

Active Young People Limited

# Ivetsey Bank Hospital

## Inspection report

Ivetsey Bank  
Wheaton Aston  
Stafford  
ST19 9QT  
Tel: 01785840000  
www.activecaregroup.co.uk

Date of inspection visit: 17 January, 18 January, 24 January  
Date of publication: 20/03/2024

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

### Ratings

#### Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services well-led?

Requires Improvement



# Summary of findings

## Overall summary

Ivetsey Bank Hospital, formerly known as Huntercombe Hospital Stafford, is a child and adolescent mental health service for 37 children and young people aged 12 to 18 years. When we inspected this service in October 2022, we identified areas of concern and took enforcement action resulting in conditions on the location's registration and the service was placed in special measures. We last inspected this service in June 2023. Improvements had been made however we identified other areas of concern and took further enforcement action. At this inspection we noted improvements across our previous areas of concern.

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


- Staff were concerned about the risk of physical assault and injury from children and young people. Not all staff felt fully supported by managers when they needed time off work.
- Not all staff were bare below the elbow, in line with infection prevention and control guidelines.

However:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

# Summary of findings

## Our judgements about each of the main services

| Service                                  | Rating   | Summary of each main service |
|--|--|------------------------------|
| Child and adolescent mental health wards | Requires Improvement  |                              |

---

# Summary of findings

## Contents

### Summary of this inspection

Background to Ivetsey Bank Hospital

Page

5

Information about Ivetsey Bank Hospital

6

---

### Our findings from this inspection

Overview of ratings

8

Our findings by main service

9

---

# Summary of this inspection

## Background to Ivetsey Bank Hospital

Ivetsey Bank Hospital Stafford is a child and adolescent mental health service, provided by Active Young People Ltd since 28 February 2021.

The service provides care for 37 children and young people aged 12 to 18 years. The hospital admits informal and detained children and young people.

Ivetsey Bank Hospital consists of 3 wards: Hartley, Thorneycroft and Wedgewood. Hartley ward is a psychiatric intensive care unit (PICU) providing 12 beds.

The PICU 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. The extra care area is used for young people who require long term segregation to manage their care needs. This area was in use at the time of our inspection.

Thorneycroft ward is a general child and adolescent mental health (GAU) 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.

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 disordered eating conditions. The ward was closed to admissions at the time of our inspection and there were only 3 young people admitted.

Ivetsey Bank 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

We previously inspected the service in June 2023. At that inspection, we undertook an unannounced comprehensive inspection to follow up on concerns raised around patient safety at the inspection in November 2022.

We rated the service as inadequate in well led and requires improvement for the other domains.

At this inspection we carried out an unannounced focussed inspection and reviewed progress made against the Warning Notices served to the provider at the previous inspection. We visited the site between 17 January and 24 January 2024 and inspected the Safe and Well led domains.

## What people who use the service say

# Summary of this inspection

Young people we spoke with told us staff helped them to progress, and they were involved in decision making about their care. They worked with staff to develop care plans and positive behaviour support plans with members of the multidisciplinary team. They were offered copies of their care plans.

All the young people said there were lots of activities with lots of choice. Most young people told us they liked the staff and staff were kind.

Some patients on Thorneycroft said they did not always feel safe when the ward was disturbed and staff could not attend to their needs as quickly as they wanted due to a higher than usual level of incidents.

Young people said that staff listened to them when they had concerns and acted quickly to make improvements when needed. They had been asked their views on how the service could be improved, such as new furniture and decoration.

## How we carried out this inspection

We visited the hospital on the 17, 18 and 24 January 2024.

Our inspection team consisted of 2 CQC inspectors.

During the inspection, the inspection team:

- visited all 3 wards and looked at the quality of the environment and observed how staff were caring for children and young people
- attended 2 meetings related to the management of the wards and hospital
- spoke with 6 children and young people who were using the service
- spoke with 17 staff
- looked at 7 care and treatment records of children and young people
- 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:

- The service must ensure it complies with infection prevention and control best practice and staff are bare below the elbow. (Regulation 12 (2)(h))

### Action the service **SHOULD** take to improve:

# Summary of this inspection

- The service should ensure that all non-contact forms are completed following administration of rapid tranquilisation when children or young people refuse physical observations. (Regulation12)

# Our findings


## Overview of ratings

Our ratings for this location are:

|  | Safe                 | Effective     | Caring        | Responsive    | Well-led             | Overall              |
|--|----------------------|---------------|---------------|---------------|----------------------|----------------------|
| Child and adolescent mental health wards | Requires Improvement | Not inspected | Not inspected | Not inspected | Requires Improvement | Requires Improvement |
| Overall                                  | Requires Improvement | Not inspected | Not inspected | Not inspected | Requires Improvement | Requires Improvement |



# Child and adolescent mental health wards

|          |  |
|----------|--|
| Safe     | Requires Improvement  |
| Well-led | Requires Improvement  |

## Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

### Safe and clean care environments

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

#### Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Environmental risk assessments were completed and in date. Actions were in place and were monitored by managers. Staff were aware of identified actions.

Staff could observe children and young people in all parts of the wards. Blind spots were mitigated using convex mirrors and through enhanced observations. Closed circuit television cameras (CCTV) were in place across communal areas on Hartley and Thorneycroft ward. It was only reviewed when required, such as following an incident, complaint or for audit purposes.

The extra care area consisted of a living area, bedroom, dining area and bathroom. This area was used for children or young people who required long term segregation and was in use at the time of our inspection. Staff were designated to this area and had 2 observation areas where they could clearly see the young person.

The ward complied with mixed sex accommodation. The wards had single sex bedroom corridors and separate bathrooms. A staff member was allocated to monitor bedroom corridors when a young person of the opposite sex, or who identified as the opposite sex, was placed on the opposite corridor.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. Ligature risk assessments were completed and in date.

Staff had easy access to alarms and children and young people had easy access to nurse call systems.

#### Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Maintenance issues were discussed and logged in community meetings. The service undertook environmental quality walks to assess and identify areas for improvement. At the time of our inspection, the hospital was being decorated and environmental improvement plans were in place across the entire site.

# Child and adolescent mental health wards

Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing. Hand hygiene audits were completed. However, not all staff were bare below the elbow. This had not improved since our last inspection.

## Seclusion room

The Seclusion room allowed clear observation and two-way communication. It was clean and had a toilet and a clock. Films could be projected onto a wall for the young people to watch.

## Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. At our previous inspection, staff did not always check emergency equipment and medicines daily. We reviewed each ward and found that a system was in place. Emergency bags were checked weekly, tagged, and sealed. We reviewed records from 1 January to 22 January 2024. Tags had been checked daily to ensure they were still in place and unbroken. Staff completed monthly audits. Staff carried out emergency scenarios to enhance their skills and identify any learning points.

Staff checked, maintained, and cleaned equipment. Medical devices had been calibrated and checked to ensure they worked correctly in December 2023.

## Safe staffing

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

## Nursing staff

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

The service had reducing vacancy rates for support workers. At the time of our inspection, there were 18.6 vacancies for support workers which equated to 11%. This had improved since our previous inspection. The service had 15.6 vacancies for qualified nurses which equated to a 47% vacancy rate. This had slightly improved since our previous inspection. Vacancies were covered by regular bank and agency staff who had worked in the service for several months or years.

Managers limited their use of bank and agency staff and requested staff familiar with the service. They made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health. At the time of our inspection, levels of sickness were highest for qualified nurses at 16%.

Managers accurately calculated and reviewed the number and grade of nurses and support workers for each shift. The hospital used the safer staffing tool and reviewed staffing requirements regularly. Staff said there were enough staff although some said when the wards were busy it could be difficult to get a break.

# Child and adolescent mental health wards

The ward manager could adjust staffing levels according to the needs of the children and young people. Staffing was reviewed in daily operations meetings and was adjusted quickly when needed. All staff, including bank staff had access to a messaging app. so they could pick up shifts when they were available.

Children and young people had regular one to one sessions with their named nurse. We saw this reflected within the electronic care record and young people told us they regularly spoke with staff and were involved in their care and treatment plans.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed. At our previous inspection, young people on Thorneycroft said they could not always access fresh air when they wanted due to staffing issues. At this inspection, young people told us they still had to be escorted off the ward by staff so they could unlock the doors, and had to wait at times, however they did not highlight this as an issue. They accepted that had at times staff were busy and they had to wait for a while. Staff told us that all patients had access to the garden area, or when individual risks had been highlighted, this would be managed through appropriate care plans. Access to fresh air was discussed with young people each week in community meetings.

The service had enough staff on each shift to carry out any physical interventions safely. Each ward had an allocated staff member who could attend incidents across the hospital site.

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

## Medical staff

The service had enough daytime medical cover and a doctor was available to go to the ward quickly in an emergency. The hospital had an out of hours duty system at night time and would use emergency services if required.

Managers could call locums when they needed additional medical cover and made sure they had a full induction and understood the service before starting their shift.

## Mandatory training

Staff had completed and kept up-to-date with their mandatory training. All courses had at least 85% compliance and the majority were above 90% compliance.

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Alongside mandatory training, staff had access to refresher training, delivered by the matron. Staff could request training they thought could be beneficial. At the time of our inspection, over 60 staff had attended online for a restrictive practice session. There was specific training for staff that worked with the young people with eating disorders.

## Assessing and managing risk to children and young people and staff

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

# Child and adolescent mental health wards

## Assessment of patient risk

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

## Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. All clinical staff attended handovers at the commencement of their shift and had access to care plans and risk management plans. Senior staff attended a daily operational meeting to discuss and review patient risk over the previous 24-hour period.

Staff identified and responded to any changes in risks to, or posed by, children and young people. On Hartley ward, all 9 of the young people who were admitted were on nursing observations to maintain their safety. Nursing observations were also in use on the other wards but to a lesser degree. Staff could easily increase or decrease nursing observations, dependent on the young people's presenting risks. All staff received training on the provider's observation and engagement policy, followed up by a competency assessment.

Some children and young people had developed positive behavioural support plans so staff knew how to manage their specific individual risks and could intervene early when required.

Staff could observe children and young in communal areas of the ward and followed procedures to minimise risks where they could not.

Staff followed policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. Prohibited items were kept in a locked room, only accessible by staff. Children and young people had access to these items under supervision.

At our previous inspection, young people told us there were not always enough activities. At this inspection, all patients we spoke with said there were plenty of activities to do. We observed young people being engaged with activities and education. Each ward now had an activity coordinator, and all the young people had an activity timetable. Activities were discussed in community meetings and young people could request what they wanted to do for the following week. The service completed monthly audits to ensure young people undertook or were offered at least 25 hours of therapeutic interventions and activity each week, as outlined by NHS England. The service was mostly meeting these requirements. The latest audit shared with CQC for October 2023 showed that Hartley ward provided an average of nearly 27 hours of therapeutic interventions or activities per patient each week, Wedgewood was 32 hours and Thorneycroft was just under the 25 hours at 24.3.

At our previous inspection, staff did not always regularly review young people's physical health and complete Paediatric Early Warning Scores (PEWS) correctly. We reviewed 7 care notes and saw that staff regularly reviewed, monitored and care planned physical health. Audits were completed weekly for each ward and results discussed with staff. Staff received training in sepsis awareness, oral health, pressure ulcer prevention and management and attended refresher training for physical health and PEWS. In December 2023, 87% of staff had received PEWS competency refresher training.

## Use of restrictive interventions

Levels of restrictive interventions were low. Reducing restrictive practice was reviewed and monitored in monthly clinical governance meetings. Staff and young people were aware of what was a prohibited item.

# Child and adolescent mental health wards

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. Between 17 October 2023 and 17 January 2024, the service had 922 restraints. These were highest on Thorneycroft ward at 465, followed by Hartley at 354 and Wedgewood at 102. We viewed CCTV on Thorneycroft ward for a period of 6 hours on a day when there had been a high number of incidents and subsequent restraints. We saw staff use de-escalation techniques and some of the interventions documented within the young people's positive behaviour support plans. The service was reviewing the incidents for that day, and it had been particularly unusual to have that amount within such a brief period of time. Initial findings were that some staff had been reticent to help restrain or take control of an escalating situation, due to inexperience or confidence. The service planned to review the CCTV footage with each member of staff involved as a learning opportunity to identify areas for individual improvement and further training needs.

One young person told us they had raised a complaint about staff being 'rough' whilst they were in restraint and showed us bruises that they had received following the incident. Staff told us they were reviewing the incident and had taken the complaint seriously.

Not all young people received a debrief following restraint. However, staff said that young people did not always want to engage in a formal debrief, although they offered one. The service monitored how often a debrief was given. Out of the 922 times restraint was used, only 175 were completed. We saw attempts from staff to offer debriefs to young people within the care records and incident reviews.

Staff understood the Mental Capacity Act definition of restraint and worked within it. All clinical staff received restraint training and subsequent refresher training.

At our previous inspection, staff did not always follow National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation (RT). Young people's physical health observations were not always monitored post administration of RT. From 17 November 2023 to 17 January 2024, there were 17 incidences of RT. All of these were on Hartley ward. We reviewed all 17 RT records. Staff recorded when the young people refused post RT physical observations and completed non-contact forms. However, 3 non-contact forms were either not completed or missing. The service completed audits to ensure that staff followed NICE guidelines and submitted their results to CQC every month. Completion of post RT paperwork was reviewed every morning in the operations meeting.

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

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

## Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. Staff completed safeguarding adults and safeguarding children and were 93% and 96% compliant respectively. Staff eligible for safeguarding adults and children level 3 were 98% compliant.

# Child and adolescent mental health wards

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Safeguarding was discussed in community meetings. Children and young people were reminded to raise any concerns to staff. Social work staff provided guidance, advice and support to staff.

Staff followed clear procedures to keep children visiting the ward safe. Family visiting areas were available off the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

## Staff access to essential information

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

Patient notes were comprehensive, and all staff could access them easily. At our previous inspection, the provider's electronic care notes system had not been working since August 2022, which was beyond the provider's control. However, the issue had been rectified and the electronic note system had been working for several months prior to this inspection.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

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

## Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Between 17 November 2023 and 17 January 2024, the service had reported 362 incidents on Hartley ward, 558 on Thorneycroft ward and 51 on Wedgewood ward. Of these, 11 were for moderate injury or hospital treatment. The majority had been for no harm or minor injury.

We reviewed incidents recorded within the electronic care notes. Staff completed body maps and neurological observations following incidents.

Staff raised concerns and reported incidents and near misses in line with provider policy. Incidents were discussed in handovers, and daily operational meetings with managers, leaders and member of the multidisciplinary team.

The main concern from staff was the risk of injury and assault during incidents or restraints from the young people, and they did not always feel safe. Some staff we spoke with had received an injury at some point; all knew of staff who had

# Child and adolescent mental health wards

required time off work due to injury. Between 17 October 2023 and 17 January 2024, staff had reported 46 injuries; 40 were injuries from the young people. Some staff say that they felt supported by their managers, although not all did, particularly whilst they were at home and could not attend work due to their injury. Managers have told staff that they should report all physical attacks to the police.

The service had no never events on any wards. Managers shared learning with their staff about never events that happened elsewhere.

Staff understood the duty of candour and received training on it. They were 96% compliant. They were open and transparent and gave children, young people and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Initial support was provided by line managers and peers. Staff could attend weekly reflective practice meetings and received monthly supervision with their line manager.

Managers investigated incidents thoroughly. The service was quick to respond to incidents or when they identified any potential issues. Rapid reviews of incidents identified learning and any actions quickly.

Members of the social work team and senior managers reviewed CCTV to review incidents when required or when they received a complaint or allegation. Incidents, themes and trends were reviewed and monitored in monthly clinical governance meetings. Several incidents had been reported on Thorneycroft ward involving multiple young people on one day. Managers were quick to review and planned to involve staff when reviewing CCTV footage.

Staff received feedback from investigation of incidents, both internal and external to the service. Feedback was shared in team meetings or with individuals when required.

Staff met to discuss the feedback and look at improvements to patient care. Senior staff attended a monthly lessons learnt subcommittee and information was cascaded to staff in team meetings and handovers. A service wide lessons learnt, and risk bulletin was available for staff. The service had started to share essential information staff needed to know following incidents in the group messaging app.

There was evidence that changes had been made as a result of feedback. Staff across the hospital were reminded about how to safely observe young people who were at risk of ligature whilst in bed. This had been cascaded to staff in various forums and meetings.

## Is the service well-led?

Requires Improvement 

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

### Leadership

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

# Child and adolescent mental health wards

Since our previous inspection, there had been many changes to the leadership team. The hospital director role had been recruited to, and the medical director post was advertised with an interim in place. The matron had recently left, however had been replaced by one of the ward managers in an interim role.

Managers were experienced and knowledgeable and had worked in child and adolescent mental health services for several years.

The hospital director made out of hours visits. The service had advertised for a night co ordinator role to provide night time leadership and improve consistency.

## Vision and strategy

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

The vision and values of the service were displayed across the site and were part of the induction for new starters.

## Culture

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

Staff said managers were supportive and approachable. The hospital director had commenced a breakfast club for staff to drop into to facilitate discussion and to get to know each other. Staff were positive about this and said leaders were available if they needed them.

Staff felt respected and valued. Staff were encouraged to have 1-1 sessions with leaders and managers if they needed to. Staff were grateful and felt appreciated when they received a personalised card and voucher from the hospital manager at Christmas.

Managers told us they supported staff who had received an injury at work. They offered welfare checks following the incident and weekly well-being calls for staff who needed time off work. All staff had access to the employee assistance programme phone line, which was available 24 hours a day, 7 days a week. Monthly reflective practice sessions led by the psychologist were open for all staff to attend when they wanted to. Managers supported staff to report all physical attacks to the police. The police visited the hospital and attended community meetings to meet staff and the young people. However, not all staff said that they felt supported, and said that the support offered was inconsistent. Staff who needed time off work did not always receive well-being checks. One staff said the call from their manager made them feel pressured to say when they were returning to work, rather than feeling supported and comforted.

Staff we spoke with said they felt confident to raise a concern if they needed to and felt they would be listened to. The hospital had a Freedom to Speak Up Guardian who staff could contact if they had any concerns or issues. The hospital manager had set up a 'Your say' forum, to encourage staff to meet with him and discuss any concerns they may have. They could also meet with him confidentially and on a 1-1 basis whenever required.

Some staff felt that boundaries regarding the children or young people's language should be more robustly adhered to and dealt with quickly. This was in relation to young people using racist language towards some staff members.

The service had introduced a staff wellbeing programme and encouraged staff to become wellbeing champions to help develop the programme and prioritise support to staff. Staff could attend activities such as yoga, mindfulness and reiki.



# Child and adolescent mental health wards

Managers encouraged staff development and there were opportunities to attend training and improve skills.

Staff said they worked well with each other and helped each other out, including the other wards when required.

## Governance

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

Managers met daily in operational meetings to review any incidents from the previous 24 hours, including completion of required paperwork, staffing levels, patient observation levels, initial learning from incidents and any other issues.

There was a clear clinical governance framework in place and senior leaders along with ward managers and key members of the multidisciplinary team attended monthly clinical governance meetings. Minutes of those meetings showed there was a standard agenda and clear actions assigned to relevant people. Governance had improved since our previous inspection.

The service monitored complaints and compliments. There were no complaints in October 2023, 4 in November, 3 in December and 3 in January 2024. Two were upheld and the others were resolved immediately. Managers were aware of concerns and acted quickly to resolve them. Between 17 October 2023 and 4 January 2024 there were 21 compliments.

Managers had implemented a regular feedback friends and family test forms to help improve feedback.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. The service had a programme of audits and managers used results from audits to make improvements. The service sent results of some of these audits to CQC as requested, following our last inspection. The service had invited the provider collaborative to review samples of CCTV footage of restraints, to gain assurance and promote transparency.

Staff received regular supervision and an annual appraisal. At the time of our inspection, clinical staff were 86% compliant for supervision and 81% compliant for their appraisal.

## Management of risk, issues and performance

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

The hospital had an up-to-date risk register. Managers were able to add items onto the risk register as necessary and these risks were reviewed regularly at clinical governance meetings.

## Engagement

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

The service worked closely with the provider collaborative, and they regularly visited to monitor progress against action plans.

# Child and adolescent mental health wards

## **Learning, continuous improvement and innovation**

The service had developed a rolling programme of online refresher sessions and staff could request topics. There had been positive feedback from staff, and they were well attended. The staff 'what's app' group contained information about staffing and shifts, learning and other relevant information.

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 | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment   |
| Treatment of disease, disorder or injury  | <ul style="list-style-type: none"><li>The service must ensure it complies with infection prevention and control best practice and staff are bare below the elbow. (Regulation 12 (2)(h))</li></ul> |