Affinity Healthcare Limited

Cheadle Royal Hospital

Inspection report

100 Wilmslow Road
Heald Green
Cheadle
SK8 3DG
Tel: 01614289511
www.priorygroup.com

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

Ratings

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

Summary of findings

Overall summary

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

- On this inspection we inspected the child and adolescent mental health wards and this changed the location ratings to requires improvement overall and requires improvement for safe and well-led.
- On this inspection, we rated the child and adolescent mental health wards as inadequate overall and inadequate for safe and well led, requires improvement in effective and responsive and rated caring as good.
- We have used ratings from previous inspections for other core services to aggregate ratings to location level in line with our guidance.

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 	Our rating of the core service of child and adolescent mental health wards went down. We rated it as inadequate because: • The service did not always provide safe care. The ward environments were not always well maintained. The wards had high vacancy rates and were reliant on agency and bank staff. • Staff assessed and managed risk well but did not always update risk assessments after incidents. • The service recorded high levels of restraint and seclusion. • Staff did not always ensure they monitored young people's physical health. Staff did not ensure that physical health monitoring took place after every incident of rapid tranquilisation. They did not always ensure that medication side effects were monitored. • Young people and their families told us they were not always involved in investigations. • Managers did not ensure that staff received training, supervision and appraisal. Mandatory training, supervision and appraisal figures were below the providers target. • Some young people told us that agency staff did not always treat them with dignity and respect. • Some carers told us they did not feel supported by the hospital. They told us that communication was not always good, they were not informed about incidents and were not supported during home leave. • The ward environments did not ensure that the care environment was dignified. There were broken windows, graffiti to some doors and the décor was not therapeutic and aligned to the needs of children and young people. • Young people did not have easy access to outside space. • Discharge planning was generic and only developed as children and young people approached discharge.

Summary of findings

- The service was not well led and the governance processes did not ensure that ward procedures ran smoothly. Audits had not ensured ward environments were maintained and trends in incidents were not identified.
- Competency check lists and agency profiles outlining staff training were not always available so managers could not reassure themselves the agency staff working were suitably trained.

However:

- Most staff treated children and young people with compassion and kindness, respected their privacy and dignity, and understood their individual needs.
- The service provided a range of treatments suitable to the needs of the children and young people 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 the children or young people on the wards. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff mainly understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment. However, in one case we found that a best interest decision had not been completed for a young person.

Summary of findings

Contents

Summary of this inspection

Background to Cheadle Royal Hospital

Cheadle Royal is a 150-bed hospital with 13 wards which included patients with diverse nursing needs. Adults with acute and psychiatric intensive care needs. Adults with personality disorders. Adults with eating disorders and adults requiring long stay rehabilitation.

There are three child and adolescent mental health wards

• Woodlands

• Orchard

• Meadows

Woodlands is a female only 10 bed low secure ward, Orchard is a 15 bed mixed sex ward offering acute services and Meadows is a 10 bed mixed sex ward for children and young people requiring Psychiatric Intensive Care.

The hospital is registered to provide assessment or medical treatment for persons detained under the Mental Health Act andTreatment of disease, disorder, or injury. The deputy hospital manager had recently become the registered manager.

This was an unannounced comprehensive inspection, carried out in response to concerns about the safety of the child and adolescent mental health wards.

This core service was last inspected on 26, 27, 28 April 2022.

At this inspection, we identified breaches of.

Regulation 12 – Safe Care and Treatment. This breach had not been met at this inspection because the service had not ensured that clinic rooms were checked and maintained appropriately.

Regulation 15 – Premises and Equipment. This breach had not been met at this inspection because we found doors that had been graffitied by the children and young people who had chipped away the paint and this damage had not been addressed.

Regulation 17 – Good Governance. This breach had not been met at this inspection because the hospital's governance processes had not ensured that the issues regarding the clinic rooms and medications were addressed in a timely and appropriate manner.

Regulation 18 – Staffing. This breach had not been met at this inspection because the hospital's governance processes had not ensured that the issues regarding the clinic rooms and medications were addressed in a timely and appropriate manner.

What people who use the service say

Summary of this inspection

We spoke with 12 children and young people and with three parents who visited the hospital while we were inspecting. We spoke with two other parents after the inspection.

The children and young people we spoke with came from different parts of the country, often requiring families to travel several hours to visit. All wanted to be in a hospital nearer to home. Some complained about agency staff and that they felt some did not engage with them. However, everyone we spoke with could name at least one member of staff who had done something to help them when they needed support.

Of the five parents we spoke with only one felt the ward had kept them informed about the care and treatment their loved ones were receiving. The four all cited incidents they had not been informed of, a lack of communication and a lack of support when the children and young people returned home for leave. Some had been promised daily phone calls during leave periods but these had not been delivered.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited all the child and adolescent mental health wards at the hospital
- looked at the quality of the environment
- observed how staff were caring for the children and young people
- spoke with 12 children and young people who were using the service
- spoke with three ward manager
- spoke with 13 other staff members
- looked at 16 care and treatment records of clients and 24 prescription charts and
- 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 provider must ensure that improvements are made to the environment to provide a dignified and safe setting with access to outside space which is maintained appropriately. (Regulation 15(1)(2)).
- The provider must ensure that systems and processes are operated effectively to assess, monitor and improve the quality and safety of the services provided. (Regulation 17(1)(2)).
- The provider must ensure that there are enough suitably qualified, skilled and experienced staff to meet the patients' needs. (Regulation 17(1)(2)).
- The provider must ensure that they are aware of and monitor the skills and suitability of all staff working in the service. (Regulation 17(1)(2)).
- The provider must ensure that all staff complete mandatory training. (Regulation 17(1)(2)).

Summary of this inspection

- The provider must ensure that it reduces the incidents of physical intervention. (Regulation 17 (1)(2)).
- The provider must ensure that physical health monitoring is completed following the use of rapid tranquilisation and in order to monitor medication side effects. (Regulation 17(1)(2)).
- The provider must ensure that the children's and young person's risk assessments accurately reflect their risks and that these are reviewed and updated in line with the providers policy. (Regulations 12(2)(a)).

Action the service SHOULD take to improve:

- The service should ensure that communication with families is improved and that they are given information appropriately about incidents involving young people and children.
- The service should ensure discharge plans reflect the individual needs of the young people and children.
- The provider should ensure that care plans for the children and young persons with complicated needs reflect that need and give staff clear instructions and those who have mobility issues have a personal evacuation plan.
- The Provider should continue to review and monitor changes to medicines processes to help ensure they are safely adopted and support continued improvement in the safe handling of medicines.
- The provider should ensure that young people and families are involved in the investigation of incidents.
- The provider should ensure all staff understand they can access computer care systems.
- The provider should consider the development of a specialist eating disorder post within CAMHS as part of the care pathway.

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	Good	Requires Improvement	Inadequate	Inadequate
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Inadequate

Child and adolescent mental health wards

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

Is the service safe?

Inadequate

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

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished and fit for purpose, although not always well maintained.

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.

Staff could observe children and young people in all parts of the wards. The ward layouts did not allow staff to observe all parts of the ward and there were blind spots across each of the wards. Staff used regular observations and presence around the ward to mitigate and manage these risks. Staff were aware of their responsibilities regarding this.

The hospital complied with same sex guidance on mixed sex accommodation. Meadows and Orchard were mixed sex accommodation. All children and young people had single bedrooms with ensuite facilities. Staff considered how the mixed sex environments were managed and could act if they had any concerns in relation to this.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. Staff undertook audits to consider and reduce any potential ligature risks on the ward. Each ward also had a ligature footprint map of the ward which used colour coded symbols to represent different risks. This meant staff new to the ward had a visual aid to potential ligature anchor points and their location.

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

Maintenance, cleanliness and infection control

Inadequate

Child and adolescent mental health wards

Ward areas were generally clean, although not always well maintained, well furnished or fit for purpose. Cheadle Royal hospital is a Victorian building which has restrictive planning regulations to preserve the historical integrity of the building, therefore the three wards are limited architecturally compared with more modern purpose-built facilities. For example, all three wards do not have ground level access to outdoor space. The design of the wards is dictated by the design of the original building.

We found on Meadows, the children and young people had graffitied, scratched and chipped paint on doors that had been repainted since the last inspection. This did not contribute to a pleasant environment for the children and young people and was also an infection control issue, as it would not be possible to appropriately clean these areas. It was not clear whether the provider had considered any alternative measures to prevent this from happening in the future. The doors were in the same condition as we found previously at the last inspection of the core service in April 2022.

We also found on Woodlands that the clinic door was in a similar state to the doors on Meadows, and there were several rooms including the dining room and treatment room that had broken windows. The provider had installed an additional double-glazed window unit on the interior of existing windows so that there was no safety risk from the broken glass. There was another double-glazed exterior window unit and it was the internal exterior windowpane that was broken in all the windows. This did not contribute to a therapeutic environment.

On Orchard ward we saw several bedrooms either without curtains or curtains that were too short. We were told that curtains were on order but they had still not arrived.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed cleaning rotas and spoke with cleaning staff; they were able to show us up to date and comprehensive records. During the inspection we saw continuous cleaning activity, and the children and young people told us that the wards were always clean and tidy, especially bathrooms and eating areas.

However, cleaning staff told us there were four vacancies throughout the whole hospital and they were covering those duties. All cleaning staff we spoke with had worked at the hospital a number of years and all stated they were happy, felt safe and enjoyed cleaning on the wards.

Staff followed infection control policy, including handwashing. The hospital's COVID-19 policy did not include wearing face masks at the time of inspection; however, some staff were still wearing them as a personal choice.

Seclusion rooms

The Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. Two of the three wards (Meadows and Woodlands) had seclusion rooms and all wards could access a seclusion room if it was required.

On our last inspection the seclusion room on Woodlands had been damaged by the children and young people. This damage had been repaired. The bed and walls were made of a special padded material to prevent injury from headbanging. This material had been renewed.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. All wards had their own clinic rooms, some had an additional room just for physical observations. All wards had equipment and space to undertake physical observations and monitoring.

Medication cupboards were not over-stocked and medication was in date. Emergency drugs were available and within date. Oxygen and resuscitation equipment, including defibrillators, were all maintained and recently checked. This was an improvement since the last inspection.

Staff checked, maintained, and cleaned equipment. Clinics were clean, tidy, and equipment requiring calibration had stickers to show when it was last checked. Sharps boxes were all in date, and not overly full.

Safe staffing

The service did not have enough nursing and medical staff, who 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 did rely on bank and agency staff to make up staffing numbers, however ward staffing levels were maintained.

Managers monitored and reviewed staffing levels to ensure that the ward could be managed safely to meet changes in demand such as increased observations. Managers explained how they would access support across the hospital if staffing numbers were a concern. However, staff told us they wanted to see an increase in permanent members of staff.

The service had high vacancy rates. There were 11.74 nurse vacancies out of an establishment of 33.9 and 21.11 vacancies for health care assistants out of an establishment of 99.61.

Vacancies varied from ward to ward.

Meadows had 1.75 nursing vacancies with a new recruit going through employment checks and 11 health care assistants with two of those posts filled. Orchard had 5.3 nursing vacancies with one of those post to filled imminently and 3.75 health care assistants. Woodlands had 4.69 nursing vacancies and 6.36 healthcare assistants with one of those to be filled.

The service did offer agency staff long term contracts, for example on Orchard ward one of the agency nurses on nights worked the same shifts every week and was well known to the young people.

The service had high rates of bank and agency nurses and health care assistants. In the three months prior to the inspection, bank staff covered 720 shifts and agency staff were used to cover 2241.5 shifts. Compared to the last inspection in July 2021 the use of bank staff had reduced from 807 shifts, however the use of agency staff had increased from 732 shifts. This was a 306% increase in the use of agency staff since the last inspection nine months previously.

Managers were reliant on the of use of bank and agency staff and requested staff familiar with the service. Managers had contracts with a small number of agencies. We spoke with a number of agency staff who were contracted to work at the hospital, most of those we spoke with had been at the hospital for several months and some for much longer.

Inadequate

Child and adolescent mental health wards

In the three months prior to our inspection there had been nine occasions where staffing was under the recommended level. Six of these shifts required nurses, on five of these occasions an extra health care assistant worked and a senior manager covered the other one. No ward had been left without nursing cover. Out of the three health care assistant shifts one was covered by the ward manager.

The provider had engaged a recruitment specialist, attended local college employment fayres as well as hosting open days.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. There was evidence that new staff completed a ward induction booklet as well as being assessed to ensure they were competent to conduct observations. Ward managers told us they did not sign time sheets without seeing the completion of these documents. However, when we examined the agency files the hospital was unable to provide the completed documents for all agency staff working at the service.

Managers supported staff who needed time off for ill health. Managers and staff told how they had supported each other through periods of ill health.

Levels of sickness were low and reducing. In 2022 Meadows had a monthly average of 5.81% of staff with sick leave, Orchard had 3.5% and Woodlands 6,72%. The overall average for the service was 5.34% which was lower than at the last inspection at 6.25%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the children and young people. However, it had been several years since the provider had revisited the staffing ladder to reassure themselves that it still reflected the needs of each ward.

Children and young people had regular one to one session's with their named nurse. Children and young people told us the name of their named nurse and we saw care plans and personal behaviour plans in their bedrooms.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed. There were no recorded incidents of children or young people having escorted leave cancelled. During our inspection it snowed, we saw the physical education teacher organised impromptu outdoor activities such as snowball fights. All three activity co-ordinators posts were vacant but a health care assistant had been allocated above the ward numbers to fulfil that role.

Staff shared key information to keep children and young people safe when handing over their care to others. The wards operated differently, Meadows and Orchard produced their own daily handover sheet, which was a document created electronically, each ward had designed its own handover sheet. Woodlands had a hospital designed weekly handover sheet which was updated daily. All these reflected risks associated with the children and young people

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Staff reported that they could access support when required. The provider had arrangements in place to ensure that cover was always available. We saw in patient notes where doctors had attended out of hours to review a patient's medical needs.

Managers could call locums when they needed additional medical cover. There was one speciality doctor who was on a full-time contract as a locum.

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

Mandatory training

Staff had not completed and had not kept up to date with their mandatory training. At the last inspection in 2022 the provider had taken actions to improve the mandatory training levels on Woodlands and Meadows.

However, on this inspection the training figures had fallen. There was a 90% target for all staff to have completed mandatory training. Reducing Restrictive Intervention Training was low in all three wards (Meadows 52.6, Orchard 77.5 and Woodlands 44.9%), Basic life support was also low (Meadows 46.6%, Orchard 32.2% and Woodlands 57.4%).

Managers told us that they had enough staff on each shift to carry out any physical interventions safely. The provider monitored staffing levels and resource across each ward to ensure there were appropriately trained staff to attend to any incident if required. On nights there was a hospital manager to address any staffing needs.

Intermediate life support training had improved with 87.7% of staff trained.

Staff completed eLearning which included Fire Safety, Infection control 1, Infection control 2, Health and Safety, Manual handling 1, Equality and diversity, Information governance, Counter fraud, Conflict resolution, Medication management, Mental Health Act, Mental capacity act and DOLS. All of these were recorded as “under 70%”.

The mandatory training programme did meet the needs of the children and young people. There were children and young people who either had a diagnosis of autism or learning difficulties or their diagnosis reflected similar needs. Training on autism was mandatory and 96 staff had completed the autism module over two years.

On all three wards we found children and young people who were either diagnosed as having an eating disorder or their diets were being monitored as concern about that person developing an eating disorder. There were patients being fed by nasogastric tube. There was no individual lead on eating disorders for children and young people.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had recognised that training figures were below the required level. There was an action plan in place with eight additional RRIT courses for the end of March, and staff had been offered pay to complete online training at home.

Assessing and managing risk to children and young people and staff

Staff did not always assess and manage risks to children, young people after incidents. They followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. Staff did not always complete physical health checks after rapid tranquilisation. The ward staff participated in the provider’s restrictive interventions reduction programme.

Assessment of patient risk

Inadequate

Child and adolescent mental health wards

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, but not always after any incident. We examined 16 risk assessments. Staff were aware of when they were required to review and consider a patient's risk assessment. All children and young people had an up to date risk assessment in their care records which was recorded weekly. However, risk assessments recorded on the hospital electronic care records were not always reassessed after incidents and were mostly updated after the weekly ward rounds chaired by the ward consultants.

Staff used a recognised risk assessment tool. The hospital used the Strategic Tool for Assessing Risks (STAR).

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. All staff we spoke with could identify what risks each patient presented. When conducting general observations, staff carried a folder within which was an individualised profile of each child or young person. Staff observing those requiring closer one to one observation had the risks outlined on the observation sheet as well as advice on triggers and how to support the young person to de-escalate. For example, we saw staff step into the bedroom to supervise children and young people in the bathroom who had a history of using ligatures to self-harm in that room.

However, on Woodlands a patient who was on 2:1 observation and had mobility issues, did not have a personal evacuation plan as to what staff should do in the event of an evacuation.

Staff identified and responded to any changes in risks to, or posed by, children and young people. We saw from incidents that staff did make dynamic decisions and reassess risk in response to incidents. For example, we saw that staff had used tamper safe clothing on a young person in response to self-harm risks. Staff had recorded these incidents, but the risk assessment was not update until ward rounds two days later.

Staff were aware of their responsibilities when observing the children and young people and what they needed to consider when doing this. Managers acted where issues or incidents were identified with a staff member's understanding of observations. There was an observation competencies checklist and new members of staff were observed to ensure they understood their role. We observed a member of staff stop a young person pulling a poster from the wall. When asked why they had done that the member of staff gave a detailed reply outlining the risk that the young person used paper to damage property.

Staff followed policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. Searching children and young people's rooms and property was based on individual risk assessment.

Use of restrictive interventions

Levels of restrictive interventions were high. In the 12 months before the inspection there were 5824 incidents of which 3311 involved restraints with three prone restraints. However, the hospital categorised incidents according to severity.

1. Severe harm/impact: Appears to have resulted in permanent harm.
2. Moderate harm/impact: significant but not permanent harm.
3. Minor harm impact: Minimal harm to a person and minimal impact on service.
4. No harm/impact: No injury, loss, damage or disruption
5. Near Miss: Potential to cause harm but was prevented before an actual incident took place.

Out of the 3311 incidents involving restraint 1134 were classified as no harm (34%). These were incidents where young people were physically redirected, for example, away from confrontation with another young person.

Incidents causing minor harm accounted for 2136 restraints (65%) and these were low level restraints where the hold lasted longer or was resisted.

There were 27 incidents (less than 1%) of moderate harm, 14 of these were interventions to prevent self-harm and 9 to stop violent behaviour.

There were no incidents of severe harm.

Staff were aware of how to report restrictive interventions especially low level incidents. We saw one example where four incidents were recorded against one young person where they tried to ligature four times in quick succession. The hospital also recorded all nasogastric feeding incidents as a restraint, even when the young person consented and this accounted for 238 restraints in total.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.Levels of restrictive interventions were monitored by managers and fluctuated as per the acuity of the ward. Managers and staff considered where restrictive interventions had been required and ways in which these could have been prevented or reduced. However, this had not demonstrated a reduction in the overall amount of restraint used.

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.Managers told us that restraints could occasionally result in prone restraint being used unintentionally, for example if a patient manoeuvred into this position, but that staff were not trained in, and did not use prone restraint intentionally. If prone restraint did happen during a restraint staff were required to record this as part of an incident so it could be reviewed. Prone restraint is the restraint of a young person in a chest down position NICE guideline NG10: Violence and aggression also recommends avoiding prone restraint, and only using it for the shortest possible time if needed due to the risks associated. Managers reviewed closed circuit television and had a restraint trainer lead who reviewed incidents.

These were recorded per ward as follows;

Meadows: 808 restraints out of 1849 incidents

Orchard: 1436 restraints out of 2547 incidents

Woodlands: 1067 restraints out of 1428 incidents.

Staff understood the Mental Capacity Act definition of restraint and worked within it. Staff were aware of least restrictive practice and applied blanket restrictions on children and young person's freedom only when this was justified. Each ward had some items that were not allowed on the ward, but many items were individually risk assessed.

We observed staff on observation and saw them redirecting children and young people away from potential issues. One young person was becoming agitated and staff engaged them to tidy their room.

Staff did not always follow National Institute of Health and Care Excellence guidance when using rapid tranquilisation. In the 12 months prior to the inspection there were 192 incidents of rapid tranquilisation. One acutely unwell patient

was involved in 57 incidents. We found on Woodlands ward in October and November 2022 there had been 10 incidents where physical observations were not completed or recorded following the use of rapid tranquilisation. The hospital explained these were due to having a majority of agency nursing staff on those shifts. The hospital had since introduced a new system of recording these incidents to ensure the physical health checks were completed and recorded. Physical health observations must be completed because rapid tranquilisation is a potentially high-risk intervention that can result in a range of side effects linked to the medication and dose.

When a child or young person was placed in seclusion, staff kept clear records and followed best practice guidelines. In the 12 months prior to the inspection, seclusion had been used 115 times across the three wards with Meadows being the highest usage at 90 times. The use of seclusion had reduced from the previous inspection (143).

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. There were 11 long term segregations recorded in the last 12 months. We looked at these records and whilst in long term segregation children and young people still spend time with their peers and used the same facilities such as the tv lounge or computer games console. All these incidents occurred on Meadows, the psychiatric intensive care unit, where the most unwell children and young people were treated.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Not all staff received training on how to recognise and report abuse, appropriate for their role. Safeguarding training figures were low (Meadows 73.50, Orchard 51.10 and Woodlands 44.9%). We saw that managers had seven safeguarding courses booked to increase the numbers trained.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff discussed any incidents in the previous 24-hours at daily safety huddles to ensure all safeguarding concerns were captured and reported. From August 2022 to January 2023 staff had made 328 safeguarding referrals.

Staff followed clear procedures to keep children visiting the ward safe. A specific visiting room was available to book for visits with children which were separate from the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Teams included staff who were safeguarding leads on the ward and acted as links between the ward and hospital safeguarding team. Staff told us they felt confident to raise and report concerns and could give us examples of where they had done so.

Each ward was allocated a social worker from the hospitals safeguarding team.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff did not always understand they had access to clinical information, from the hospital computer system or that they could update clinical records.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Staff on three wards could access information about the children and young people and records were stored securely.

Patient notes were comprehensive but not all staff could access them easily. Records were clear and up to date. Staff were aware of how to navigate the patient records and reported no concerns about the system. However, number of agency staff told us they did not have access to the hospital computer system, after the inspection the provider gave evidence that each ward had a generic log in which all agency staff could use.

Medicines management

Medicines management

The service generally used systems and processes to safely prescribe, administer, record and store medicines. The hospital was reviewing medicines processes for example, on discharge from hospital and for record keeping following rapid tranquilisation, to support improvement.

Staff generally followed systems and processes to prescribe and administer medicines safely. We saw some instances where prescribing did not match with Mental Health Act paperwork, but this had largely been identified and addressed through ward audits. The hospital had attributed some recent medicines incidents and gaps in the physical health monitoring paperwork after rapid tranquilisation to agency nurses. Medicines management was included within agency nurse induction and processes had been reviewed to help ensure that records were clearly and fully completed. Additional medicines training and updates were provided to qualified staff throughout the year.

Staff reviewed children and young people's medicines regularly as part of ward rounds. However, the clarity and completeness of records about medicines and any changes varied across the wards. We did not see many instances where monitoring tools to assess side effects such as tiredness or nausea had been used but were told of plans to raise staff awareness of these.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. . We saw evidence of the checks carried out by the community pharmacist, and clinic checks conducted during the inspection found that medication was being stored properly, all were within date, and cupboards were not overstocked.

Following audit managers were reviewing processes in line with national practice to help ensure that complete checks of medicines were made and recorded on admission to the service. Similarly, there were ongoing discussions about the quantity of discharge medicines supplied and the provision of written medicines information to support to children and young people on discharge from hospital.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. We saw that safety alerts were sent to wards by the pharmacy service and shared with staff.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The hospital group participated in the recent 'NHS England Children and Young People's Psychotropic Medication Audit' (October 2022) to promote discussion and reflection on appropriate prescribing helping to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff regularly reviewed the effects of medicines on each patient's physical health.

Track record on safety

Inadequate

Child and adolescent mental health wards

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Children, young people and their carers told us they did not think managers always investigate incidents. We saw managers share lessons and learning 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. Incidents and concerns for safety were raised in the morning briefing to ensure incidents were reported appropriately. The wards used a weekly briefing sheet which built up a day by day immediate history of each patient. Incidents were recorded within the hospitals computer care system.

Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff reported serious incidents clearly and in line with provider policy.The service reported 22 serious incidents in 2022, nine of which were related to the use of ligatures, five were young people self-harming while on leave, two were assaults on staff and two were absent without leave reports. All had been investigated and we saw hospital alerts that had been sent to all staff following incidents. Investigations had been completed in a timely manner and all those involved informed of the results.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong. The three ward managers we spoke with gave examples of incidents which had met the threshold for the duty of candour and explained the actions that they had taken in respect of these incidents. At the last inspection there had been three incidents where a letter had not been sent, on this inspection we found letters had been sent on all occasions.

Managers debriefed and supported staff after any serious incident. Staff were aware of support available following incidents and managers explained how they would support staff when these happened.

Managers did investigate incidents. However, children. young people and their families told us that on occasions where they raised concerns, they felt like their voice was not heard and they were not certain investigations had been conducted.

Children, young people and their families were not always involved in these investigations. They told us they were given feedback when they complained and that they were aware how issues they had raised were resolved. However, this did not always happen. One patient told us they had complained about a health care assistant being aggressive towards her when they checked if she was ligaturing and had not received feedback.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they discussed incidents not only in team meetings but also as soon as practicable after incidents.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Managers could give examples where learning following incidents had been implemented on the wards.

Inadequate

Child and adolescent mental health wards

Is the service effective?

Requires Improvement

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after. Within the care plan system there was a separate entry for the assessment of the children and young people as they were admitted to the ward. In all of the records we looked at the young person had been assessed on the day of admission.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Care records showed that physical health assessments were on-going from admission, we saw daily checks taking place for weight, pulse, blood pressure and other aspects of physical healthcare, with the patient's consent. Some children and young people required more detailed observations related to long term physical conditions, these were being carried out. The refusal of physical health checks by children and young people and the different approaches taken by staff to encourage their engagement were recorded.

Where there were young people receiving clozapine the specialty doctor understood the risks and did daily physical health checks.

Out of the 14 physical health checks we examined all were complete.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs. The hospital computer care system allowed staff to develop care plans around the patient's needs. Each care plan fed into a different aspect of patient care, allowing a holistic approach to nursing.

However, there was one young person who required restraint twice a day for a medical procedure. This required specially trained nurses and (as the young person did not consent) trained staff to restrain them. Staff could explain exactly what they proposed to do and we witnessed them prepare. Staff were calm and the lead nurse gave precise instructions on how staff were to support the young person. Staff would firstly try to engage the young person and ask them to consent to the treatment before using restraint. We were told that this procedure had been developed in partnership with the providers restraint instructor and the young person's consultant.

While there was some verbal handover, for example telling staff what equipment they would need, there was no documented plan giving staff detailed instruction on how to restrain the young person and still support them through the procedure. There was also no clear best interest decision outlining why this procedure and methodology was the least risky and least restrictive option for the young person.

Staff regularly reviewed and updated care plans when children and young people's needs changed. Care plans were reviewed weekly in conjunction with that young person's consultant. We also saw staff discussing care plans and those conducting observations had reminders of care plans such as distraction techniques and advice on how that young person liked to be approached.

Care plans were personalised, holistic and recovery-orientated. On all three wards there were comprehensive care plans.

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.

Staff provided a range of care and treatment suitable for the children and young people in the service and delivered care in line with best practice and national guidance. We saw a variety of activities for children and young people to engage with. Each ward had its own occupational therapist and they had access to their own kitchen. The children and young people told us they particularly enjoyed pet therapy. Several were planning to take national qualifications and were working toward them. One young person was also volunteering at a local café.

Staff identified children and young people's physical health needs and recorded them in their care plans. Nurses were using standardised tools to carry out an assessment of the patient to understand their physical health needs, including Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA).

We saw from records that the children and young people received a full medical within 24 hours of admission. This included, pulse, pulse oximetry, respiration, weight BMI, temperature, blood screening and ECG.

Health care assistants had been trained to complete physical health assessments.

Staff made sure children and young people had access to physical health care, including specialists as required. We saw that children and young people had accessed dentists and opticians.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration. Those who were diagnosed with an eating disorder were monitored for food intake and had physical health in line with national guidance. Where a young person refused to be weighed staff would estimate their weight.

Staff could access a dietician to support and saw children and young people admitted with an eating disorder were assessed by the dietician within 24 hours.

We also saw in clinical notes that where those not diagnosed with an eating disorder began to lose weight this was noted and the young people engaged about their eating habits with staff monitoring their intake.

All nurses were trained on how to fit a nasogastric feeding tube, but only Woodlands ward did this.

The children and young people told us that any religious or dietary needs were met with halal food and vegan diets supported.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. These included the national early warning score (NEWS2), a system for scoring routinely recorded physiological measurements in order to identify acutely ill children or young people.

Staff used technology to support children and young people. through the use of phones and video calling facilities to contact family, especially when they were unable to visit in person.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. These included audits of clinic room fridge temperatures, infection control, care planning and record keeping.

Managers used results from audits to make improvements. We saw evidence of audit discussion and actions recorded in governance meeting minutes. However, we were concerned that those responsible for daily governance tasks were also responsible for other tasks such as preparing data and reports for commissioners and therefore not solely focused on delivering improvement on the wards.

Skilled staff to deliver care

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 did not ensure all staff had the range of skills needed to provide high quality care. They did not always support staff with appraisals and supervision. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the children and young people on the ward. The wards had access to a variety of specialisms and additional support including psychiatrists, specialist doctors, psychologists, occupational therapists, art and family therapists. However, there were children and young people who had more specialist needs than others and we saw this support was not always evident within the care plans.

Managers did not always ensure 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. Approved agencies were contracted to supply staff who had a set standard of qualifications. We examined 30 agency staff profiles and found 13 had no experience of working in children and adolescent wards prior to starting work. Also, the hospital was unable to provide staff profiles for all agency staff so managers could not reassure themselves that staff were suitable and qualified.

Managers gave each new member of staff a full induction to the service before they started work. Each new member of staff completed a training program before working on a ward and were provided with a “buddy” for support when they started on the ward. Staff we spoke with felt they had been well prepared to start work on the wards.

Managers supported staff through regular, constructive appraisals of their work. The hospital policy was for all staff to have received an appraisal by April every year. Currently for 2022/23 Orchard ward 27 staff members (66%) had completed appraisals (uncompleted appraisals included 1x Maternity Leave and 2 x Staff seconded to University on Nurse Apprenticeships). Woodlands ward 15 staff members (68%) had completed appraisals (uncompleted appraisals included 1x Long term sick at that time and 1 x Staff seconded to University on Nurse Apprenticeships). Meadows ward 22 staff members (81%) had completed appraisals (uncompleted included 3 x Maternity Leave).

Managers did not always support medical staff through regular, constructive clinical supervision of their work. In 2022 the monthly percentage of staff receiving supervision was 48.15%. Meadows had monthly percentage of 75.58%, Orchard 55.88% and Woodlands 67.20%.

Managers made sure staff attended regular team meetings or gave information to those who could not attend. There were monthly ward meetings, but we saw staff discuss various items of business in the morning meeting. Managers raised issues at these daily meetings and did not wait for the monthly ward meeting.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The psychology team and social work team had taken specialist training. Two psychologists had taken Autism Diagnostic Observation Schedule (ADOS 2) training. The social work team had undertaken training in understanding sexual violence and trauma and were currently completing an Improving Access to Psychological Therapies (IAPT) course.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers investigated incidents and did remove staff from the ward whilst they investigated the incident. There had been a number of staff subject to extra supervision as a result of individual errors.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit children and young people. They supported each other to make sure children and young people had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. Each ward had its own multidisciplinary meeting and these were structured around the needs of the children and young people on that ward. The minutes were recorded on the individuals care notes system. We attended multi-disciplinary team meetings at Orchard and saw a full team discussing the individual needs of the young person as well as the young person having a voice.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. There was not a generic handover form across all wards and so each ward had developed their own method of having and recording the handovers. Staff reported that they found the handovers useful. However, we were concerned that staff who worked across all three wards had to adapt to a different system.

Ward teams had effective working relationships with other teams in the organisation. Each ward had its own allocated social worker, psychological support, occupational therapy and teaching staff. We saw teachers leave the classroom and go to the child or young person on the ward and deliver education.

Ward teams had effective working relationships with external teams and organisations. During our inspection we saw and spoke with a number of visiting professionals such as speech and language experts and commissioners.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Inadequate

Child and adolescent mental health wards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain children and young people's rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The hospital employed Mental Health Act administrators and staff knew when to ask them for support.

Staff knew who their Mental Health Act administrators were and when to ask them for support. There was clear information about who the administrators were and how to contact them.

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. Staff confirmed these were available for them on the hospital's intranet.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. Details of advocates including pictures were displayed in different locations within each ward. Children and young people spoke to them regularly and they were well known to the staff.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time. We saw that children and young people had their rights explained to them and this was clearly recorded in the patient record. Where they refused or did not have capacity, we saw this clearly explained. We also saw that staff continued to explain their rights to those who had refused or reassessed capacity.

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 and/or with the Ministry of Justice. We saw children and young people taking section 17 leave, children and young people told us that sometimes they may have to wait for a member of staff to take escorted leave. We saw a number of parents collecting children and young people for leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw evidence of this when we looked at consent documentation and medicines records including the young people taking clozapine.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed. We examined 14 patient's prescription charts and related mental health documents and found them to be correct.

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed posters to tell them this.

Care plans included information about after-care services available for those children and young people who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. We looked at an audit that confirmed this.

Inadequate

Child and adolescent mental health wards

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The staff we spoke with demonstrated a good understanding of the application of the Act in their day-to-day work.

There were no Deprivation of Liberty Safeguards applications made in the last 12 months and managers knew which wards made the highest and monitored staff so they did them correctly.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff confirmed these were available for them on the hospital's intranet.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision. Consent to treatment and a patient's capacity were clearly recorded in all patient records. However, for one person being restrained there was no best interest decision to record her lack of consent for the treatment.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered their wishes, feelings, culture and history. We saw examples of best interest decisions, the responsible clinician along with the multidisciplinary team had documented these decisions in line with the providers policy.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve. We looked at an audit that confirmed this.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations. We saw that children and young people were consulted about their own care and treatment without a parent or guardian being present.

Staff knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this.

Inadequate

Child and adolescent mental health wards

Is the service caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They respected children and young people's privacy and dignity. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for children and young people and gave children and young people help, emotional support and advice when they needed it. We spoke with children and young people across the service, even those who did not like the hospital spoke positively about staff who they worked with. Staff were described as supportive, kind, respectful and caring.

One patient told me when they were particularly distressed a member of staff had held their hand for over an hour until they felt better, another said a staff member had drawn an Indian henna hand tattoo to distract from thoughts of self harm.

Staff supported children and young people to understand and manage their own care treatment or condition. We saw that children and young people had copies of their care plans and understood the treatment they were receiving. Staff and managers explained how they involved the children and young people in their care and treatment. Children and young people were invited to and included in meetings regarding their care and treatment. The children and young people gave examples of when staff had taken the time to explain aspects of their care and treatment to help them have a better understanding.

Staff directed children and young people to other services and supported them to access those services if they needed help. We saw that external professionals were available for specialist assessments such as speech and language. A number of children and young people were still being supported by their hometown school and there were facilities available to allow this engagement.

Children and young people said staff treated them well and behaved kindly. Children and young people were generally positive about how staff treated them on the wards although some young people commented that not all staff were as good as others. When asked about this agency staff were always mentioned by the children and young people.

Staff understood and respected the individual needs of each child or young person. We saw in handovers that staff knew the children and young people well. Staff were able to tell us about them and their histories, and how they recognised if they were having a difficult time and how they would interact with those receiving care to support them.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people. They told us they knew how to complain and felt they could to do so without concern. Some had raised minor concerns and were happy that staff had taken them seriously and dealt with the issues raised. However, one patient felt her verbal complaint about an agency staff member being aggressive while checking for a ligature had not been acted upon.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. Although some parents old us they were not informed about incidents or supported during home leave. They ensured that children and young people had easy access to independent advocates and to child helplines.

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission. Wards had admission packs or information that they gave to children, young people and carers. They also had staff information boards with information and pictures of staff.

Staff involved children and young people and gave them access to their care planning and risk assessments. Care records showed that children and young people were always offered copies of care plans, and risk assessments showed evidence of patient involvement. We saw printed copies of care plans and personal behaviour plans in their bedrooms.

Staff made sure children and young people understood their care and treatment and young people in decisions about the service, when appropriate. Staff involved children and young people in meetings about their care and treatment and ensured that they had a voice during these.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held on all wards, we saw minutes from meetings on notice boards. These showed consideration of the children and young people's thoughts and outlined attempts to improving the service.

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

Staff made sure children and young people could access advocacy services. Children and young people told us they were aware of advocacy services. We saw advocates on wards supporting children and young people.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke with 5 carers.

Staff did not always support, inform and involve families or carers. Children and young people told us their loved ones were able to visit, including siblings where appropriate. Carers were able to attend care programme approach (CPA) meetings.

Inadequate

Child and adolescent mental health wards

We saw family visiting and some spoke positively about the support their loved ones had received. We spoke with one parent whose child on Meadows had made significant progress and they considered the hospital as the best their child had been care for in. Two other parents of children on Orchard were not as complimentary. They felt they were not informed about incidents when they occurred as quickly as they should have been and did not think the hospital had kept its promises about daily contact during home leave.

Staff helped families to give feedback on the service. We saw from minutes of multi-disciplinary meetings that those present were asked for their views on the care plans proposed. Those carers who had complained felt the staff did listen and that there was no adverse treatment of the child or young person involved.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Requires Improvement

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

Access and discharge

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

Managers made sure bed occupancy did not go above 85%. On Woodlands and Meadows managers had restricted admissions to eight beds out of ten available and Orchard which had 15 beds would be restricted to 80% occupancy.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to or were discharged before they were ready. Managers took part in weekly bed management meetings where length of stay and discharge was discussed.

The service had out-of-area placements. The service accepted out of area placements due to the needs and requirements of young people. Staff and management on the wards explained how they attempted to ensure links between the children and young people and their home teams were maintained.

When children and young people went on leave there was always a bed available when they returned. The hospital always kept the same bedroom for children and young people who went on leave.

Children and young people were moved between wards during their stay only when there were clear clinical reasons or it was in their best interest. All three wards specialised in caring for children and young people who had different needs, therefore the transfer of these from one ward to another was not a regular occasion. However, all three wards worked closely together and any transfer was easily facilitated.

Staff did not move or discharge children and young people at night or very early in the morning.

The psychiatric intensive care unit always had a bed available if a child or young person needed more intensive care. The hospital had a psychiatric intensive care unit on site which could be referred into by the other wards if required.

Discharge and transfers of care

Managers monitored the number of children and young people whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. In the previous 12 months 21 children or young people had their discharge delayed. The largest reason for delays was with community teams finding an appropriate placement which affected 14 children and young people, five were delayed waiting for a placement at another hospital, one was delayed due to concerns about how the proposed placement met the needs of the young person and another was delayed as they turned 18 and a proposed place on an adult ward was withdrawn immediately before the proposed transfer.

Managers were aware of the reasons for any delayed discharges and could describe the actions that were being taken by the ward staff to manage the situation.

Children and young people did not have to stay in hospital when they were well enough to leave. The staff worked closely with community teams and care co-ordinators to plan discharge and all children and young people had a discharge plan.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. Children and young people's care and discharge was discussed in weekly multidisciplinary meetings with those involved in that decision-making present to support transitions of care.

However, discharge plans were mostly generic, especially for new admissions and often not in place when a child or young person first entered the wards. We did see as discharge came closer these plans were then developed.

Staff supported children and young people when they were referred or transferred between services. During the inspection one young patient was transferred to another hospital. All the staff and their peers gathered and gave the young person a farewell to remember. This was clearly a personal event with lots of thank you and best wishes for the future. The young person was made to feel they were moving on because they had accomplished something and the transfer was to be viewed with excitement.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. However, the overall décor did not reflect the age range the accommodation was being used for and the outdoor spaces were not always accessed by individual young persons. Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and children and young people individually risk assessed could make hot drinks and snacks at any time.

Each child or young person had their own bedroom, which they could personalise. Children and young people had a secure place to store personal possessions. Bedrooms had a secure locker for possessions.

Staff used a full range of rooms and equipment to support treatment and care. Woodlands had a new multi-sensory room. Meadows and Orchard had de-stimulation rooms and there were plans for the installation of a multi-sensory rooms.

Each ward had its own classroom and there were separate dining areas and lounges.

On Woodlands and Orchard wards children and young people would often congregate on corridors playing games and jigsaws instead of using the provided lounges. However, this was due to the architectural design of the wards with long corridors which created natural meeting points.

While the wards were mostly decorated to a safe, clean standard, the décor itself was not homely or therapeutic or in keeping with environments for children and young people.

The service had quiet areas and a room where children and young people could meet with visitors in private.

Children and young people could make phone calls in private. When we inspected in 2021 Meadows was in the process of implementing mobile phones at the time of the inspection. On this inspection we found that on all three wards children and young people had access to mobile phones. The use of mobile phones was individually assessed.

The service had an outside space but children and young people could not access this easily. All three wards had outdoor spaces but all three wards were on the first floor, if not second floor of the building. This meant that young people could not access the space easily and those with mobility issues would have difficulty accessing the outside space. There was no direct lift access to each wards open space. If a young person refused to return to the ward staff faced the prospect of escorting the young person upstairs. If this did happen staff would remain with the young person until they gave consent to return to the ward.

All three outdoor spaces were large with little or no furniture and no purpose-built activity equipment except a basketball hoop.

Children and young people were individually risk assessed to be allowed kitchen access to make their own hot drinks and snacks and those whose risk assessment prevented access to the kitchen were dependent on staff. We saw staff supply those children and young people with drinks on request.

The service offered a variety of good quality food. There was a changing menu and food was mostly prepared off the ward and brought ready for service. Most of the children and young people were positive about the food quality on the wards.

On Woodlands there was a separate diet for those whose dietary intake needed monitoring, staff also told us they purchase additional food as suggested by the dietician for those with additional dietary needs.

Children and young people's engagement with the wider community

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

Staff made sure children and young people had access to opportunities for education and work, and supported them. All children and young people accessed education either through the onward classroom or with support from their previous school. We spoke with a number who were studying for GCSE exams. One patient had unescorted leave and did volunteer work at a café in the community.

Inadequate

Child and adolescent mental health wards

Staff helped children and young people to stay in contact with families and carers. Children and young people we spoke with told us they were able to use phones and computers to maintain contact with their families, and that their families were invited to attend their care programme approach meetings if this was something the young person wanted.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. A number of young people came from communities several hours away. However, we saw that young people had bonded with each other and did enjoy visits into the local community. Carers were encouraged to attend and support young people with leave and we saw carers collecting loved ones. Carers from communities some distance away told us they accommodated overnight leave by booking their own local hotels.

Meeting the needs of all people who use the service

The service met 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 or other specific needs. The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The wards were located across different levels of the hospital. Two of the wards were directly accessed by a lift which was available for those who may have had difficulty using the stairs.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain. There was access to information on all the wards. There were notice boards and leaflet racks, which included a range of information. This included information about the ward, treatments, medication, advocacy and clinic.

The service had information leaflets available in languages spoken by children, young people and the local community.

Managers made sure staff, 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. The service could supply specialist diets and design menus as suggested by the dietician. For example, Vegan and Halal options were available.

Children and young people had access to spiritual, religious and cultural support. They told us that, if they wanted, they could access religious or cultural support. Staff told us this could be facilitated.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, however children and young people told us complaints were not always investigated.

Children, young people, relatives and carers knew how to complain or raise concerns. In the last 12 months there had been six complaints made across the service. All of these were fully or partially upheld with one still being investigated. Meadows had one complaint; Orchard had five with Woodlands recording none. These complaints were about staff attitude/restraint, concerns about care and the environment.

Inadequate

Child and adolescent mental health wards

Children and young people told us that they knew how to complain but suggested that most complaints they raised were dealt informally and quickly by staff. The provider did investigate formal complaints and took those investigations seriously including reviewing CCTV where appropriate.

The service clearly displayed information about how to raise a concern in patient areas. There were noticeboards with signs outlining the complaint process on the wards, as well as in the communal areas where visitors might arrive.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they tried to deal with complaints informally in the first instance and knew the policy and how to support those making a formal complaint.

Managers did not always investigate complaints. Children and young people told us they had complained, and no investigation had been started. One incident was recorded in the clinical notes but not as an incident and therefore not investigated. This meant that the children and young people felt they were not listened too when raising concerns. We raised this with the ward manager who was aware of the incident. However, there was no assurance that an investigation had commenced.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. Staff told us that they tried to deal with complaints informally in the first instance and knew the policy and how to support children and young people in making a formal complaint. However, some carers told us they felt they had not been informed of incidents and outcomes.

Managers shared feedback from complaints with staff and learning was used to improve the service. Where managers had investigated, we did see managers had shared feedback from complaints with staff and learning was used to improve the service.

The service used compliments to learn, celebrate success and improve the quality of care. There had been 11 compliments, Meadows with five, Orchard with one and Woodlands with five. They were mostly from families in the form of thank you cards and positive feedback.

Is the service 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 and were visible in the service and approachable for children, young people, families and staff.

The ward managers for Woodlands and Orchard had been in place for some time and were experienced managers within the CAMHS service. The interim manager on Meadows had been replaced with a permanent ward manager who had experience of managing an adult ward previously since the last inspection.

Staff told us managers were visible, approachable and supported them in their day to day tasks. They were willing to get involved in day to day work where needed to support staff and children and young people to deal with difficult situations. Staff reported feeling valued by their manager and received regular feedback. Ward managers could explain clearly how the teams were working to provide high quality care.

They told us they had opportunities for leadership development and they had undertaken leadership training.

Since the last inspection the hospital director had changed. This was the third change in three years. The new hospital director had served as a deputy to the three previous managers and knew the hospital and staff well.

One of the consultants was also a clinical director of CAMHS and there was also a national specialist director for CAMHS who provided clinical leadership for the CAMHS service at Cheadle Royal. However, neither of these had attended the clinical governance group for six months. There was no manager who was individually responsible for the quality assurance of this service who reported directly to senior managers who were reliant on audits and quality improvement reports to assure themselves regarding safe care and treatment. However, we found that these audits did not provide managers with the correct information. For example, we were presented data that showed low supervision meetings on one ward. When we raised this the ward was able to produce data which showed much better supervision. It was not clear how those responsible for data collection through audits satisfied themselves that the data was accurate.

Vision and strategy

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

The visions and values of the service were displayed around the ward. Staff we spoke to could tell us the visions and values and explain how they were followed to ensure all staff were working together.

Some staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. All staff we spoke to including permanent and agency felt a connection with the hospital. We met a large number of staff who had worked there for decades.

Culture

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

All staff we spoke with said they felt supported and valued at the service, with both management and staff saying they felt the staff team were happy. Staff, especially those on Woodlands told us the role had been particularly stressful in the months before the inspection due to acuity and the challenging patient needs, but felt they were managed and supported by colleagues and senior staff. They quoted that the ward had been reduced from ten bed to eight beds. Staff on Meadows and Orchard also reported that managers had listened to concerns and on Meadows reduced from ten to eight beds and committed to keeping Orchard at 80% capacity.

There were no reports of bullying or harassment at the service, and all staff we spoke to knew how to use the whistleblowing process. All staff told us that they felt they could raise concerns to management about the service without fear of retribution.

Inadequate

Child and adolescent mental health wards

We saw no evidence of a closed culture at the service. Managers we spoke with had identified the risk of closed cultures and had put operating procedures in place. Rotas were prepared to prevent this. For example, staff were rotated to ensure they worked with different staff members. There was a night manager nurse responsible for the hospital and they attended wards unannounced. Senior managers also did night time visits.

Governance

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

There were a number of issues identified throughout the inspection that had not been identified via the provider's own governance processes. Where they had been identified, the provider had not taken enough rapid action to rectify them. A number of these concerns had been identified at our previous inspections of this service and the required improvements had not been made and / or embedded.

This included the poor standards of the environment on Woodlands and Meadows.

There were a number of concerns about staffing including; poor oversight of agency staff skills, and low compliance with mandatory training, supervision and appraisal. Vacancy rates remained high.

Audits in place had not identified concerns, for example, in the completion of physical health checks following the use of rapid tranquilisation and risk assessments not always being updated following incidents.

We could see how the provider was monitoring the use of restrictive interventions, however, the use of restraint and seclusion remained high.

It was not clear how incidents were investigated and who instigated that investigation. Children, young people and their families or carers were not always included in incident investigation. There was no evidence that audits would have identified the need for an investigation. For example, the need to investigate a complaint about an aggressive health care assistant recorded in clinical notes had not have been identified.

However, the service had some governance processes in place. The new hospital manager had refreshed the governance structure which had an overarching clinical governance committee chaired by either the hospital or medical director. There was a medicine's management and a patient safety group which oversaw issues such as safeguarding, infection control, risk and restrictive practice, medicine management, staff engagement, health and safety and quality. These were attended by ward managers.

There was a clear framework of what must be discussed at a ward level in team meetings to ensure that essential information, such as learning from incidents, was shared and discussed. There was a standard agenda to ensure consistency and items included lessons learnt, governance, staffing and safeguarding. Meetings served a clear purpose and were well managed.

However, despite this governance framework to ensure consistency, the three wards were still operating different systems to manage patient risk.

Managers had made necessary changes (reducing bed capacity due to concerns regarding patient safety and staffing). They had supported staff to take additional online learning for autism. They had acted to manage staff where failings were identified. Where issues had been identified to the senior management team, they addressed those issues on an individual basis.

Managers, despite high vacancy figures had ensured the wards were staffed to safe levels and the children and young people were safe. They monitored staff fill rates for each ward, on a clinical and non-clinical staff level and also broke down the figures into day and night shifts.

Staff understood the arrangements for working with other teams, both within the service and external to it, to meet the needs of the children and young people.

The provider had policies to guide staff in the day-to-day operation of the service.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not always use that information to good effect.

There was a risk register which demonstrated that individual wards had raised risks to be included within the service risk register. Risks included, staffing and training compliance regarding safeguarding and restraint.

Managers discussed and monitored risk daily at morning handover meetings, and risk was regularly discussed at clinical governance meetings.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. There were continuity plans in place for all service areas.

Leaders had access to information that supported them to adapt and develop performance. They used the information gathered to generate improvement. The service managed information via electronic dashboards, which held a range of information, such as care plans, risk assessments, physical health checks and daily activity, and were updated regularly.

Using the dashboards, the information could be evaluated in total across the service and any issues noted.

Although the service had a number of methods to monitor and evaluate performance, outcomes and changes from this were not evident in improving the quality of the service.

Information management

Staff engaged actively in local and national quality improvement activities.

The service used systems to collect data from wards, which were not onerous for frontline staff.

Staff had access to the equipment and information technology needed to do their work. They used technology to update records, which meant current information was always accessible.

Staff were committed to sharing information so that choices and decisions were supported. Information governance systems included confidentiality of records.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

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.

Information was shared with staff, young people and carers about the work of the provider via the intranet, bulletins, newsletters, carers meetings etc. Staff had regular meetings and information was shared via monthly lessons learnt bulletins that included learning from other services.

Children, young people and carers gave feedback on the service via surveys, community meetings and carer events. Families said that they were invited to meetings about their relatives' care and that they could approach the ward managers or social worker with any queries.

Learning, continuous improvement and innovation

Meadows, Orchard and Woodlands were all members of the Quality Network for Child and Adolescent Mental Health. They were all working towards accreditation and all had peer review visits planned for 2023.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must ensure that systems and processes are operated effectively to assess, monitor and improve the quality and safety of the services provided. (Regulation 17(1)(2)). • The provider must ensure that there are enough suitably qualified, skilled and experienced staff to meet the patients' needs. (Regulation 17(1)(2)). • The provider must ensure that they are aware of and monitor the skills and suitability of all staff working in the service. (Regulation 17(1)(2)). • The provider must ensure that all staff complete mandatory training. (Regulation 17(1)(2)). • The provider must ensure that it reduces the incidents of physical intervention. (Regulation 17 (1)(2)). • The provider must ensure that physical health monitoring is completed following the use of rapid tranquilisation and in order to monitor medication side effects. (Regulation 17(1)(2)).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider must ensure that improvements are made to the environment to provide a dignified and safe setting with access to outside space which is maintained appropriately. (Regulation 15(1)(2)).

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider must ensure that the children's and young person's risk assessments accurately reflect their risks and that these are reviewed and updated in line with the providers policy. (Regulations 12(2)(a)).

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found managers had failed to establish and operate effective management processes to ensure that; 1. the environment was maintained, 2. managers identified patterns and learnt from incidents, 3. audits identified that risk assessments were not always updated after incidents, 4. the three CAMHS wards identified risk through the same procedure, 5. agency staff had been inducted onto the wards properly and agency staff profiles ensure managers knew who those staff were and what experience and training they had. 6. Staff were sufficiently trained for their role.