Active Young People Limited

Ivetsey Bank Hospital

Inspection report

Ivetsey Bank
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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?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Ivetsey Bank hospital formerly known as Huntercombe Hospital Stafford is a child and adolescent mental health service for 37 male and female children and young people aged 8 to 18 years.

At our last inspection this service was placed into special measures due to concerns identified. The overall rating is requires improvement and the hospital remains in special measures.

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

- The care notes system was not working and had not been for a number of weeks. This was beyond the provider's control, and systems had been put in place to ensure staff could provide comprehensive and contemporaneous notes. However, some aspects of the provider's IT system meant nursing staff could not always input onto the notes system in a timely manner. Some staff did not always know where some information was located.
- We found some medicines and clinical tests were out of date, and opening dates were not completed on some sharp's boxes and liquid medicines. Medicine audits had not been effective and had not identified these issues.
- Only 37% of staff on Thorneycroft ward had received regular supervision and only 69% across the whole hospital which was not in line with the provider's policy.

However:

- The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They monitored the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Apart from medicines, staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included a range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, and appraisal. Staff on Hartley ward and Wedgewood ward received regular supervision. 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 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.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that could provide aftercare. They provided facilities that promoted comfort and dignity and met their needs.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly. Improvements had been made across the whole service since our last inspection

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to Ivetsey Bank Hospital

Ivetsey Bank hospital formerly known as Huntercombe Hospital Stafford is a child and adolescent mental health service for 37 male and female children and young people aged 8 to 18 years. The hospital admits both informal and detained children and young people. Ivetsey Bank hospital is divided into 3 separate wards; Hartley, Thorneycroft and Wedgewood.

Hartley ward is a psychiatric intensive care unit (PICU) providing 12 beds. The PICU unit offers care to children and young people suffering from mental health problems who require specialist and intensive treatment. There is an additional bed in the extra care area, which can be utilised for young people who require long term segregation. Thorneycroft ward is a general child and adolescent mental health (CAMHS) acute assessment unit with 12 beds for young people aged 12 to 18 years. The children and young people treated there have a range of diagnoses from psychosis and bipolar disorder to depression and deliberate self-harm. Wedgewood ward is a specialist eating disorder unit (EDU), which provides services for 12 children and young people. The children and young people treated here have a diagnosis of anorexia nervosa, bulimia nervosa, or other similar disorders.

Ivetsey Bank has a registered manager and it is registered to provide the following regulated activities:

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

We most recently inspected the service in October 2021 and carried out a full comprehensive inspection. We rated the service as inadequate overall, with key questions rated as:

- Safe was inadequate
- Effective was requires improvement
- Caring was inadequate
- Responsive was good
- Well-led was inadequate.

As the service was rated inadequate it was placed into special measures. Services placed in special measures will be inspected again within six months, following publication.

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

- The service must ensure that Hartley ward has the equipment and furnishings to meet the sensory needs of the children and young people on the unit. (Regulation 9).
- The service must ensure that care records are personalised, goal orientated and demonstrate involvement from children and young people. (Regulation 9).
- The service must ensure that the blind spot on the stairs on Wedgewood unit is mitigated through the use of parabolic mirrors to ensure clear lines of sight. (Regulation 12).
- The service must ensure that infection, prevention control measures are embedded in practice and staff adhere to the infection control principles in line with the provider's policy and national guidance. (Regulation 12).
- The service must ensure the environments on all wards are clean, well furnished, well-maintained and fit for purpose. (Regulation 15).

Summary of this inspection

- The service must ensure that senior managers are visible and approachable for both staff and children and young people. (Regulation 17).
- The service must ensure that there are systems in place to monitor observations and ensure that these are recorded at the relevant times. (Regulation 17).
- The service must ensure that there are robust systems in place to ensure that staff working during a night shift are appropriately undertaking their roles. (Regulation 17).
- The service must ensure that there are robust audits in place to monitor and improve the quality of care, with clear actions where appropriate. (Regulation 17).
- The service must ensure that there are sufficient members of suitably qualified, competent, skilled and experienced nursing staff working to meet the needs of people using the service. (Regulation 18)

At this inspection, we found the service had met the above actions.

What people who use the service say

Children and young people were generally positive about their care. They said they felt safe, there were enough activities, staff were caring and they were involved in their care.

Families and carers said their loved ones were kept safe and staff looked after them well. Most said they received good communication although 2 carers thought it could be more frequent. Two carers were enthusiastic about the way their loved ones mental health had improved and said that the hospital was 'lovely and very caring' and staff went 'above and beyond'.

How we carried out this inspection

This was an unannounced inspection to see how the provider had improved the service since our previous inspection in October 2021. During the inspection, the inspection team:

- visited all three wards and the extra care area, looked at the quality of the environments and observed how staff were caring for children and young people
- spoke with 5 children and young people who were using the service
- spoke with 7 family members and/or carers of children and young people using the service
- spoke with 19 staff members
- looked at 15 care and treatment records of children and young people
- looked at 12 medicine prescription cards
- attended one multi-disciplinary team meeting
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

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

Summary of this inspection

Action the service MUST take to improve:

- The service must ensure that medicines are stored correctly and out of date medicines disposed of correctly. (Regulation 12 (2)(g))
- The service must ensure that staff action issues identified in medicines audits. (Regulation 17 (2)(c))
- The service must ensure that nursing staff are able to input clinical information onto the interim care notes system in a timely manner. (Regulation 17(2)(c))
- The service must ensure that staff receive supervision in line with the provider's policy. (Regulation 18(2)(a))

Action the service SHOULD take to improve:

- The service should ensure psychology provision is available to all children and young people in their preferred style. (Regulation 9)

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

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

Safety of the ward layout

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. The provider completed environmental risk assessments and ligature audits; risks were mitigated by the use of individual's risk assessments, staff supervision and mirrors.

At the last inspection, we told the provider that they must ensure that the blind spot on the stairs on Wedgewood ward was mitigated with the use of a mirror. We found that this has been rectified and a convex mirror was in place.

The ward complied with guidance on mixed sex accommodation. There were separate bedroom corridors for male and females. Bedrooms were not en-suite and there were separate male or female allocated bathrooms and toilets so young people did not have to walk through areas of the opposite sex. Wards also had separate lounge areas.

Staff had easy access to alarms and children and young people had easy access to nurse call systems in bedrooms, bathrooms and communal areas.

Maintenance, cleanliness and infection control

At the last inspection, we said that the provider must ensure that the environments on all wards were clean, well furnished, well maintained and fit for purpose. We saw that improvements had been made across the three wards. They had all been decorated and had new furnishings.

At the last inspection, we said that Hartley ward must ensure that it had equipment and furnishings to meet the sensory needs of children and young people. The ward had adapted the quiet room to ensure that aids were available to

support patients, including those with sensory needs who needed time to sit quietly or have time to themselves. The room had comfortable seating and a projector produced calming coloured lights and images. Members of the occupational therapy team used a range of aids and equipment to assess, monitor and provider treatment for young people with sensory needs and sensory profiles were in place.

Across the three wards, noise reduction panels had been inserted onto ceilings which helped reduce overall noise on the wards.

At the last inspection, we said that the provider must ensure that infection prevention control measures were embedded in practice and staff adhered to the infection control principles in line with the provider's policy and national guidance. The windows on Hartley and Thorneycroft wards had been cleaned and cleaning records were up-to-date, and the premises were clean.

We saw that staff adhered to infection prevention control procedures such as wearing face masks, cleaning their hands before they entered the hospital and applying hand sanitiser when moving about the building and before entering wards. Staff had the opportunity to change face masks regularly, and they were readily available across the hospital site. Staff were bare below the elbow. Managers monitored this through quality walkarounds, closed circuit television (CCTV) reviews and infection control audits.

Seclusion room

The seclusion room was on Hartley ward. It allowed clear observation and two-way communication and had a toilet and a clock. However, it was being used for a young person who required long-term segregation (LTS), along with an adjacent room. The young person had been in LTS for a number of weeks and it was unlikely that the requirement for LTS would end soon. Managers told us that if a child or young person required seclusion, they could use the quiet room or their bedroom, however this did not have the same features as the seclusion room.

The service also had an extra care area, located near to reception which could accommodate 1 young person. This consisted of a living area, bedroom, dining area and a bathroom area. Staff could clearly see the young person from 2 designated observation areas. This area was primarily used for children or young people who required long term segregation. This was also in use at the time of our inspection.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Audits of records demonstrated staff completed daily checks of medicine fridges and clinic room temperatures.

Staff generally checked, maintained, and cleaned equipment. However, we were concerned that the blood glucose monitors were not being checked properly in line with the manufacturers guidelines to ensure they worked correctly. Staff did not know how to check the monitors. We raised this immediately with the service. This was quickly rectified, and the service ordered new monitors for each ward immediately which would require daily checks and be easier for staff to maintain and include in their daily checks. Managers told us staff would receive training to ensure they knew how to test the new monitors to ensure they were working appropriately.

Safe staffing

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

Requires Improvement

Child and adolescent mental health wards

Nursing staff

At the last inspection we said that the provider must ensure that there were sufficient members of suitably qualified, competent, skilled and experienced nursing staff working to meet the needs of people using the service. This had improved and was ongoing. The provider had been undertaking ongoing recruitment and had employed qualified nurses from overseas. Several of these nurses had started in their role, and more had been recruited and had an induction date organised. Recruitment had been thorough, and all overseas candidates had to undergo an interview and an objective structured clinical examination (OSCE), in line with the nursing and midwifery council (NMC) requirements.

Current vacancies for qualified nurses across the service were 14.3, however 3 international nurses were working as senior support workers whilst waiting for their OSCE, 7 other international nurses had been recruited to and were going through the commencement process, and 1 was employed by the service and would get their PIN number in March 2023.

Current vacancies for support workers were 88.9, however 3 were due to start, 40 international support workers had been recruited to and were going through the commencement process, and 10 were due to start in October 2022. Managers had regular slots for interviews and continued to actively recruit. Vacancies were covered by regular bank and agency support workers.

Managers, staff and patients told us there was enough staff to keep children and young people safe, although the wards can feel stretched when patient observations are high, or a staff member calls in sick. Managers were able to move staff around the hospital to support wards when they were short of staff or there was increased activity.

We looked at the rotas for all three wards for week commencing 5 September 2022. All 3 wards had a short fall of 1 health care worker or 1 qualified nurse for at least 1 shift. However, qualified nurses were still present on each ward and tasks were not missed. This included out of hours and the weekends. Managers told us that members of the multidisciplinary team were available when required and did not impact on patient care.

Managers used bank and agency staff regularly for all shifts and requested staff familiar with the service. Most of the agency staff had been working with the service for a number of years and were allocated regular shifts. Some agency staff we spoke with had worked regular shifts at the service for over 3 years.

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

Managers supported staff who needed time off for ill health. Managers monitored levels of sickness. The highest group who had time off sick were support workers at 10% from 1 June 2022 to 31 August 2022.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift and the ward manager could adjust staffing levels according to the needs of the children and young people. Staffing numbers were high across all 3 wards due to the needs of the children and young people. For example, Hartley ward required 23 or 24 staff each shift for the week that we inspected. One young person required 10 staff to help to keep them safe.

Children and young people had regular one to one sessions with their named nurse. This was evident within the care records that we reviewed.

Requires Improvement

Child and adolescent mental health wards

Children, young people and staff told us they rarely cancelled escorted leave or activities, even when the service was short staffed, and they had enough staff on each shift to carry out any physical interventions safely.

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.

Managers could call locums when they needed additional medical cover. There was 1 consultant psychiatrist vacancy for Wedgewood ward, which was covered by a locum consultant psychiatrist who had worked in the hospital for over two years.

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

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Thorneycroft ward was 89% compliant with e-learning, Hartley 94% and Wedgewood 98%.

The mandatory training programme was comprehensive and met the needs of children, young people and staff. The majority of training was by e-learning, however staff attended face to face training for basic and immediate life support, physical intervention training and breakaway techniques, safeguarding children and adults' level 3, patient search and ligature, fire training and autism spectrum disorder.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to children and young people and staff

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

Assessment of patient risk

Staff used a recognised risk assessment tool and they completed risk assessments for each child and young person on admission, and reviewed this regularly, including after any incident. We reviewed 15 care records. All risk assessments were fully completed and up to date. All members of the multidisciplinary team inputted onto risk assessments.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Staff responded to any changes in risks to, or posed by, children and young people. Members of the multidisciplinary team and the ward management team met daily to identify and plan for any changes required to staffing, treatment plans or the ward to ensure children and young people were safe, following a review of the last 24-hour period and the upcoming shift.

At the last inspection we told the provider that they must ensure that systems were in place to monitor observations and ensure that they were recorded at the relevant times. We found that this had improved. Staff recorded all observations concurrently and nursing staff checked that records had been fully completed on each shift. Senior staff

completed monthly audits of observation records, participated in quality walkarounds and reviewed closed circuit television (CCTV), which gave assurance that staff were observing children and young people in line with the provider's policy. All staff had recently completed competency testing to ensure they knew their roles and responsibilities when undertaking patient observations.

The service had a list of contraband items. Managers and staff told us that access to other items was individually risk assessed and apart from contraband there were no blanket restrictions.

Staff followed procedures to minimise risks where they could not easily observe children and young people, such as staff placement and mirrors.

Staff followed the provider's policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. Staff completed a search when they were concerned about risk or thought contraband had been secreted.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Children and young people attended restrictive practice meetings and restrictive practice was discussed in community meetings. Reducing restrictive practice was an agenda item for clinical governance meetings. The provider had introduced a comprehensive restrictive practice magazine for children and young people.

Staff on Hartley ward gave examples of how they constantly reviewed and discussed risk to ensure that children and young people were kept safe within the least restrictive environment, specifically for those within long term segregation (LTS). This was also evident when we reviewed care plans.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. We reviewed CCTV whilst on inspection. We saw that staff used de- escalation techniques when a child or young person became distressed or agitated, and when they did have to use restraint, this was done in line with the provider's policy and procedures. We saw that documentation in care records was completed appropriately and incidents were recorded following all restraints and physical intervention. All staff received training in de-escalation techniques.

Between 1 June and 31 August 2022, staff used restraint 851 times. This was highest on Hartley ward at 581 times. Thorneycroft ward used restraint 168 times and Wedgewood ward 101 times. We did not report on levels of restraint at our inspection, so cannot compare to our previous findings. However, we were satisfied that staff recorded all levels of restraint and that the service could monitor and review the restraint each time.

Staff followed NICE guidance when using rapid tranquilisation. Staff on Hartley ward had administered rapid tranquilisation 67 times between 1 June and 31 August 2022. This had increased since our last inspection. Staff said this was for the same few children and young people who had complex needs. We looked at 4 prescription and administration records and 5 care records on Hartley ward. Staff carried out post administration observations in line with the provider's policies and procedures and good practice guidelines.

No children or young people were in seclusion when we inspected.

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 (LTS). At the time of our inspection 5 young people were placed in LTS; 3 on Hartley ward, 2 on Thorneycroft. Two were in the seclusion suite and extra care suite respectively; 3 were segregated within their bedrooms. They were supported with extra staff and had access to outside space and other facilities. They could still participate in activities, including those outside of the hospital. Staff we spoke with understood how to manage the young people in LTS, so they were restricted as little as possible, but were also kept safe. This was reflected within the care records we reviewed and our observations whilst on inspection.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role and staff kept up-to-date with their safeguarding training. By 15 September 2022, staff were 97% compliant with safeguarding children and 95% compliant with safeguarding vulnerable adults. Staff who were required to complete level 3 safeguarding training were 94% compliant.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act. Safeguarding was discussed daily in clinical meetings to ensure appropriate decisions were made to keep people safe.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Social workers took a lead in safeguarding and liaised with the local authority and local safeguarding leads. They had good relationships and participated in safeguarding investigations.

Staff followed clear procedures to keep children visiting the ward safe. All visitors used the designated visitor rooms.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider had made 20 safeguarding referrals to the local authority in the 3 months prior to the inspection. One had required the provider to further investigate under section 47. Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff did not have easy access to clinical information and it was not always easy for them to maintain high quality clinical records – whether paper-based or electronic.

Care notes were generally comprehensive and all staff could normally access them easily. However, at the time of our inspection the electronic care notes system that all clinical staff used was not working and had not been for a number of weeks. This was beyond the provider's control and was an issue with the care notes system and had effected other hospitals across the Country. Day to day information was now readily available, however historic information such as admission information, and initial assessments was missing. Managers and staff had adapted; templates had been replicated, care plans and risk assessments had been reproduced and patient's daily progress notes restarted. However, this had not been without issue. Due to a problem with some aspects of the provider's IT system, nurses and support workers were unable to easily input information onto the adapted system. It took a significantly longer time than other members of the multidisciplinary team who had easier access. This meant there could be a delay in information being

inputted into the system and some staff were not always sure where the information was located. For example, one young person from Wedgewood ward still had a 72-hour care plan in place despite being on the ward for 6 days. Nurses told us the care plan was likely updated but uploading to the system was time consuming and the task had not been fully completed. Managers told us that the issue had been escalated to the board and a solution was being looked into, and they knew how frustrating this was for staff.

Medicines management

The service used systems and processes to safely prescribe, administer, and record medicines. However we found issues with the storage of medicines and we found some out of date medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff completed managing medicines training; they were 94% compliant. Medicines management audits took place and actions were in place; however we found issues with incorrect storage and disposal of medicines which had not been picked up during the audits.

We reviewed 12 medicine prescription charts which were completed correctly. Doctors reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines and decision-making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff generally stored and managed medicines and prescribing documents in line with the provider's policy. Clinic areas were organised, clean and tidy. However, there was no opening dates on 1 medicine disposal bin, 1 needle sharps bin and 1 liquid medicine bottle on Wedgewood ward and 1 liquid medicine bottle on Hartley ward. We found some expired medicines and expired pregnancy and drug test kits on Thorneycroft ward. These issues had not been actioned following the medicines audit.

Staff followed current national practice to check children and young people had the correct medicines and reviewed the effects of each child or young person's medication on their physical health according to NICE guidance. Children and young people received regular blood tests and an electro cardiogram (ECG) when required.

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

Track record on safety

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported all incidents and near misses in line with provider policy. The provider reported 1457 incidents from 1 June 2022 to 31 August 2022; Hartley ward reported 655, Thorneycroft 561 and Wedgewood 241. The majority on all the wards was for self-harm. All incidents were reviewed and discussed daily with senior managers.

Requires Improvement

Child and adolescent mental health wards

Staff received training in and 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.

Managers investigated incidents thoroughly and supported staff after any serious incident and provided a debrief. Senior staff used CCTV to investigate incidents or complaints when required. The service also had CCTV monitoring in 2 bedrooms on each ward and footage was monitored by an external company who contacted the ward staff if they had any concerns. Children and young people were allocated a bedroom with additional CCTV monitoring following discussion in multidisciplinary meetings and with children and young people and parental consent if this was required. This was always done for the best interest of the young person and discussed with them fully.

Staff received feedback from investigation of incidents, both internal and external to the service and staff met to discuss the feedback and look at improvements to patient care. Managers discussed incidents in clinical governance meetings and learning was cascaded to staff through staff meetings and handovers. Incidents involving battery swallowing had led to extra training for staff to increase their awareness and help them identify potential incidents before they occur. Staff received a lessons learnt bulletin each month, which included improvements made from other services.

There was evidence that changes had been made as a result of feedback. For example, pens had been banned from Hartley ward for a period of time due to the risk of ingestion by the young people deemed to be at risk. The decision had been withdrawn once the young person at risk had been discharged.

Managers shared learning with their staff about never events that happened elsewhere within team meetings, emails and newsletters.

Are Child and adolescent mental health wards effective?

Requires Improvement

Our rating of effective stayed the same. 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.

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

Staff regularly reviewed and updated care plans when children and young people's needs changed, and they developed a comprehensive care plan for each child or young person that met their mental and physical health needs. Care plans were personalised, holistic and recovery-orientated. At the last inspection, we told the provider they must ensure that

care records were personalised, goal orientated and demonstrated involvement from children and young people. We reviewed 15 care records. We could see that improvements had been made and the child's or young person's voice was evident. All young people and children had a positive behavioural care plan in place, which were written in their voice and were personalised and individual.

The provider had just implemented a quality improvement project to introduce a standardised framework, so all members of the multidisciplinary team provided input into care planning. There was a core number of care plans which encompassed all aspects of the young person's care. The aim was to ensure that all care plans were consistent, concise and information was easy to find and to keep updated across all the wards and the provider's wider children's and young people's mental health services.

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; however, face to face time with a qualified psychologist was not available. 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.

Children and young people could attend the hospital school, Monday to Friday and teachers and staff worked well together. During the inspection we observed chidren and young people attending school. Teachers attended multidisciplinary team meetings and handovers and faciliatated the ongoing educational needs of the children and young people until they were discarged and could attend their schools in the community.

Children and young people were able to choose which activities they took part in during weekly community meetings and these formed parts of children and young people's occupational therapy care plans. Children and young people had individual timetables that detailed their activities, many of which were 1-1 with the occupational therapy team. Activities were available in the evenings and weekends. Children and young people told us there were enough activities and they enjoyed them.

There was a large occupational therapy team with an occupational therapist and occupational therapy assistant for each ward. The occupational therapist who worked on Wedgewood ward was specialised in working with people with eating disorders.

Occupational therapists assessed children and young people with sensory needs, using a wide range of evidence based tools and aids, and developed specialist activity plans that met their individual needs. The occupational therapists had received sensory integration training and produced sensory profiles.

There was a range of other therapies such as art therapy, music therapy, family therapy, physical therapy and yoga therapy. A therapy dog came to the wards weekly.

The psychology department offered a range of evidence based therapies to meet the needs of the children and young people, however the lead psychologist only offered remote therapy, not face to face. Some children and young people did not like this method, however psychology assistants were available and offered sessions face to face.

Requires Improvement

Child and adolescent mental health wards

Staff delivered care in line with best practice and national guidance. Staff ensured that young people and children had access to a copy of their positive behavioural support plan, including those who were high risk and could not have a printed copy.

Hartley ward had re-introduced 'Safewards.' Safewards is a model designed to improve the safety on mental health wards for everyone including patients, staff and visitors. Wedgewood ward had already introduced Safewards as a quality improvement project.

Staff identified children and young people's physical health needs and recorded them in their care plans. The dietician worked closely with children and young people on Wedgewood ward and provided assessments and treatments in line with current national guidance for people with eating disorders. Staff made sure children and young people had access to physical health care, including specialists as required. There were good links with healthcare professionals such as the local GP and dentist. Staff supported children and young people to attend appointments.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration. The dietician completed diet plans for children and young people on Wedgewood ward. All qualified nurses were trained in naso-gastric tube feeding. Staff adhered to current national guidance regarding eating disorders.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. A gym instructor attended each ward at least twice a week.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. The service used outcome measures such as Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and the Children's Global Assessment Scale (CGAS). The occupational therapy team used the Child Occupational Self-Assessment (COSA) as a self-assessment tool on children and young people's admission and the model of human occupational screening tool (MOHOST) as an assessment tool and outcome measure. The psychology team used Becks Depression Inventory (BDI), the Revised Children's Anxiety and Depression Scale (RCAD) and the Eating Disorder Examination Questionnaire (EDE-Q).

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements. The service participated in the provider's annual audit cycle. Recent audits (July 2022) included hand hygiene, patient observations, supportive engagement, incident cycle, reducing restrictive practices and safeguarding. We reviewed a selection of audits and saw that actions were included and were monitored in clinical governance and staff meetings.

Skilled staff to deliver care

The ward teams had access to a range of specialists required to meet the needs of children and young people on the wards. Qualified psychology input was provided on a remote basis. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers supported staff with appraisals, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, not all staff received regular supervision.

The service had access to a full range of specialists to meet the needs of the children and young people on the ward, including nursing, medical, occupational therapy, psychology, social work, dietetics and administration. However, access to qualified psychology was remote and not face to face. An additional full time psychologist who could offer face to face therapies had been appointed and was due to start in November 2022.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. Staff told us it was comprehensive and prepared them to work within the service. The children and young people were involved in the induction and introductions to the ward.

Managers supported staff through regular, constructive appraisals of their work; 83% of staff were up to date.

Managers supported staff through regular, constructive clinical supervision of their work. The provider's supervision policy stated staff should receive supervision every 6 weeks. The overall compliance for supervision was 69%; Hartley ward was 73%, Wedgewood 100%, however Thorneycroft was only 37%. Managers said this was because the previous manager and left and the new one had had leave.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Since the last inspection, the lead occupational therapist had started to provide autism training for all of the clinical staff, including agency staff. At the time of the inspection, 50% of staff had undertaken the training and this was now incorporated in staff induction. Staff told us it had been informative and helped them understand the needs of the children and young people. All children and young people had a positive behavioural support (PBS) plan in place, which had been developed with them. Staff received specific training for PBS plans and were 90% compliant. Staff received specialised training in working with people with eating disorders.

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

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 from a range of disciplines attended regular multidisciplinary meetings to discuss children and young people and improve their care. Children and young people and their families were invited to attend and participate.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. Ward staff attended handover at the change of each shift.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. Staff, young people and families worked closely with other healthcare professionals involved in their care to support care and discharge planning.

Requires Improvement

Child and adolescent mental health wards

When we inspected, there were 7 Looked After Children admitted to the service. This meant that the local authority had parental responsibilities. Social workers liaised with the appropriate local authorities regularly to ensure these children and young people were being supported to get their appropriate care packages.

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff across all 3 wards were 94% compliant with Mental Health Act level 2 training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice and they knew who their Mental Health Act administrators were and when to ask them for support.

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

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were referred to the service. Posters were displayed in ward areas. We spoke with the advocate who told us that staff were open and transparent and they worked closely together.

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. We saw this was recorded clearly in the child or young person's notes each time and audited by the Mental Health Administration team.

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed.

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.

Requires Improvement

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. Staff across all 3 wards were 91% compliant with Mental Capacity Act training.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access.

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.

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.

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations and knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this.

Are Child and adolescent mental health wards caring?

Good

Our rating of caring improved. 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.

Requires Improvement

Child and adolescent mental health wards

We spoke with 5 children and young people. They were generally complimentary about staff. We observed staff being discreet, respectful, and responsive when caring for children and young people. Staff gave children and young people help, emotional support and advice when they needed it. Children and young people said they could talk with staff whenever they needed and they were approachable and supportive. However, one young person said that some agency staff were not always helpful.

Staff supported children and young people to understand and manage their own care treatment or condition. Children and young people we spoke with said they had enough information about their care and were involved in decisions. One young person on Hartley ward specifically said that staff had listened to her and had included her preferences, for example, how she liked to be restrained.

In addition, we reviewed the results from the recent (August 2022) children and young people survey for Wedgewood and Hartley ward. Results showed 95% of children and young people said they got enough information about their care.

Children and young people said staff treated them well and behaved kindly. We observed staff being kind and there was lots of helpful interactions between staff and young people. Survey results showed 94% of children and young people who participated said that staff treated them kindly and with respect.

Staff understood and respected the individual needs of each child or young person. Staff were knowledgeable about the children and young people they looked after and could confidently describe their care plans, likes and dislikes.

Children and young people who had previously been admitted to the hospital and had had a subsequent admission said that they could see improvements. They said staff felt more caring, interacted more and they got on better with staff. There were a lot more activities and children and young people enjoyed them.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people. One young person had told us they made a complaint about another young person bullying them. Staff had acted quickly and dealt with her complaint appropriately and to her satisfaction.

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. 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.

Staff involved children and young people and gave them access to their care planning and risk assessments and they were involved in decisions about the service, when appropriate. Children and young people we spoke with said they were involved in their care planning and received a copy if they wanted one. They could make changes if they wished to. Survey results showed 69% of children and young people felt involved in their care.

Staff made sure children and young people understood their care and treatment. Care plans were written in easy read format when required or requested. Young people said staff explained their care and treatment plans and they were given the opportunity to ask questions.

Requires Improvement

Child and adolescent mental health wards

Children and young people could give feedback on the service and their treatment and staff supported them to do this. Apart from the recent survey, children and young people attended and actively participated in community meetings and restrictive practice meetings. Actions were raised and logged and regularly reviewed. 'You said, we did' actions were displayed following feedback. One young person told us they had made a complaint in the past which had been responded to appropriately.

Staff supported children and young people to make decisions on their care. Young people said they were included in plans about their care and were encouraged to make decisions and plan for the future.

Staff made sure children and young people could access advocacy services. The advocate attended weekly and their details were easily available on the ward. The advocate told us that managers listened and responded when concerns were raised.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke with 7 family members or carers. Overall, family members or carers said that they thought staff supported, informed and involved them and they received lots of communication and were able to attend multidisciplinary reviews. Parents consent was sought when applicable. One parent said they did not always get enough information about their family member. They said there was one occasion when they did not get a call back during the night when they had contacted Thorneycroft ward with a concern.

Families and carers had been involved in communication plans and their views had been considered within care plans.

Staff helped families to give feedback on the service and families felt confident to raise concerns and the service would address them.

Are Child and adolescent mental health wards responsive?

Good

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

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital.

Staff reviewed referrals carefully and considered the impact to the ward mix and acuity of the children and young people already admitted. At the time of the inspection, Hartley ward was closed to referrals due to the acuity of some of the children and young people, and the amount of staff required to keep them safe.

Managers regularly reviewed length of stay for children and young people to try to ensure they did not stay longer than they needed to. Children and young people had discharge plans with clear timeframes in place to support them to move to a community setting or a new provider based on their individual needs. At the time of the inspection, the majority of children and young people were from the Midlands area.

Managers and staff worked to make sure they did not discharge children and young people before they were ready and when they went on leave there was always a bed available when they returned. They were moved between wards during their stay only when there were clear clinical reasons, or it was in their best interest.

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. Five children or young people's discharge was delayed; 3 on Hartley and 2 on Thorneycroft. The young people whose discharge was delayed had very complex needs which required a bespoke discharge package or a more secure environment. Managers were proactively working and planning with National Health Service England (NHSE) and other providers to identify suitable placements to try to ensure discharge was as timely as possible. Some placements had been identified although the assessment process from the other provider was still ongoing at the time of our inspection.

Children and young people did not have to stay in hospital when they were well enough to leave and staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well.

Staff supported children and young people when they were referred or transferred between services.

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. Each child and young person had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and children and young people had access to hot drinks and snacks.

Each child or young person had their own bedroom, which they could personalise and they had a secure place to store personal possessions. Separate lockers were available to secure items that required staff supervision. However, bedrooms did not have en-suite facilities. Male and female bathrooms and toilets were available across the wards.

Staff used a full range of rooms and equipment to support treatment and care. The service had a gym and an occupational kitchen separate from the wards.

Hartley ward had a quiet room which also helped children and young people with sensory needs. It contained a light dimmer, a projector with soothing colours and lights, and comfortable seating such as a rocking chair and bean bags. Noise reduction panels were placed in the ceiling.

The service had quiet areas and a room where children and young people could meet with visitors in private. One visitor room was close to the reception area so visitors did not have to walk through the hospital, and another was situated outside in a cabin.

Children and young people could make phone calls in private. They had access to their mobile phones and electronic devices unless this was individually care planned due to risk.

The service had an outside space that children and young people could access easily. There was a large garden and basketball court that all wards could use. The garden was basic with little plants or flowers. Children and young people in long term segregation had supervised access to their own outside space as well as the large garden space.

Requires Improvement

Child and adolescent mental health wards

The service offered a variety of good quality food. Children and young people on Thorneycroft ward could make their own hot drinks and snacks and were not dependent on staff. On Hartley ward children and young people did not have access to the kitchen and were dependent on staff. Wedgewood ward had set times for meals and snacks.

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. Children and young people attended in-house school sessions throughout the day and were able to attend college courses where appropriate. Teachers had good links with the children and young people's community schools to ensure there was continuity of education.

Staff helped children and young people to stay in contact with families and carers, with regular visits from family and home leave when appropriate and agreed with the multidisciplinary team, the young person and family.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. Dependent on individual risk assessments, children and young people were supported to access the community and were encouraged to participate in community activities outside of the hospital.

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. A lift was available for access to Thorneycroft ward which was on the first floor.

At the last inspection, we told the service they should ensure that staff follow children and young people's preferences in regard to the pronouns they wish to be addressed by. We saw that this had improved. Staff were knowledgeable about children and young people's wishes and were guided by them, especially those whose gender identity was fluid. We also saw this reflected in care notes.

Staff made sure children and young people could access age-appropriate information on treatment, local service, their rights and how to complain. Posters were displayed across the wards with information about activities and therapies, many of which had been designed by the children and young people.

The service could produce information leaflets available in languages spoken by children, young people and the local community and managers could make 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 and they had access to spiritual, religious and cultural support. A multi-faith room was available for all children and young people to use.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Requires Improvement

Child and adolescent mental health wards

Children, young people, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in ward areas.

Staff understood the policy on complaints and knew how to handle them and managers investigated complaints and identified themes. The service had received four complaints since June 2022. They had been upheld.

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. Managers shared feedback from complaints with staff and learning was used to improve the service in team meetings and they used compliments to learn, celebrate success and improve the quality of care.

Are Child and adolescent mental health wards well-led?

Requires Improvement

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

Leadership

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

At the last inspection we told the provider they must ensure that senior managers were visible and approachable for both staff, children and young people. The hospital manager attended the ward community meetings and met regularly with the young people on the ward. Staff said that they saw managers regularly and they were approachable. The hospital manager attended the breakfast club with children and young people.

Managers were knowledgeable and had the skills and experience to perform their roles. They had a good understanding of the service they managed and were approachable.

All 3 ward managers were new in post. The ward manager on Wedgewood was interim, the other 2 had recently been promoted from within the service. Ward managers met together regularly and had monthly supervision and support from the head of nursing. Staff said ward managers were supportive, open and approachable.

Vision and strategy

Staff were getting to know and understand the provider's vision and values and how they were applied to the work of their team.

Vision and values formed part of the staff induction process. Most staff were aware of the provider's vision and values, however some staff could not talk confidently about this with the inspection team.

The provider had changed from the Huntercombe Young People Ltd to Active Care Group prior to our inspection. Their 3 behaviours were: Kind and honest, Listen, learn and act, Fair and inclusive. Therefore, Active Care Group's vision and values were new to staff and the service was still in the process of fully integrating these into every day practice.

Requires Improvement

Child and adolescent mental health wards

The provider celebrated success through their staff awards, based upon their 3 behaviours.

Culture

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

Staff said they felt respected, supported and valued. Staff said they felt supported by the senior leadership team, and staff supported each other and worked well together.

Staff and managers on Hartley ward told us morale had improved and was still improving. Staff said they felt more engaged following recent changes to the leadership and saw lots of improvements on the ward. For example, support workers told us they appreciated being invited to attend and participate in multidisciplinary meetings, and felt their voices were now heard. Staff who had left and now returned said they could see and feel the difference in staff engagement and morale. Staff on Thorneycroft and Wedgewood wards also said that morale was good.

The service participated in an employee of the month, which also included the inclusion of bank and agency.

Staff said they could raise concerns without fear. Information on how to raise a concern was displayed so all staff could see it.

Governance

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

At the last inspection we told the provider that they must ensure there were systems in place to ensure that staff working during a night shift were appropriately undertaking their roles. Senior managers undertook monthly CCTV audits across all three wards to ensure that staff were adhering to policies and procedures and performing their roles appropriately. They focused on nights and weekends. Managers also undertook spot checks and quality walk abouts on random nights once a month, to seek further assurances.

At the last inspection we told the provider that they must ensure there were robust audits in place to monitor and improve the quality of care, with clear actions where appropriate. The hospital adhered to the provider's comprehensive annual audit cycle. We looked at examples of completed audits and could see appropriate actions were documented when required. However, not all actions from medicines audits had not been actioned. Medicine audits were completed by an external pharmacy company.

The agenda for clinical governance meetings provided a framework to ensure essential information was shared and discussed. For example, the agenda included staffing and associated items, incidents, safeguarding, infection control, patient experience, reducing restrictive practices, audits and quality assurance and lesson sharing. Governance records showed that all items on the agenda were discussed, including any ongoing actions. Actions and decisions made from the meeting were recorded, and previous actions were reviewed to discuss whether they were completed or ongoing.

The service had developed an action plan following the last inspection which was regularly reviewed and scrutinised by the Chief Executive and other members of the board.

Requires Improvement

Child and adolescent mental health wards

Management of risk, issues and performance

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

The provider had a risk register. The issue regarding the care notes system and the time-consuming process required by nursing staff to create and store clinical documentation had been escalated to the board by the hospital managers, however they were still waiting for an outcome. There was one other item on the risk register; excessive heat during the recent heatwaves.

The care notes issue had also affected other providers and some NHS trusts. It had been declared a serious incident by National Health Service England (NHSE).

The site improvement plan contained all information from audits, CQC action plan, lessons learnt, actions from serious incident reviews, and any internal policy updates. The plan was comprehensive and contained all outstanding actions which were monitored and updated regularly.

Information management

Staff collected analysed data about outcomes and performance.

Children and young people were able to develop and improve the service. There were regular children and young people community meetings to provide feedback and children and young people surveys.

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.

Managers had been involved in provider collaboration events, which included children and young people's participation and engagement.

Staff, children and young people received the comprehensive hospital newsletter regularly celebrating the service achievements and what's been going on across the hospital.

Learning, continuous improvement and innovation

Staff engaged actively in local and national quality improvement activities.

The service had participated and implemented a standardised framework for care planning to aid consistency across it's CAMHS sites, as part of a quality improvement project. The aim was to provide a consistent, concise approach to care planning, and reduce the risks associated with too much, or little information.

The service took part in national quality improvement services. Wedgewood ward was due to be re assessed and hoped to regain accreditation with The Royal College of Psychiatrists under The Quality Network for Inpatient CAMHS.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that medicines are stored correctly and out of date medicines disposed of correctly. (Regulation 12 (2)(g))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure that issues identified in medicines audits are actioned. (Regulation 17 (2)(c)) • The service must ensure that nursing staff are able to input clinical information onto the interim care notes system in a timely manner. (Regulation 17(2)(c))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The service must ensure that staff receive supervision in line with the provider's policy. (Regulation 18(2)(a))