Dorset County Hospital NHS Foundation Trust

Dorset County Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Dorset County Hospital

Inspected but not rated

Background to the inspection:

Dorset County Hospital NHS Foundation Trust provides services for children and young people living in West Dorset.

The hospital provides care for young people up to the age of 18 years with complex and chronic illnesses as well providing care and treatment for emergency admissions. The inpatient services provide care for children and young people up to their eighteenth birthday.

The service has one inpatient ward (Kingfisher Ward), a paediatric assessment unit, an end of life care suite and a child health unit in a separate building where most of the outpatient services are provided. The inpatient ward is not a designated ward to treat children and young people with mental health conditions although patients are admitted to Kingfisher Ward until a designated inpatient bed becomes available. This can at times be for a prolonged period due to shortages in inpatient beds in the wider healthcare system, for children and young people requiring mental health services.

The trust also provides a community children and young people service. The outpatient service and child community services were not included in the focused inspection.

Children are also cared for in other areas of the hospital for example for surgery and in the emergency department. On occasions, children and young people are admitted to the critical care unit before being retrieved by specialised paediatric units when this is required.

Activity

Between 1 August 2021 and 31 July 2022, four children and young people were detained under the Mental Health Act 1983 and 277 children and young people attended the hospital following acts of self-harm. Of these, 155 (56%) children and young people were admitted to Dorset County Hospital. The majority (117) were admitted to the Kingfisher Ward and 31 were admitted to the paediatric assessment unit (PAU). This represented 9% of the overall number of children and young people's admissions to the paediatric Kingfisher Ward and 2% of admissions to PAU.

The service was last inspected in May 2016 when it was rated as good across all five domains we inspect.

Services for children and young people

Inspected but not rated

Overall summary of findings:

- Systems and processes to investigate and follow up safeguarding concerns were not always effective. Not all staff had completed the safeguarding training required of their role.
- Facilities and premises in the emergency department were not in line with national guidance to ensure children and young people were kept safe, including those who presented with an acute mental health episode and/or had a learning disability and/or autistic children and young people.
- Staff did not document environmental risk assessments to ensure children and young people admitted were kept safe.
- Staff did not document using the risk assessment tool as required in the trust's Children and Young People Mental Health Policy.
- Staff absence was high at the time of our inspection.
- There were no regular audits to assess if care and treatment provided was compliant with care pathways based on national guidance.
- There was a lack of clarity regarding the clinical leadership for overseeing treatment of children and young people who needed treatment of mental health conditions.
- There was a lack of documented evidence to confirm staff had the correct knowledge and understanding of how to obtain consent for treatment for children and young people.
- Clinical leaders did not feel empowered to escalate concerns externally when this was required.
- There was a lack of governance processes to effectively assess and record the capacity of children and young people, throughout the service and with partner organisations, to ensure children and young people with mental health needs received effective treatment.

However:

- Staff on the inpatient ward worked to improve the environment to ensure it was safe and met the needs of children and young people.
- The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.
- Staff kept detailed records of children and young people's care and treatment when children were admitted with physical health needs. Records were clear, up to date, stored securely and easily available to all staff providing care.
- The service mostly managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services.

Services for children and young people

- Leaders had the skills and abilities to run the service. Leaders understood and managed the priorities and issues the service faced.
- Staff working on the inpatient ward felt respected, supported and valued.
- Leaders and teams recognised key risks to the service and mostly used effective systems to mitigate these.

Is the service safe?

Inspected but not rated

Safeguarding

Systems and processes to investigate and follow up safeguarding concerns were not always effective. Not all staff had completed the safeguarding training required for their role. However, staff understood how to escalate concerns about children, young people and their families to protect them from abuse and the service worked well with other agencies to do so.

The records we reviewed, did not demonstrate effective awareness and understanding of safeguarding risks or appropriate responses. We reviewed 22 care records for children and young people admitted with mental health conditions. These records did not demonstrate effective awareness and understanding of safeguarding risks or appropriate responses. We saw examples of safety risks being confused as safeguarding risks. A review of records suggested that inappropriate safeguarding reassurance was made because of their involvement with Children and Adolescent Mental Health Services (CAMHS). The records asked *'[are there] any child protection/safeguarding concerns?'* to which the response was often *'[the child is] being followed up by CAMHS'.*

In the emergency department, there were systems to alert staff if children and young people with known safeguarding concerns attended the department. The children's safeguarding team reviewed notes each day to ensure all relevant action and onward referrals had been acted upon. However, these reviews were not recorded consistently in-patient records to demonstrate further review of risks or that a more holistic review had been carried out.

Children and young people who attended the emergency department at Dorset County Hospital rarely received a holistic assessment of their needs. Staff knew how to identify children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff liaised with external teams and health visitors for patients seen out of their home area, such as those on holiday. This enabled staff to check on safeguarding status and risks for patients not known to the trust or other local services.

Not all staff had completed the safeguarding training specific for their role on how to recognise and report abuse. Records showed all staff on Kingfisher Ward had completed Safeguarding Children Level two training, and 71% had completed level three training. Training compliance was slightly less in the emergency department where 80% of staff had completed level two training and 61% had completed level three training. The trust's target was 90% training compliance. Trust training records confirmed paediatric clinical leads and the named responsible executive lead had received and mostly completed children's safeguarding training (88% compliance) at an appropriate level to their role.

There was a programme of supervision for all staff who were involved with children's safeguarding both in the emergency department and on Kingfisher Ward. However, there was no evidence that recommendations or outcomes of supervision reviews were recorded in patient case notes in any of the 22 records we reviewed.

Services for children and young people

In the emergency department, staff were aware of how to make a safeguarding referral and had access to policies and procedures for additional advice. There were processes to alert staff if any safeguarding concern were raised or had been raised in the past. Staff liaised with external teams and health visitors for patients seen out of their home area, such as those on holiday. This enabled staff to check on safeguarding status and risks for patients not known to the trust or other local services.

For children and young people admitted to the Kingfisher Ward with mental health issues, including self-ham, there was a more detailed review included in the pathway care documents to explore contextual safeguarding concerns using a specific tool known as HEADSSS. The assessment tool was designed to consider factors such as home, education/ employment, activities, drugs/drinking, sex. Self-harm, depression & suicide and safety, including social media/online safety. This offered an opportunity to apply a holistic approach when assessing safeguarding concerns.

Staff on Kingfisher ward and the paediatric assessment unit worked, as part of a safe multidisciplinary care team, with safeguarding and social service colleagues to check child protection registers to ensure patients were not subject to an existing plan. For example, the trust safeguarding team routinely joined daily handover meetings to plan care for patients seen in the department.

Staff took action to protect young people from harm where they had concerns about neglect, welfare, or exploitation. They demonstrated attention to detail when speaking with young people to identify and interpret unmet need. For example, staff ensured young people had access to private, supported conversations when they needed to speak about personal matters or concerns. However, although actions were taken there was little evidence recorded to confirm these were followed up by applying further professional curiosity.

Paediatricians worked across the hospital and with community and statutory services to provide on-demand advice and assessment for patients where there was a child protection concern. Staff were proactive in engaging child protection services and police when they suspected exploitation, sexual abuse, or trafficking.

Staff noted a significant increase in the number of adolescents presenting in the emergency department with drug or alcohol overdoses and those with no physiological needs but complex mental health needs. Staff were adapting services to meet these changes with the resources at their disposal. Leaders reported there were limited specialist mental health service capacity in the region which caused significant pressure on the hospital.

Staff had access to a ‘Safeguarding children and Young People policy and Procedures’ (2022). This policy provided links to guidance and procedures for staff who identified safeguarding concerns in children and young people.

Environment and equipment

Care premises were not always safe for children and young people who attended the hospital with mental health conditions. Facilities and premises in the emergency department were not in line with national guidance to ensure children and young people were kept safe, including those who presented with an acute mental health episode and or lived with a learning disability and/or autism. However, staff on the inpatient ward worked to improve the environment to ensure it was safe and met the needs of children and young people.

The design of the environment did not always follow national guidance. In the emergency department, there was no designated area or waiting room for children and young people who attended the department. There was also no designated mental health assessment room which provided a safe environment for people suffering a mental health

crisis. This was because extensive building work and alterations were being made to the emergency department. Staff were aware of the challenges caused by this and had undertaken an impact assessment. However, the specific risks and impact of not having a designated area for children and young people, including those experiencing a mental health crisis had not been considered as part of the impact assessment.

Staff on Kingfisher ward and the paediatric assessment unit recognised the need to adapt the environment in response to increased mental health needs amongst adolescents by refurbishing clinical areas to be safer and more secure. For example, in recognition of increasing presentation of self-harm and suicide risk, staff were remodelling areas of the ward to ensure they were free from ligature risks and other potential areas of harm. Staff designed this based on learning from previous patients, including the need for safety-locked electrical outlets.

Kingfisher ward and the paediatric assessment unit were equipped with sensory spaces for autistic patients. These were age appropriate and a specialist play team facilitated safe access.

The service had suitable facilities to meet the needs of children and young people's families. Staff ensured younger and older children were separated appropriately. There were specific areas for children based on their age and staff demonstrated a clear understanding of how to respond to peer pressure between young people for issues such as eating disorders, sexual health, and alcohol misuse.

The service had enough suitable equipment to help them to safely care for children and young people. Staff in the emergency department and in the critical care unit told us they had access to equipment to provide safe care for children and young people of different ages and sizes.

Assessing and responding to patient risk

Staff did not document environmental risk assessment to ensure children and young people admitted were kept safe. However, staff completed and updated other risk assessments for each child and young person and removed or minimised risks.

Children and young people’s medical records demonstrated a frequent focus on the presenting need. The trust’s Children and Young People Mental Health Policy required staff to complete risk assessments for each child and young person when they attended the emergency department and when they were admitted to the paediatric inpatient unit. In the 22 records we reviewed the risk assessment tool contained in the trust’s policy was not included in the records. A section on risk assessment was included in the CAMHS referral forms completed by trust staff. However, these were completed inconsistently and did not demonstrate that all individual risks had been identified and assessed or that mitigating action had been identified and taken to manage the assessed risk whilst the child or young person was in the trust’s care. These risk assessments included a history of the child or young person’s medical and social history. For example, we reviewed one patient care record which showed the records focused upon their behaviour rather than the possible reasons behind the behaviour and impact on their well-being.

The service had access to onsite psychiatric liaison (adults) on site every day (24 hours) and access to children and adolescent mental health services (CAMHS) between 8am and 8pm. The CAMHS service was not onsite so face-to-face visits could be difficult to arrange if these were required later in the day. Children and young people were sometimes admitted to the paediatric inpatient ward to await an assessment from CAMHS although there was not a physical health condition that required them to be admitted to the acute hospital.

Staff completed an assessment for the level of mental health observations required. However, this assessment was inconsistently recorded in the 22 records we reviewed. This enabled staff to assess the child or young person’s risk to self

and others and mitigate these by enhanced observation, including one to one care and hourly observations. There was a Children and Young People Mental Health Policy (2021) which set out a red-amber-yellow and green escalation of risks, indicators and actions. However, it was not always clear how this policy was used to inform the actions and levels of assessment to keep children and young people at risk of self-harm, safe. The red-amber-yellow-green risk assessment was not completed in any of the 22 records we reviewed.

Staff worked to ensure children and young people with mental health needs were accommodated in the most appropriate clinical area for their condition. This included a risk assessment for self-harm and ensuring staff could observe the patient appropriately. However, we did not see any evidence of environmental risk assessments in patient records, including ligature, sharps, ingestion or absconding risks, being completed for young people who were at risk of self-harm in any of the 22 records we reviewed for children and young people who were admitted with mental health conditions.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. There were processes to ensure handovers were safe and included all relevant information. Staff in the ED department printed relevant information from the electronic care records when children and young people were admitted to the inpatient paediatric ward as electronic patient records were not available to staff on inpatient wards.

Shift changes and handovers included all necessary key information to keep children and young people safe. Handovers were multidisciplinary and we saw staff reviewed medical and psychological information about each patient. Staff included discussions with other professionals such as social workers and family liaison officers and reviewed known and potential risks for each patient. Clinical staff supplemented handovers with a safety huddle after each ward round to update care plans or implement new referrals if these were required to meet patient need.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.However, staff absence was high at the time of our inspection.

The service had enough nursing and support staff to keep children and young people safe. All nursing staff who worked on Kingfisher ward and the PAU were required to have completed, and to maintain paediatric training.

The nursing establishment was two registered nurses on the PAU and three registered nurses on Kingfisher ward on each shift. Two healthcare support workers supported nurses across both units. However, there was high level of sickness amongst nursing staff. At the time of our inspection, eight staff were off sick. However, the service adjusted the inpatient bed capacity to ensure there were enough staff to look after patients and provide safe care.

There were arrangements to access further staffing from a neighbouring NHS trust, if there were specific concerns relating to patients with mental health conditions and were awaiting transfer to an inpatient mental health facility. These staff provided one-to-one supervision but if these shifts could not be filled, the ward staff were required to provide the same level of supervision in addition to their usual duties.

The service had recently changed staffing on the paediatric pre-assessment and day surgery unit, to include a dedicated senior staff nurse in charge and nurses specialising in surgical modalities.

Services for children and young people

A range of non-clinical staff worked in the unit as part of wider care support. For example, two teachers and a teaching assistant led the classroom and a team of play therapists led the recreation areas on Kingfisher ward.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep children and young people safe. Two consultants worked in the ward each day. A named consultant was designated consultant of the week and took the lead on continuity of care for admitted patients and liaison with other services, such as the emergency department and the safeguarding team. They were supported by a team of senior house officers, registrars, and junior doctors. However, medical staff were not trained to provide specific treatment for mental health conditions.

In the emergency department, there was one consultant in paediatric emergency medicine (PEM) and a senior paediatric nurse. Staff could call on medical and nursing staff from the paediatric inpatient ward if required when the PEM and/or senior paediatric nurse was not available.

Records

Staff did not always record patient care and treatment in enough detail when they documented care and treatment for children and young people who were admitted with mental health conditions. However, staff kept detailed records of children and young people's care and treatment when they were admitted with physical health conditions. These records were clear, up to date, stored securely and easily available to all staff providing care.

We reviewed 22 patient records for children and young people who attended the emergency department and/or were admitted to the inpatient paediatric ward. There were significant gaps in documentation relating to risk assessment and overall risk management plan for children and young people admitted with mental health conditions. For example, we reviewed patient records relating to young people admitted with eating disorders and found there were no risk assessments that followed national guidance from the Royal College of Psychiatrists such as guidelines for the Management of Medical Emergencies in eating disorders: Guidance of Recognition and Management (2022) or the previous guidance from 2010. However, we spoke with staff who discussed how they used this guidance, which demonstrated their awareness although the review of records showed the guidance was not consistently applied.

Patient notes for children and young people admitted with physical health needs, were comprehensive and all staff could access them easily. Assessments were clearly documented in patient records. These included referrals to other teams and any observations about potential unmet need of the patient, such as interventions for learning disabilities or mental health needs.

It was not always clear if staff had private discussions with patients away from their parents. For example, a number of patients were seen for drug or alcohol-related needs. It was not clear if this conversation had taken place in an environment in which a young person would feel comfortable disclosing this information.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Services for children and young people

Staff followed systems and processes to prescribe and administer medicines safely. Nursing staff used patient group directions (PGDs) to safely administer five key medicines. PGDs enable non-prescribing staff to administer specific medicines to patients within structured criteria for age and condition.

A pharmacist attended Kingfisher ward daily to review each patient and worked with the medical team to ensure prescribing was appropriate.

Staff stored medicines securely. They managed controlled drugs (CDs) in line with national requirements, including in relation to storage and dispensing. The pharmacy team monitored the temperature of storage areas using a remote device, which enabled them to act in the event temperatures were outside of the safe range.

A rapid tranquilisation kit was stored on Kingfisher ward. Trained staff used this kit in the event violent behaviour from a patient put others at risk of harm. A consultant carried out a best interest assessment prior to staff tranquilising a patient. Staff used the Paediatric Innovation, Education, and Research Network (PIER, 2018) guidance on the use of tranquilisers.

Nursing staff received competency-based training and assessment in the administration of medicines to children and young people.

Incidents

The service mostly managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. The senior team empowered staff at all levels to engage in the incident management system. For example, any member of staff who reported an incident or near miss could arrange a team meeting to discuss it. This helped to embed learning from incidents and staff said it contributed to an open and honest working culture.

Staff reported 14 incidents relating to mental health conditions in children and young people's services on the electronic incident reporting system between 1 August 2021 and 31 July 2022. Seven incidents related to 'self-harm'. There were no reports regarding staff shortages on the inpatient ward although five incidents had been recorded in the paediatric community nursing team.

We reviewed one investigation into a reported incident. While the investigation considered questions from the parent of the child, there were no clinical key lines of enquiry considered to fully investigate the incident. However, actions and improvement recommendations were identified as a result of the investigation.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. However, this was not always clearly recorded and there were no regular audits to assess if care and treatment provided as documented, was compliant with care pathways based on national guidance.

Services for children and young people

Staff provided care and treatment in line with national guidance, including that issued by the National Institute for Health and Care Excellence (NICE) and various royal colleges. The senior clinical team secured input from specialists to deliver enhanced care, such as from a respiratory nurse specialist. For example, there was specific guidelines for staff to follow concerning the care of children and young people with eating disorders who were admitted to the paediatric inpatient ward. This guidance was replicated in a specific care pathway. However, there were no audits to assess if care and treatment was delivered in line with the care pathway.

The senior nursing team had introduced a new mental health assessment form for admissions. This was a comprehensive approach to ensuring staff recognised mental health needs as early as possible. It was based on international best practice and included triage for drug and alcohol use, pre-consent for certain treatment, and an initial three-week care plan. The team had the assessment form peer reviewed for efficacy and were in the process of a region-wide launch of the form following recognition of its usefulness for patient care.

Staff were working to establish more consistent care pathways for adolescents admitted with drug or alcohol-related needs. The work focused on patients who did not live in the area and so were not known to social services. Staff were working with community colleagues to establish behavioural support interventions for this patient group.

Most of the policies we reviewed were current and up to date. However, the 'Paediatric Standard Operating Procedure (version 2, 2019) should have been reviewed in April 2022. The service used some evidence-based polices which were used across the county and therefore were not specifically adapted to the trust itself. Leaders explained this was to ensure a consistent approach across Dorset.

The hospital had implemented a ward accreditation scheme. Based on a set of performance and quality standards, the accreditation was led by a panel of reviewers not connected to the individual ward, which provided a peer review structure. Kingfisher ward had achieved silver accreditation, on a gold, silver, bronze, scale. This reflected consistent standards of care, staff told us they were proud of this award which reflected their approach to evidence-based practice.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

A nurse had trained as the nutrition and hydration link specialist for Kingfisher ward. They worked with dieticians and other specialists and used their knowledge to support colleagues on the ward. They organised a focus week on nutrition and hydration to raise awareness of good management alongside clinical care in young patients. We spoke with one patient who said they had enough to eat and drink and they appreciated staff offering them ice cubes to stay hydrated and cool during a period of very hot weather.

An advanced nurse practitioner led the development of an eating disorder standard operating procedure. This was in response to an increase in adolescents presenting with needs relating to this condition. Staff discussed nasogastric tube placement (a thin tube inserted into the stomach) with patients at risk of malnutrition, including consent, in advance of it being needed. Doctors prescribed fortified liquids if patients could not tolerate solid food. A multidisciplinary team was involved with care planning for patients with malnutrition or an eating disorder. The team followed a structured care pathway for initial treatment and documented reviews in a single document to support good standards of condition tracking. Staff received additional training in how to support and provide care for a child or young person requiring treatment for an eating disorder.

Services for children and young people

Competent staff

The service mostly provided support to ensure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. On the paediatric inpatient ward, staff had access to competency-based training and assessment in a range of topics including new starter/induction training, naso-gastric (NG) feeding (feeding through a small tube directly into the stomach) and medicines management.

In the emergency department, there was an educational lead who held oversight of staff compliance with mandatory training and competency-based training.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The senior team supported staff to develop into more specialist and senior roles and provided them with structured training opportunities to do so. For example, a paediatric advanced nurse practitioner deputised for the divisional paediatric matron as part of a leadership development strategy.

Staff did not always receive specialist training for their role. This was in part due to training being suspended during the COVID pandemic. Staff from the paediatric inpatient ward, the emergency department and porters were invited to attend specific training in 'prevention management of violence and aggression' (PMVA). This training was provided by a neighbouring NHS trust. Face-to-face training had recommenced after this was paused during the pandemic. Records showed 24 staff (including 20 porters) received this training in 2019 and a further two porters completed the training in 2020. Only one person had completed PMVA training on the paediatric ward.

Staff on the paediatric unit, including the paediatric assessment unit, in the emergency department and porters were offered an in-house in break-away, physical interventions (safe holding), NG feeding (under restraint) and how to use ligature cutters. Training compliance records showed seven staff in the emergency department and one staff member on Kingfisher ward had completed an e-learning model in conflict resolution in 2022 but data showed no porters had completed this training. Staff had been unable to attend face-to-face training in physical intervention training during the pandemic (2021) but the delivery of this training had now been recommenced.

In response to a significant increase in the number of patient presentations of autistic children and young people or children and young people with a learning disability, or both, the head of child therapies had prepared specialist training and guidance for nursing staff to provide more effective interventions for this patient group. Outpatient physiotherapists and occupational therapists supported this training, which helped ward staff to reduce sensory triggers in the environment.

At the time of the inspection, the trust did not provide specific training on learning disability and autism, known as 'Oliver McGowan training'. This training became mandatory for all staff working in health and social care in July 2022. The trust was working with NHS England to introduce this training as soon as possible and was expected to be available in towards the end of October 2022.

Senior nurses each led a small team of nurses and were responsible for appraisals, training, and performance management. This system provided good opportunities for leadership development.

Services for children and young people

Each nurse and healthcare support worker had a specialist link role, such as for pain, safeguarding, and infection prevention and control. They worked with specialist colleagues across the hospital to develop their knowledge and skills and apply this to their work.

Multidisciplinary working

There was a lack of clarity regarding the responsibility to provide treatment of children and young people who needed treatment of mental health conditions. However, doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families.

The service had secured more consistent working pathways with the child and adolescent mental health services (CAMHS) team from a neighbouring NHS trust. The CAMHS lead consultant was in the process of recruiting a mental health champion from each grade of nursing staff on Kingfisher ward to improve local knowledge and skills. However, the CAHMS team did not provide treatment for children and young people with mental health conditions on the inpatient ward. They supported the paediatric inpatient ward with additional staff when they could, to meet the needs for specific one-to-one care and monitoring of patients at risk of self-harm.

While staff spoke of good working relationships with external providers, there was a significant lack of partnership working to ensure children and young people received the care and treatment, including delivery of psychosocial interventions, they needed for mental health conditions, including self-harm while they were admitted to the inpatient ward. We were told there was a memorandum of understanding (MOU) being set up in the wider Dorset healthcare system to enable partnership working. However, this MOU was scheduled to have been implemented in April 2022 but had not yet been signed off.

The patient records at Dorset County Hospital suggested that children and young people presenting with mental health conditions, including self-harm, received a brief assessment by CAMHS psychiatric liaison. For example, there were no management plans recorded for staff to follow. Evidence to assure that this was not the case was sought and found in CAMHS records, which were detailed and thorough and considered the child holistically in the context of their family and community. Following the inspection, we told the CAMHS services about the lack of management plans to support the service to meet the needs of children and young people attending or admitted to the hospital.

The records we reviewed for children and young people who had been admitted to the paediatric wards for treatment for eating disorders showed very close working between the eating disorder service clinicians and the paediatric teams. The records showed that the teams worked together constructively before and during hospital admission to deliver care and to try to minimise the restrictions on the children and young people.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families.

An advanced nurse practitioner led the development of an integrated liaison meeting as part of a strategy to embed safeguarding more fully into care and treatment. This was a multidisciplinary weekly meeting that included the safeguarding team and external partners. It meant patients with safeguarding needs received targeted, specialist review during their inpatient spell and after discharge. We observed a meeting as part of our inspection and noted staff had an in-depth understanding of the needs of patients and their families. This included a deep understanding of the impact of pressures on families and their options for community intervention and support. Minutes of meetings were not recorded although actions and learning were recorded on a spreadsheet which was discussed in a monthly paediatric clinical governance meeting.

Services for children and young people

The service recognised there was an increase in children and young people attending with psychosocial concerns often leading to mental health conditions or self-harm. The trust had raised this externally and worked with the wider healthcare system to find solutions. Staff escalated to the executive team when patients no longer needed to be admitted for physical healthcare conditions, but it was not clear how effectively this was escalated further. Senior service leads did not feel empowered to escalate directly to external partners when this situation arose as they had been told to escalate this to the trust's executive team.

Kingfisher Ward, the paediatric assessment unit, the paediatric pre-assessment and day surgery unit, and the end of life care suite were all co-located and easily accessible from each other. This enabled staff to work closely together and to keep patients under their care in a dedicated children and young people's area.

Care and treatment were multidisciplinary by nature and staff worked together to ensure those with specific skills worked in the most appropriate area. For example, the team had recently changed staffing in the paediatric day surgery unit to focus on staff with orthopaedic and ear, nose, and throat training. A range of other teams joined handovers and safety huddles as needed. These included the community nursing team, the transitions team, the trust's learning disability liaison nurse, and the safeguarding team.

A consultant-led ward round took place daily and was attended by a multidisciplinary team including nursing, safeguarding, and pharmacy. Physiotherapists and orthotists worked in the paediatric outpatient department alongside consultants to provide multidisciplinary, 'one-stop' care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

There was a lack of documented evidence to confirm staff had the correct knowledge and understanding of how to obtain consent for treatment for children and young people. Staff did not always protect the rights of children and young people subject to the Mental Health Act 1983. Decisions were not always documented to demonstrate how decisions to deprive children and young people of their liberty were lawfully made.

Staff explained their understanding of Gillick Competence and Fraser Guidelines and how they supported children who wished to make decisions about their treatment. However, records suggested that children and young people at Dorset County Hospital did not have their voices heard or their wishes and feelings adequately considered. The voice of the child was absent in more than half the records we reviewed and was limited in the remainder. In one child's records, the focus was on the impact the child had on others, rather than their own needs and risks. This restricted the provision of individualised child-centred care, support and intervention that is responsive to meeting needs and reducing risks.

Staff did not always record consent to treatment in the children and young people's records. There was incorrect recording in some records about capacity to consent when it should have said competence. In cases where parental consent had been relied upon for treatment for 16 and 17 year old young people there was no record of an assessment of capacity being made to provide evidence that the young person lacked capacity to consent to treatment.

There was a lack of clarity regarding consent/capacity/competence for admission for treatment and for treatment decisions. Tick-box recording on a 'yes/no' basis was sometimes not completed and was never decision-specific. For example, the decision for which consent, or capacity/ competence was being asked was not recorded on the standard forms included in the case records. We did not see any well-recorded capacity/competency assessments in the 22 records we reviewed.

Services for children and young people

Recording of parental consent to treatment was poor. In one set of notes, we saw one case relying on an undated hand-written record by a staff member that a parent had given verbal consent to (NG) feeding for a 16-year old young person. There was no record of a capacity assessment indicating the young person lacked capacity to consent to treatment. This NG feed continued for some time but there was no record of later attempts to confirm parental consent and, in this case, there was a history of disagreement recorded between the two parents regarding the appropriate treatment.

Documentation of the use of formal powers under the Mental Health Act (MHA) 1983 showed that there was a lack of full understanding by some clinicians regarding these powers. We reviewed two records that included the formal use of powers under the MHA 1983. In one patient record a section 5(2) holding power had been used in a circumstance where it was not clear it was appropriate to use this power. A doctor may only use this holding power to prevent inpatients from leaving hospital whilst waiting to carry out a mental health assessment. The patient had been visiting the paediatric ward daily on a voluntary basis for nasogastric (NG) feeding and then returning home. It was not clear in the records that the doctor had considered fully whether a section 5(2) holding power could be used in this situation. The doctor had sought advice, but it was not clear that all relevant information had been shared in order to ensure correct advice was given in this complex case. This means there was a risk that the young person could have been unlawfully deprived of their liberty.

Multidisciplinary staff recognised the need for improved consent processes when patients were referred by another specialty. This could increase risk to the patient and delayed appropriate treatment. Staff were working at trust level to address this issue.

Staff received and were mostly up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards at the level required of their role. The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) only applies to patients over 16 years and patients over 18 years respectively. Training compliance was monitored and showed compliance with level one training in MCA and DoLS was 94% (Kingfisher Ward) and 100% in the emergency department against a trust target of 90%. At level two the compliance was 84% (Kingfisher Ward) and 85% in the emergency department.

Is the service responsive?

Insufficient evidence to rate

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services.

The inpatient ward mostly provided care and treatment for children and young people with physical health needs. Staff recognised the increase in patients with mental health conditions and worked to make adjustments to ensure children and young people living with mental health problems, autism, learning disabilities, and long-term conditions received the necessary care to meet all their needs. Staff were adapting spaces to accommodate patients with complex mental health needs, including those at risk of self-harm. For example, the team had secured a protective cot for young autistic children that allowed for clinical care to be delivered in an environment that promoted low sensitivity. The cot was designed by specialists in young peoples' autism based on international research and included features such as discreet access for line placement that would enable clinical staff to draw blood without alarming the patient as much as it could in an open trolley or bed. The cot was furnished with soft material to prevent injury.

Services for children and young people

Kingfisher ward had a dedicated end of life care suite. This was a private area with clinical monitoring equipment, a kitchen, and a bedroom for parents to stay with their child. Staff adapted the space to individual family needs and used tools to ensure dignity and privacy.

Staff facilitated rapid self-referral access to the inpatient paediatric unit for patients with long-term conditions. This meant parents could call the unit directly and request a medical review and be seen on the same day, between 8am and 8pm. Staff ensured this applied to people staying in the area on holiday or extended visits.

Staff designed the playroom to build positive interactions with young people. It included virtual reality and sensory equipment used to distract, socialise, and reduce anxiety. The ward had a secure outdoor play area where young people could get fresh air in a safe environment equipped with a range of toys and equipment.

Wards were designed to meet the needs of children and young people with physical health needs and their families. Each cubicle on the ward was equipped with a foldaway bed to enable a parent to stay in the same room as their child.

Staff used individualised resources to support patients with their care journey designed to meet their needs and reduce anxiety. For example, the unit had a child car used for patients to 'drive' themselves to the day surgery unit accompanied by staff.

Parents and patients, we spoke, with said they felt staff had adapted the service to their individual needs. For example, an adolescent patient said they appreciated the efforts of the play therapy team to offer them access to a games console. One parent said, "[Staff] have been lovely to us, nothing has been too much trouble."

We observed they treated people with respect and ensured they discussed each person's preferred pronouns and used these in notes and when discussing the patient.

Feedback from patients and parents was generally positive. When feedback suggested improvements could be made, this was noted so that improvements could be considered.

Is the service well-led?

Inspected but not rated

Leadership

Leaders recognised when to escalate care and treatment and understood and managed the priorities and issues the service faced but they were not always empowered to make decisions about escalation of issues concerning care and treatment for children and young people admitted with mental health conditions.

Leaders were demonstrably focused on cross-divisional and external working opportunities to drive innovative care and maintain high standards of safety. For example, the team had established a consistent working contribution to the hospital mortality group and had supported new working processes to better incorporate community nursing colleagues into care planning for patients with complex needs. However, senior service leads did not feel empowered to escalate directly to external partners when children and young people no longer had medical needs but had other complex needs that prevented them from being discharged. Instead they had been told to escalate this directly to the trust's executive team.

Services for children and young people

Children and young people services were provided within the family services and surgery division. This incorporated a clinical director, a service manager, a paediatric matron, and a divisional director of nursing.

A divisional head of nursing for family services and surgery was responsible for care and treatment on Kingfisher ward, the paediatric assessment unit (PAU) and children's day surgery. The divisional manager and director of nursing provided senior leadership. An interim ward manager led Kingfisher ward and the paediatric assessment unit, and a lead nurse was responsible for paediatric pre-assessment and day surgery.

Leaders were visible and approachable in the service for patients and staff. Staff said the senior and local leadership teams were visible and readily contactable whenever they needed support. The divisional leads carried out weekly walkarounds of Kingfisher ward and the PAU as part of a strategy to establish a regular presence without increasing the anxiety of young people who needed a more consistent staff presence of people they recognised on the ward.

Culture

Staff felt respected, supported and valued. However, leaders did not always feel empowered to escalate concerns externally when this was required.

Staff were focused on the needs of patients receiving care. Staff spoke of how they worked to ensure patients received the right care in the right place as far as they were able to. They spoke of their concerns about meeting the needs of children and young people who did not need to be admitted to the hospital for physical health needs. Senior service leads did not feel empowered to escalate directly to external partners when children and young people no longer had medical needs but had other complex needs that prevented them from being discharged. Instead they had been told to escalate this directly to the trust's executive team.

The trust recognised the impact dealing with children and young people may have on staff's well-being. The trust offered safeguarding children supervision, which offered an opportunity for staff to discuss individual cases to promote a positive outcome for the patient and ensured there was an ongoing clear focus on children's well-being. There was one group supervision on the Kingfisher ward every six months, but more frequent sessions could be arranged if required. However, we saw no evidence of safeguarding supervision being documented in children and young people's records in any of the 22 records we reviewed. This did not provide assurance that practitioners receiving safeguarding supervision documented any agreed actions to ensure these were implemented.

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff told us they had escalated concerns to managers and leaders as required.

The senior team fostered a clear safety culture, which we saw was embedded in all aspects of care. For example, staffing structures and ratios, and decisions about capacity and flow, were made in the best interest of patient safety taking the capacity of the department into account. When the service was not fully staffed the senior team capped admissions rather than move nurses from adult services. This ensured care was delivered by the most appropriate staff.

Staff fostered a culture of safe working practices. For example, day shift staff checked with night shift colleagues each morning to make sure they felt awake and alert enough to get home safely.

Governance

Services for children and young people

There was a lack of inpatient mental health care provision in the region and a lack of governance processes, throughout the service and with partner organisations, to ensure children and young people with mental health needs received effective treatment.

There was a lack of inpatient bed facilities to deliver mental health care in the region, which had a substantive negative impact on the trust. Staff recognised increasing numbers of young people, especially adolescents, presenting at the emergency department with mental health needs. This meant the service was increasingly called upon to provide care for patients with complex mental health needs when patients did not require to be admitted for physical health reasons. Senior and executive leaders were not clear about their clinical responsibility for children and young people who were admitted to the inpatient ward when there was no medical need for the patients to be admitted. Executive leaders and service leaders told us the specialist mental health clinical responsibility of the patients passed to a neighbouring NHS provider when a patient had been detained under Section 2 of the Mental Health Act (1983). They told us they did not have the expertise to provide specialist mental health care and treatment while external partners did not perceive the hospital environment conducive to treatment for mental health conditions. This meant children and young people remained in the acute hospital without access to the full range of psychological therapies and specialist mental health inpatient support that they were assessed as requiring.

We reviewed the service level agreement between Dorset County Hospital NHSFT and the neighbouring NHS trust providing mental health care and treatment. The agreement was signed in 2017. There had been a pause in the annual review of the agreement during the COVID-19 pandemic and we noted it had not been updated since the previous nominated representative for the trust left in March 2021. The list of services to be provided did not include clarity about who should provide treatment of patients who could not be discharged home because of their ongoing mental health condition.

Staff on Kingfisher ward and the paediatric assessment unit worked jointly in governance processes to provide holistic, safe care. The referral and escalation systems meant they were trained but they did not always feel empowered to engage the multidisciplinary team and contact specialists when this was necessary for patients with complex needs.

The senior team worked to ensure governance was cross-organisational, which meant staff worked closely with community colleagues and primary care doctors to coordinate care that was timely and reduced delays in the system. Each month a different senior staff nurse was allocated to a quality assurance role as part of quality and performance monitoring. This role involved monitoring data to assess performance and areas for improvement. Staff said access to information was consistently good and helped them to maintain an understanding of overall performance.

There were processes to review the notes of all children and young people who presented to the trust to identify those with safeguarding concerns. Notes were reviewed daily by the children's safeguarding team. All patients were discussed in a multidisciplinary meeting with external stakeholders in a weekly integrated liaison meeting. Reported incidents concerning children and young people attending or admitted with mental health conditions, including self-harm, were discussed in a quarterly safeguarding group.

Management of risk, issues and performance

Leaders and teams recognised key risks to the service and mostly used effective systems to mitigate these. However, risks were not always recorded on risk registers at service level or escalated at trust level.

Services for children and young people

Staff identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff told us about the increasing number of children and young people who were admitted to the unit with no physical health needs. Risks related to staff wellbeing and to maintaining safe staffing levels on the paediatric inpatient ward had not been entered onto the risk register although staff and leaders spoke of the impact this was having on the service.

Staff shortages were a key risk on Kingfisher Ward and the senior team capped admission numbers to ensure it remained safe. However, this was not recognised as a risk on the service's risk register

There was a risk registered on the services risk register relating to external multiagency delays resulting in delayed discharge of complex paediatric patients. The risk level was assessed as low risk meaning that it was not escalated to the trust risk register.

There was another risk on the paediatric risk register concerning children and young people who were admitted to Kingfisher Ward with an eating disorder, the risk reflected this patient group were often admitted for long periods of time before they could be moved to a more suitable place. There were some actions identified and the risk register showed the risk was due to be reviewed on 31 August 2022.

The whole staffing team demonstrated awareness of risk and issues and demonstrated their dedication to addressing these. For example, clinical staff on Kingfisher Ward had identified a need for better clinical monitoring equipment for patients with complex medical needs. They had secured procurement of new remote blood oxygen monitoring equipment and were installing these in a high observation bay with monitoring equipment at a dedicated nurse station. This would reduce clinical risk by providing staff with a more effective system to deliver care.

Following a serious incident in which staff received physical injuries and psychological trauma from a young person, the organisational development team were establishing targeted, bespoke support for all members of staff. This included multidisciplinary debriefs led by psychologists as well as wellbeing checks, and face to face counselling. This reflected a good response to a significant level of risk to staff welfare and wellbeing.

All staff were enrolled on a rolling programme of prevention and management of violence and aggression (PMVA) that met NHS Protect standards. This was in response to a substantial increase in violence against staff and aimed to equip them with better skills to de-escalate situations and safely restrain children and young people.

Information Management

Information systems were integrated and secure.

Each month a different senior staff nurse was allocated to a quality assurance role as part of quality and performance monitoring. This role involved monitoring data to assess performance and areas for improvement. Staff said access to information was consistently good and helped them to maintain an understanding of overall performance.

Areas for improvement

MUSTS

Services for children and young people

- The trust must improve systems and processes to investigate and follow up on any allegations, evidence or concerns raised about safeguarding issued when children and young people present to the emergency department and/or are admitted to the paediatric service (Regulation 13 (2) (3)).
- The trust must assess the impact of the building work in the emergency department to ensure mitigating actions are identified to ensure the premises are suitable for the purpose for which they are being used (Regulation 15 (1) (c))
- The trust must ensure care and treatment is provided with the consent of relevant persons. There was a lack of documented evidence that the child's voice was heard, and that staff fully understood the complexity of consent, capacity and competency (Regulation 11 (1)).
- The trust must ensure all risks, including environmental risks, associated with children and young people admitted to the hospital are assessed and mitigated. Clear evidence of this must be recorded in patients' medical notes (Regulation 12 (2) (a) (b))

SHOULDS

- The service should introduce a system to improve staff compliance with mandatory training including conflict resolution and physical intervention training for those staff groups this applies to, to meet trust targets.
- The service should consider how policy guidance is used to inform the 'assessment for the level of mental health observations 'required and document this in children and young peoples' medical notes.
- The service should improve processes to review policy and guidance to ensure these are current and reflect most recent evidence-based guidance.
- The trust should continue to participate in discussion with the wider healthcare system to set up systems of support and accountability for the care and treatment of children and young people who do not required admission to the paediatric inpatient ward for physical health needs.
- The trust should empower senior clinicians to make direct referrals to external partners for ongoing treatment and to ensure timely referrals.
- The service should consider introducing audits to assess compliance of care and treatment to meet national guidance as set out in care pathways.
- The service should consider using clinical key lines of enquiry for the investigation of incidents in addition to questions raised by parents.

Our inspection team

We carried out a focussed inspection in response to a significant incident which was shared with CQC by the trust.. We concentrated on specific key lines of enquiry focussing on the pathway for children and young people who present with and/or are admitted to the paediatric ward (Kingfisher Ward), with mental health conditions, including self-harm. We also looked at how the service meet the needs of children and young people with mental health conditions and/or self-harm and who also had a learning disability or autism.

We spoke 23 staff members from different departments, including nurses, consultants, medical staff, managers and support staff during our inspection. We spoke with one patient and three parents of children who were admitted to Kingfisher Ward for a physical health condition. We inspected the paediatric inpatient ward (Kingfisher Ward) and spoke with staff from the emergency department and critical care unit who may also be involved with the care and treatment of children and young people. We reviewed 27 care records, including 22 care records for children and young people admitted with mental health needs. We also looked at documents such as policies and procedures. We also spoke with external stakeholders who contributed to care and treatment of children and young people presenting with mental health conditions, including self-harm.