing staff to observe them safely. Furniture was bright and colourful whilst being suitable for the environment. This meant on Gardener Unit the furniture was weighted so Children and Young People were not able to lift it.

Staff followed infection control policy, including handwashing. We observed staff to be wearing masks throughout our visit. We were asked to wear masks whilst in clinical areas in accordance with the trust policy following the government relaxation of Covid-19 guidance.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. The seclusion room on Gardener Unit had access to outdoor space that Children and Young People could use once risk assessed to do so. The de-stimulation area just outside seclusion had artwork that had been created by a patient who had spent longer periods in seclusion. Staff told us that this had created some therapeutic activity for the patient, and this helped to relax them to see this through the seclusion room window.

There was a self soothe box in the seclusion office that staff could use with Children and Young People. For example, wipe away marker pens that were safe for patient that were used to play games such as noughts and crosses on the window between seclusion and the staff area. It also included activities such as colouring, “where’s Wally” and handheld sensory equipment. There was a welfare checklist that was completed for each patient in seclusion. This included things the Children and Young People liked, family visit times and practical items like shower gel and DVDs.

The service had secured funding for some projects such as the transformation of the old seclusion facilities into a new state of the art facility.

Our findings

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. At our last inspection, we had found that some medical devices had not been checked in accordance with the trust policy. During this inspection, we found that this had been resolved, all medical equipment had been checked and was dated as to when the next check was due. There was no out of date equipment in the clinic rooms. We found that the clinic room audits were robust and were able to quickly pick up on any errors.

Staff checked, maintained, and cleaned equipment. There was a weekly medical device cleaning form in the clinic room that we reviewed. We found all equipment to be clean and contain clean stickers with a date.

Safe staffing

The service had enough nursing and medical staff, who knew the children and young people and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep children and young people safe.

The service had low and reducing vacancy rates. There had been a recruitment event the weekend before our inspection. The event had been well attended and there had been several staff recruited into vacant posts.

The service had low rates of bank and agency nurses and healthcare assistants. Managers limited their use of bank and agency staff and requested staff familiar with the service. Typically, staff who worked permanently on the wards would pick up some extra shifts to help when there were gaps in staffing. There was also a regular cohort of bank staff who knew the wards and the Children and Young People well and had access to the trust training and electronic records system. All staff who worked on Gardener Unit needed to be key trained prior to starting work.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had low turnover rates. Most staff who left the service did so for personal development. This included going back to education, moving into a different role within CAMHS or gaining a promotion. The service operated an internal rotation pilot project. This aimed to enable nurses to rotate through vacant posts within the CAMHS service developing skills and knowledge in different clinical settings in order to reduce the number of vacant posts in the service.

Managers supported staff who needed time off for ill health. Occupational health referrals were made for staff that required support in returning to work.

Levels of sickness were low, and Covid-19 accounted for the largest proportion of absence.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. On the Gardener Unit every effort was made when planning staffing to ensure that there were enough male staff on duty as it was an all-male unit.

The ward managers could adjust staffing levels according to the needs of the children and young people.

Our findings

Children and young people had regular one to one sessions with their named nurse.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep children and young people safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Out of hours, the hospital at night team were on hand for support. This team was made up of skilled and experienced staff including senior nurses and consultants.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had generally completed and kept up to date with their mandatory training. During the Covid-19 pandemic, some courses were unable to run face to face as planned. The service had also had periods where staff were off work or isolating in accordance with government guidance. This had meant that some training had fallen below the expected levels. However, we did see that this was improving each month and that staff were booked on courses and were given time to complete online training.

The mandatory training programme was comprehensive and met the needs of Children and Young People and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers were able to show us on an electronic system an overview for their staff. This told them when training was due to expire and showed as amber if the date was near. If a staff member was in red, this told managers that the training had expired and needed to be booked as soon as possible. Managers did tend to plan and encourage staff during supervision to book on courses where required.

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the trust's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. We found that risk assessments were completed to a high standard. Staff

worked in conjunction with the Children and Young People to create a safety tool which included the patient views on what works well for them and what doesn't. These were RAG rated to show how to manage different behaviours in different situations. For example, some Children and Young People preferred to be quiet during an incident and have less staff present, others liked to talk about things other than the incident (e.g., pets or family) to help them to relax.

The risk assessments included past risks of the patient both to themselves and others as well as current risks. Incidents were incorporated into the risk assessment in a meaningful way, not just listing the incidents that have occurred but explaining what the predisposing factors were and what de-escalation plan worked well in the situation as well as the Children and Young People view.

Staff used a recognised risk assessment tool called Short-Term Assessment of Risk and Treatability tool.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. We spoke to staff during our inspection and asked them about the patient group. They were able to tell us in detail about Children and Young People' risks, early warning signs and how to de-escalate situations based on the patient's presentation. We found that staff knew Children and Young People very well and had taken the time to document small details about Children and Young People that meant they could be managed in a safe way decreasing incidents.

We were able to see how risk was discussed in various forums each day. This included handover, multi-disciplinary meetings and in one-to-one sessions between Children and Young People and staff. Some Children and Young People on the ward frequently tied ligatures, the care plans for these were particularly person centred and staff had worked closely with the Children and Young People to ensure the plan met their own personal needs during these distressing events.

Staff identified and responded to any changes in risks to, or posed by, children and young people.

Staff could observe children and young people in all areas of the wards. We attended a multi-disciplinary meeting for Children and Young People on Pegasus and Phoenix Ward. We found that patient observation levels were discussed in detail. We were able to hear how staff constructively challenged each other in order to come to an agreement about what was best for the patient. This included how higher observation levels could sometimes be detrimental to Children and Young People, whilst understanding the risks presented by reducing observations. There were spot checks carried out by senior leaders to ensure that observations were being carried out in a meaningful way. This ensured that staff actively engaged and spoke with Children and Young People when they were observing them to be able to effectively monitor their mental state.

Staff followed trust policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. When a young person returns from leave they are risk assessed and a decision is made on the degree of search which may need to be done. There were also two random searches per week of patient bedrooms on Gardener Unit. If required, some Children and Young People were asked to complete a urine drug screen on return from leave, but this was specifically care planned only for Children and Young People who needed them. On Junction 17, Children and Young People were not routinely searched, if there was a specific reason to search a patient then this was individually planned. Staff carried out pat down searches or used a wand.

Use of restrictive interventions

Our findings

Levels of restrictive interventions were low. The seclusion room on Junction 17 had been decommissioned. This was changed to a sensory room and the children and young people had designed and implemented this, they had named it "the chill zone". The healthy wards group were monitoring the impact of this and were reporting back to senior leaders at regular meetings. The use of seclusion had been low prior to the decommissioning of the room and staff and children and young people wanted to use the room as a more therapeutic space.

In September 2021, the Gardener unit had secured funding to look at improving the seclusion facility. There were ongoing discussions with estates and facilities teams about how this would look. There was going to be a media wall so that music and lighting could be changed to suit the needs of the person using it.

The use of restraint and seclusion had markedly decreased from last year to this year. The total number of PMVA incidents that required physical intervention for last year were as follows:

Phoenix Ward 435

Pegasus Ward 176

Gardener Unit 38

For this year to date (still one quarter left until the year was complete at the time of our inspection) figures were as follows:

Phoenix Ward 133

Pegasus Ward 25

Gardener Unit 10

The use of rapid tranquilisation has also decreased year on year. Last year there were:

Phoenix 50

Pegasus 23

Gardener Unit 10

This year to date (still one quarter left until the year was complete at the time of our inspection) there were:

Phoenix 4

Pegasus 7

Gardener Unit 0

Despite the Gardener Unit being a medium secure environment, there were very little restrictions other than those that are required for the type of unit. Children and Young People had access to the "cyberzone" where they could use the

internet under observations from staff. This was thoroughly risk assessed to ensure it was safe for each patient that accessed it. This was done in an individualised way, where each patient had a passport for the cyberzone, this outlined the rules of use, signing in and out procedure and a part which explained what each patient could and could not access. This was recognised in the Quality Network for Inpatient CAMHS report.

On Junction 17, there were also very few restrictions for Children and Young People. Children and Young People had access to the outdoor areas, kitchen and lounges as well as their bedrooms throughout the day. The wards did still use plastic plates and cups which were left out for Children and Young People to access. However, there was metal cutlery which was brought out for mealtimes. There had been discussions in recent ward meetings about the use of ceramic plates and cups, this was done in conjunction with the Children and Young People and at that time it was not thought to be safe if they were always to be left out. This is an ongoing discussion with the ever-changing patient group.

There was a restrictive practice audit which was completed monthly. This asked questions about any specific restrictions and the reasons for them. It was discussed in the monthly positive and safe meetings. We were able to see minutes from those meetings where restrictions were discussed, this included when staff had recognised that perhaps some unnecessary restrictions were being placed on Children and Young People and raised this via the meeting. One example of this was explaining to staff that there was no set bedtime for Children and Young People. Children and Young People were encouraged to have good sleep hygiene but ultimately it is their decision when to go to bed.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The course put an emphasis on restraint being a last resort and taught staff how to see early warning signs that someone was becoming distressed or agitated and gave them the tools to manage this to avoid a restraint situation.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. Staff we interviewed were able to explain the guidance to us in terms of physical health monitoring. However, staff told us that this was rarely used. The service was taking part in the Kings College London's Safe wards project. This was a national project that was still in the early stages. Staff reported that the ward did well in the benchmarking process. The project involved the team attending networking meetings so they could share ideas with other forensic services. As the project goes forward, staff told us they will review this in terms of any reduction in incidents to gauge its success.

When a child or young person was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was put in long-term segregation. There was nobody in long term segregation at the time of our inspection.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Our findings

Staff received training on how to recognise and report abuse, appropriate for their role. There were two safeguarding leads at Junction 17 that staff could approach for advice or support. Staff we spoke to had a good understanding of safeguarding and were able to explain to us how they would recognise, report and monitor safeguarding concerns on the wards. Safeguarding was well embedded into everyday practice at all levels.

Staff kept up to date with their safeguarding training.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. There were rooms available off both wards for children and families to visit. They were always away from the main ward area and on Gardener Unit visits were always supervised.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We were able to review recent safeguarding referral whilst on site. These had been made and documented appropriately and shared with relevant people involved in children and young people's care.

Managers took part in serious case reviews.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. The service used electronic records and staff reported the system was easy to use. The service had been using the same system for some time now and staff were able to quickly and effectively find their way around this.

When children and young people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. The electronic system required a username and password to access.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. All qualified staff completed an annual medicines competency assessment as well as training for administering medicines. If there was a medicines error, then staff were asked to complete an incident form as well as a reflective piece. This would then be discussed in supervision and all medication errors were reviewed by the medicines lead. There were also further support measures in place such as supervised medicines rounds and further training.

Our findings

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. The medicines Children and Young People are prescribed were always reviewed in multi-disciplinary meetings. We were able to observe these and see how medicines were discussed with Children and Young People, this included their effectiveness, side effects and dosage. Children and Young People were encouraged to give their opinions and ask questions.

Staff stored and managed medicines and prescribing documents in line with the trust's policy.

Staff followed current national practice to check Children and Young People had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Decision making processes were in place to ensure young people's behaviour was not controlled by excessive and inappropriate use of medicines. When required medicines guidance was in the clinic room. Staff were able to explain to us what this entailed and how and when this was reviewed. Reviews of when required medicines was also part of the medicine chart audit which was done weekly.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance. Staff were able to tell us about specific medicines that required different monitoring. These included examples of Olanzapine depot where physical observations were required to be increased and Clozapine where regular blood tests were required.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Staff knew what incidents to report and how to report them. The service used an electronic recording system for incidents. All staff we spoke to knew how to use this and had access to it.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events on any wards. Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Our findings

Staff received feedback from investigation of incidents, both internal and external to the service. Current incidents were fed back in supervision and team meeting. For incidents that were concluded there was a monthly poster that was displayed that staff could read. The service had also started a lunch and learn session where incidents were sometimes discussed, especially changes that had been made as a result of learning from incidents.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. One example of this was the introduction of a handheld phone that staff could carry once the main reception was closed. This meant that staff could answer the phone and listen to voicemails out of hours from the main ward. This was implemented following an incident where voicemails were not picked up in a timely manner when reception was closed.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussions and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each child or young person. If the admission was an emergency, then it would begin on admission. If an admission, was planned which was usually the case, then staff would go out to assess the patient prior to their arrival. All members of the multi-disciplinary team were involved in the assessment process including nurses, doctors, psychologists, therapists and the patient and their families/carers.

Care plans were personalised, holistic and recovery orientated. They included the Children and Young People views and addressed each area of the patient's life such as their mental wellbeing, physical health and social interactions, amongst other things.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We found that physical health monitoring was robust. Children and Young People had physical health baseline checks carried out on admission and then at regular intervals throughout their stay (time frames varied dependent on patient need, but at least once per week). This included, weight, blood pressure, pulse and temperature monitoring. Some patient needed more checks including blood tests. This was managed in a sensitive way with extra work being done with some Children and Young People who needed more support around this. If a patient refused, this was clearly documented, and further attempts were made to carry out the observations.

We saw Children and Young People with complex health problems being managed safely and in a supportive and patient centred way. Care plans that we reviewed for physical health conditions such as diabetes, were done in conjunction with the relevant specialist staff but documented in a way the patient could understand and be involved.

Our findings

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when children and young people's needs changed. Children and Young People care plans were always a working document. This meant they changed over time to adapt to the Children and Young People changing presentation.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the children and young people in the service.

Staff delivered care in line with best practice and national guidance. (From relevant bodies e.g., NICE). There was a full team of therapists on the unit. Psychologists were an integral part of the team and offered both group and one to one therapy for patients. This included managing emotions and solution focused therapy. The team also facilitated formulation sessions. The family therapist was based across all wards, there was no waiting list for this, and patients were referred quickly and easily. There was also a music therapist and an art therapist.

Staff identified children and young people's physical health needs and recorded them in their care plans. Physical health checks were carried out weekly for most patients. This included blood pressure, weight, height and pulse. For patients who required it this was increased as required. We could see where any abnormalities were escalated to the doctors on site and results recorded in records.

Staff made sure children and young people had access to physical health care, including specialists as required. We saw good examples of this during our records review. We were able to see how referrals to specialist teams such as diabetes nurses were made. Care plans were robust and included lots of individual details about how the children and young people were able to manage the illness with support from staff.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration. The dining area was spacious on all wards. During our tour we saw that there was enough seating for all Children and Young People and that fruit and cereal was readily available if Children and Young People wanted some. The menu was a four-week rotating menu where the Children and Young People could make a choice of what food they wanted each day. Children and Young People told us that the food was of a good quality, some Children and Young People would have liked larger portions although they did say that they could ask for a second helping if they wanted some more.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. Staff encouraged Children and Young People to make healthy food choices as much as possible. Take-aways were discouraged more than once or twice per week. Some Children and Young People were taking medication that could increase appetite and weight so staff tried to educate Children and Young People about the importance of exercise and a healthy diet. There were food technology courses available at the college where Children and Young People could gain a qualification in this area. There was also information around the wards about healthy eating.

Our findings

There was access to a gym for all wards, as well as an outdoor gym. Children and Young People were able to use this with trained staff and it was reported that this was used a lot. The hospital site was no smoking and there was access to smoking cessation.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes.

Staff used technology to support children and young people. The wards all had access to a range of technology. There were lots of laptops that Children and Young People could use for communication with family and friends and college work. The music room had a full recording studio where Children and Young People could create their own recordings with the help of the music teacher or music therapist.

There was a well-established research team based within the CAMHS service, this consisted of a consultant psychiatrist and a clinical psychologist amongst other colleagues. They described a research project that the staff and Children and Young People at Junction 17 were involved in. This was an external project that was developing an app for young people who have been victims of sexual abuse. They were just about to begin the second stage of the study where they would test the app with young people to get feedback on its effectiveness.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

The services had recently had a QNIC peer review following their accreditation in 2020. The Gardener Unit had received their feedback and it was extremely positive. Junction 17 were still awaiting their feedback at the time of our inspection.

There were regular audits that were carried out by all levels of staff on the wards. These included audits of clinic rooms, emergency equipment and records. Feedback from audits was shared with the whole team at staff meetings or if they related to individual staff these were shared during supervision.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of children and young people on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of the children and young people on the ward. The wards had a wealth of staff that worked within the team. This included, doctors, nurses, healthcare assistants, psychologists, music and art therapists, family therapist, occupational therapists and junior doctors, education staff and pharmacists.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff. Staff were able to access specialist training according to their role. There was a CAMHS specific induction that the service had developed for all new staff. These included parts delivered by all the specialist team listed above and lasted for three days. There were plans to incorporate more patient experiences into this in the form of a piece of music developed by one patient about his journey through the service. We were able to listen to this during the inspection and the piece was both powerful and moving.

Our findings

Managers gave each new member of staff a full induction to the service before they started work. There was a trust wide induction that all new staff attended, this involved mandatory training such as fire safety, health and safety and the trusts managing violence and aggression training package. All staff had to attend induction prior to commencing employment.

Managers supported staff through regular, constructive appraisals of their work. The trust appraisal programme was carried out annually. Staff told us that this was meaningful, and they were able to use these to develop themselves, either in the form of training or development within their own role. Appraisal figures for all wards were over 80%.

Managers supported staff through regular, constructive clinical supervision of their work. Supervision rates for all wards was over 90%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed minutes of team meetings to see how often they happened and what was discussed. We also spoke to the staff about the team meetings, they told us they were held on a monthly basis and that all staff were encouraged to attend. Staff could attend in person or virtually. All meeting minutes were shared with the team via email and discussed in supervision.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit children and young people. They supported each other to make sure children and young people had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multi-disciplinary meetings to discuss children and young people and improve their care. We observed one of these meetings on the day of our visit. We found that there was a large multi-disciplinary presence who were all involved in the meeting. The Children and Young People were invited and encouraged to see the team and they were given choices about their future care and treatment.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. We reviewed notes from the handover meetings and found that all aspects of the Children and Young People care relevant to the team were discussed, this included risk, leave off the ward, observation levels and incidents.

Ward teams had effective working relationships with other teams in the organisation. The teams worked closely with the community CAMHS teams as well as the local safeguarding team and the Forensic CAMHS team. The education provision within the service worked very closely with both wards and staff from college were part of all discussions about patient care.

Our findings

Ward teams had effective working relationships with external teams and organisations. Lots of the children and young people on the wards did not live in the local area. This meant that the team had to liaise with home teams such as the community mental health teams and local schools to ensure the best care was provided for the patient. The team also had good relations with lots of the social care housing facilities both locally and nationally due to often placing children and young people in these services on discharge. The team ensured relevant professionals were invited to meetings about their patients and were offered video links if they could not attend in person.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain children and young people's rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time. There were leaflets available in easy read and other languages for those that needed them.

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor when they needed to.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed.

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those children and young people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Our findings

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered their wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations.

Staff knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

Kindness, privacy, dignity, respect, compassion and support

Our findings

Staff treated children and young people with compassion and kindness. They respected children and young people's privacy and dignity. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Feedback from Children and Young People and carers was universally positive. All felt that staff went that extra mile to provide care for themselves or their loved ones. Staff were respectful and positive in their interactions with Children and Young People, as well as during meetings when Children and Young People were not present, such as handover and ward rounds. There was a strong sense of a great partnership between staff and Children and Young People when it came to the Children and Young People care.

Children and Young People told us:

“Never in my life have I met people who cared so much for me”

“Staff would not give up on me, even when I had given up on myself”

“They genuinely care”

Staff were discreet, respectful, and responsive when caring for children and young people. All Children and Young People we spoke to told us that staff knocked before entering their room. We observed interactions between staff and Children and Young People during our visit. We found that staff took the time to speak to Children and Young People in a way that made them feel both valued and respected. Children and Young People told us that they felt that staff genuinely cared for them and did not give up on them, even when they were at their lowest.

Staff gave children and young people help, emotional support and advice when they needed it. Staff spent a lot of time talking to Children and Young People and their families. This was done in several different ways, some more formal than others. Children and Young People were invited once per week to speak to the multi-disciplinary team about their care formally. However, consultant psychiatrists were seen on the wards talking to Children and Young People on a much more regular basis than this. One patient told us that the consultant psychiatrist had spent time on the ward with them sharing a meal whilst chatting. This made the patent feel at ease and able to talk more openly. There were lots of different staff members for Children and Young People to talk to during activities, formal therapy sessions with the art and music therapists. Lots of Children and Young People accessed family therapy where they were able to discuss issues with their family in a therapeutic and guided way.

Staff supported children and young people to understand and manage their own care treatment or condition. All Children and Young People we spoke to could explain to us about the medication they were prescribed. Children and Young People showed us leaflets about their medication which they also told us was explained to them during multi-disciplinary meetings when any new medication was started, or changes were made. Children and Young People told us they were consulted on their opinion about new medication and offered alternatives if they were unsure. Some Children and Young People told us that the pharmacy team had taken the time to speak to them on an individual basis about their medication, when they had requested further information. We saw evidence in care plans of very specific ways to manage situations for different Children and Young People. There were clear plans in place of how staff could manage this to try and reduce the need for extra medication or use of restraint. Staff tried their best to ensure Children and Young People had access to things they enjoyed prior to being admitted to hospital. For example, there was access to the gym, cookery, books to read and electronic gaming equipment. Children and Young People told us how they were involved in developing these care plans by telling staff how they felt they would like to be treated in certain situations.

Our findings

Staff directed children and young people to other services and supported them to access those services if they needed help.

Staff understood and respected the individual needs of each child or young person.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people. The team worked in a way that meant that constructive challenge was always welcomed. This was evident in handover notes, team meeting minutes and psychology formulation sessions. Staff worked in order to do the best job they could for the patient group, we saw examples in team meeting minutes where some staff had raised concerns about bedtimes being imposed. This was discussed by the team and clear direction given that Children and Young People were able to decide on their own bedtimes, this was also discussed alongside the need for good sleep hygiene to be promoted in a way that was supportive and not restrictive.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that children and young people had easy access to independent advocates and to child helplines.**

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission. Children and Young People we spoke to told us that they were shown around the ward by staff on arrival. They were introduced to the staff on duty, given information about the ward such as mealtimes and visiting times and shown their bedroom. The staff from the education department came to speak to them and explained how the college worked, and what they could do as part of their education whilst on the ward. The Gardener Unit had developed “101 things to do on Gardener Unit” which Children and Young People received on admission.

Staff involved children and young people and gave them access to their care planning and risk assessments. It was clear from reading care plans that Children and Young People were actively involved in these. We saw specific guidance from Children and Young People on how they would like to be managed in different situations. This explained what they would like staff to talk to them about if they were feeling unwell and what type of approach worked best for them. For example, to discuss the issue that was ongoing at a later time, in the moment to talk about things they enjoy such as hobbies or spending time with family, and what they did not want such as injections or to be placed in seclusion. When we spoke to Children and Young People, they confirmed their involvement. They told us that if they did not want to be involved this was revisited at regular intervals to see if their decision had changed. They were always offered a copy of their care plan, some Children and Young People did not want one, but they were still offered.

Staff made sure children and young people understood their care and treatment (and found ways to communicate with children and young people who had communication difficulties). We spoke to Children and Young People, and they were all able to tell us what medication they took and the dose. Children and Young People were involved in a range of psychological therapies such as art, music and family. Children and Young People were able to explain it to us in a way that they understood. For Children and Young People who had communication difficulties we saw other ways of communication being used, such as flash cards in red, amber and green which allowed Children and Young People to tell staff how they were feeling without having to tell them.

Our findings

Staff involved children and young people in decisions about the service, when appropriate. The service was developing a "moving on group". This was in order to get young people involved in service development. There were also plans to get the Children and Young People involved in the CAMHS induction, the service had discussed this with Children and Young People to be able to approach this in a way that meant young people did not feel under pressure to get up and speak in front of groups of staff. They had come up with innovative ideas such as recording Children and Young People who gave consent presenting their journey through the service, one patient had created a piece of music which had been recorded at the college where they gave their interpretation of their journey at the service through a piece of rap.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. The Children and Young People were given the opportunity to give feedback during the ward community meetings. This was documented in a "you said, we did" format. Ward managers were responsible for actioning the issues raised and these were fed back to Children and Young People at the next meeting. The ward managers also presented these at the senior leadership meetings so more senior staff were aware of any issue's Children and Young People were raising. There was also a feedback form that could be accessed using QR codes around the building and in reception where Children and Young People and their careers and families could give more in-depth feedback about all aspects of the service.

Staff supported children and young people to make decisions on their care.

Staff made sure children and young people could access advocacy services. The advocacy service staff provided a familiar face on the ward for all Children and Young People, and they were able to support the Children and Young People in several ways. Advocates were welcomed at community meetings, multi-disciplinary meetings and on a day-to-day basis on the ward. They were able to raise issues on behalf of, or in a supportive way with Children and Young People. Staff reported good working relationships with the advocacy service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We observed a multi-disciplinary meeting during our inspection. During this meeting Children and Young People' carers were invited to take part. This was done either if person, if possible, but some families who lived further away were able to join by zoom calls if they wished to. We saw the consultant psychiatrist actively calling patient families to request their input into the meeting. The service had carer leads on each ward and they organised carers events. Unfortunately, due to the increase in Covid-19 restrictions prior to Christmas 2021, the last event had to be cancelled. However, there was a trust wide carers event which received positive feedback. The service also had a family ambassador role, this was similar to an expert by experience role at CQC whereby someone who has had direct experience of using the service (E.G a family member of a patient) was available to support current Children and Young People, families and carers. This meant that families were supported by someone who knew how to navigate the system and could give tips and advice on how to manage difficult emotions and situations from their own experience.

Staff helped families to give feedback on the service. This was done in a number of ways to make it accessible for all. There were traditional feedback forms and comment boxes in waiting areas and onwards. However, the service had also introduced a QR code that could be scanned for patients and relatives to give feedback electronically. This had been well received and was quickly and easily accessible in areas where people spent most time.

Staff gave carers information on how to find and complete a carer's assessment.

Our findings

Is the service responsive?

Good  

Our rating of responsive stayed the same. We rated it as good because:

Access and discharge

Staff managed beds well. A bed was available when needed and children and young people were not moved between wards unless this was for their benefit. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, children and young people did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Managers made sure bed occupancy did not go above 85%. Admissions to all wards was well managed and there was no waiting list for beds. Pre-admission assessments were detailed and looked at other options prior to admission that may be utilised.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to.

The service had no out-of-area placements.

Managers and staff worked to make sure they did not discharge children and young people before they were ready.

When children and young people went on leave there was always a bed available when they returned.

Staff did not move or discharge children and young people at night or very early in the morning.

The was no psychiatric intensive care unit for young people within the trust. If a patient needed this level of care, a referral would be made to the nearest one. There were two within the local area.

Discharge and transfers of care

The service had a low number of delayed discharges in the past year.

Managers monitored the number of delayed discharges.

The main reason we identified that delayed discharge was when Children and Young People needed a new placement in a social care place or a private property. The funding for these could take some time to agree and depending on the needs of the patient, a wait for a particular home could be lengthy.

Whenever a patient was identified as being a delayed discharge, this was raised to senior leaders immediately so they could assist in moving the patient on as quickly and safely as possible.

Our findings

Staff carefully planned children and young people's discharge and worked with care managers and co-ordinators to make sure this went well. Care co-ordinators were kept involved throughout the patient's admission in order to facilitate discharge when required.

Staff supported children and young people when they were referred or transferred between services. Children and Young People rarely moved to another ward during their admission. However, if a patient turned 18 during their stay they may have needed to move to an adult ward. This was planned and manged sensitively with involvement from both teams, consultants and family.

The service followed national standards for transfers of care.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and children and young people could make hot drinks and snacks at any time.

Each or young person had their own bedroom, which they could personalise. During our inspection we toured each of the wards. We found that young people had been encouraged to personalise their bedrooms. This was especially the case on the Gardener Unit where young people tended to have much longer lengths of stay. When each patient was discharged, the estates team redecorated the room prior to a new patient arriving. During our visit there were several rooms being redecorated ready for new admissions.

Children and young people had a secure place to store personal possessions. There was a safe in each of the bedrooms. For items that may be deemed higher risk, such as aerosols, glass bottles and cans, Children and Young People could keep those items in separate storage and staff could get this for them when they needed it.

Staff used a full range of rooms and equipment to support treatment and care. There was a vast amount of indoor and outdoor space for Children and Young People across the service to use. There were lots of rooms available for activities and therapies, as well as plenty of space for visiting. The Gardener Unit had a separate dining space that was set out like a social area, this included a pool table, outdoor space and a servery where Children and Young People could go up and choose their meals. This space was used regularly and could also be used if Children and Young People needed a quieter area outside of mealtimes.

On the walk from the wards to other areas of the building, there were sensory walks on the floor. These consisted of footprints, bees and arrows that Children and Young People could follow or walk on whilst going from one place to another. There were also chalk boards around the wards that young people could use to draw on and communicate.

There was a large education provision which had lots of rooms set up for different subjects. There was access to lots of technology including laser cutters and equipment for cooking and bricklaying. There was an outdoor gym and an indoor gym which Children and Young People could access with trained staff. The music room had a vast range of musical equipment including a full recording studio. This was fully sound proofed and was well used.

On Junction 17 there was a sensory room which had been named the "chill zone" by Children and Young People. Whilst some Children and Young People had care plans in place around the use of this, it could also be accessed freely by Children and Young People who wanted to utilise the equipment.

Our findings

There was a multi-faith room where young people could go to pray or just spend some quiet time reflecting on their thoughts. The service had good links with the trust chaplain service and there was access to a range of materials for different cultural needs.

The Gardener Unit had developed a cyber space where Children and Young People could access the internet with staff supervision. This was used daily, and young people reported they loved it. They told us they used it to watch YouTube, TED talks and to do research for college work. This was a great achievement, and it was noted in the QNIC report that the staff team were told that it couldn't be done in a medium secure unit, but they had.

The service had quiet areas and a room where children and young people could meet with visitors in private.

Children and young people could make phone calls in private. On Junction 17 young people had access to their own mobile phones. However, there was also a payphone in a private area that they could access if they did not have a mobile phone. On Gardener Unit Children and Young People did not have access to their own mobile phones, however, this was something that due to the success of the cyber zone, was being discussed at ward meetings. Children and Young People in Gardener could use the ward pay phone.

The service had an outside space that children and young people could access easily. There was access to an outdoor gym which had recently been installed. The seclusion room for Gardener Unit also had an outdoor space.

Children and young people could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food.

Children and young people's engagement with the wider community

Staff supported children and young people with activities outside the service and made sure children and young people had access to high quality education throughout their time on the ward.

Staff made sure children and young people had access to opportunities for education and work and supported them. During our visit we met with many of the young people that were in Children and Young People at the service. On Gardener Unit all the young people were attending the college for education. The college and the ward worked very closely together to ensure that young people were able to access education at the right level for them. We met one patient who was accessing a local college outside of the hospital, they were supported by staff to access public transport to get there and back.

The education facility at the hospital was rated as good by OFSTED. The education team attended the multi-disciplinary meetings for Children and Young People, not just those who were accessing education, but also those who they wanted to encourage to start attending or increase attendance. The education team would support some sessions on the ward if Children and Young People were not well enough to go over to the college. Children and Young Peoples natural interests and skills were considered when planning education. For example, a patient who had shown a natural aptitude for beauty therapy was encouraged to attend more practical sessions to begin with to enhance and improve those skills whilst working towards a qualification.

Staff helped children and young people to stay in contact with families and carers. All families and carers were encouraged to be involved in their loved one's care. They were invited to relevant meetings either in person or via technology. There was plenty of space for visitors to meet with their loved ones on the unit. Leave with families and

carers was also encouraged, so Children and Young People who were informal or had leave to go off the ward were able to go out in the local area in adherence with the leave plan. During the pandemic, the trust ensured that there were plenty of laptops available so Children and Young People could contact family and carers via video call and on Gardner unit there was a dedicated phone for calls via an online messaging service.

The trust offered free parking on the hospital site at the time of our inspection. This meant that relatives and carers could visit their loved ones without incurring the cost of parking for long periods. The service would also arrange for taxis for visitors to and from the local tram station as well as supporting families to apply for subsidised travel if they qualified for this.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. We saw that there was a strong focus on trying to maintain links with the local community. Children and Young People we spoke to were accessing several community initiatives. This included a cycling club, attending local college and visiting local attractions with staff such as museums and football grounds.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There was lots of information on the wards about identity, LGBT+ and information on support networks, local community and online forums. The staff had access to training and information sessions around this too. There had recently been a “lunch and learn” session around transgender.

Staff made sure children and young people could access age-appropriate information on treatment, local service, their rights and how to complain.

The service had information leaflets available in languages spoken by children, young people and the local community.

Managers made sure staff, children and young people could get help from interpreters or signers when needed. Staff told us that there was never an issue accessing these services. During the pandemic this could be accessed over the telephone or via video conferencing if visitors were unable to make it to the wards.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. Feedback about the food was good, some patients stated they would like larger portions and we fed this back to the provider. However, there was a strong focus on healthy eating as some medications do have side effects of weight gain or appetite increase. This meant that staff spent lots of time explaining to patients about the importance of a healthy diet, exercise and eating things such as sugary drinks and take aways in moderation.

Children and young people had access to spiritual, religious and cultural support. There was a multi faith room on both units. These had access to religious books and other items required for different religious groups to pray.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Our findings

Children, young people, relatives and carers knew how to complain or raise concerns. We asked this during our visit, although all said they had no issues to raise, they felt confident on how they would approach this if they needed, they also felt sure they would be listened to and taken seriously.

The service clearly displayed information about how to raise a concern in patient areas. There were posters and QR codes that patients and relatives could scan to give feedback, as well as traditional comment boxes and feedback forms.

Staff understood the policy on complaints and knew how to handle them. Staff were able to tell us where information was situated about how to complain and how this was explained to the patients on admission and routinely at community meetings and one to one session.

Managers investigated complaints and identified themes. Complaints were discussed at team meetings and senior leadership meetings. Feedback was given on the outcome if appropriate and shared with the team for learning.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good

Our rating of well led stayed the same. We rated it as good because:

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had an excellent understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff.

There was a large senior leadership team who were based within the same buildings as the wards. We spoke to 12 staff and they all told us that the senior leaders in the service were visible, reliable and knowledgeable about the service. Staff told us they were approachable and often spent time on the wards. This included at team meetings, giving advice in difficult situations and taking part in important meetings regarding patient care and the staff team. The senior team consisted of a service manager for CAMHS, a head of operations and an operations manager. There was a ward manager for each ward who had both worked in the service for some time.

Leaders understood their service very well. They understood what it was good at, what needed to improve and the challenges they faced going forward. Managers had access to information that told them how the teams were

performing. This included staffing, training levels, sickness levels and information such as restraint figures and use of temporary staff. The leaders monitored this and discussed it month on month in the senior leadership meetings, to ensure that any issues were quickly identified. They quickly picked up on themes and trends that were emerging and were able to support teams to manage this.

Children and Young People and staff all knew who the leaders were, could approach them and saw them often in the service. All staff and Children and Young People knew who the senior leadership team were. They were present on the wards daily and knew Children and Young People individually. This was clear at our inspection as senior leaders walked around with us, they addressed Children and Young People by name and were able to tell us about Children and Young People not only in terms of their inpatient stay, but also their likes and dislikes, hobbies and families.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff and Children and Young People were involved in decisions about the service, when we spoke to staff, we were able to get a clear understanding of where the service was going. The service had secured funding for some projects such as the transformation of the old seclusion facilities into a new state of the art facility. The service wanted to move towards implementing a crisis pathway for Children and Young People, this would include short stay beds and a home treatment team working into the community.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected, supported and valued by their peers and managers. Staff felt really privileged to work for the service. Staff we spoke to told us that they loved their work, they were proud to be a part of the young people's service. This was clear when walking around the wards and speaking to staff. They all knew the Children and Young People well, Children and Young People told us that staff genuinely cared and had taken the time to get to know them. Staff were able to challenge each other in a constructive way for the greater good of the Children and Young People.

Managers were supported by human resources if they had concerns about staff performance and could access this quickly.

There was a wellbeing lead in post who worked within the service. Their role had been received well and had reportedly improved the morale of the team massively. It initially started post Covid-19 in order to support staff with anxieties around returning to work or working during the pandemic. The post had grown since then and staff really appreciated this.

The wellbeing lead was able to spend one to one time with staff (outside of formal supervision arrangements) to discuss issues that they may be worried about or need support with. This did not need to be work related. The wellbeing lead could signpost to many services that staff could access for support. They had also set up social events for staff which included a calypso barbeque in the summer and an afternoon tea. Staff were able to call in and spend time with

colleagues. They had also arranged a trip to the local RHS site where there was a Christmas light show, staff received a discount and could go for a social evening with colleagues. The wellbeing lead had also set up a monthly staff recognition award, this was where staff could nominate a colleague for some shopping vouchers if they felt they had done something that deserved recognition at work.

The lead had made bids for some money from the Captain Tom fund and had been successful in each of the seven bids. There were plans to use this money to make a "zen space" where staff could relax. There was also an annual dragons den scheme which was run by the trust. The wellbeing lead had secured some money from this, one was for some cycling equipment and bicycles and the other was for musical equipment.

Managers supported staff during their appraisals and discussed career progression and development. We spoke to staff who had been supported to further their education through learning. Senior leaders had completed Masters level qualifications. If staff found training externally that would benefit the service, this was encouraged and supported. We met with staff who were being supported to complete their nurse training by the service. Two members of the team had recently completed an online course to become professional nurse advocates. This enabled them to give restorative supervision. There was training in quality improvement at bronze, silver and gold levels for all staff on the unit.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Managers had a clear framework of items they must discuss at each ward, team and directorate meeting. There was a set agenda for meetings, and this was reflected at ward level meetings and upwards. Items included, restrictive practice, safe wards, learning from incidents and staff health and wellbeing.

Managers had access to data for their own team on the computer system. They could see at a glance how their own team was performing. This would highlight any issues for managers to see, for example, if training was due to expire.

Staff implemented recommended changes following reviews of the service. At our last inspection we found that some items of emergency equipment had not been checked. Following our inspection, the team implemented a weekly emergency equipment check which included cleaning, calibrating and ensuring equipment was not out of date or due to expire. We found that this had worked well and notified a marked improvement in this area.

Staff undertook or participated in local clinical audits and acted on the results.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff kept the risk register up to date and knew how to escalate any concerns. Staff concerns matched those on the risk register. The ward managers had access to and could add to the risk register for the service. This could be escalated up to the trust risk register if needed.

Our findings

The service had clear plans for dealing with emergencies and staff understood these. The trust had a business continuity process which included identifying and mitigating the risks in relation to disruption of services including flooding or fire, pandemic, a cyber-attack on the computer system, severe staffing shortages and other key risks. There was a ROC team that supported teams daily with staffing, disseminating staff from wards that had enough staff to those who were short.

Managers had good oversight of their own budgets. The service was within budget for the last financial year. Staff were encouraged to find ways to use leftover finances to improve the ward and environment for Children and Young People and staff as well as funding training for staff.

Information management

Staff engaged actively in local and national quality improvement activities. The Gardner unit had recently received their feedback from the Quality Network for Inpatient CAMHS. The feedback was overwhelmingly positive and praised the staff team for the work they did**.** Junction 17 were still awaiting their report at the time of our inspection.

The systems to collect ward and directorate data did not create extra work for frontline staff.

Staff had access to equipment and technology that worked well and supported them to do their work. The care records systems were electronic. Staff told us that they had enough computers to access the records when needed.

Information governance systems clearly stated the policy on confidentiality of patient records.

Team managers had access to information that supported them.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff, Children and Young People and their carers could access up to date information about the services they used and the trust. The service had developed information packs about each ward which was given out to Children and Young People and their relatives at the point of admission. The trust website was very easily navigated and there was a lot of information included on it for Children and Young People and their families. The trust also provided a lot of leaflets for Children and Young People and carers on different mental health issues, medicines, support networks,

Children and Young People and carers could give feedback about their care and in ways that reflected their individual needs. Managers used the feedback from Children and Young People and carers to make improvements to the service. The wards all held weekly community meetings. Children and Young People were encouraged to attend these and to take a lead. This was an opportunity for Children and Young People to give their views on service development, everyday ward issues and make plans for the week ahead.

Managers and staff involved Children and Young People and carers in decisions about changes to the service. Children and Young People were involved in all decisions about the service. This included the way the ward was furnished and decorated, involvement in staff interviews and giving feedback on proposed changes to the service.

Our findings

Children and Young People and staff could meet with the senior leadership team to give feedback. Staff met with ward managers and more senior staff at staff meetings.

Learning, continuous improvement and innovation

Managers gave staff time and support to think about how to improve the service and innovative ways of working.

Managers supported staff to take part in research. Staff knew about quality improvement methods and could apply them. There was a well-established research team within the CAMHS service. They took part in both internal and external research, this involved Children and Young People as well as staff.

They had recently been involved in a project regarding the development of an app for victims of sexual abuse called "I-Minds". The second study had recently received approval, and this was for a clinical trial to evaluate the app, this would be done by conducting interviews with young people prior to using the app and after to see if there were benefits.

Our findings

Outstanding practice

The Gardner Unit had introduced a cyber zone for the Children and Young People in a medium secure facility. This was recognised by the Quality Network for Inpatient CAMHS team as good practice despite the difficulties managing this in a secure environment. The cyber zone had been developed in conjunction with the Children and Young People using thorough risk assessments and cyber passports.

There was a well-established research team within the CAMHS service. They had recently been involved in a project regarding the development of an app for victims of sexual abuse called “I-Minds”.

Our inspection team

Our inspection team consisted of four inspectors and two specialist advisers who currently work within child and adolescent mental health services