Priory Healthcare Limited

The Priory Hospital North London

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Overall summary

Priory Hospital North London is an independent hospital which provides care and treatment to young people and adults with mental health problems and substance misuse problems. There are 2 adult wards and 1 ward for young people. Birch Ward treats children and young people with acute mental health problems and has 8 beds.

Our rating of this service for children and young people went down. We rated it as requires improvement because:

- We rated the service as requires improvement for safe and well-led. When aggregated with the previous ratings for the acute adult wards this means the overall rating for the hospital is now requires improvement.
- Staff did not always monitor young peoples' physical health in line with the provider's Standard Operating Procedure (SOP) or national guidance after they had received medicines via rapid tranquilisation. This meant young people may be at potential risk of harm. The provider's SOP more closely mirrors national guidance for rapid tranquilisation monitoring in adults than the national guidance for children and young people.
- The ward environment required improvement. The medicines trolley in the clinic room was not clean, and young people reported ongoing issues with the effectiveness of the ward's washing machine. The environment was not suitable for young people admitted with autism spectrum disorder.
- Medicines management required improvement. For example, two staff did not always sign the controlled drugs book in line with the provider's policy. Liquid medicines were not always labelled with the dates they were opened or when they were due to expire. Staff did not make it clear what had happened to medicines stored in the fridge after the fridge temperate had exceeded the recommended temperature. This meant staff could not be sure medicines administered to young people were suitable for use.
- Some parents felt concerned staff did not encourage their children to engage with the education or therapy on the ward, or to eat a balanced diet.
- Young people and carers were still not yet formally involved in the operation of the hospital. Young people had weekly community meetings and carers felt able to contact managers with any concerns but plans to involve service users on interview panels or in clinical governance meetings were yet to be implemented.
- Our findings from the other key questions demonstrated the governance processes needed strengthening. For example, improvements were needed with oversight of medicines management issues, ensuring post-rapid tranquilisation physical health monitoring was completed appropriately, and ensuring actions from audits were addressed. Managers did not always have access to accurate data, for example on incidents, to enable good oversight of the service.

However:

- We rated the service as good for effective, caring and responsive.
- Staff assessed and managed most risks well and followed good practice with respect to safeguarding. They knew the young people and their individual risks well. Young people were kept separate from adult service users. Staff used restraint only after attempts at de-escalation had failed. Where managers had concerns about the safety and quality of care of a young person, they had engaged other stakeholders and considered alternative care options.
- Staff developed holistic, recovery-orientated care plans informed by comprehensive assessments. Staff used the positive behavioural support (PBS) model to understand young peoples' behaviours which challenge.
- The team included or had access to a range of specialists required to meet the needs of young people and worked well together. Managers supported staff to complete their training, appraisals and supervision.

Summary of findings

- Staff treated young people with compassion and kindness and understood their individual needs. They actively involved young people, and their carers where appropriate, in decisions and care planning. Staff provided carers with daily updates about their child's wellbeing and care. Young people had regular access to an independent advocate.
- Staff planned and managed discharge well. Young people had access to high-quality education throughout their time on the ward. The on-site school was rated as 'Outstanding' at their last inspection in March 2023.
- Leaders were visible and approachable to young people and staff. Staff felt respected, supported and valued.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Requires Improvement 	See summary above.

Summary of findings

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Summary of this inspection

Background to The Priory Hospital North London

We carried out a comprehensive inspection of the child and adolescent mental health service (CAMHS) because the service had not been inspected since 2019. We wanted to check on improvements made since this inspection. We had also received a complaint from a family member which gave us concerns about the safety and quality of the service.

This was an unannounced inspection.

During this inspection, we inspected and rated all the key questions for the CAMHS ward; safe, effective, caring, responsive, and well-led.

Priory Hospital North London has one ward for children and young people: Birch Ward. This is an 8-bed ward for both males and females with acute mental health problems up to 18 years of age. During the inspection, hospital leaders informed us they had closed 1 bed to new admissions due to the high acuity and challenging behaviours of young people. In the lead up to the inspection, several staff had been assaulted by young people and required treatment.

The NHS commissions beds for children and young people at The Priory Hospital North London. The hospital has two pathways; one with the local collaborative and another with the national Priory referrals NHSE team. As such, the hospital accepts and reviews referrals of children and young people based locally as well as out of area. At the time of our inspection there were 3 out of area young people on Birch Ward.

The provider is registered to provide the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury.

There was a registered manager in post.

We last conducted a comprehensive inspection of The Priory Hospital North London in October 2019. At that time we rated the hospital as requires improvement for safe, and good for effective, caring, responsive and well-led. We rated the hospital as good overall. In February 2022 we conducted a focused inspection of the two acute wards for adults of a working age and psychiatric intensive care units. These wards were rated as good in all 5 key questions.

Following the 2019 inspection, we issued a requirement notice on the provider concerning Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This action related to the CAMHS wards, of which there were two at the time. We also issued a number of actions we felt the provider should take to improve. During this inspection we found the provider had improved in some areas, but there were still some actions that were yet to be established.

What people who use the service say

Summary of this inspection

We spoke with 6 young people and 6 family members. Overall, young people spoke positively about staff, in particular the ward manager, clinical psychologist and education team. Young people were generally happy with the education and therapy offering, and they received copies of their care plans. However, some young people told us they were bored on weekends because there were no trips. They also shared negative feedback about some maintenance issues such as the washing machine and living room environment.

Overall, parents of the young people we spoke with were positive about the care their children had received. Parents were very pleased with the levels of communication from staff. However, most parents did not know how to make a formal complaint and there was not a formal way for them to feedback on the operation of the hospital.

How we carried out this inspection

During the inspection, the inspection team:

- Conducted a review of the environment and clinic room for Birch Ward
- Spoke with the hospital director and the director of clinical services
- Spoke with the ward manager
- Spoke with 8 other members of staff including 2 nurses (one permanent, one preceptorship), 2 healthcare assistants, the consultant psychiatrist, the clinical psychologist, the CAMHS social worker and the ward administrator.
- Spoke with 6 young people using the service
- Spoke with 6 parents or carers of young people using the service
- Looked at 4 prescription charts
- Looked at 4 patient records
- Observed a daily 'flash' meeting and a daily multidisciplinary (MDT) handover
- Reviewed a range of other documents related to the running of the service

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

CAMHS service

- The service must ensure that young peoples' physical health is checked appropriately after they have received medicines via rapid tranquilisation, in line with national good practice guidelines and the provider's standard operating procedure. (Regulation 12)
- The service must ensure it uses systems and processes to safely store and manage medicines in line with the provider's policy. This includes securely storing medication waiting for disposal; storing medication at the correct temperature; and correctly signing when administering controlled medication. (Regulation 12)

Summary of this inspection

- The service must ensure they implement ways to formally involve young people and carers in the governance and wider operation of the hospital. (Regulation 17)
- The service must ensure governance processes operate effectively and that local procedures and policies are met. This includes safe medicines management and oversight of physical health monitoring following rapid tranquilisation. It also includes ensuring managers have access to accurate data about incidents and other operational matters to enable them to have effective oversight of the hospital. (Regulation 17)

Action the service SHOULD take to improve:

Birch Ward

- The service should ensure that all staff complete the mandatory learning disability and autism training so they are sufficiently trained to work with young people who have autism spectrum disorder.
- The service should ensure that information is displayed on the ward to ensure all young people are aware that CCTV is in use in communal areas.
- The service should ensure they improve their internet connectivity so staff are able to access and maintain records in relation to young peoples' care and treatment.
- The service should ensure that ward equipment such as the washing machine is repaired quickly when not working.
- The service should consider ways to make the ward environment more suitable for young people with diagnoses of autism spectrum disorder, for example, implementing a sensory room and improving noise levels and lighting on the ward.
- The service should ensure they keep the clinic room trolley clean.
- The service should ensure all children and young people admitted to the ward are provided with sufficient introductory information.
- The service should ensure activity timetables include activities on weekends.
- The service should ensure carers are provided with information about how to make a formal complaint.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Child and adolescent mental health wards

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

The ward was safe, well furnished and fit for purpose. However, the clinic room was not always kept clean and some maintenance issues took too long to resolve.

Safety of the ward layout

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. Staff completed audits to identify ligature anchor points on the ward and how to mitigate these risks. Staff were aware of where ligature cutters were kept. The last ligature audit was completed in February 2023.

Staff could not always observe children and young people in all parts of the ward and managed this by using convex mirrors and increasing observation levels.

There were closed-circuit television cameras (CCTV) within communal areas. Young people were informed about use of CCTV in their welcome information pack and by signs on outer doors. However, there were no signs on the ward as a reminder for young people who were unable to leave the ward.

A member of staff was allocated to be responsible for security matters during the daily morning 'flash' meeting. We saw staff recorded their actions in a folder, and that these were mostly completed.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. Staff wore personal alarms and checked these were functioning at the start of each shift. The ward manager regularly tested response times to alarm calls through monthly emergency scenario drills. The most recent drill had been to assess how staff responded to an incident of choking with no breathing. The ward manager said they provided staff with feedback after each scenario to improve their responses to any future emergencies.

The ward complied with guidance and there was no mixed sex accommodation. All bedrooms had en-suite facilities so young people did not have to share bathroom facilities with members of the opposite sex. Managers considered the gender mix of staff on the ward during their daily 'flash' meeting. However, there was only one living room which meant young people did not have access to single sex day rooms.

There was no seclusion room present on Birch Ward. Situations involving heightened risks to patients were managed by increasing the levels of observations.

Maintenance, cleanliness and infection control

The service maintained the ward environment. Much of the ward had been recently painted, although there was some damage to the lounge which the provider has since addressed.

Staff discussed any maintenance issues within the daily 'flash' meeting. Young people said they experienced ongoing issues with the washing machine. They had raised this repeatedly since a community meeting on 13 February 2023 and the action was noted as ongoing at the time of our inspection. We saw evidence that the maintenance team had promptly tested the machine after young people initially raised concerns. Maintenance found it was being overloaded and displayed instructions for effective use. However, during our inspection, young people told us the issues were ongoing. They said the machine drawer was dirty which made their clothes smell, and it took 4 hours to dry clothing.

Staff followed infection control policy, including handwashing.

The ward appeared visibly clean during the inspection and domestic staff followed a cleaning schedule that covered most areas of the ward.

Clinic room and equipment

Birch Ward had two clinic rooms. There was a small clinic room only used by staff and young people on the ward, and a larger treatment room which was shared with another ward. The larger treatment room contained an examination couch and equipment such as weighing scales. External domestic cleaning staff were responsible for cleaning this larger treatment room and completed a cleaning checklist. We saw some gaps in the cleaning records in the four months before our inspection, for example on most weekend days and for the first week of March 2023.

Nursing staff were responsible for cleaning equipment within the clinic room each day and noting when this had been done. There was an equipment cleaning checklist which was audited weekly by the nurse in charge or ward manager. This included the medicines fridge, blood pressure monitors and stethoscopes.

However, we observed that the medicines trolley in the clinic room was dirty. This had not been identified by staff or managers. We made the provider aware and a new clinic room cleaning schedule, which included the medicines trolley, was created.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. At our previous inspection of the CAMHS service in 2019, we found a small number of disposable medical items were out of date. At the current inspection we found this had been addressed. All staff were aware of where emergency medicines and equipment were located.

Records showed all equipment had been calibrated at a suitable frequency according to the manufacturer's recommendations. A recent audit recognised the oxygen was due to run out in April 2023. We saw evidence that replacements had been ordered.

We observed that the clinic room only had one sink, instead of a separate sink for hand washing, which would have been good practice.

Staff recorded the medicine fridge temperature and escalated the issue to maintenance when the temperature went above the required limit.

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

In our last inspection we said the provider must ensure sufficient staff were deployed to Birch Ward. We found staffing on the ward had improved since our last inspection.

The service had enough nursing and support staff to keep children and young people safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the children and young people. For example, when there was a higher acuity of patients, more staff were booked to support young people and colleagues.

Managers discussed staffing every day during 'flash' meetings. The staffing establishment for Birch Ward was 2 nurses and 2 healthcare assistants (HCA) during day shifts, with extra HCAs if young people were on enhanced observations. At night the service planned for 1 nurse and 2 HCAs, again with extra HCAs if required.

Senior leaders told us they had fully recruited to nursing vacancies. A number of these were preceptorship nurses and/or being onboarded to the service so they used agency staff to support the ward. Managers said there was a high turnover with HCA roles. The service used regular agency HCAs where possible so they were familiar with the ward and the young people. The service was about to begin a recruitment drive for new HCAs.

We reviewed staffing rotas for the week prior to our inspection. The ward had the correct establishment for its needs during day and night shifts. Staff receiving their induction period were not counted within the staffing numbers. Shifts were usually made up of permanent, bank and agency staff. However, on the Saturday and Sunday night shifts there were no permanent members of staff. Managers said they tried to use agency staff who were familiar with the service. One locum agency worker had been there for 7 years and another for 3 years. A staff member was allocated to focus on activities on 3 of the 8 rotas we reviewed.

The service had only logged 1 staffing incident in the 3 months prior to our inspection which was due to low staffing numbers. On this occasion, the ward manager was informed and staff from another ward helped. Staff described an improved picture with staffing and said morale had improved. Two members of staff said it was challenging when short staffed and two others said they would like more permanent HCAs.

Requires Improvement

Child and adolescent mental health wards

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Staff and managers told us an integral part of the induction process was to allow new starters to shadow existing staff members.

Overall, all 6 parents we spoke with were very complimentary about the staff on the ward. They described how some staff built good rapport with their children and said communication and updates from staff was excellent. However, some young people told us their weekly supermarket trip was often cancelled due to lack of staff. The provider informed us there had not been any cancellations due to lack of staff. On the first day of our inspection, activities could not go ahead due to staff resources being needed to manage the acuity of the ward. The ward manager said this had not happened since January 2023.

The turnover rate was 3% of staff over the 12 months prior to the inspection. This had reduced since our last inspection of the ward.

Levels of sickness across Birch Ward was 5.8% over the previous 12 months. Managers supported staff who needed time off for ill health and completed back to work forms on their return.

Children and young people had regular one to one sessions with their named nurse or HCA. The clinical psychologist offered weekly one-to-one sessions.

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

Staff shared key information to keep 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. There was a ward doctor and consultant psychiatrist working during the daytime. A registered medical officer was available out of hours.

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

Most staff had completed and kept up-to-date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training. The overall training compliance for the ward was 94.8%. It included training on reducing restrictive interventions, immediate life support, basic life support, fire safety, safeguarding and emergency first aid.

A new learning disability and autism training had been introduced as mandatory from 6 February 2023, and 77% of nurses and HCAs had completed this. The Health and Care Act 2022 made this training a requirement for regulated services from 1 July 2022.

Assessing and managing risk to children and young people and staff

Requires Improvement

Child and adolescent mental health wards

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 only after attempts at de-escalation had failed. The ward did not have a restrictive interventions reduction programme, but ward staff were keeping restrictive practices under review. However, staff did not always complete physical health monitoring following rapid tranquilisation in line with the provider's policy.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

We observed that some risk management plans were brief, with only a sentence for each risk identified. However, each young person had a child-friendly wellbeing and safety support plan (WSSP) which detailed risks and actions they and staff should take if they experienced a deterioration in their mental state. More information on the WSSP can be found under the 'effective' domain of this report.

Enhanced personal emergency evacuation plans (PEEP) were in place for 2 patients on the ward to address specific vulnerabilities. These detailed any hazards presented by or to service users, and actions staff must take to ensure everyone was safe in the event of an emergency evacuation. Managers informed us the other young people had generic PEEPs.

Management of patient risk

We reviewed 4 care records during our inspection. Staff updated risk assessments regularly.

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Risks to young people were discussed every day during daily 'flash' meetings between managers and multidisciplinary team (MDT) handovers.

Staff identified and responded to any changes in risks to, or posed by, children and young people. For example, additional staff were requested if a young person's risks increased.

Staff followed procedures to minimise risks where they could not easily observe children and young people. This was mainly through regular observations, convex mirrors, and CCTV.

Staff followed the provider's policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. In our last comprehensive inspection of the hospital in 2019, we said the provider should review the blanket practice of searching all patients' bedrooms twice per month. During this inspection, all staff we asked said bedroom searches were random, or based on risk, and young people were asked for consent. This was in line with the provider's policy. One patient confirmed their bedroom had never been searched. Staff reminded young people during a community meeting that regular checks and room searches were to ensure safety. The provider's policy states searching practices must not become routine without cause, and that searches must form part of patients' treatment plans. The ward manager said most of the young people at the time of our inspection had risks of self-harm. They also said young people had been known to pass harmful items to each other. Most staff told us searches were done in response to individual risk and consent was sought.

Staff completed a 5-point risk assessment every time a young person was due to leave the ward. During the inspection we observed the education team request risk assessments for all young people they were taking on a walk. This risk assessment assessed young peoples' mental states, relational security, medicines compliance, leave status, and whether there had been any self-harm or aggression in the previous 24 hours.

Use of restrictive interventions

Staff did not fully and consistently follow NICE guidance or their own standard operating procedures (SOP) when using rapid tranquilisation medicines. We looked at 8 incidents where one young person had received rapid tranquilisation between 8 December 2022 and 8 March 2023. The young person was noted to have fallen asleep on 5 occasions shortly after being given rapid tranquilisation medicines. The provider's SOP and NICE guidance for adults states patients' vital signs should be monitored every 15 minutes if they appear to be asleep until there are no further concerns about their physical health. For 4 of the 5 incidents, we did not find clear evidence that staff increased the frequency of monitoring to every 15 minutes when the young person had fallen asleep. The young person was sometimes already on continuous one-to-one observations, but observing staff did not note respiration rates every 15 minutes, they only commented that breathing was seen. This meant staff could not effectively assess whether the young person's physical health was deteriorating as they did not have respiration rates to use as a benchmark. This was particularly important given the young person consistently refused most other physical health observations (i.e. pulse, temperature, blood pressure), which meant respiration rates were the main way staff could assess for decline. Most documentation did not clarify the frequency of physical observations agreed by staff, whether there were further concerns about the person's physical health, or the time monitoring stopped. Two patients told us staff did not always check on them after administering rapid tranquilisation. Post-rapid tranquilisation physical health monitoring was an area of improvement on the ward improvement plan at the start of 2022 and this action remained ongoing at the time of our inspection. Furthermore, NICE guidance has 2 sections about rapid tranquilisation; one about rapid tranquilisation in adults and another about rapid tranquilisation in children and young people. The section for children and young people states physical health and emotional impact of rapid tranquilisation should be monitored continuously. The provider's rapid tranquilisation SOP more closely mirrors NICE guidance for adults.

However, 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. We looked at 7 incident forms which detailed the de-escalation techniques staff used before moving to restraint. Staff were able to explain what they had learnt in training about de-escalation techniques and how to restrain children and young people if necessary. Staff had access to training from an accredited trainer.

In our last inspection, we recognised the provider monitored restrictive interventions, but said the provider should ensure that a restrictive interventions reduction programme was operated. During this inspection, we saw evidence the service considered and reviewed restrictive practices reduction interventions.

Staff regularly reviewed any blanket restrictions applied to individuals or all young people on the ward. For example, young people were not allowed their phones before 4pm on weekdays and asked to give staff their phones by 10pm each night. This was so phones were only used outside of the therapeutic programme. If a young person had a therapeutic need for their mobile phone outside permitted hours, this was reviewed and care planned.

Safeguarding

Requires Improvement

Child and adolescent mental health wards

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 ward had two safeguarding leads.

Safeguarding matters were discussed within the daily 'flash' meeting and monthly clinical governance meetings. The safeguarding leads attended a provider safeguarding forum with the lead for Priory CAMHS every 6 weeks where lessons learnt from across Priory sites were shared. A new schedule of meetings with the local authority designated officer were being planned to discuss safeguarding issues, ask for advice and share learning. At the time of our inspection one of these meetings had happened.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding board in the staff office detailing the process for raising a safeguarding matter and who to contact. Safeguarding processes were detailed within ward team meeting minutes.

Staff kept up-to-date with their safeguarding training. At the time of our inspection, 100% of nurses and 92.9% HCAs on Birch Ward had completed their mandatory safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The ward's social worker told us they could make referrals to the multi-agency safeguarding hub (MASH) if necessary and had good links with the local authority. The main aim of MASH is for different agencies to share information about know risks to young people and to make quicker decisions about what to do.

Staff followed clear procedures to keep children visiting the ward safe. Rooms could be booked outside of the ward if anyone under 18 years old was visiting a service user.

All bedrooms were en-suite. Young people did not mix with adult service users during their stay.

Staff access to essential information

Staff had easy access to clinical information – whether paper-based or electronic. However, the service had ongoing issues with internet connectivity which sometimes impacted staff ability to use the electronic system effectively.

All staff on the ward, with the exception of "irregular agency" staff, could access the electronic records system. Most notes were electronic. Some exceptions included the physical health observation sheet and the enhanced observations sheets. Staff also discussed each young person during the daily MDT handover and notes from these meetings were added to their records.

The service experienced continual issues with the internet dropping in and out. When the internet was not working it meant the electronic records and systems could not be accessed easily which delayed notes being uploaded onto the system. Staff we spoke with said internet issues happened quite often but were usually resolved quickly each time. Staff knew how to report IT issues and senior leaders were aware of the issues. The ward manager told us they asked staff to type their clinical notes onto an offline document and update the records as soon as possible afterwards. Poor Wi-Fi coverage and issues with IT equipment featured on the hospital's risk register. We experienced difficulties in accessing some records and systems during our inspection which caused some delays.

Requires Improvement

Child and adolescent mental health wards

Medicines management

The service did not always use systems and processes to safely store and manage medicines in line with the provider's policy. However, staff safely prescribed medicines and regularly reviewed the effects of medicines on each child or young person's mental and physical health.

Medicines requiring disposal were not stored securely. In the clinic room we saw a large quantity of medicines for disposal in a box which was not secure. The external pharmacist was responsible for disposing of the medicines every week, but three staff we spoke with were unable to tell us when this last happened. Ward staff as well as external domestic cleaners had unsupervised access to the room. Therefore, there was a risk that medicines could be misused or diverted. We raised this with the provider who confirmed they had ordered a suitable new medicines disposal box.

Liquid medicines did not always have a date when they were first opened. This was not in line with the provider's policy and meant the service could not be assured they were still suitable for use. This had also been identified in a medicines audit completed by the external pharmacist in February 2023. Although actions had been taken to rectify this, it was identified again in the audit conducted in March and on inspection.

Staff monitored fridge temperatures where medicines were stored. However, we saw that the temperature had exceeded the maximum recommended temperature on 3 consecutive days in February 2023. Staff escalated the issue to maintenance on the third day, but they did not appear to have informed the ward manager as per the provider's policy. Records did not show what actions had been taken for the medicines in the refrigerator at the time. Therefore, the service could not be assured that the medicines were safe to use during or after this period.

The service conducted monthly checks of their medicines to identify those that were close to expiry or had expired.

Controlled drugs (CDs - medicines which are subject to additional controls due to their potential for misuse) were stored securely. Medicine cupboards and the medicines fridge were locked. Keys to access medicines were only held by the nurse in charge of medicines for the shift and the director of clinical services.

Staff kept records about the storage and administration of CDs and there were no discrepancies between CD stocks and the CD book. However, on the day of our inspection, we noted the controlled drugs book was only signed by one nurse instead of two. We informed the provider who explained a serious incident had occurred on the ward that prevented the nurse from countersigning the book. However, the evidence indicated this was not an isolated incident. For example, an external medicines management audit in March 2023 identified another date where several entries were not all double signed. The provider's policy states two signatures, one by the person administering the drug and the other by someone witnessing this, are required.

Staff had access to up-to-date medicines resources relevant to young people. Managers required staff to complete competency checks before administering medicines to young people. The provider planned to introduce an electronic system for recording the prescribing and administration of medicines. A pilot had shown reduced errors. All sites were due to have this system by December 2023.

We looked at 4 prescription charts. Each time a young person refused their medicines this was noted on the prescription charts using the correct code. The charts recorded allergies. The dosages and any changes were clearly documented.

The ward was supported by an external pharmacist who visited weekly. They completed audits which included the ward's medicines management processes.

Staff reviewed young people's medicines regularly and provided specific advice to them and carers about their medicines. Initial assessments carried out on admission to the ward included medicines and physical health observations. Young people and carers were involved when making decisions about their treatment. For example, one parent we spoke with said their feedback on what had previously worked well for their child was taken on board by the psychiatrist in deciding what to prescribe. Young people were invited to ward rounds and the consultant provided parents with a weekly update over the telephone.

The service ensured young people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each child or young person's medicines on their physical health according to NICE guidance. Young people were offered weekly physical health checks, such as blood pressure and pulse monitoring, to assess for issues caused by their medicine. Young people could be weighed weekly with their consent. A ward doctor was available 9am to 5pm during the week, but there was always a resident medical officer on site if required out of hours.

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 shared lessons learnt from incidents across the organisation with the whole team. The provider investigated incidents and made improvements where needed. When things went wrong, staff gave children and young people honest information and suitable support.

Staff reported serious incidents clearly and in line with provider policy. Managers investigated incidents thoroughly.

Issues related to Birch Ward discussed during clinical governance meetings were cascaded to ward staff. For example, managers recognised incidents were not properly documented on the provider's system. This was subsequently discussed in the ward's team meeting and additional training was arranged. During our inspection, we saw evidence that a range of incidents were reported.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong. We looked at a sample of incident forms which were completed after restraint and/or rapid tranquilisation had been used. We saw that staff updated parents after these incidents.

Managers debriefed and supported staff after any serious incident. Staff were positive about support from senior leaders. Weekly reflective practice sessions were available to staff. However, one HCA told us it had been a while since they were last able to attend. A nurse told us they were trying to find a new time for the session so more people could attend.

Managers from the different wards had just started to attend a new patient safety forum meeting. They looked at information discussed in the regional patient safety meeting to inform their discussion. Topics discussed included regional updates, policies, patient safety initiatives and any actions. There was a section for patient and carer experience, but this was blank in the minutes we reviewed. A new patient safety representative had recently started at the hospital. They planned to attend patient safety forums and community meetings to speak with service users.

Requires Improvement

Child and adolescent mental health wards

There was evidence that changes had been made as a result of feedback and reviewing themes of incidents. For example, staff conducted a deep dive into patterns of incidents on Birch Ward and found most happened outside of education and therapy times. As a result, staff introduced additional activities outside of these times, such as pet therapy, evening trips twice a week and film nights on a Friday.

The evidence indicated staff shared information about lessons learnt from across the ward and wider provider. However, in January 2023, the provider conducted a quality walk around of Birch Ward. During this process they spoke with 2 members of staff, one was new to their role and one was an agency worker. Neither of these members of staff were aware of the term “learned lessons” or how these were communicated within the team. Furthermore, despite ward staff having access to lessons learnt from the ward, the wider hospital, and across the provider, all examples staff gave us about learning related to the care of one individual rather than the wider ward or hospital.

Is the service effective?

Good

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

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 discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery-oriented.

We reviewed 4 care records during our inspection. These records were personalised, holistic and recovery-orientated.

Staff completed a comprehensive mental health assessment of each young person either on admission or soon after. Staff assessed young people’s physical health soon after admission and regularly reviewed this during their time on the ward.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs. These were separated into four areas: keeping healthy, keeping well, keeping safe, and keeping connected. Each care plan contained recovery goals expressed by the young person and goals from the staffing team if different. They also detailed the actions needed from the young person, different staffing teams (medical, nursing and therapy) and carers to achieve their goals.

Staff regularly reviewed and updated care plans when children and young people's needs changed.

Young people had child-friendly wellbeing and safety support plans (WSSP) they created with staff. These plans outlined early warning signs of deterioration with their mental health, triggers, and what they and staff could do to help improve difficult situations. These were based on the positive behavioural support (PBS) model which focuses on proactive and reactive strategies to help people manage challenging situations and behaviours. Young people and the MDT contributed to these PBS plans and staff we spoke with displayed knowledge about tailored strategies to help individuals. Staff recorded when they offered young people a copy of their care plan.

Requires Improvement

Child and adolescent mental health wards

Young people confirmed they received copies of their care plans, but said there was sometimes a delay.

Staff completed care plan audits to assess areas such as quality, risk management and patient involvement.

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 participated in clinical audits. However, some parents felt that the staff could be more assertive about the young people participating in therapy, activities and following a healthy lifestyle.

Staff provided a range of care and treatment suitable for the children and young people in the service. Young people had access to clinical, educational and counselling psychologists.

Birch Ward had a timetable of therapy-based groups, education and other activities that young people could engage with. These included dialectical behavioural therapy (DBT) skills, mindfulness, pet therapy, and dance therapy. There was a group trip to a local supermarket on a Tuesday evening and a community trip on a Thursday evening. A reduced timetable of therapy and activities was available during school holidays. The young people and one parent said they had nothing to do on weekends. We were told an activities coordinator came on weekends and had arranged movie nights, puzzles and games. Staff were in the process of risk assessing a new make-up group requested by young people.

Staff delivered care in line with best practice and national guidance. The ward used a DBT informed approach in order to provide young people with skills to regulate their challenging emotions and behaviours. Nursing staff were offered a DBT informed reflective session every two weeks. The service was reviewing the time of this so more nurses could attend. A new family therapist had started just before our inspection and some young people and carers had started these sessions. Two parents attended a DBT skills group and were extremely complimentary about the therapist, support and skills they learnt.

Feedback from 3 parents we spoke with was that staff could more assertively encourage young people to attend therapy, education, take prescribed medicines or eat a better diet. The service provided evidence to show how they monitored and encouraged young people to make healthier choices, and attend education and activities.

Records showed staff made sure children and young people had access to physical health care, including specialists as required.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. The service had recently purchased some new bicycles to encourage young people to exercise.

Staff used technology to support children and young people. For example. staff arranged video calls with external professionals to ensure they could attend a meeting and be involved in a discussion with the young person.

Staff took part in clinical audits, including care plan audits and environmental audits. An external pharmacist completed a regular medicines audit.

Skilled staff to deliver care

Requires Improvement

Child and adolescent mental health wards

The ward team included or had access to a range of specialists to support the needs of children and young people on the ward. Staff received appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The multi-disciplinary team (MDT) included a CAMHS consultant, ward doctor, psychologists, a social worker and a therapy assistant. A locum occupational therapist started in January 2023 and worked on Birch Ward 2 days a week. The MDT met daily during the week and worked closely with the nursing team and staff from the education department.

Two parents described initial delays they had experienced with therapy and a high turnover of staff but said this had recently improved. They spoke very positively about the team and the therapy available to them and their children. Therapy staff acknowledged a high turnover and the challenges that had come with being short staffed.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. 94% of staff received appraisals during the last appraisal cycle.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. We found this had improved since our last inspection. The supervision log for Birch Ward showed 100% of the 12 nursing staff received clinical supervision in January 2023. Staff told us they received regular supervision and found it helpful. This included a locum agency nurse. They discussed topics such as wellbeing and training needs. Newer staff received more regular supervision and managerial support if required.

The clinical psychologist and consultant psychiatrist received monthly supervision from an external source in addition to line management supervision.

Staff were offered regular group supervision and reflective practice sessions, however, staff were exploring new times to allow more people to attend.

The ward had accepted referrals for young people with a diagnosis of autism spectrum disorder (ASD). Two parents said the environment and care could be improved for young people with ASD. 77% of staff had completed their mandatory learning disability and autism training, but the provider needed to ensure all staff completed this training.

Managers provided additional training to staff. For example, the director of clinical services delivered a DBT-based training course about working with young people. This course aimed to train staff on working with young people who had experienced trauma, had ASD diagnoses, and other specific issues. The training also covered skills such as de-escalation techniques and managing incidents. At the time of our inspection, 100% of staff on Birch Ward had completed this training. 83% of staff on the ward had completed 'managing behaviour that communicates distress' training. Staff had also attended training on behavioural approaches to the management of ASD.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Meeting minutes were typed up and available for staff to access after the meetings.

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

Multidisciplinary and interagency team work

Requires Improvement

Child and adolescent mental health wards

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 team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. We observed an MDT meeting which included nurses, education staff, medical staff and therapy staff. Staff discussed each young person on the ward and shared a range of information including the level of observations, any risks or incidents that had occurred in the previous 24 hours, their mood, if they had engaged with education or therapy, interaction with peers, compliance with medicines, contact with family, and discharge plans.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. Notes from the day and night shift handovers were uploaded to each young person's electronic care record.

The CAMHS consultant psychiatrist led weekly ward rounds. Young people were invited to attend these. Parents said they were invited to attend some meetings and were given regular updates on their child's care by staff.

Ward teams had effective working relationships with other teams in the organisation. They worked closely with the education team who were based on the ward. There was a head of education, 2 full-time teachers, 1 part-time teacher and a full-time teaching assistant. Managers of the different wards also met daily to share information and risks.

Ward teams had effective working relationships with external teams and organisations. The team discussed the involvement of external teams during their morning MDT handover meeting. One parent and young person told us the ward staff had arranged a meeting with them to try and secure suitable post-discharge accommodation. Three other parents told us that ward staff had tried to involve external agencies such as community mental health teams and social workers in their meetings, but these external teams had not always attended. If external teams did not attend important meetings about young people, the MDT rearranged these urgently. Staff told us about the importance of working with external agencies, particularly prior to young people being discharged from the ward so they had support and a plan in place.

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. At the time of our inspection, 100% of Birch Ward staff had completed training on the Mental Health Act.

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 administrator was and when to ask them for support. The Mental Health Act administrator attended clinical governance meetings and provided updates on adherence to the Act as well as common errors.

Staff used a data monitoring dashboard which contained information such as the date a section was due to end, when the young person's rights were last read and when they were due to be read again.

Staff could access detention papers when needed and stored copies of children and young people's detention papers and associated records correctly. In 2022, the service learned from an incident where staff had misplaced some section documents. In response, managers put in a new system and planned to introduce a tracker to ensure their own oversight of adherence to the Mental Health Act.

Young people had easy access to information about independent mental health advocacy. During weekly community meetings, young people were reminded the advocate visited the ward every Monday.

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.

Records showed staff kept track of when they read young people their rights under the Mental Health Act and how often this was repeated. Staff audited this and had identified when improvement in this area was needed. We saw that staff discussed these audits during clinical governance meetings.

The service displayed posters to tell children and young people admitted to the service informally that they could leave the ward freely.

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. At the time of our inspection, 91.5% of Birch Ward staff had completed training on the Mental Capacity Act.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations. This is a test in medical law to decide whether a child of 16 years or under is competent to consent to medical examination or treatment. If a child is Gillick competent, they give informed consent and do not need parental permission. Team meeting minutes contained the definition of Gillick Competency and stated this was to be discussed at each meeting.

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

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.

Information about confidentiality and consent was provided to carers within the welcome booklet. It stated that there could be times staff would not be able to share all information about their child's care and treatment if the young

person did not consent to this. Carers were informed they would be given weekly updates regarding their child's progress and well-being. One set of team meeting minutes showed a discussion between staff about a young person having provided consent for both of their parents to receive information about their care. An action was noted for staff to call both parents.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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.

We spoke to 6 young people during the inspection.

Staff were discreet, respectful, and responsive when caring for children and young people. We witnessed some positive and friendly interactions during our inspection. We observed staff discussing young people in a respectful manner during meetings. Staff displayed a strong understanding of their individual needs and circumstances.

Staff gave children and young people help, emotional support and advice when they needed it. All young people had a named key worker who they had dedicated time with each week. Some of the young people also attended one-to-one and group therapy sessions. Overall, young people and parents were very positive about the current therapy available.

Staff supported children and young people to understand and manage their own care treatment or condition. Young people were invited to weekly ward rounds with the MDT and were given copies of their care plans.

Staff directed children and young people to other services and supported them to access those services if they needed help. For example, the ward manager had recently attended a meeting between a young person, their parent, and a potential future housing placement. The young person and their parent were very positive about the manager's support during this process.

Children and young people said most staff treated them well and behaved kindly. The young people told us they liked most staff. They were particularly complementary about the education and therapy offering. Parents said staff were polite and respectful to them and their children. However, some young people told us some staff members were quick to restrain them and that it sometimes caused them pain.

Staff understood and respected the individual needs of each child or young person. Care plans had been adjusted to try and accommodate differing needs. For example, two parents told us staff had been responsive to their children by giving them more space when needed.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people.

Requires Improvement

Child and adolescent mental health wards

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment. They ensured that children and young people had easy access to independent advocates. There was more work to do to develop the involvement of young people and carers in decisions about the service.

Involvement of children and young people

A welcome pack was available to young people on admission to help introduce them to the ward, but some young people we spoke with said they were not given information on admission.

Staff involved children and young people and gave them access to their care planning and risk assessments, although young people said there was sometimes a delay.

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. Young people could access easy read documents for topics such as their rights under the Mental Health Act or what to expect if an informal admission, information sharing, and transitioning to adult services.

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

Staff made sure children and young people could access advocacy services. An advocate visited the ward weekly. Young people said the advocate was nice and tried to help them.

Children and young people could give feedback on the service and their experience and treatment and staff supported them to do this. Young people were invited to weekly ward community meetings. Staff who attended community meetings included managers, the CAMHS social worker and the clinical psychologist.. Some of the young people we spoke with described these meetings as “boring” and “rubbish.” The community meeting minutes noted young people wanted more activities and the update said the new activity co-ordinator would introduce these. Young people told us staff had acted quickly in relation to some issues they experienced. For example, staff put a protector around the TV so they could begin watching TV again after it was damaged.

Since the last inspection, leaders had made some attempts to involve young people in the operation of the service, but these had not been successful. For example, staff had tried to find ways to encourage young people to attend clinical governance meetings, but no young people had attended since November 2022. We did not see any evidence that the provider had explored other ways to formally involve young people, such as young people being on interview panels.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke to 6 parents of 6 young people on Birch Ward. Parents were very positive about the communication they had with most staff. They said they received daily phone calls from staff which they found helpful and informative. All parents said they received an update via phone from the

consultant following ward rounds. Parents were usually updated following incidents and about medicines their child was prescribed. Parents were involved with care programme approach (CPA) meetings. However, the most recent audit of CPA documentation, which was reviewed for a sample of 3 young people, found the carers feedback section from the CPA report was not sent to any of the carers along with the invitation to the meeting.

Two parents attended a dialectical behaviour therapy (DBT) skills group so they could learn the same skills their children were taught at therapy sessions. The parents said these sessions were to gain skills and support, and they were extremely complimentary about the therapist.

Staff did not always give carers information about a carer's assessment. We asked two family members about carers assessments and both said they had not been given this information by staff on the ward.

Although carers we spoke with said they felt comfortable emailing or phoning staff on the ward to give feedback, there was not a formal method for this.

Is the service responsive?

Good

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

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. As a result, children and young people did not have to stay in hospital when they were well enough to leave.

Birch Ward had 2 referral pathways. One with the local collaborative and another with the provider's national referrals NHS England team. Admission decisions were clinically based and made between the ward manager and consultant psychiatrist.

At the time of the inspection, the service had 7 young people using the service. There were 8 beds available on the ward, but senior leaders had closed to new admissions due to the acuity of the ward.

As the service accepted national referrals, some young people and their families had further to travel to visit the ward or if home leave was granted. Staff made efforts to help with this. For example, transport had been arranged to take young people to their homes during leave from the ward.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. There was a data monitoring dashboard which detailed admission dates, how many days the young person had been admitted for, and their planned discharge dates. At the time of inspection, the longest length of stay was around 3 and a half months.

Managers and staff worked to make sure they did not discharge children and young people before they were ready. Staff supported young people with their discharge by extending length of leave from the ward, engaging their external schools, and granting overnight leave.

Requires Improvement

Child and adolescent mental health wards

Young people were moved between wards during their stay only when there were clear clinical reasons or it was in their best interest. For example, the ward manager said on rare occasions young people had been moved to an adult ward at the hospital if they had turned 18 years old while on Birch Ward.

Discharge and transfers of care

Managers monitored the number of young people whose discharge was delayed and took action to reduce them. Children and young people did not have to stay in hospital when they were well enough to leave. Managers discussed discharges and any delays during their daily 'flash' meetings. At the time of our inspection, a young person had experienced a transfer delay due to a suitable bed not being available elsewhere. Staff had regular discussions about this young person internally as well as with external bodies such as commissioners.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. The on-site education team linked in with young people's schools in the community to create a plan to facilitate reintegration following discharge. The ward manager said they only discharged young people when they felt satisfied there was support in place for them.

The service followed national standards for transfer. For example, staff invited practitioners from the relevant ward or community-based services to attend meetings and meet the young person.

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, but improvements could be made to better support autistic young people. Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. Young people said the food was of good quality and they could ask staff for hot drinks and snacks at any time.

Each young person had their own bedroom, which they could personalise. Staff told us young people could personalise their bedrooms if this had been risk assessed. However, we observed bedroom walls were quite bare at the time of our inspection.

Young people could add messages of hope to a mural in the communal area when discharged from the ward.

Children and young people had a secure place to store personal possessions. The ward had lockers for personal items and contraband items such as aerosols. There was a safe in the nurse's office for valuables and lockers for young people to charge their mobile phones. Two young people told us staff had lost their phone chargers.

Staff used a range of rooms and equipment to support treatment and care. They shared a large meeting room with one of the adult wards for ward rounds and CPA meetings. There was a small clinic room dedicated to the ward and a larger treatment room which was shared with an adult ward. The school classroom was based in a room on the ward.

The service had quiet areas and a room where children and young people could meet with visitors in private. Parents could visit their children on the ward, although there was not a specific room for visitors. They could also meet outside in the hospital grounds if this had been risk assessed or the young person was an informal admission. Rooms off Birch Ward could be booked for visitors under 18 years of age.

Requires Improvement

Child and adolescent mental health wards

Children and young people could make phone calls in private. Young people had access to their mobile phones between particular timeframes. There was also a ward phone that young people could use to make and receive calls.

The service had an outside space. There was a dedicated fenced garden which meant young people were not using the same space as adult service users. However, young people could only access the garden if escorted by staff because there was no direct access to it from the ward. The garden contained picnic tables and there was sports equipment for playing games. The young people we spoke with did not like the garden and described it as a "pig pen." The service had purchased some new bicycles so young people could go on bike rides.

There was an activities timetable which covered Monday to Friday. Young people we spoke with told us they got bored on weekends. Senior leaders told us many young people often went on leave over the weekends, but that they had a new activities coordinator who arranged movie nights, puzzles and games.

Hot meals were served in an on-site canteen based off the ward at set times, and young people were aware of these times. Staff brought young people their meals if they had been risk assessed as not having leave from the ward. Young people could ask staff to store food in the ward fridge and they had access to bread and biscuits on the ward.

Young people told us they liked the food and the hot chocolate. They could ask staff to make them hot drinks whilst on the ward. Staff made the hot drinks in the kitchen and brought these to the young person, as patients did not have access to the kitchen.

The ward accepted young people with autism spectrum disorder (ASD), but the ward environment was not well designed to support these young people. For example, the doors were not soft closure, the environment could be noisy, and there was no dedicated sensory room. One parent we spoke with said the lighting was either dark or bright and that the sensory toys provided were not helping their child. Some staff said having a sensory room would be beneficial.

Young people had to leave the ward environment via an uncovered pathway to access meals in the hospital dining room. At our previous inspection in 2019, managers told us about plans to create a covered pathway to make the journey more comfortable for young people. The application for this work had been turned down by the Council and at the time of inspection, the hospital was awaiting the outcome of their appeal against this decision.

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 supported them. Young people spoke very positively about the education team. The team liaised with community schools to help plan young peoples' education schedules ahead of discharge or when they were on leave from the ward. Some parents told us they wished staff were more assertive with making their children attend education classes.

The on-site school was registered with Ofsted and had been rated 'outstanding' at their last inspection in March 2023.

Staff helped children and young people to stay in contact with families and carers. They were allowed access to their own mobile phones at specified times of the day, and the ward phone was available for calls if required.

Requires Improvement

Child and adolescent mental health wards

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. Community meetings were held weekly, and young people could engage in group activities to build relationships. The CAMHS social worker was helping a young person secure voluntary work after their discharge date. On the second day of our inspection, the education team had arranged a visit from the fire service who were due to speak to the young people about careers in the fire service and provide an interactive session.

Meeting the needs of all people who use the service

In most cases, the service met the needs of young people, such as those with a protected characteristic. Staff helped young people with communication, advocacy and cultural and spiritual support. However, the ward was not accessible to young people, visitors or staff who used a wheelchair.

In some cases, the service could support and make adjustments for people with specific needs. For example, providing information in easy read formats. Managers made sure staff, children and young people could get help from interpreters or signers when needed.

Staff made sure children and young people could access age-appropriate information on their treatment and the service. Staff wrote child-friendly wellbeing and safety support plans which clearly outlined individual triggers, risks, and what kept them well so staff could support them.

Children and young people had access to spiritual, religious and cultural support. Contact details of community leaders from different religions were displayed on the ward. The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. The 'you said, we did' board had a request from young people to make the food more child friendly. Staff told us the young people were encouraged to provide feedback on the food they would enjoy.

The ward had information boards which contained information such as the ward rules, school and therapy timetables, and safeguarding information. There was a 'be proud' board which displayed schoolwork.

The ward was not accessible to wheelchair users. Birch Ward was on the top floor and there were no lift facilities.

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. Some carers were not familiar with the complaints process.

For the period March 2022 to March 2023, Birch Ward recorded 5 complaints and 1 concern on their system. One of the complaints was partially upheld, 2 were ongoing and 1 was withdrawn.

The service had an informal and formal complaints system in place. Senior leaders kept a complaints log to monitor all complaints, compliments and concerns they received and managers were assigned to investigate complaints. The service clearly displayed information about how to raise a concern in patient areas. The hospital director had oversight of the more serious complaints and young people and carers could contact them directly. Managers shared information about complaints during clinical governance and their daily 'flash' meetings.

Requires Improvement

Child and adolescent mental health wards

Four of the 6 parents we spoke with said they had not been told how to make a formal complaint. The provider had welcome packs for carers which explained the informal and formal complaints procedures at the end, but the process was not widely known.

Staff understood the policy on complaints and knew how to handle them. Staff encouraged young people to provide informal feedback to them. This included during ward rounds, community meetings or during their one-to-one time with their named nurse or healthcare support worker. The hospital had recently appointed someone who would have oversight of all complaints.

Staff knew how to acknowledge complaints and young people and their families received feedback from managers after the investigation into their complaint. Parents told us staff were good at communicating with them when they had concerns, but 1 said some of their concerns were dismissed.

We saw evidence that managers shared feedback from complaints with staff and learning was used to improve the service. For example, following one complaint from a parent about a specific issue, two actions to improve future practices were noted and carried out.

The process to identify themes across complaints could be improved. Of the 5 complaints recorded, 3 contained complaints from separate people about poor care related to seizures. We did not see any evidence this was identified or discussed between the staffing team.

The service used compliments to learn, celebrate success and improve the quality of care. Compliments were logged on the electronic system and good work was recognised during team meetings.

During weekly community meetings, young people were reminded complaints should be raised with a nurse or the ward manager.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

Hospital leaders and managers of Birch Ward were relatively new to their roles. Since the last inspection of the CAMHS service in October 2019, the management teams had changed. The patients we spoke with were very complimentary about the ward manager. A new deputy ward manager was due to start in post shortly after our inspection.

Staff were extremely positive about the support offered by leaders within the service. They told us managers were approachable and visible on the ward. Staff reported senior managers were quick to respond to issues on the ward and had helped out where necessary. Parents felt they could approach managers if they had any concerns.

Requires Improvement

Child and adolescent mental health wards

Vision and strategy

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

The provider's values aimed to improve the quality and experience of care for young people. The values are striving for excellence, being positive, putting people first, acting with integrity, and being supportive. Staff aimed to deliver care in line with these values. We observed staff treating young people with dignity and respect.

Staff were due to attend an away day following our inspection. Senior leaders said this would be an opportunity for team building and for staff to discuss future goals for the service.

More work needed to be done to involve young people and families in the development of the overall service.

Culture

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

Staff on Birch Ward spoke positively about working at the hospital and with the entire team on the ward. All staff we spoke with felt supported by managers and senior leaders at the hospital. We saw evidence senior leaders held debriefs with staff following significant incidents and attended meetings with families of young people. The senior leaders paid tribute to the staff and said they were lucky to have them. Staff said morale at that time was good and told us they liked working well as a team and working with the young people.

There were opportunities for development and career progression. For example, some nurses had progressed into management roles.

There was an external employee assistance programme available to staff. This provided staff with access to counselling as well as financial and legal advice if required. Managers could refer staff, or staff could self-refer. However, not all staff we spoke with were aware of this available resource.

There were staff networks available for all employees to join should they wish. Some examples of the networks included a disability and difference network, a parents' network, an LGBT+ network, and a black and minority ethnic network.

On the request of staff, a staff away day for was planned with the aim of providing team building exercises and a space to work on goals.

Governance

There was a service improvement plan in place and we noted that since our last inspection in 2019, several improvements had been made to the ward. Despite this, our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level.

Requires Improvement

Child and adolescent mental health wards

Since our last inspection of the ward in 2019, the provider had recruited new nursing staff and Birch Ward had sufficient staff deployed on each shift to meet patient needs. Supervision rates had improved. Staff met regularly to share information about patient risks, presentation and care.

Results from audits were not always used effectively to make improvements to the service. For example, managers communicated outcomes of audits, such as life limited medicines not being dated, as an area of improvement with staff. However, at the time of the inspection we found ongoing issues which suggested learning from audits had not been effectively embedded. Issues picked up within a quality walk round of Birch Ward in January 2023 did not appear to be discussed in the subsequent clinical governance meeting or team meetings in February 2023.

Although managers had introduced a rapid tranquilisation tracker so they had oversight of its use, staff did not always monitor young peoples' physical health in line with the provider's SOP after they had received rapid tranquilisation medicines.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care and used that information to good effect. The risk register did not reflect the risks reported by leaders and dashboards did not always accurately reflect what was happening on the ward.

Although we saw evidence to suggest managers discussed and had access to information about incidents on the ward, the data monitoring tool they used was not reliable. For example, one patient had assaulted staff on numerous occasions which had led to multiple restraints. The data monitoring tool only stated this patient had 1 incident of restraint in the 3 months prior to our inspection which was inaccurate. This meant managers could not be assured the tools they used to oversee care of young people reported reliable data.

The hospital had a risk register which managers could add risks to, but we saw this had some items that had not been added or updated to reflect current risks known to managers. For example, managers discussed staff burnout as a risk, but this had not been added to the risk register. Managers also acknowledged that a past risk of staffing numbers had been managed through successful recruitment, but this risk had not been updated on the risk register since October 2021.

Senior leaders told us they were recruiting for a director of quality and a quality administrator.

Information management

Staff collected and analysed information about performance.

The service collected and analysed information to understand issues and performance within the service. For example, managers collected data on incidents such as the number of incidents each month, the categories of these incidents, and any learning.

Staff had access to equipment and information technology required to do their work. However, the hospital had been experiencing ongoing issues with their internet access. The impact of this was that patient records could not always be immediately accessed and there were sometimes delays to uploading information to care records. Managers were aware of the issues and were actively trying to resolve the matter.

Minutes taken during team meetings were typed up and available to staff on their shared drive. This meant staff who were unable to attend could access important and up-to-date information about the ward.

The hospital made notifications to external bodies as needed, including statutory notifications to the Care Quality Commission.

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.

When needed senior leaders engaged with commissioners and the provider's CAMHS service line lead to discuss suitability of the service for an individual and alternative options.

Staff and carers we spoke with gave examples of the team working closely with external agencies, for example community mental health teams, social workers, and prospective accommodation providers. Staff were aware of the importance of working with other health and social care providers to plan ongoing support before patients were discharged from the service.

Senior managers within the hospital were visible and accessible on Birch Ward. The hospital director had arranged debrief meetings with staff after serious incidents. They had also met with young people following serious incidents.

In our last inspection of the CAMHS wards in 2019, we said that the provider should reintroduce and develop ways for young people and carers to be more involved in the operation of the hospital. The service told us they had plans to develop the involvement of young people in the way the service ran, however, we found there were still improvements to be made. We saw evidence staff had tried to find ways to involve young people with clinical governance meetings, but at the time of our inspection this had not been successful or embedded. There was no other evidence of ways leaders had tried to involve young people to be more involved in the operation of the hospital, aside from providing feedback during community meetings. Carers we spoke with told us there was no formal method for them to provide formal feedback on the operation of the hospital. All carers told us they felt comfortable contacting ward staff if required. Carers spoke positively about the communication they received regarding their child's care.

Some actions from community meetings were dealt with quickly, while others remained ongoing for weeks. For example, young people asked for ear defenders during the community meeting on 23 February 2023 and these had been ordered by the meeting on 13 March 2023. However, young people had reported issues with the washing machine on 13 February 2023 and this action remained ongoing at the time of the 20 March 2023 community meeting.

The ward had developed welcome packs for people admitted to Birch Ward. These provided carers and young people with a range of practical and logistical information about the hospital and what they could expect during their treatment.

Staff had up-to-date information about the ward through a variety of team meetings and MDT meetings. Meeting minutes, such as those from clinical governance and team meetings, were accessible from a shared drive. This meant staff could access them if they missed the meeting or wanted to refresh their memories.

Learning, continuous improvement and innovation

Requires Improvement

Child and adolescent mental health wards

Senior managers from other wards conducted quality walk rounds and internal inspections were completed. Actions were added to the ward improvement plan following feedback from an incident in December 2021 and an internal inspection in May 2022. Progress and outstanding work required was updated most months, and the director of clinical services met weekly with ward managers to discuss ongoing actions.

Young people had access to a range of innovative activities. For example, they were able to participate in dance psychotherapy and pet therapy. The ward's psychologist led twice daily weekday groups during the morning and after the school day. 'Sunrise intentions' allowed young people to decide how they intended their day to be. 'Sunset reflections' allowed a space for young people to reflect on what had gone well and what could have made their day better.

Birch Ward was accredited by the Royal College of Psychiatrists Quality Network for Inpatient CAMHS (QNIC). This is a national project with the purpose of sharing and achieving best practice. The service's accreditation was reviewed annually, with the next QNIC review planned for June 2023.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure that young peoples' physical health is checked appropriately after they have received medicines via rapid tranquilisation, in line with national good practice guidelines and the provider's standard operating procedure. The service must ensure it uses systems and processes to safely store and manage medicines in line with the provider's policy. This includes securely storing medication waiting for disposal; storing medication at the correct temperature; and correctly signing when administering controlled medication.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must ensure they implement ways to formally involve young people and carers in the governance and wider operation of the hospital. The service must ensure governance processes operate effectively and that local procedures and policies are met. This includes safe medicines management and oversight of physical health monitoring following rapid tranquilisation. It also includes ensuring managers have access to accurate data about incidents and other operational matters to enable them to have effective oversight of the hospital.