Shrewsbury and Telford Hospital NHS Trust

The Princess Royal Hospital

Inspection report

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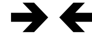
Ratings

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

Our findings

Overall summary of services at The Princess Royal Hospital

Inadequate 

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. Together the hospitals have just over 700 beds and assessment & treatment trolleys.

The trust provides acute inpatient care and treatment for specialties including cardiology, clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery.

Princess Royal Hospital is the trust's specialist centre for inpatient head and neck surgery. It includes the Shropshire Women and Children's Centre, the trust's main centre for inpatient women's and children's services.

Approximately 90,000 children are within the trust's catchment area. Children and young people's services at this location consists of; a children and young people's inpatient ward, children's haematology and oncology, a children's assessment unit, children's outpatient department and children's day surgery.

We carried out this unannounced, focused inspection of the children's and young people's service because we had received concerning information about the safety and quality of the provision of the assessment and treatment of children and young people who presented to the service with acute mental health needs and/or learning disabilities.

At this inspection we inspected using our children and young people's framework. Children and young people's services at the trust were last inspected in November 2019 where it was rated as requires improvement overall.

In November 2019, in response to trust wide concerns we urgently imposed a condition on the trust's registration that stated they must have an effective system in place to ensure de-escalation management and restrictive interventions were completed in line with relevant national guidance. At this inspection, we found the systems around restrictive interventions were not in place within children and young people's services.

We have inspected other core services at the trust since November 2019. At inspections in June 2020 and October 2020, we took enforcement action and told the trust it must make significant improvements in relation to two specific issues. However, at this inspection we found these improvements had not been made in the children and young people's services.

In June 2020, we urgently imposed a condition onto the trust's registration that stated they must devise a process to ensure the accurate clinical risk assessment and care planning of future patients. At this inspection, we identified that this process was not in place in children and young people's services.

In October 2020, we served a warning notice to the trust that told them they needed to make significant improvements to its safeguarding systems by 1 February 2021. At this inspection, we found these improvements had not been made in children and young people services.

Our findings

Please refer to our previous trust and location reports for further details of regulatory action taken.

We did not inspect any other services as this was a focused inspection in relation to children's and young people's services. We did not enter any areas designated as high risk due to COVID – 19. We continue to monitor the trust closely to identify new and emergency risks and track the trust's progress against their improvement plan.

Using the children's and young people's framework, we inspected elements of the key lines of enquiry of safe, effective, responsive and well-led. Our rating of this location went down. We have rated the service as inadequate and have taken enforcement action as a result of this inspection to promote patient safety.

We also used our urgent enforcement powers and placed conditions on the trust's registration in relation to: inadequate safeguarding systems that exposed children and young people to the risk of abuse and harm; inadequate assessment and management of risks relating to children and young people's mental health, those with learning disabilities and those with behaviours that challenged which placed children and young people at risk of avoidable harm; and inadequate staff training which meant children and young people with mental health and learning disability needs were not being cared for my staff who had the skills to keep them safe.

We also served a warning notice telling the provider they must make improvements to ensure all care plans are individualised and meaningful for each child and young person.

During our inspection we visited the children's ward and two adult wards where young people between 16 and 18 years of age had been admitted. These two wards were the Acute Medical Assessment Unit (AMU) and an escalation ward which was a temporary medical ward.

We reviewed the records of five children and young people who were receiving care in hospital at the time of our inspection. We also reviewed the records of two children and young people who had been detained under Section 2 of the Mental Health Act 1983 at the trust during November 2020. Detention under Section 2 of the Act means that a person has been legally detained for assessment of their mental health; this can last for up to 28 days.

Following our inspection, we reviewed records relating to three additional children and young people who had been admitted to the hospital over the five days following our inspection

We spoke with 14 nurses, two ward managers, two play specialists, a doctor, a student nurse, a security supervisor, a teacher, the deputy chief operating officer, the mental health matron, the paediatric lead for transition, the lead nurse for women and children, a pharmacist and the lead safeguarding nurse for children. We also spoke with four children and young people and three carers and parents.

We reviewed the care records of 10 children and young people and reviewed staff training records, and governance records; such as minutes of safeguarding audit information and relevant policies and procedures.

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

Services for children and young people

Inadequate

- Staff we spoke with did not fully understand how to protect children and young people from abuse and did not consistently follow local and national guidance in order to make safeguarding referrals where safeguarding concerns were present. Our review of records also confirmed poor practice around recognising and managing safeguarding concerns.
- Staff caring for children and young people on adult wards did not access the required training on how to recognise and report abuse.
- Children and young people admitted due to a deterioration in their mental health or those with learning disabilities did not receive adequate risk assessments on admission and those risks assessments that were completed were not updated as required. Therefore, action was not always taken to ensure all their needs were met and that risks were managed effectively.
- Staff did not assess and manage risks to children and young people or follow best practice in anticipating, de-escalating and managing behaviours that challenged. Effective systems were not in place to ensure restrictive practices, such as restraint were completed safely and appropriately by staff who had undertaken nationally recognised training.
- The service did not always prescribe and administer rapid tranquilisation medicines safely, exposing children and young people to the risk of harm.
- The service did not always manage patient safety incidents well. Managers did not always adequately investigate incidents and share lessons learned with the whole team and the wider service.
- The service did not always provide care and treatment based on national guidance and evidence-based practice. For example, the trust's children's safeguarding policy did not state that all clinical staff working with children and young people required level three safeguarding training.
- Staff lacked understanding of the Mental Health Act 1983 including their responsibilities and duties under the Act. This meant the rights of patients subject to detention under the Mental Health Act 1983 were not always protected.
- The service did not ensure that it deployed enough skilled and competent staff to provide care and treatment to children and young people who were admitted with mental health needs and learning disabilities.
- The service was not inclusive, and it did not always take account of children, young people and their families' individual needs and preferences.
- Leaders did not have the skills and abilities to run the service. They understood some of the issues the service faced. However, they did not always take ownership of the issues that they needed to in order to keep children and young people safe.
- Leaders within this service were only visible and approachable to staff who worked on the children and young people's ward. They were not visible or approachable to staff who cared for young people on adult wards.
- Leaders and teams did not manage performance effectively. They did not always identify and escalate relevant risks and issues and did not always identify actions to reduce their impact. They did not always have effective plans in place to cope with unexpected and infrequently encountered events.

However:

Services for children and young people

- Staff coordinated the care of children and young people admitted with mental health needs and learning disabilities with other services and providers when required.

Is the service safe?

Inadequate

Safeguarding

Staff did not understand how to protect children and young people from abuse and the service did not consistently follow local and national guidance in order to make safeguarding referrals where safeguarding concerns were present. Staff did not always access the required training on how to recognise and report abuse. When this training was completed, it was not always effective.

Staff did not consistently identify and report safeguarding concerns in line with local and national guidance. This meant children and young people were not always protected from abuse. Four of the 10 care records we reviewed showed significant safeguarding concerns. One of these concerns included an allegation of abuse from the child against hospital staff. Another included alleged child exploitation. Staff did not recognise the need to promptly refer these concerns to the local safeguarding teams as required. Two of the four concerns had not been identified and acted upon by staff at the trust. Therefore, safeguarding referrals to the local authority were made by CQC inspectors. The third concern resulted in staff making a safeguarding referral after we raised the concern multiple times during the inspection. This referral was made four days after the concern was first recorded in the patient records. The fourth concern resulted in a safeguarding referral being made by staff following when the child was discharged from hospital. This was three days after the safeguarding concern was identified. Delaying these referrals placed other children and young people at risk of harm as the concerns in these cases related to the safety of care in a children's home where other children and young people resided and concerns about child exploitation which would have placed other children in the local community at risk.

Adequate assessment and triage of potential safeguarding concerns did not always take place. Five of the 10 records we reviewed showed potential safeguarding concerns. These concerns related to the children and young people's self-harming behaviours. Patient records for these five children and young people showed a lack of professional curiosity in terms of probing the reasons behind the trigger for their self-harm in order to identify if a safeguarding referral was required. No safeguarding referrals had been made for these five children and young people and their patient records did not provide us with assurances that an appropriate assessment had been completed to identify whether there were any safeguarding concerns. Therefore, CQC inspectors made local authority safeguarding referrals for these five children and young people as a precautionary measure to ensure they were safeguarded.

Staff displayed a lack of understanding of their safeguarding responsibilities. Reasons given by staff when asked why safeguarding referrals had not been made for the cases referred to above included; 'The patient already has a social worker', 'They've [the child] been fine on the ward' and, 'There are no safeguarding concerns'. These responses showed a lack of understanding of what a safeguarding concern was and the safeguarding process.

The trust had implemented an information sharing form to their internal safeguarding processes. This form was known as the green form. Staff completed the green form to record any safeguarding concerns they had identified, and the form was sent to the trust's own children's safeguarding team. The trust's safeguarding team then reviewed the information on the green form to identify whether a formal safeguarding referral was required. The use of this form had created

confusion amongst staff as some staff thought filling in the green form constituted a safeguarding referral. Therefore, some staff believed they were completing safeguarding referrals when they had not. Patient records demonstrated this as four of the patients records we reviewed had a tick in the safeguarding referral made box when no referrals had been made. In these four cases, only the green information sharing form had been completed.

The green form system also created a potential delay in the safeguarding referral process. Staff were completing these forms out of hours believing they were making referrals. However, the trust's internal safeguarding team only worked office hours Monday to Friday. This meant green forms completed out of hours would not be picked up by the trust's safeguarding team until they were next in the office. This delay posed a significant risk to the safety of children and young people.

Staff did not always have access to the required training on how to recognise and report abuse. The intercollegiate document, 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019' states level three training is required for all clinical staff working with children, young people and staff who could potentially contribute to assessing, planning, intervening and/or evaluating the needs of a child or young person. Staff working on adult wards who cared for 16 and 17-year olds had not been included in the trust's level three safeguarding children's training as required. Trust data demonstrated that between 1 November 2020 and 31 January 2021, 91 young people aged 16 and 17 had been admitted onto adult wards. These 91 young people had not been cared for by staff with the appropriate safeguarding training.

When safeguarding training was completed, it was not always effective, and the trust had not recognised this. The examples listed above outline missed opportunities to safeguard children and young people appropriately had occurred even though trust records showed that staff had completed training on the children and young people's ward. Trust record showed that for nursing and healthcare staff for level two training was 85% had completed this and 97% had completed level three training. Compliance levels for medical staff for level two training was 80% and compliance with level three training was 100%.

Assessing and responding to patient risk

Children and young people admitted due to a deterioration in their mental health or those with learning disabilities did not receive adequate risk assessments on admission and those risks assessments completed were not updated as required. Therefore, action was not always taken to ensure all their needs were met and that risks were managed effectively

Staff did not complete or update adequate risk assessments for each child and young person who was admitted with mental health need or learning disability. During our inspection, we reviewed the patient records of seven children and young people who were either current inpatients or had been an inpatient in November to December 2020. None of these records contained adequate risk assessments that clearly recorded each child and young person's risks that were associated with their mental health needs or learning disability. These risks included; absconding from the ward, self-harming behaviours and potential violence and aggression. This meant children, young people, staff and visitors were not always protected from avoidable harm.

Immediately following our inspection, we used our urgent enforcement powers and told the trust to provide us with assurances that all children and young people who were admitted to the service at that time had appropriate risk assessment and mitigation plans in place. This resulted in us reviewing the records of a further three children and young people who had been admitted over the five days following our inspection. We found that risk assessments were in place for these three children and young people. However, they lacked the detail required to ensure the risks associated

with their mental health needs had been appropriately assessed and where risks were identified, these had not been appropriately mitigated. For example, a young person who had been admitted following a serious attempt to cause harm to themself did not have an appropriate risk assessment in place that assessed and mitigated the risks the ward environment posed to them.

Some children and young people admitted to the service on occasions displayed behaviours that placed them or others at risk. If all recognised de-escalations techniques fail it may be appropriate, on occasions, to use physical interventions in these situations in the form of physical restraint to keep the child, young person and others safe. We found that national guidance was not being followed to ensure the risks associated with the use of restraint were being assessed, mitigated and reviewed. The records of two of the 10 children and young people whose notes were reviewed showed they had been restrained by staff on multiple occasions. Adequate risk assessments, care plans and monitoring were not in place to ensure the use of restraint was safe and appropriate. Accurate records detailing the type and length of restraint were not maintained and no debriefs took place for the children, young people and staff to review the impact of each episode of restraint. This meant national guidance was not followed and safe systems were not in place to protect children and young people from unsafe or inappropriate use of restraint.

Staff did not assess and manage risks to children and young people or follow best practice in anticipating, de-escalating and managing behaviours that challenged. The records of one child showed that the management of their behaviours generally relied on the use of rapid tranquilisation; this meant that the child or young person would have been restrained to allow rapid tranquilisation to be given. Rapid tranquilisation refers to the use of medication to manage acute behavioural disturbances by calming or sedating the patient, to reduce. the immediate risk of harm to self and/or others and reduce agitation and aggression. The records of one child showed they received rapid tranquilisation medicines on 27 occasions during their admission.

Children and young people were not always appropriately monitored post administration of rapid tranquilisation to ensure their health and safety. When rapid tranquilisation is administered, patient observations are required to assess and monitor the patient’s physical health. The trust had a standard operating procedure (SOP) in place that detailed the actions staff should take when rapid tranquilisation was required. This included hourly observations post administration of rapid tranquilisation, until a senior doctor had assessed and documented no ongoing concerns about the child or young person’s physical health. The records of one child who was detained under the Mental Health Act showed they had received rapid tranquilisation on 27 occasions. This child’s records did not provide any details of how/whether the SOP was followed in terms of post rapid tranquilisation observations for any of the 27 occasions where rapid tranquilisation was administered.

Medicines

The service did not always prescribe and administer rapid tranquilisation medicines safely, exposing children and young people to the risk of harm.

Rapid tranquillisation was not always prescribed and administered in a safe manner. Records showed that one child received double the safe dose of this medicine on two occasions during incidents where rapid tranquilisation was required. This placed the child at significant risk of harm. The first incident where the child received an unsafe dose of rapid tranquilisation occurred because the trust had no agreed protocol for staff to follow to ensure rapid tranquilisation in children and young people was safe. The second incident occurred due to poor oversight and monitoring of medicines administration by staff.

Incidents

Services for children and young people

The service did not always manage patient safety incidents well. Managers did not always adequately investigate incidents and share lessons learned with the whole team and the wider service.

The trust did not learn from incidents to ensure safety systems were reviewed and improved to protect children and young people from avoidable harm. Only one of the two incidents where a child had received an unsafe dose of rapid tranquilisation had been reported as an incident. This meant staff had not identified that this was a reportable incident the second time this incident occurred.

We reviewed incident data at the trust for the six months prior to these incidents and found another incident from June 2020 where a child/young person had been given too much medicine during an incident where rapid tranquilisation was required. The incident records show staff reported there was no rapid tranquilisation protocol for children and young people. Despite this, action was not taken to ensure an appropriate protocol was put in place to prevent further incidents from occurring.

Is the service effective?

Inadequate

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

In November 2019, we urgently imposed a condition on the trust's registration that stated they must have an effective system in place to ensure de-escalation management and restrictive interventions were completed in line with relevant national guidance. CQC had been monitoring compliance with this condition through the regular review of data submissions sent to us from the trust. However, shortly before this inspection, as the result of a serious incident, we identified that the trust had not submitted the required data detailing restraint that took place in children and young people's services.

At this inspection, we found the systems around restrictive interventions were not in place within children and young people's services. The policies in place around the use of restrictive interventions in children were being reviewed at the time of this inspection. Therefore, the 2019 condition had not triggered an urgent review of those procedures to ensure they were effective and appropriate.

In October 2020, we warned the trust to make improvements to their safeguarding systems. At this inspection, we reviewed the latest Safeguarding Children and Young People Guidelines and Procedure, which had been reviewed in November 2020. We found this policy did not incorporate all relevant national guidance. For example, the policy stated that only staff who predominately work with children, young people and adults who are parents/ carers required training in level three children's safeguarding. This meant the policy did not reflect the national safeguarding guidance reported on under safe which referred to all staff who potentially worked with children and young people being required to complete level three safeguarding training.

This policy also continued to contain out of date and inaccurate content. The policy referred to incorrect Health and Social Care Act regulations and also referenced CQC outcomes which have not been in use for over five years.

Services for children and young people

Staff lacked understanding of the Mental Health Act 1983 including their responsibilities and duties under the Act. A lack of understanding of the requirements of the Mental Health Act placed children and young people at risk of being inappropriately restricted and their rights not being upheld. We reviewed the detention documentation for two children and young people who had been detained at the trust in November and December 2020. These documents included errors which had not been identified or rectified. Examples of errors included; options indicating the doctor's status were not crossed out, as required by the form and reasons given as to why informal treatment was no longer appropriate were not all relevant. These errors should have been picked up following scrutiny when the paperwork was accepted by the hospital managers. Errors should be identified and rectified where possible.

Competent staff

The service did not ensure that staff were competent for their roles with regards to the provision of care and treatment to children and young people who were admitted with mental health needs and learning disabilities.

Staff were not always appropriately trained to use restrictive interventions, such as restraint. The Restraint Reduction Network Training Standards - Standard 3.6 refers to the need for staff to complete annual refresher training in restraint. The trust did not train their own staff in the use of restrictive interventions. Therefore, they used agency staff and security staff when restraint was required. We reviewed the training records of agency and security staff who were involved in the care and treatment of the two children and young people who were restrained in November and December 2020. We found that these staff had not all completed annual refreshers in restraint training. For example, 70 agency staff had been employed to care for one of these children. Records showed that 16 out of the 70-agency staff had not completed their annual refresher in restraint training as required. This meant these children and young people had been exposed to the risk of harm and inappropriate use of restraint.

Records also showed that some security staff were completing restrictive interventions without having completed any restraint training at all. For example, one restraint record showed that out of the three-security staff involved in that restraint, only one had completed the appropriate restraint training. Not ensuring all security staff were appropriately trained in restrictive interventions placed children and young people at significant risk of harm through the potential use of unsafe and/or inappropriate restraint.

Staff told us that since out last inspection, they were seeing higher numbers of children and young people being admitted with acute mental health needs. However, their mandatory training to work with children and young people had not changed to reflect this change.

Following our inspection, we asked the trust to send us confirmation of the mental health and learning disability training offered to staff and compliance rates for the completion of this training. The trust told us that there was a one-off learning disability workbook for staff to complete alongside a two-hour training session for clinical staff. Trust level compliance for this training was 38%. The trust told us that during 2020, mental health training from the local mental health trust was provided to some staff. No training compliance rates were shared with us for this training. Neither of these trainings were classed as mandatory for clinical staff.

The trust also told us that de-escalation training was going to be provided to some staff groups on an ad hoc basis. Again, this training would not be mandatory to ensure staff had the skills they required to effectively manage behaviours that challenged.

Services for children and young people

Is the service responsive?

Inadequate

Meeting people's individual needs

The service was not inclusive, and it did not always take account of children, young people and their families' individual needs and preferences. Staff coordinated care with other services and providers where possible.

The service was not inclusive. Young people aged 16 and 17 were not always given the choice of being admitted to the children and young people's ward. We asked the two 17-year olds admitted to adult wards if they had been offered a choice of being admitted to the children and young people's ward as opposed to an adult ward. Both told us they had not been offered this choice and were unaware of the differences that the two different environments would offer them.

The service did not always take account of children, young people and their families' individual needs and preferences to ensure they received person centred care. For example, two children and young people had care plans in place around eating and drinking with the aim of supporting them to reach a healthy target weight. These plans were very restrictive and had not been individualised to them. It stated that they could not choose foods from the food trolley at mealtimes and that staff had to choose on their behalf. However, the children and young people's care records showed no record of their food preferences to ensure they did not receive food that they genuinely disliked.

Our November 2019 inspection identified there was no transition policy in place at the trust to ensure children and young people had an appropriate and effective transition to adult services. At this inspection, we saw that a policy had been in place since August 2020. However, staff told us it had not been fully embedded within all children and young people's specialities, but progress was being made.

There was a named paediatrician transition lead. A business case was in progress for the addition of a lead transition nurse. Staff told us that the addition of a lead transition nurse would help embed the transition policy at the trust.

Staff coordinated care with other services and providers where possible. Patient records showed and staff told us that they engaged with other provider's and professionals about the care and treatment of children and young people who presented with acute mental health needs and/or learning disabilities. This included making prompt referrals to mental health teams as and when required. We saw and staff told us that they frequently struggled to access out of hours support for children and young people with acute mental health and/or learning disability needs. This was due to inadequate local and national commissioning of out of hours services and a lack of specialist inpatient facilities for this cohort of patients. This lack of appropriate commissioning of services was outside of the trust's control.

Is the service well-led?

Inadequate

Leadership

Services for children and young people

Leaders did not have the skills and abilities to run the service. They understood some of the issues the service faced. However, leaders did not always take ownership of the issues that they needed to in order to keep children and young people safe. Leaders within this service were only visible and approachable to staff who worked on the children and young people's ward. They were not visible or approachable to staff who cared for young people on adult wards.

Leaders did not have the skills and abilities to coordinate the safe and effective care of children and young people who were admitted to the hospital with mental health needs, behaviours that challenged and learning disabilities. Despite staff telling us that since our last inspection, there had been an increase in the numbers of children and young people presenting with acute mental health needs, there was a lack of leaders and clinicians with the appropriate skills set to ensure safe systems and effective oversight was in place for this cohort of patients.

Leaders had not made the improvements required following previous inspection at the trust. For example, after our 2019 inspection, we told the trust they needed to implement an effective system to ensure de-escalation management and restrictive interventions were completed in line with relevant national guidance. At this inspection as reported under safe and effective, we found that these improvements had not been made and embedded within children and young people's services.

Leaders were aware of some of the issues that challenged the service with regards to the admission of children and young people with mental health needs, behaviours that challenged and learning disabilities. These issues included; poor access to out of hours mental health support and their reduced capacity to provide care to children and young people with complex challenging needs. They escalated these issues to the commissioning groups and the mental health providers. However, they did not take ownership and act on the immediate issues that they needed to in order to keep children and young people safe. For example, they did not check that specially commissioned staff were appropriately skilled to provide safe care and treatment. Two of the children's records we reviewed were detained under the Mental Health Act 1983. The local Clinical Commissioning Group (CCG) who commission NHS services commissioned specialist packages of care for these two children whilst they were admitted to the trust. This included the provision of agency staff to provide specialist care. Leaders at the trust did not ensure the agency staff were appropriately trained to provide this care. Leaders reported that these checks had been completed by the CCG. However, as the overall provider responsible for these children's care, leaders at the trust should have completed these checks. As reported under safe, we found that 16 of the 70-agency staff used to support the care of one of these children were not up to date with the required training to ensure they were equipped to use restraint safely.

Leaders did not ensure that trust policies reflected the procedures that staff were advised to follow. Staff were following safeguarding processes that were not included in the trust's approved safeguarding policy. The trust had implemented an information sharing form to their internal safeguarding processes. However, this was not recorded in the latest safeguarding policy had not been updated to reflect this. The use of this form had created confusion amongst staff as some staff thought filling in the green form constituted a safeguarding referral. Therefore, some staff believed they were completing safeguarding referrals when they had not.

Staff on the children and young people's wards told us that their leaders were visible and approachable. However, staff on adult wards who cared for young people did not have the same level of access to children and young people's services leaders.

Services for children and young people

There was a risk that important messages from leaders would not be effectively cascaded to all staff within children and young people's services. Although staff told us ward meetings did take place, these were not always minuted. This meant staff who were not present at these meetings could not access the information that was discussed. We asked for the minutes of the children and young people's ward meetings from November 2020 to the time of our inspection. However, no minutes had been made.

Management of risk, issues and performance

Leaders and teams did not manage performance effectively. They did not always identify and escalate relevant risks and issues and did not always identify actions to reduce their impact. They did not always have effective plans in place to cope with unexpected and infrequently encountered events.

Effective systems were not in place to enable staff to consistently identify and monitor the care that 16 and 17-year olds were receiving on adult wards. During our inspection we asked the senior management team for a list of 16and 17-year olds who were on adult wards. We were given a list containing the names of two young people. When we went to review these young people's care, we found one of the young people was an adult so should not have been on the list. There was however a second 17-year-old whose name was not on the list we were given. Following our inspection, we were also made aware of a third 17-year-old who was admitted to an adult ward at the time of our inspection. Therefore, the system in place at the time of our inspection only identified one of the three 16 and 17-year olds who were in patients at the time of our inspection. This meant the system was ineffective and staff could not use it to have continuous oversight of the care of children and young people at the trust.

Audits completed to benchmark the trust against local standards were not always completed correctly. Therefore, safety concerns were not always identified by the trust. In November 2020 the trust had completed the Telford and Wrekin Section 11 Agency Self-Assessment Template 2020-2021 (An audit where the trust measured themselves against locally agreed safeguarding standards). We found this audit had not identified the safeguarding system concerns we raised at this inspection. For example, the trust had rated themselves as 'good' for having an appropriate safeguarding training plan in place. However, we found staff on adult wards who were caring for young people had not completed the required level of children's safeguarding.

Poor compliance with trust policies had not been effectively addressed through the use of audits. For example, the children's safeguarding lead nurse told us that safeguarding audits had identified staff were sometime using adult documentation for young people aged 16 and 17. They said they reminded staff to use the children's documentation during their safeguarding drop in sessions. However, this method of feedback to staff had not been effective as we found examples where adult documentation had been used for 16 and 17-year olds during our inspection.

Effective monitoring to check the staff's compliance with restrictive intervention policies and procedures was not in place. This meant some incidents involving restraint were not appropriately recorded on the trust's restraint documentation for managers to review. For example, one child's nursing and medical records from November and December 2020 showed they had been restrained on at least 23 occasions. However, only 16 of these restraints had been recorded on agreed forms as per procedure.

We reviewed the children and young people's services risk register and found some risks we identified during this inspection had not been identified and recorded on this register. This included; admissions of children and young people who have no physical health needs and require a place of safety for their acute mental health needs, lack of

competent staff to care for children and young people with acute mental health needs, behaviours that challenge and learning disabilities and the poor oversight of the care of young people aged 16 and 17 who are admitted to adult wards. This meant these risks did not have appropriate oversight from senior leaders and the board to ensure appropriate mitigation was in place to protect children and young people from receiving unsafe care.

Where risks had been identified and recorded on the risk register, we found that staff compliance with the mitigation plans was poor. One risk had been recorded on the risk register that related to the care of children and young people with mental health and learning disabilities. This related to the poor access to out of hours support from acute mental health teams. The risk mitigation plan referred to the use of, 'Individual risk assessments undertaken to understand children and young people's needs and to identify what action was required to mitigate risk to each child, young person, other patients, relatives, carers and staff'. However, all 10 of the patient records we reviewed did not show that appropriate, individualised risk assessments had been completed.

The risk register mitigation plan also stated, 'This assessment [risk assessment] will include the safest place to care for the child or young person'. None of the 10 patient records we reviewed showed that appropriate environmental risk assessments plans had been put in place to ensure children and young people with acute mental health needs and learning disabilities were cared for in the safest place. The children and young people's ward had no ward level environmental risk assessment that clearly identified hazards such as ligature points to ensure staff could identify where the riskier and safer areas of the ward were located.

The trust did not always have effective plans in place to cope with unexpected and infrequently encountered events. Staff told us they had seen an increase in the numbers of children and young people who presented with significant mental health issues, learning disabilities and behaviours that challenged over the past year. The trust had a formal agreement in place with the local mental health trust that stated how they would work together to provide training and administration associated with the Mental Health Act. However, there was no formal contract in place that outlined the specific support required to ensure the needs of children and young people with significant mental health needs, learning disability of behaviours that challenged were met.

The contract for the provision of children and young people's mental health services at the trust was commissioned by the clinical commissioning group (CCG) from the local mental health trust. However, despite the reported increase in admissions in this cohort of patients, the trust had not worked with the CCG and mental health trust to ensure effective plans were in place to meet the needs of children and young people with significant mental health needs, learning disability of behaviours that challenged.

Areas for improvement

Areas that the trust must improve:

- The trust must ensure robust safeguarding systems and processes are in place and are operated effectively in line with national and local standards and procedures. Regulation 13 (1)(2)(3).
- The trust must ensure all relevant staff caring for children and young people complete level three children's safeguarding training. Regulation 18 (1)(2)(a).
- The trust must ensure restraint is used only when absolutely necessary after all other de-escalations' methods have been undertaken and when restraint is needed it should be undertaken by staff have completed nationally recognised training line with national guidance. Regulation 13 (1)(4)(b).

Services for children and young people

- The trust must ensure individualised clinical and environmental risk assessments are completed to identify, assess, mitigate and review the risks relating to children and young people's mental health, behaviours that challenge and learning disability needs. Regulation 12 (1)(2)(a)(b).
- The trust must ensure rapid tranquilisation is prescribed and administered safely. Regulation 12 (1)(2)(g).
- The trust must ensure it has appropriate systems to assess, monitor and improve the quality of its services, such as maintaining accurate and contemporaneous records and learning from all incidents to prevent avoidable harm. Regulation 17(1)(2)(a)(b).
- The trust must ensure that the rights of children and young people detained under the Mental Health Act 1983 are consistently protected and that staff understand their responsibilities when caring for children and young people detained under the Act. Regulation 13 (1)(5)
- The trust must ensure that there are enough suitably skilled and competent staff (including bank and agency staff) to provide care and treatment for children and young people who have mental health needs and learning disabilities. 12 (1)(2)(c).
- The trust must ensure the preferences of children and young people are assessed and planned for in order to provide person centred care. Regulation 9 (1)(a)(b)(c).
- The trust must provide 16 and 17-year olds with the choice of receiving their care and treatment on a children's and young people's wards where appropriate. Regulation 9 (1)(a)(b)(c).
- The trust must implement effective oversight and monitoring systems to ensure all children and young people under the age of 18 receive safe and appropriate care and treatment. Regulation 17 (1)(2)(a)(b).

Areas that the trust should improve:

- The trust should continue to work towards embedding the transition policy within all children and young people's services.
- The trust should implement a system to ensure staff can access the information discussed in ward meetings.

Our inspection team

The team that inspected the service comprised a lead inspector, a children's inspector, a Mental Health Act reviewer and a specialist advisor who was a registered mental health nurse.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care