Care Quality Commission

Sussex Partnership NHS Foundation Trust

Child and adolescent mental health wards

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Child and adolescent mental health wards

Requires Improvement ⬇

Chalkhill delivers a Tier 4 Child and Adolescent Mental Health Service (CAMHS). Chalkhill is run by Sussex Partnership NHS Foundation Trust and is a 16-bedded mixed gender inpatient unit where young people are admitted if they require assessment and treatment for acute mental health needs. Chalkhill is a sole Mental Health facility in the grounds of a general acute hospital, exclusively for 12–17-year-old young people. They offer assessment and treatment of a wide range of mental health difficulties and needs, as well as support for eating disorders and disordered eating.

Chalkhill was last inspected in December 2016 and was rated as Good overall with Outstanding in Caring.

We carried out this unannounced focused inspection because we received information of concern regarding the safety and wellbeing of the young people, high levels of incidents leading to harm, staff training and competence, low staffing numbers, ineffective observations of young people and poor leadership and support. Before the inspection the trust along with the commissioners of the service had identified some safety concerns and had an action plan in place to address. However, the action plan had not been fully implemented and some of these areas remained a concern during this inspection.

We inspected safe and well-led. Following this inspection, the ratings for safe and well-led went down from good to requires improvement. This meant that the overall rating for the service also went down from good to requires improvement.

Following this inspection, we served the trust with a Warning Notice, because we found that significant improvement was needed to ensure that there was effective oversight of processes and practices, staff competence and support and risk assessing the health, safety and welfare of young people. The Warning Notice required the provider to make improvements to meet the legal requirements set out in the Health and Social Care Act by 11 August 2023. In response to the warning notice, an updated action plan was provided, which set out the actions they had taken to immediately address the safety concerns and the actions they planned to take to mitigate remaining risks.

Prior to the inspection, the trust had capped the occupancy levels at 12 beds. This was to ensure a safe patient to staff ratio during the recruitment of clinical staff. Following our inspection and feedback, the trust paused any new admissions and worked to safely discharge some of the young people where appropriate. Post inspection, the trust continued to provide us with information about the detailed actions being taken that allowed us to monitor the service. The trust had regular engagement with us as part of that monitoring process.

Our rating of services went down. We rated them as requires improvement. Our key findings were:

- The ward was not always safe, clean or well-maintained. Staff did not always assess and manage risk well. The environmental security checks and the documentation used to support this did not always capture risks or enable appropriate mitigation to be put in place. Repairs to the ward were not carried out in a timely manner which added to the clinical pressures on the service.

Our findings

- Staff were not always able to keep young people safe from avoidable harm. There were high levels of repeated incidents which caused harm and potential harm to young people where injury was sustained. Staff did not always identify and report all incidents or near misses of incidents. Incidents were not always reviewed and investigated by competent staff. Incidents were not consistently monitored, and action was not always taken to remedy the situation, to prevent further occurrences and to make sure improvements were made as a result.
- Staff did not always manage risk well. Although staff completed daily environmental checks of the service environment, they did not always identify, remove or reduce risks that were evident on the ward.
- Staff did not always assess and manage risks to young people and themselves. Risk assessments did not always identify or address all a young person's needs.
- Staff did not always develop care plans that appropriately reflected young people's assessed needs. Care plans were not always personalised, holistic and recovery oriented. Staff did not always use the information in the care plans when delivering care to young people.
- There was not enough staff deployed with the skills, expertise and experience to meet the needs of the young people. There was a reliance on agency and bank staff, especially at night. There was no assessment of staff competence and some of the staff did not know how to safely support the young people. Staff told us they were not receiving regular supervision and did not feel supported by the service management to carry out their role.
- Staff from the different disciplines did not always work together effectively and this resulted in gaps in the young people's care.
- There were indicators of a closed culture at the service. The trust did not ensure practice at the service was open and transparent. Staff and young people told us they did not always feel safe or supported to raise concerns. Staff reported exceptionally low morale.
- Staff did not always follow the trust's policy and procedures on the use of enhanced support when observing young people assessed as being at higher risk of harm to themselves and others.
- Blanket restrictions were evident on the ward which restricted the young people's movement around the service.
- Feedback from young people and relatives and carers was negative. Young people did not always feel safe on the ward.
- The governance processes did not always operate effectively. Risks were not always managed well, with oversight, monitoring and learning from incidents being poor. The trust processes for reporting and reviewing incidents was not effective. Despite the trust already having an action plan in place, the trust did not have adequate assurance mechanisms in place. They had not identified that young people were not always receiving safe care and had not acted to make improvements in a timely manner.

However:

- All staff spoke positively and, in a kind, caring and respectful manner about the young people. Our observations of interactions between most staff and young people also reflected this.
- The mandatory training programme was comprehensive and met the needs of young people and staff.
- Staff completed risk assessments for each patient on admission, using a recognised tool.
- Young people eligible to take leave were able to take this with the support from staff.
- There had been successful discharges where young people had been supported to move on from the service.
- There had been recent positive changes to the management of the service.

Our findings

- The service had access to a range of specialists including nurses, occupational therapists, physical health nurses, psychologists and social worker.

What people who use the service say

Young people told us they did not always feel safe on the ward. They told us staff were varied in their approach, and whilst there were certain staff they described positively, they also spoke about staff who they felt did not know them well and did not listen or help them when needed.

What carers and relatives of people who use the service say:

Relatives told us they did not feel their young person was safe or well looked after at all times at the service. They told us about communication concerns, specifically when incidents and investigations happened and not being informed or kept updated. They felt they had to always phone and request information repeatedly as key workers were not always keeping them up to date with their young persons care and their lives whilst they were at the service. They felt there was a lot of agency staff who did not know the young people and their needs well. One relative did say they were invited to multidisciplinary team meetings to discuss their young person's care and they felt the service was welcoming when they attended.

Is the service safe?

Requires Improvement ↓

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

Safe and clean care environments

The service was not always safe, clean, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed a daily environmental risk assessment of all ward areas, including the young people's bedrooms, communal areas and the outside garden space. However, the environmental checklist used was not always effective and did not always support staff to consistently identify risks. For example. the checklist only included bedroom numbers and ward areas such as lounge, quiet space rooms and garden areas listed. There was no guidance for staff on what they should be specifically checking for. We observed checks being completed and identified several risks not being identified. For example, unlocked doors that we were told should have been locked, broken items in the garden spaces, and bedroom areas not being checked in line with the environmental risk assessment. We also identified contraband items such as vapes on the ward. There was hospital-issued linen and towels left unattended in communal spaces, which was an assessed ligature risk. When we identified these risks to staff on inspection, they were not always escalated to the team for discussion or removed.

During the inspection, 3 staff told us the alarm fobs, used to call for assistance, did not work in one of the garden spaces. They told us the trust were aware of this as, new sensors had been ordered but had not been installed. We tested the alarm system in the garden and found they did not work. Not all staff were aware of this risk. Although new sensors had been ordered, this risk was not reported on the environmental checks, reported as an incident or on the ward's risk

register as part of any oversight and monitoring. No further action had been taken to reduce the risk until the new sensors were installed. We escalated this to the trust senior leaders, and they took immediate action and closed off the specific area of the garden affected and ensured monitoring and prompt installation of the sensors to support the alarm system.

The layout of the ward across two floors meant that staff could not always observe young people in all parts of the ward. This was because bedrooms were on the upper floor and communal areas and the nursing office on the lower floor. Closed circuit television was in operation in some communal areas, such as the corridor spaces, this was used only retrospectively to review incidents and was not viewed consistently. The nursing office was located away from the communal areas, at the back of the ward. However, to enable staff to be able to make the necessary checks on young people, the ward procedure was that all doors should remain locked with young people needing to request access from staff.

Maintenance, cleanliness and infection control

Ward areas were not always clean, well maintained, well-furnished and fit for purpose. There was a boarded-up window in the communal area that had previously been broken and was awaiting repair. Staff told us that this had been like this for 6-8 weeks. The paintwork and decoration were tired in areas and in the upstairs area there was wallpaper torn off the walls. The communal dining area was dirty on both days we inspected, and the sink was covered in paint. Staff told us that when they made requests for ward maintenance there was no escalation process to enable urgent maintenance repairs to be completed in a timely manner to ensure safety of the young people on the ward. The maintenance request logs showed there was a backlog of requests still needing action. We escalated this to the trust senior leaders, and they took immediate action to ensure that a full review of maintenance works was carried out. This included a 24-hour response time to any urgent works identified.

Safe staffing

Not all staff knew the young people and they did not always keep young people safe from avoidable harm. However, the service had enough nursing and medical staff, who received basic training.

Nursing staff

There were sufficient numbers of staff rostered per shift but they were not always deployed to ensure that the staff on shift had the knowledge, skills, experience and competence to meet the needs of all the young people. There was no assessment of staff competence and some of the staff did not know how to safely support the young people.

A staffing matrix was in place which identified the minimum number of qualified and unqualified staff needed. Staff told us that there was a high staff turnover, sickness and vacancy levels across the ward. The high acuity of the young people on the ward meant staff were often on enhanced visual observations with young people. Rarely did we see staff who were free and available to interact with young people who were not on enhanced visual observations. Young people and staff told us they felt more staff were needed to ensure that they could provide better therapeutic support and more one to one time.

There was an induction process for agency staff to complete prior to working at the service, but this did not always enable agency staff to know the young people's needs. Agency staff told us that their induction was rushed and were only told "bits" about the service before commencing work. There was a reliance on agency and bank staff, especially at night. Whilst the ward manager and matron could adjust staffing levels according to the needs of the young people, the trust had recently made a trust wide change as to how far in advance agency staff could be booked. They had not carried

out a service needs assessment to ensure the new process would not impact some of their services. The new system meant agency staff could only be booked 24 hours in advance, a change from the 72 hours in advance previously in place. This meant that regular agency staff who were more familiar with the young people were often not available at short notice. The ward staff had escalated and raised this as a concern with the trust prior to our inspection. We fed back the impact that this change in booking process had on staffing deployment and after the inspection the trust amended the agency booking process for this service to enable agency booking in advance.

There was not always enough staff on each shift to carry out any physical interventions safely. Not all staff were trained in physical interventions and although managers on the ward told us they always ensured there was enough staff per shift to safely carry out any physical interventions, those staff were not always available and free to attend an incident when needed. Staff told us about 2 occasions when they have had to use other interventions as the other staff on shift were not trained in Prevention and management of violence and aggression (PMVA). This placed staff and young people at potential risk of inappropriate restraint. Training data showed that the majority of staff had been trained in PMVA and was only slightly below the trust target of 85%.

Managers did not always support non-medical staff through regular, constructive clinical supervision. All staff we spoke with said they had not received supervision in a few months, their morale was low, they said they did not feel supported by managers. Supervision data showed that supervision was being booked. We fedback this disparity between what staff told us and the data. The trust said that they would look into this as it could be that although supervision was being booked it may have had to be cancelled.

Medical staff

In working hours the service had enough medical cover and doctor’s available to attend to any emergency. However, out of hours medical cover was limited. The ward had one permanent, full-time, child and adolescent mental health consultant. The ward also had a part-time staff grade doctor and a range of doctors in training who also supported the young people. Out of hours medical cover was spilt, depending on time. Between the hours of 5pm and 8pm, duty cover was provided by an on-call doctor who worked for the trust at another site, located approximately 45 minutes away from the ward. Between 8pm and 8am medical cover was provided by the duty doctor covering the local emergency department of another trust, located on the same site. Contact was made via the on-call mobile phone. However, it was a known risk that there was an issue with the mobile phone reception for the on-call doctor due to poor reception service in parts of the hospital. This meant there was a risk the on-call doctor may not be able to be contacted when needed. Staff reported variable levels of support received from the on-call doctors as staff felt they did not have the knowledge of CAMHS.

Mandatory training

The mandatory training programme was comprehensive and met the needs of young people and staff. Most staff had completed and kept up to date with their mandatory training. Managers monitored mandatory training and staff were alerted when they needed to update their training. Training modules included CAMHS clinical risk assessment and safety management, 85% substantive staff completed, fire safety awareness, 85%, paediatric immediate life support level 3, 85%, safeguarding children level 3, 79%. The trust also monitored training compliance for bank staff. The data shared with us showed variable levels of training compliance, with some staff due or overdue in certain modules.

Our findings

Some staff did not receive specific training to support the needs of some of the young people, such as autism awareness and trauma informed care, which meant that they were at risk of their needs not able to be met in a consistent way. However, additional non-mandatory training was completed by 13 staff: National Development Team for Inclusion (NDTI) - Autism Awareness and sensory perception training. Autism Programme – NDT. The trust did not have a process in place to assess staff competence following training to support the effectiveness of training.

Assessing and managing risk to children and young people and staff

Staff did not always assess and manage risks to young people and themselves well.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool. Risk assessments and risk management plans were not always updated when the risk of a young person had increased or changed following an incident. They did not always address how those risks could be managed safely and appropriately to respond to each young person's changing needs. We discussed some recent incidents with staff and they were not aware of what action was being taken to support the young person or reduce the likelihood of these incidents recurring. In some cases, we saw that this led to further incidents and near misses.

Management of young people's risk

Staff did not always know about risks to each young person and did not always act to prevent or reduce risks. Staff did not always share key information to keep young people safe when discussing a young person's risk and handing over their care to others. We observed a shift-to-shift handover and looked at previous handover documents, which lacked detail. For example, they included identified risks for each young person such as ligaturing, self-harm, diagnosis, Section details, primary nurse, and brief updates about the young person during that period, but no details to aid staff understanding about the risks to support consistency of care. For example, for one young person it was recorded not to give the young person nail varnish in a glass bottle, but the reason why was not given

Young people's risks regarding their leave from the service were assessed regularly and in accordance with the trust policy to enable them to take regular leave.

Staff did not always identify and respond to any changes in risks, or posed by, young people.

We observed two multidisciplinary team meetings where young people, and their risks were discussed. There was little discussion amongst the team about risk management and mitigation following an incident. We fed this back immediately. At a further meeting we observed, we noted much more discussion about risk management, with key members of the team taking accountability for actions to ensure risk assessments were updated, and changes communicated to ward staff and the young person.

Staff could not always observe young people in all areas of the garden space due to the layout of the service. Staff told us that because young people had to ask for any doors to be unlocked, this meant that risks could be minimised as the practice was that whomever unlocked the door it was that staff's responsibility to stay with the young person. During the inspection, we observed one young person who should have been on regular observations had been locked outside on their own in one of the secure garden spaces. We immediately informed staff and they went and checked on the young person. In response to this we later saw signs up on the garden doors reminding staff to remain with young people when in the outside space.

Our findings

Staff did not always follow trust policies and procedures when they were searching young people or their bedrooms to keep them safe. There were repeated incidents where young people had accessed contraband items and used them to self-harm or had items such as vapes which could be a fire risk. Staff told us they had not received search training, and personal and environmental searches were not consistent or effective in identifying, mitigating and removing risk. This had not been reviewed by the trust despite many noted incidents. Staff and young people told us that some staff were not managing prohibited items being brought onto the ward from leave or by people visiting.

Staff did not always follow the trust's policy and procedures on the use of enhanced support when observing young people who were assessed as being at higher risk of harm to themselves or others. There had been incidents where young people had managed to gain access to areas on the ward that they should not have been able to access, and incidents of self-harm with ligatures and some young people did not require enhanced support as they were deemed a lower risk and in some cases, staff would only need to complete 15, 30 minute or hourly checks. However, during both days of inspection, we observed the general observation folder, where records of these checks would be made, left in the office and records completed retrospectively.

Blanket restrictions were evident and variable on the ward. For example, young people at times had to ask for cold drinks as they were not always readily available in the dining room area. We were told that due to one young person's risk behaviours, all young people had to ask for staff to make them hot drinks and were not able to do this for themselves. It was the ward policy that all the internal ward doors, to the lounge, quiet room, garden space and bedroom floor and bedrooms were to remain locked. None of the young people had been individually assessed as being able to have access to a key or fob for access to any of these areas. Young people and staff told us this was a blanket rule.

Staff access to essential information

Not all staff had easy access to clinical information and it was not easy for them to maintain high quality clinical records.

Care plans for each young person were variable and were not always personalised, holistic or recovery-orientated and were not always specific to the young person's needs. Some lacked input from the young person or their relatives where appropriate. Conversations we had with young people and their families confirmed they were not always involved in creating their care plans.

Young people's notes were variable and not always comprehensive. Staff told us not all staff could access them easily. During the inspection, we observed two agency staff unable to access computer records for the young person they were supporting on enhanced observations as they did not have working log ins and needed a permanent member of staff to log them on using their log on code.

Staff did not maintain complete, accurate and up to date records in respect of each young person when an incident had occurred. For example, we identified incidents recorded in daily notes that had not been reported on the trust incident reporting system. We were told by staff and young people of incidents that had happened but not been reported for investigation or review.

Staff told us if they had been off the ward for a few days, on their return the handover only recapped the last 24 hours and apart from logging on and reading each young person's electronic records, which they did not have time allocated to be able to do, they could not keep up-to-date with changes in young people's risks or care plans. We observed two incidents occurred as a result of staff not being aware of up-to-date information about the support needs of the young people.

Our findings

Reporting incidents and learning from when things go wrong

The service did not always manage young people's safety incidents well. Staff did not always recognise incidents and report them appropriately. Managers did not always investigate incidents nor share lessons learned with the whole team and the wider service. When things went wrong, staff did not always apologise or give young people honest information and suitable support.

Staff did not always recognise and report incidents that caused harm or had the potential for harm. Incidents should have been reported on the trust wide incident management system. There was a system of reviewing which included review by a band 6 or 7 nurse. However, due to vacancies, these reviews were not carried out and there was a backlog of 148 incidents for the service that needed to be reviewed and action plans considered for each incident. This was flagged on the trust's database, but no action had been taken to resolve the backlog until it was identified as part of the inspection. This meant management plans for each of the individual incidents had not been discussed and risk of repeated incidents occurring.

Incidents were not always reviewed and thoroughly investigated by competent staff. The trust did not ensure that incidents were monitored, and action taken to remedy the situation, prevent further occurrences and make sure improvements were made as a result. Young people and their families told us they had not been involved in any review of investigations to aid further learning and prevention.

We saw that one young person had multiple incidents of tying ligatures throughout the day, the level of risk and support they needed was not reviewed, which meant that staff were not fully aware of how to prevent this and keep the young person safe. There had been multiple incidents of young people grabbing staff keys and passes, and using them to access locked off areas. While key belts had been ordered for staff no other action had been taken to mitigate this risk.

The trust did not ensure that all near misses where a situation had the potential to cause harm was reported. They did not ensure staff knew how to identify a potential near miss.

There was no system or process to support learning from incidents across the service. Staff did not receive feedback and incident discussion was not embedded into ward culture or to identify and share lessons learnt and good practice. Incident data reviewed during and immediately after the inspection continued to show some repeated incidents. Little improvement had been made to learn from some incidents which continued to expose young people to risk of harm.

We did not see any evidence of duty of candour. Staff could tell us what it meant but could not give any examples as to when young people and their families may have been given a full explanation when things went wrong. We raised concerns about the lack of duty of candour regarding an incident involving delays in a young person receiving medical intervention for an injury.

Is the service well-led?

Requires Improvement ↓

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

Our findings

Leadership

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

The ward management had undergone some changes in the months prior to the inspection. The ward matron was newly appointed, having been in post approximately five months and although this was their first ward matron post, they had experience of working with children and young people. The ward manager was also new to the manager role and was undertaking the role on an interim basis. They too had experience of working with children and young people. Various other trust senior leaders supported the service and were visible on site. The presence of trust senior leaders on site had increased prior to our inspection as a response to some concerns identified by the trust and quality audit checks by commissioners.

Young people and their families told us they knew who the immediate ward managers were and they were visible on the wards. The young people knew that some of the senior leadership team had been to visit the ward but were not aware who they were or why they were there.

Culture

Staff did not always feel respected, supported or valued. They told us they could not always raise any concerns without fear of repercussions.

Feedback from staff was variable about the support they received from managers and the senior leadership team in the service. Most staff felt they could approach their immediate managers to seek advice or raise concerns. However, nearly all staff we spoke with did not feel the same about the trust senior leadership team in the service. Staff told us they felt the senior leadership team in the service had not always been supportive and they feared a blame culture when things went wrong.

The senior leadership team had implemented drop in coffee and breakfast mornings to encourage staff to come and speak to them. However, the uptake at these meetings had been minimal.

All staff we spoke with told us they felt there was a divide between the nursing and healthcare staff and the rest of the multidisciplinary team. They felt accountability and responsibility was always pushed onto individual members of the team and not embraced as a team. They said there was no whole team reflections to support a better more supportive working environment. Staff told us they used to have external support to help with team wide reflections and practice, but they left and have not been replaced.

There were indicators of a closed culture. Staff did not develop the service in response to learning from incidents. The structure of meetings for staff to discuss the safety and quality of the service was not always effective. Although there were some processes for escalating and monitoring service risk, these processes were not always followed by staff and the processes were not effective at mitigating and managing risk and protecting young people from avoidable and potential harm.

Staff told us they felt the ward lacked systems and processes that could support them in working better as a team. They told us they felt there was a lack of boundaries amongst some staff with the young people and this led to issues for other

Our findings

staff when trying to implement boundaries to keep young people and staff safe. For example, some staff were not actively removing items of contraband that young people had access to such as vapes or access to electronic items outside of the young person's agreed care planned hours. This then had a negative impact on the young person's sleep health and mood and behaviours.

All staff we spoke with told us they did not receive regular supervision or appraisal and did not always feel supported. Many of the staff reported feeling burnt out in recent months due to the pressures of working on the ward amongst the intense scrutiny they felt under due to patient and ward safety and performance concerns. Some staff were visibly upset when speaking with the inspection team about how they felt. Trust data indicated staff were receiving regular supervision, however, when we fedback what staff had told us the trust confirmed they would look into this discrepancy and take any required action.

All staff we spoke with spoke positively and in a kind, caring and respectful manner about the young people. Our observations of interactions between most staff and young people also reflected this.

Governance

Findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

Prior to our inspection, the service had two improvement plans in place in response to concerns raised by the trust's internal quality audit checks and one by commissioners. Our inspection identified that despite the trust being aware of many of the concerns noted at this inspection, actions taken to drive improvements were not always effective and many of the concerns remained. In response to us seeking urgent assurances around some safety concerns the trust acted swiftly in updating their improvement plans and taking action to mitigate risks.

There was a lack of effective systems and processes to support a safe environment and safe delivery of care for the young people. For example, there was not a clear framework of what must be discussed at ward handovers and multidisciplinary team handovers to ensure essential information such as changes to a young person's risk or incidents were shared and discussed, and appropriate action taken to prevent or minimise occurrences.

Because of a backlog of incidents to be reviewed by senior management and incidents that should have been reported but were not always identified as an incident or reported by staff, reviews and learning from those incidents had not happened and therefore no changes to practice had been implemented where needed to prevent re-occurrence.

Not all staff at all levels were clear about their roles, responsibilities and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.

Management of risk, issues and performance

Staff did not always have access to the information they needed to provide safe and effective care and therefore could not always use that information to good effect.

The service did not have effective systems and processes in place to monitor risk and performance. Daily meetings such as shift-to-shift handovers, nursing huddle and the MDT handover did not effectively support the running of the service, or the safety of the young people and staff. There were gaps in discussions, for example about young people's individual risk and the management plans to support them and their care. Topics such as security issues, incidents and staffing issues were discussed but the managers did not always form plans and actions and assign those actions to people to ensure they were addressed and resolved.

Our findings

None of the staff could tell us what the key risks for the ward were. We reviewed the risk register for the ward and looked to see what the mitigating actions were and what had been escalated higher up to the trust wide risk register. The ward risk register was basic, did not contain all the key information, there was no accountability for that risk assigned to anyone to action and monitor and the mitigation in place was not effective. Risks identified during the inspection, which were also known to the managers and senior leaders such as the fob alarms not working in the garden spaces and the on-call doctor mobile reception issues, were not on the ward or trust wide risk register.

Our findings

Areas for improvement

Action the trust 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 trust MUST take to improve:

Core service

- The trust must ensure the ward environment is safe, clean and well maintained and repair works completed in a timely manner. (Regulation 12)
- The trust must ensure staff assess risk, manage, and mitigate that risk and plan care to meet young people's individual needs. (Regulation 12)
- The trust must review the incident reporting and management system to ensure its effectiveness. (Regulation 12)
- The trust must ensure they have robust governance and assurance processes in place at all levels to make sure the service manages risk and provides safe care to the young people. (Regulation 17)

Action the trust SHOULD take to improve:

Core service

- The trust should ensure that sufficient numbers of staff are deployed who have the knowledge skills and experience to meet the needs of the young people.
- The trust should seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service.

Our inspection team

How we carried out the inspection

The team that inspected the service comprised of two CQC mental health inspectors and one specialist advisor with a mental health nursing background.

Before the inspection visit, we reviewed information that we held about the service.

This was an unannounced, focussed inspection We inspected the key lines of enquiry relating to safe and well-led.

During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff were caring for young people
- spoke with 2 young people
- spoke with 8 relatives and/or carers
- spoke with the matron and interim ward manager
- spoke with 13 other staff members including doctors, nurses, occupational therapists, psychologists, family therapist and health care support workers
- attended and observed two MDT handover meetings, one shift-to-shift handover, two nursing huddle meetings and one environmental security check
- looked at 7 young peoples' care and treatment records
- reviewed incidents, risk registers, improvement/action plans, environmental risk assessments and enhanced observation records
- looked at policies and procedures and other documentation relating to the running of the service.

You can find further 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

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

This section is primarily information for the provider

Enforcement actions

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 17 HSCA (RA) Regulations 2014 Good governance