Huntercombe Young People Ltd

Huntercombe Hospital Stafford

Inspection report

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Date of inspection visit: 6 October to 16 October
Date of publication: 10/03/2022

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Inadequate
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

Huntercombe Hospital Stafford is a child and adolescent mental health service for 37 male and female children and young people aged eight to 18 years. The hospital admits both informal and detained children and young people. Huntercombe Hospital Stafford is divided into three separate wards; Hartley, Thorneycroft and Wedgewood.

We most recently inspected the service in September 2018 and carried out a full comprehensive inspection. We rated the service as good overall, with key questions rated: safe, effective, responsive and well-led as good and caring as outstanding.

At this inspection, we undertook an unannounced inspection of all key questions:

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

We visited the location on the 6 and 7 October 2021 during the day shift and due to concerns identified, we carried out a further visit on 12 October 2021 during the night shift. Following the onsite inspection visits, we carried out remote interviews with staff members and evidence gathering until 19 October 2021.

Our rating of this location went down. We rated it as inadequate because:

- Not all staff were wearing personal protective equipment correctly or were bare below the elbow. Not all staff were observed to follow good hand hygiene practices and hand washing was inconsistent upon entry and exit to wards. There were no maximum capacity signs on doors and there was a lack of social distancing.

The service did not always have sufficient permanent staff to meet children and young people's needs to keep them safe and relied on agency staff to fill vacancies.

- Children and young people's care and treatment was not always provided in a well-furnished, well-maintained or clean environment which did not always meet the needs of children and young people with Autism.
- Children and young people's records were not always personalised, goal-orientated, strengths based or demonstrated children and young people and family involvement.
- Staff on Hartley ward did not always respect children and young people's preferences with regard to the pronouns that they wished to be addressed by.
- The hospital director within the service was not visible or approachable to staff or children and young people.
- Some staff were sat with their eyes closed for prolonged periods of time whilst carrying out observations. There were not robust systems in place to ensure that staff working during the night shift were undertaking their roles appropriately.

Summary of findings

- Observations were not always recorded at the time they occurred and were completed retrospectively or not at all. There was a system in place to monitor the recording of observations, but this did not highlight any issues.
- Audits that were in place were not robust to monitor and improve the quality of care and did not always demonstrate clear actions where appropriate.

However:

- Psychology and occupational therapy care plans were well written and provided individual detail about children and young people's care and treatment.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare.
- Children and young people made choices and took part in activities which were part of their planned care and support.
- Children and young people's physical health was assessed on admission and reviewed on a daily basis throughout their stay.

As this service has been rated inadequate it will be placed into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Inadequate 	The summary is contained in the overall summary at the beginning of the report. Our rating of this service went down.

Summary of findings

Contents

Summary of this inspection

Background to Huntercombe Hospital Stafford

Huntercombe Hospital Stafford is a child and adolescent mental health service provided by Huntercombe Young People Ltd. The provider took over the service on 28 February 2021 from the previous provider. The service provides care for 37 male and female children and young people aged eight to 18 years. The hospital admits informal and detained children and young people. Huntercombe Hospital Stafford is divided into three wards; Hartley, Thorneycroft and Wedgewood wards.

Hartley ward is a psychiatric intensive care unit (PICU) providing 12 beds. The PICU unit offers care to children and young people suffering from mental health problems who require specialist and intensive treatment. There is an additional bed in the extra care area, which is attached to the ward, which can be utilised for young people who require long term segregation and was occupied at the time of our inspection.

Thorneycroft ward is a general child and adolescent mental health (CAMHS) acute assessment unit with 12 beds for young people aged 12 to 18 years. The children and young people treated there have a range of diagnoses from psychosis and bipolar disorder to depression and deliberate self-harm.

Wedgewood ward is a specialist eating disorder unit (EDU), which provides services for 12 children and young people. The children and young people treated here have a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or other similar disorders.

Huntercombe Hospital Stafford has a registered manager and is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

In September 2018 we carried out a full comprehensive inspection. We rated the service as good overall, with key questions rated: safe, effective, responsive and well-led as good and caring as outstanding.

We told the provider it should take the following action to improve:

- The provider should ensure that all staff on one-to-one in Hartley ward record observations on the observations forms in a timely manner. (Regulation 12).
- The provider should ensure that they continue with their recruitment and retention strategy in order to reduce high reliance on agency staff. (Regulation 18).
- The provider should ensure that all staff are up to date with prevent and manual handling practical training. (Regulation 18).

During our inspection we found that there were still concerns with staff not recording observations in a timely manner or at the appropriate times and vacancy rates remained high. However the service was up to date with prevent and manual handling practical training.

You can read our findings from all of our previous inspections by selecting the ‘all reports’ link for Huntercombe Hosptial Stafford on our website at: www.cqc.org.uk

Summary of this inspection

How we carried out this inspection

During the inspection, the inspection team:

- visited all three units and the extra care area, looked at the quality of the environments and observed how staff were caring for children and young people;
- spoke with 12 children and young people who were using the service;
- spoke with two family members and/or carers of children and young people using the service;
- spoke with the registered manager, head of quality and governance, head of nursing and ward managers for each unit;
- spoke with 19 other staff members including; nurses, support workers, occupational therapist, psychologist, social worker and family therapist;
- looked at 14 care and treatment records of children and young people;
- looked at 15 prescription cards;
- attended one multi-disciplinary team meeting, one handover, observed two occupational therapy sessions and attended an operations meeting;
- looked at a range of policies, procedures and other documents relating 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:

We told the service that it must take action to bring in line with five legal requirements:

- The service must ensure that Hartley ward has the equipment and furnishings to meet the sensory needs of the children and young people on the unit. (Regulation 9).
- The service must ensure that care records are personalised, goal orientated and demonstrate involvement from children and young people. (Regulation 9).
- The service must ensure that the blind spot on the stairs on Wedgewood unit is mitigated through the use of parabolic mirrors to ensure clear lines of sight. (Regulation 12).
- The service must ensure that infection, prevention control measures are embedded in practice and staff adhere to the infection control principles in line with the provider's policy and national guidance. (Regulation 12).
- The service must ensure the environments on all wards are clean, well furnished, well-maintained and fit for purpose. (Regulation 15).
- The service must ensure that senior managers are visible and approachable for both staff and children and young people. (Regulation 17).
- The service must ensure that there are systems in place to monitor observations and ensure that these are recorded at the relevant times. (Regulation 17).
- The service must ensure that there are robust systems in place to ensure that staff working during a night shift are appropriately undertaking their roles. (Regulation 17).

Summary of this inspection

- The service must ensure that there are robust audits in place to monitor and improve the quality of care, with clear actions where appropriate. (Regulation 17).
- The service must ensure that there are sufficient members of suitably qualified, competent, skilled and experienced nursing staff working to meet the needs of people using the service. (Regulation 18).

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by regulation, but it would be disproportionate to find a breach of the regulation overall:

- The service should ensure that staff ensure they follow children and young people's preferences in regard to the pronouns they wish to be addressed by. (Regulation 9).
- The service should ensure that staff engage meaningfully with children and young people on Hartley ward (Regulation 9)

Our findings

Overview of ratings

Our ratings for this location are:

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

Inadequate

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Wards were not always clean, well equipped, well-furnished, well-maintained or fit for purpose.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and removed or reduced any risks they identified. Staff could observe children and young people in all parts of the wards on Hartley and Thorneycroft wards. Staff managed a majority of the blind spots on Wedgewood ward through staff placement and children and young people observation levels. However, there was a blind spot on the stairs where staff were unable to see around the staircase. There was no mirror in place to support lines of sight.

Wards complied with guidance on mixed sex accommodation. There were separate bedroom corridors for male and female children and young people with allocated bathroom and toilets. Wards also had separate lounge areas. Staff monitored bedroom corridors when there was a child or young person identifying as the opposite sex or non-binary.

There were potential ligature anchor points in the service and each ward had a ligature audit in place that identified these. Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe through risk assessments and children and young people observations.

Staff had easy access to alarms and children and young people had easy access to nurse call systems in their bedrooms. There were also call buttons in bathrooms and communal areas on all wards.

Maintenance, cleanliness and infection control

Inadequate

Child and adolescent mental health wards

Children and young people care was not always provided in a well-furnished or well-maintained environment. All wards had items of furniture that were either torn or ripped and needed replacing. Wards also had areas where paint was chipped or peeling away from walls and required redecoration. We found a number of items stored in the corridor of Wedgewood ward including; a heater, fan and wheelchair. The service had planned works to redecorate and had ordered new furniture for the wards. This work was due to be completed in November 2021.

Most wards were clean. However, on Hartley and Thorneycroft wards we found windows in children and young people bedrooms were dirty with insects and dirt trapped between the glass panes. Cleaning records did not always demonstrate regular cleaning. Between the 16 and 28 September 2021, records indicated children and young people bedrooms were not cleaned on Hartley ward and between 10 and 21 September 2021 on Thorneycroft ward. Staff had not recorded why it had not been possible to clean children and young people bedrooms during those times.

The ward was loud and there was a lack of sensory equipment available for children and young people with sensory needs.

Staff did not always adhere to infection prevention control procedures or follow the provider's infection control policy. Staff on Hartley ward were observed repeatedly on closed circuit television (CCTV) footage not wearing their face mask correctly, either beneath their nose or not at all. We informed the service of this on the second day of our site visit. When we returned on site for an out of hours visit a few days later, we continued to observe staff not wearing their face masks correctly.

Staff told us and we observed that they were provided with one face mask per 12-hour shift and did not change this, despite having a break and moving between wards and other areas of the hospital. When reviewing CCTV footage, we found a number of staff on Hartley ward were not bare below the elbow, particularly during the night shift and were observed to be wearing coats and jackets with hoods. We also observed this during our inspection visits. We found hand washing upon entry and exit to wards was inconsistent amongst staff and was not always completed even when prompted by inspectors.

There were no maximum capacity signs on doors to indicate the maximum number of staff that should be in a room to ensure safe social distancing. There were several occasions during our visit where large numbers of staff were gathered together in small offices without ventilation or social distancing in place. There was a bin located in the reception area which was overflowing with used face masks on the first day of our inspection. However, we observed this had been rectified on our following site visits.

When reviewing training compliance, 90% of staff had completed online training in infection control.

Seclusion room

The seclusion room located on Hartley ward allowed clear observation and two-way communication. It had a clock, toilet and shower facilities and met the requirements of the Mental Health Act Code of Practice. The service had installed a projector through the office window in the seclusion room, with sound playing through the intercom, which was used to project DVDs into the room to help de-escalate children and young people. Staff told us this was effective in the de-escalation of children and young people.

Clinic room and equipment

Inadequate

Child and adolescent mental health wards

Clinic rooms were clean and well equipped, with accessible resuscitation equipment and emergency medications. Staff checked resuscitation equipment and defibrillators daily. Audits ensured records of checks were accurate and completed. Records demonstrated staff completed daily checks of medicine fridge and clinic room temperatures.

Safe staffing

The service did not have enough nursing staff, who knew the children and young people. Staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep children and young people safe. The hospital had assessed a staffing requirement of 33 whole time equivalent (WTE) qualified nurses and 176 WTE support workers. In 2020, the service increased the core number of support workers from 99 WTE to 176 WTE due to children and young people requiring more intense care and treatment, the level of children and young people's observations and an attempt to reduce the number of agency staff being used. At the time of inspection there were 14.4 WTE nursing vacancies (44% of the providers required workforce) and 49.2 WTE (28% of the providers required workforce) support worker vacancies. Where there were vacancies and sickness, managers used bank and agency staff to cover these shifts. The service used staff from multiple agencies that were sourced through one central organisation which the service had a contract with.

From 1 July to 31 September 2021 the service had a low staff turnover with 5 WTE support workers and 2 WTE nurses leaving and had an average sickness rate of 7.9%. There were no apparent themes or trends for leavers and managers supported staff who needed time off for ill health.

Children and young people were allocated a named nurse and key worker and had a regular one to one session on a weekly or as and when needed basis. Escorted leave or activities were rarely cancelled due to staffing levels and staff and children and young people told us this did not happen

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the wards quickly in an emergency.

Managers could call locums when they needed additional medical cover.

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

Mandatory training

Staff had completed and kept up to date with mandatory training. At the time of our inspection, the service reported a staff compliance rate of 89% for all mandatory training. Staff had access to additional training via an online platform. Managers monitored mandatory training and alerted staff when they needed to update their training.

The mandatory training programme was comprehensive but did not meet all the needs of children and young people and staff. There were a number of children and young people on Hartley ward with a diagnosis of Autism and eating disorders and staff on the ward were not provided with training in the management of these children and young people. Children and young people told us this could be difficult as they did not feel staff understood them or how to support them.

Assessing and managing risk to children and young people and staff

Staff did not always assess and manage risks to children and young people and themselves well. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of children and young people risk

Staff completed risk assessments for children and young people on admission using a recognised tool and this was reviewed regularly, including after any reported incident.

Management of children and young people risk

Staff supported children and young people to manage their own risks. Staff knew about children and young people's risks and acted to prevent or reduce those risks and responded to changes in risk to, or posed by, children and young people.

Staff followed policies and procedures when they needed to search children and young people, or their bedrooms, to keep them safe from harm. Searches were carried out on an individual basis depending on the risk presented.

During our review of CCTV, we observed at least three members of staff who were sitting with their eyes closed for prolonged periods of time on Hartley and Thorneycroft wards. When speaking with staff, they informed us this was an issue on occasion but was dealt with at a ward level rather than being escalated. There were no incidents or harm to children and young people that occurred from alleged staff sat with their eyes closed for prolonged periods of time. We reviewed observation audits that highlighted the service's awareness of lights being turned off and staff sat in a position which could lead to tiredness. There were no clear actions as to how the service planned to support staff and ensure they were not sat with their eyes closed for prolonged periods of time.

During our out of hours visit on 12 October 2021, we found Hartley ward staff had not completed observation records. At least one observation had been recorded after the event, due to the chronological order. This was found in a number of children and young people's records. When reviewing observation audits, this had not been identified. This was also found in our previous inspection in 2018.

Use of restrictive interventions

The service monitored and reported on the use of restrictive interventions. Staff reviewed and reported incidents of restraint. Incident reports were reviewed on a daily basis by senior managers at the daily operational meeting. There is a regular restrictive practice meeting that children and young people are invited to attend.

Staff made every attempt to avoid using restraint by using de-escalation techniques. However, there were some children and young people who required physical intervention immediately due to risks posed to themselves through self-harm.

Inadequate

Child and adolescent mental health wards

There had been 45 incidents of rapid tranquilisation from 1 July to 31 September 2021. Staff followed NICE guidance when using rapid tranquilisation. We reviewed children and young people's records and found observations were carried out post administration in accordance with The National Institute for Health and Care Excellence (NICE) guidance.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was placed in long-term segregation.

Safeguarding

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

Staff knew how to recognise adults and children who were at risk of suffering harm and worked with other agencies to protect them. The service reported to have a good relationship with the Local Authority Designated Officer (LADO) and the local safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had their own social work team on site to support with safeguarding referrals and staff knew who these individuals were.

Staff received training on how to recognise and report abuse, appropriate to their role. Staff were up to date with their training with 90% of staff having received face to face training in level three safeguarding and 88% received safeguarding children training online.

Staff access to essential information

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

Children and young people's records were accessible to all staff whether they were paper based or electronic. All staff, including bank and agency staff had access to the systems and records needed to support children and young people's care and treatment.

Medication management

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medications. Medication storage facilities were secure, clean and tidy. Medications were kept at the right temperature and when opened, these were clearly labelled with a date of opening and use by date.

Staff reviewed children and young people's medications on a weekly basis and provided specific advice to children and young people and carers about their medications. Doctors were able to review medication when required at any point. Our review of prescription charts demonstrated these were completed and medications were prescribed in the way required by the Mental Health Act.

Staff followed current national practice to check children and young people had the correct medications.

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

Staff reviewed the effects of each children and young people's medication on their physical health according to NICE guidance.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed children and young people safety incidents well. Staff recognised incidents and reported them. Managers investigated incidents, however lessons learned were not always shared with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

The service managed safety incidents well. Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider's policy. Staff were provided with a debrief following any incident if they needed it and were able to reflect on the incident. Managers investigated incidents thoroughly.

Lessons learned were shared effectively with staff both internally and from other services within the organisation. There were staff meetings, handovers, newsletters and emails to share information.

During our visit on 12 October 2021, we spoke to Hartley ward staff who were unaware that an incident had taken place on the previous shift, despite having received a handover. We attended the morning handover following this incident and there was no discussion of the incident to staff beginning their shift.

Staff understood the duty of candour. They were open and transparent and gave children and young people and families a full explanation if and when things went wrong.

Senior staff used CCTV footage to support the investigation of some incidents and complaints. They also completed audits of CCTV to review safety and quality in the service, as well as completing an observation audit. However, we found this to be ineffective and lacked detail of specific actions to take place. Where issues had been identified, there was no record of how the service identified to resolve those issues and who would be responsible to do so. The service also had CCTV monitoring in several children and young people bedrooms where footage is monitored by external clinicals who can contact the ward staff if they have any concerns, through an organisation called Care Protect. Children and young people were allocated a bedroom with additional CCTV monitoring after discussion in multidisciplinary meetings and with children and young people and parental consent.

Inadequate

Child and adolescent mental health wards

Are Child and adolescent mental health wards effective?

Requires Improvement

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

Assessment of needs and planning of care

Care plans were not always personalised, holistic or recovery-orientated but reflected children and young people's assessed needs. Staff assessed the physical and mental health of all children and young people on admission. They developed care plans which were reviewed regularly through multidisciplinary discussion and updated as needed.

Staff completed a comprehensive mental health assessment of each children and young people either on admission or soon after. However, we found nursing care and support plans were not always personalised to individual children and young people's needs. They were often prescriptive, lacked detail and were not written collaboratively with the children and young people. They did not focus on children and young people strengths or recovery but more on what the children and young people was unable to do due to the risk behaviours they presented. Psychology and OT care plans we reviewed contained more detail and personalisation, they provided the detail lacking in nursing care plans. Staff regularly reviewed and updated care plans when children and young people's needs changed. We also found whilst most children and young people had a Positive Behavioural Support (PBS) plan in place, this was not the case for all children and young people on Hartley ward.

Staff assessed children and young people's physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff completed the Paediatric Early Warning Score (PEWS) every shift and these were completed in full and scored, including recording children and young people's refusals.

Best practice in treatment and care

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

Children and young people had good access to physical healthcare and were supported to live healthier lives. There were good links with healthcare professionals such as; the local GP and dentist and staff supported children and young people to attend appointments. Access to specialist healthcare was available and supported when needed. We saw evidence of annual physical healthcare checks completed in children and young people's records.

Children and young people were able to choose which activities they took part in during weekly community meetings and these formed parts of children and young people's occupational therapy care plans. Children and young people had individual timetables that detailed their activities. There was a large occupational therapy team with an occupational therapist and occupational therapy assistant for each ward.

Staff monitored children and young people using recognised rating scales. The service used standard outcome measures such as Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and the Children's

Global Assessment Scale (CGAS) and different disciplines used different rating scales. The occupational therapy team used the Child Occupational Self-Assessment (COSA) as a self-assessment tool on children and young people's admission. The psychology team used Becks Depression Inventory (BDI), the Revised Children's Anxiety and Depression Scale (RCAD) and the Eating Disorder Examination Questionnaire (EDE-Q).

There were two part time psychologists working at the service providing access to a range of psychological therapies. The psychology team completed assessments such as Autism and Attention Deficit Hyperactivity Disorder (ADHD) assessments as well as talking therapies including Dialectical Behavioural Therapy (DBT) with children and young people. There was also access to a family therapist and art therapist to support care and treatment.

Skilled staff to deliver care

Managers did not always make sure they had staff with the range of skills needed to provide high quality care. Staff were not always provided with the training they needed to support the children and young people they cared for. The ward teams included or had access to the full range of specialists required to meet the needs of children and young people on the wards. Managers supported staff with appraisals and supervision and provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of children and young people including psychiatry, psychology, occupational therapy, family therapy, social work and nursing.

Staff received relevant training including; working safely with young people, positive behavioural support, physical health and physical intervention training. Additional training was available on the electronic learning system where suitable. However, staff on Hartley ward did not receive training in Autism Spectrum Disorder (ASD) to meet the needs of children and young people receiving treatment.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff. Managers provided an induction programme for any new or temporary staff. There was a clear three-week induction programme in place for new starters. Permanent staff received an induction book with a training and development programme in place. Agency staff received an induction before commencing shifts at the service.

Managers supported staff through regular clinical and managerial supervision of their work. Staff received regular supervision and supervision rates for September 2021 were 70% and appraisal rates were at 82%.

Multi-disciplinary and interagency teamwork

Staff from different disciplines did not always work together as a team to benefit children and young people or support each other to make sure children and young people had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff from a range of disciplines supported children and young people in the service. Staff held weekly multidisciplinary meetings to discuss children and young people and improve their care. Children and young people and family members were invited to attend these meetings. Teams had effective working relationships with services external to the provider and worked together to support children and young people's care and treatment.

Staff did not always make sure they shared clear information about children and young people and any changes in their care.

When we reviewed children and young people's records, we found the front sheet of the care plan was not always updated to reflect the information from the latest multi-disciplinary team (MDT) meeting. We spoke to children and young people who told us staff communication following MDTs was not always effective. Changes to observation levels and treatment programmes were not always clearly communicated between staff.

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' 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 with 88% receiving training for level one and 97% for level two. Staff were able to describe the Code of Practice guiding principles.

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

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were referred to the service. There were posters around the service with advocacy details and we reviewed the advocacy monthly reports issued to the provider.

Staff explained to each children and young people their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the children and young people's notes each time. The service had a Mental Health Administrator who ensured that rights and information regarding detention were up to date.

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.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed. We reviewed these documents during our inspection and there were no areas of concern highlighted.

Informal children and young people knew they could leave the ward freely and the service displayed posters and information to tell them this.

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 provider 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 and young people 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.

Inadequate

Child and adolescent mental health wards

Children and young people were supported to make decisions about their care. Staff understood the Mental Capacity Act 2005. Staff received and kept up to date with training with 88% of staff having completed their training. There was a clear policy on Mental Capacity Act, which staff knew how to access.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child a young person did not have the capacity to do so. We saw evidence of Gillick competency completed in children and young people's records and regular reviews of capacity at every multi-disciplinary team meeting.

Staff assessed and recorded capacity to consent clearly each time a children and young people needed to make an important decision and we saw evidence of specific capacity decisions.

When staff assessed young people as not having capacity, they made decisions in the best interest of children and young people and considered the children and young people's wishes, feelings, culture and history.

Are Child and adolescent mental health wards caring?

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat children and young people with compassion and kindness or respect children and young people' privacy and dignity. They did not always understand the individual needs of children and young people or support them to understand and manage their care, treatment or condition.

Children and young people did not always receive care that was kind or compassionate and staff were not always respectful when caring for children and young people. Children and young people on Hartley ward gave examples where staff did not use the correct pronoun when referring to children and young people as per their wishes and care plan. Children and young people also told us night staff were noisy and rude and had inappropriate conversations that children and young people were able to hear. We observed this when reviewing CCTV and saw groups of staff in bedroom corridors having conversations during the night shift, although the CCTV did not have audio and therefore the conversation occurring was not possibly to ascertain.

Staff did not always support children and young people to understand and manage their own care treatment or condition. Children and young people told us they felt staff did not always understand their mental health condition and how to support them to manage this, particularly children and young people on Hartley ward with eating disorders or autism.

During our visits we found staff engagement with children and young people to be more meaningful on Thorneycroft than Hartley ward. On multiple occasions on Hartley ward, we found staff were not engaged with children and young people and missed opportunities to do so. We observed one young person was sat on their own on the floor for two hours of our visit and the member of staff was sat away from them, not engaging in any conversation or having any interaction. When approached by the CQC inspector, the children and young people was happy to engage in conversation.

Inadequate

Child and adolescent mental health wards

Staff felt they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people. Children and young people felt they were able to raise any concerns they had and had done so. However, they were not always confident of action being taken. For example, children and young people had raised there were staff who appeared to favour certain children and young people, staff supported this had been raised but there had been no action taken.

Involvement in care

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

Involvement of children and young people

Staff introduced children and young people to their ward and the service as part of their admission. Children and young people were enabled to make choices for themselves and staff ensured they had the information they needed. They ensured children and young people understood and controlled their treatment and supported.

Children and young people had easy access to advocacy services. There was information displayed around the wards on how to access advocacy. We reviewed monthly reports the advocacy service sent to the service with regard to the children and young people they had supported and any particular themes or trends.

Staff supported children and young people to maintain links with those that were important to them. During the COVID-19 pandemic, children and young people were supported to continue accessing advocacy services and their friends, carers and relatives via video and teleconferencing. The service had a local COVID-19 visiting protocol in place to ensure face to face visits could take place when appropriate and within national guidelines.

Children and young people took part in making decisions and planning their care and treatment. Children and young people were empowered to provide feedback and staff supported them to do this. There were weekly community meetings which children and young people attended. They were asked to provide feedback on whether they had been involved in their care and treatment. We reviewed the minutes from these meetings from 1 July to 31 September 2021 and there were no occasions where children and young people raised a lack of involvement in their care and treatment. However, when we reviewed children and young people's records, there was a lack of children and young people's voice and perspective present in some care plans.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Families were able to attend weekly MDT meetings and had their views considered in relation to their relative's care plan. Staff helped families to give feedback on the service and families felt confident to raise concerns comfortably. However, when we reviewed children and young people records, there was a lack of family or carer voice or input evident in some children and young people care plans.

Are Child and adolescent mental health wards responsive?

Inadequate

Child and adolescent mental health wards

Good

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

Access and discharge

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

Children and young people did not stay in hospital for a long time. Children and young people had discharge plans with clear timeframes in place to support them to move to a community setting or a new provider, based on their individual needs. Staff liaised well with other services that provided aftercare and coordinators, so that children and young people received the right care and support when they moved on. Staff supported children and young people when they were referred or transferred between services.

The service managed admissions well and were able to pause admissions to any of the wards should they need to due to and did so when necessary. At the time of our inspection, admissions to Thorneycroft ward had been paused due to children and young people on the ward requiring more intense care and treatment.

Discharge and transfers of care

The service had five children and young people whose discharge was delayed due to lack of future placement. The service were able to monitor these regularly and worked with National Health Service England (NHSE) to secure placements as soon as possible. Managers monitored the number of children and young people whose discharge was delayed.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported most children and young people' treatment, privacy and dignity. However, Hartley ward was not suitable for those children and young people with autism and furnishings were torn or ripped in all wards. Each children and young people had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy and the food was of good quality.

Each children and young people had their own bedroom, which they could personalise and had a secure place to store their personal belongings. Children and young people had their own bedrooms but there were not en-suite facilities and bathrooms were shared on each ward. This meant some children and young people had to walk across the ward with their personal care belongings to use other facilities if the closest one to them was in use, which did not support the children and young people's comfort, dignity and privacy. There were outside cabins for children and young people to meet visitors in a private space. There was access to outside space for fresh air that children and young people were able to access easily.

The service provided children and young people with a variety of good quality food. On Hartley ward, children and young people were unable to make their own hot drinks and snacks and were dependent on staff to do so. There was a water cooler for children and young people to access cold drinks, however this was broken during our inspection. Children and young people on Thorneycroft ward had access to the dining area for snacks, cereals and cold drinks. Kettle and toaster access could be restricted depending on an individual children and young people's risk. Children and young people on Wedgewood ward had set meal and snack times where food was available.

Children and young people' engagement with the wider community

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

Staff ensured children and young people had access to opportunities for education. Children and young people attended school sessions throughout the day and were able to attend college courses where appropriate. Staff helped children and young people to stay in contact with families and carers.

Children and young people had access to mobile phones. This was individually risk assessed and phones were not available to children and young people during school hours. There were quiet areas for children and young people to make telephone calls in private, or in their own bedrooms.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. Children and young people were supported to have regular visits from family members and regular home leave where appropriate. The occupational therapy team facilitated activities that parents were able to do together with their relative at the service such as baking. Dependent upon individual risk assessments, children and young people are supported to access community activities such as; drives out, horse stables, the zoo and the seaside.

Meeting the needs of all people who use the service

The service did not always meet the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs. There was a lift in the main building for children and young people to access Thorneycroft unit on the first floor.

Children and young people on Hartley ward told us that staff did not always use their preferred pronoun when addressing them. This had been raised as an issue on Thorneycroft ward and staff responded to include pronouns into the handover to ensure children and young people were addressed appropriately. However, this learning had not been utilised by Hartley ward.

Staff made sure children and young people could access age appropriate information on treatment, local services, their rights and how to complain. Information was displayed in notice boards around the service and leaflets could be made available. Managers made sure staff and children and young people could get help from interpreters or signers when needed. The service provided a variety of food to meet the dietary and cultural needs of individual children and young people.

Listening to and learning from concerns and complaints

Inadequate

Child and adolescent mental health wards

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.

Children and young people, relatives and carers knew how to complain or raise concerns. We reviewed the service's complaints log and saw evidence of complaints made by children and young people and relatives that had been recorded, investigated and actioned and lessons learned shared with the wider service.

The service clearly displayed information about how to raise a concern on information boards around the service. There were opportunities for children and young people to feed back through community meetings and for staff at staff meetings and through supervision.

Staff understood the policy on complaints and knew how to handle them and protected children and young people who raised concerns or complaints from discrimination and harassment.

Are Child and adolescent mental health wards well-led?

Inadequate

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed. However, they were not always visible in the service and approachable for children and young people and staff.

The hospital director within the service was not visible or approachable to staff or children and young people. Some staff were unable to name the hospital director or believed they were new to the role, whilst others stated they had not met the individual despite working at the service for a considerable amount of time. Staff reported there was a disconnect between nursing staff and senior managers and information was not always communicated.

Managers had knowledge and experience to perform their roles and had a good understanding of the service they managed and the challenges they faced. Staff told us they found ward managers responsive to concerns when they raised them.

Vision and strategy

Staff did not always know or understand the provider's vision and values and how they were applied to the work of their team.

Vision and values form part of the induction process for staff. However, some staff, including senior staff, were unable to describe what the vision and values of the service were and how they applied to their role.

Culture

Inadequate

Child and adolescent mental health wards

Some staff did not always feel respected, supported and valued.

Not all staff felt respected, supported and valued by senior managers within the service. Some staff felt their discipline was not a valued part of the service as a whole. Some staff felt as though senior managers within the service did not know their name or who they were.

Staff felt they could raise concerns without fear of retribution and were able to describe the whistleblowing process.

The hospital director chairs a group to look at equality and diversity across the provider as a whole. The service had begun to collect data about staff and children and young people to have better understanding of the care they were providing and who they were providing it too.

Governance

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

The service held monthly clinical governance meetings following the CQC five domains, to monitor the effectiveness of governance systems and process.

However, our findings from other key questions showed that governance processes did not always help to keep people safe, protect their human rights and provide good quality care and support. Audits did not always operate effectively to pick up concerns or inconsistencies in the quality of care records. There was a lack of action from concerns highlighted in the previous inspection. We observed staff to be sat with their eyes closed for prolonged periods of time and not wearing PPE correctly or at all on CCTV footage and no evidence of action taken to improve this. Staff told us that concerns were not always escalated up to managers, for example staff when sat with their eyes closed for prolonged periods of time on the night shift. We found that wards appeared to be disconnected and good practice observed on one ward, was not transferred to another. For example, pronouns had been introduced in handovers on Thorneycroft ward due to children and young people raising concerns and this had not been introduced on Hartley ward where children and young people had raised the same concerns. We were not assured the systems and processes in place were adequate to pick up on concerns or action taken to improve the quality of care and treatment provided.

Management of risk, issues and performance

The service used information to make informed decisions on treatment options. Children and young people had regular multi-disciplinary meetings to review care and treatment.

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

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Inadequate

Child and adolescent mental health wards

Children and young people were able to develop and improve the service. There were regular children and young people community meetings to provide feedback and children and young people surveys. Staff were able to feedback during team meetings and supervision, however some staff told us that team meetings did not happen regularly. We asked for three months' worth of team meeting minutes and were only provided with one meeting from each ward.

The service took part in national quality improvement services and Wedgewood ward was accredited with The Royal College of Psychiatrists under The Quality Network for Inpatient CAMHS.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Environments on all wards were not clean, well furnished, well-maintained or fit for purpose.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Hartley ward did not have the equipment and furnishings to meet the sensory needs of the children and young people on the unit. Staff on Hartley ward were not engaged with children and young people and missed opportunity to do so. Care records were not personalised, goal orientated and did not demonstrate involvement from children and young people.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient members of suitably qualified, competent, skilled and experienced staff working to meet the needs of people using the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Following the inspection, a warning notice was issued to the provider which told the provider areas which must be improved. In particular: • Senior managers were not visible or approachable for both staff and children and young people. • Systems were not in place to monitor observations and ensure that these were recorded at the relevant times. • Handovers did not contain sufficient detail to provide staff with the information they needed to begin their shift. • Robust systems were not in place to ensure that staff working during a night shift were appropriately undertaking their roles. • Robust audits were not in place to monitor and improve the quality of care, with clear actions where appropriate.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Following the inspection, a warning notice was issued to the provider which told the provider areas which must be improved. In particular: • There was a blind spot on the stairs on Wedgewood unit that was not mitigated through the use of parabolic mirrors to ensure clear lines of sight. • Infection, prevention control measures were not embedded in practice and staff did not always adhere to the infection control principles in line with the provider's policy and national guidance.