Cygnet NW Limited

Cygnet Bury Forestwood

Inspection report

Bolton Road
Bury
BL8 2BS
Tel: 01617627200
www.cygnethealth.co.uk

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

Ratings

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

Summary of findings

Overall summary

We rated it as requires improvement because:

- The service did not always provide safe care. The ward environments were not all well maintained and clean. The ligature risk assessments did not include the action that staff should take to mitigate the risks. The service did not manage medicines safely and staff were not following the provider's dress code policy in relation to being bare below the elbow and staff having long, manicured nails Young people told us that they had been hurt when receiving care because staff had long nails.
- On Buttercup ward we saw that staff did not always maintain appropriate professional boundaries and were talking about their personal lives and ignoring the young person.
- The governance processes did not always ensure that staff were following policies and procedures in relation to dress code and professional boundaries. Learning from organisational whistle blowing's had not been implemented fully. For example, the policy relating to resuscitation had not been updated to include paediatric resuscitation. The recommendations from pharmacy audits has not been sustained and medicines were still not being labelled appropriately which meant that staff may administer medicines incorrectly to young people.

However:

- Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Managers ensured staff received induction, training, supervision and appraisal. The ward staff worked well together as a team and with those outside the ward who would have a role in providing aftercare.
- The service provided a range of treatments suitable to the needs of the young people and in line with national guidance and best practice.
- 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 young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of young people. They actively involved young people and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that could provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

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

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Summary of this inspection

Background to Cygnet Bury Forestwood

Cygnet Bury Forestwood has been registered with the Care Quality Commission since 30 April 2021.

Cygnet Bury Forestwood has 44 beds for children and young people aged 13 to 18.

There are four wards;

Mulberry ward- Low secure ward for females, with 12 beds

Primrose ward- PICU for males and females, with 12 beds

Buttercup ward- Low secure ward for females, with 8 beds

Wizard House – General adolescent ward for males and females, with 12 beds

Children and young people were admitted from across the United Kingdom due to the demand for beds.

Cygnet Bury Forestwood is registered to provide the following regulated activities:

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

The service has a registered manager and a controlled drugs accountable officer.

This is the first inspection of this registered location.

What people who use the service say

We spoke with 19 children and young people and 13 family members for feedback about the service.

Children and young people

Young people had mixed views about the service. Ten young people said staff care and provide good support. Five young people talked positively about their doctors, who were approachable and listened to them and they could see them in between ward rounds.

Ten people talked about easy access to advocacy and valued the support of the advocate.

All young people said their families were involved in their care and updated on their progress however, one young person did not want contact with family and staff respected this.

Three young people talked positively about their access to psychological therapies of dialectal behavioural therapy and family therapy. However, seven young people said they did not have access to psychological therapies.

Summary of this inspection

Following incidents two young people said how helpful it was to reflect following incidents and be supported through this.

Areas for improvement from young people's perspectives included 11 young people told us there were no activities at a weekend and they got bored.

Twelve young people said there was not enough staff, especially at nights where there is more agency staff who may not know the ward. This has led to activities and leave being cancelled or postponed. However, two young people said when there were regular agency staff working, they had the opportunity to get to know them and feel more comfortable.

Nine young people said that some bank and agency staff don't knock before entering their rooms.

Four young people did not know how to complain to the service.

On Buttercup ward young people said the décor was childish in parts and they had ideas to improve the décor and would like to be involved.

Eight young people said the food was unhealthy, with chips available at most meals. Two young people on Wizard House had found ants in their food. Young people also said there was limited vegetarian and vegan food choices.

Four young people said the wards were not clean.

Families

Families we spoke with had mixed experiences of the service.

Things that they said the service did well was; four family members received information about the service when their relative was admitted to the hospital.

They valued the input of the speech and language therapy provision in relation to assessments and making information more accessible for young people.

Families all received information about their relative, usually with a daily phone call for an update.

However, five family members said the information was not always that accurate, with them not being informed of incidents within the updates. This included from staff that didn't work at the service regularly, therefore they did not know their relative well.

Six family members told us there was not enough psychological therapy for their relative, with there being staff vacancies and trainees and other staff from adult services providing cover, this meant children and young people were not receiving the therapy they thought they would receive in hospital. This included staff's understanding of autism and trauma informed care.

Family members told us at times there had been a mix up with planning to visit and a room wasn't available when they arrived. Families also told us that the increase in petrol costs meant families could not visit as often as they would like due to the cost of the journey as several families lived a long distance from the service.

Summary of this inspection

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the service.

During the inspection visit, the inspection team:

• visited the service

• toured the service, including all wards and observed the care being provided, including three short observation for inspection (SOFI)

• received feedback from advocates

• spoke with 19 young people

• spoke with 13 family members

• observed five ward rounds, two morning meetings two morning handovers and young person's morning meeting.

• spoke with 18 staff including support workers, nurses, consultant psychiatrists, occupational therapists, psychologists, speech and language therapists, ward managers and the registered manager

• looked at 17 care and treatment records of people and 34 prescription cards and associated documentation.

• looked at a range of policies, procedures and other documents relating to the running of the service including staff records.

This inspection was unannounced.

The inspection covered all key questions.

The inspection team was a CQC inspector, an assistant inspector, two specialist advisors and an expert by experience who had lived experience of services.

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

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure that the environment is clean and well maintained and damage to the environment is addressed promptly. (Regulation 15)
- The service must ensure that individual medicines are labelled in line with legislation to avoid misadministration or infection. (Regulation 12)
- The service must ensure that there is an up to date policy and related practice regarding paediatric resuscitation. (Regulation 17)
- The service must ensure that staff follow the policies in relation to dress code and professional boundaries. (Regulation 17)

Action the service SHOULD take to improve:

- The service should ensure there are sufficient numbers of suitably qualified and competent staff to enable the children and young people to receive therapy and interventions in line with national best practice and guidelines to meet their needs and to support their recovery and have continuity of care.
- The service should ensure that the young person's welcome pack is up to date and includes how to complain.
- The service should ensure that the ligature risk assessments include the action that staff should take to mitigate the risks and that the most recent version of the assessment is available to staff on the ward.
- The service should continue to review the use of physical intervention and explore alternatives and involve young people in the process.
- The service should ensure that when incidents are reviewed and investigated there is learning, and contributory factors identified.
- The service should review the process for sharing information with families to ensure information is accurate.
- The service should ensure that the wards environments are decorated in an age appropriate and welcoming manner.
- The service should ensure that the service is following the assessible information standard with the recording within care records.
- The service should ensure that the learning outcomes from complaints are shared at staff meetings.
- The service should review how they seek feedback from families and involved them in the service.
- The service should continue to engage with children and young people regarding the quality and choice of food provided.

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

Requires Improvement

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards safe?

Requires Improvement

We rated it as requires improvement.

Safe and clean care environments

Not all wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough environmental risk assessments of all wards areas and removed or reduced any risks they identified. Whilst staff were aware of the risks the risk assessments were stored on a computer and not readily available for staff to access.

Staff could observe children and young people in most parts of the wards. There were some blind spots on Buttercup ward in the main communal area however, there was always a member of staff in the area to mitigate this risk. There were blind spots on Primrose ward and observations would be difficult to conduct due to the ward being over two levels. However, the ward had been split off to smaller sections due the dynamics on the ward and staff were allocated to each area for observations.

The ward complied with guidance and the mixed sex accommodation met the requirements. All rooms were en-suite and there were several lounges for young people to use.

There were potential ligature anchor points in the service. Not all staff knew about any potential ligature anchor points when we asked them. Ligature risk assessments on the wards were dated 2020; mitigation stated, 'locally managed' and did not explain to staff what they needed to do. Ligature risks were managed by staff undertaking observations to keep children and young people safe. The risk assessments submitted by the provider after the inspection were different than the ones on the ward, these were dated 2021 and 2022. This meant staff did not have access to the current assessment.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. Staff and the inspection teams had response alarms. Young people had call buttons on the wall next to their beds in their rooms.

Requires Improvement

Child and adolescent mental health wards

Maintenance, cleanliness and infection control

Ward areas were mostly clean, well maintained, well furnished and fit for purpose. However, there were areas of the wards which required maintenance; Wizard House quiet room; the side of a chair had the cover peeling off and the bucket chair had the stuffing coming out of it at the bottom. The main lounge had a red mark/dried spillage on the wall and dried tissue stuck on the wall.

Young people said they had ants in their food, staff said there were ants in the kitchen. We looked at the kitchen; food was delivered in cardboard trays and then distributed. We saw two ants; one climbing up the wall near the window and one climbing up the notice board in the kitchen, we raised this with the ward manager who said they have had problems since the building works.

Bedroom one had dirt around the bedframe and damp in the en-suite. Bedroom two had cobwebs on the ceiling. There was litter in the garden.

On Primrose ward the base of the table was dirty with dried spillages. There were stains on the ceiling in the seclusion room. The furniture in the de-escalation area was ripped.

Buttercup ward's sensory room floor was dirty. Bedroom two had damage to walls.

We reviewed the maintenance open jobs for the service and found that the Wizard House chairs had been added in June 2022 and the work had been authorised. Primrose had requested replacement furniture for the de-escalation area in January 2022. However, this had not been approved. Mulberry and Primrose seclusion's intercom was listed as not working in May 2022 and managers were waiting for options to resolve.

Staff made sure cleaning records were up-to-date and the premises were mostly clean. We reviewed the cleaning schedules which were completed by staff every day and the areas that were dirty were listed on the schedule for ongoing cleaning. Records showed deep cleans took place quarterly.

Staff followed infection control policy, including handwashing and wearing of masks. Monthly audits took place by ward managers from another ward, these included the use of personal protective equipment (PPE). However, we observed staff were not bare below the elbow and some staff also had long nails, false nails and nail varnish on. The dress code policy dated May 2022, stated "All staff who come into contact with service users or who are working in a clinical/ residential area are required to follow Bare Below the Elbows (BBE) guidance." And "Nail varnish, gel and false nails are not permitted for those staff who are also required to be BBE, or who work with food products. Nails should be sufficiently short to ensure safe contact with individuals in our care and good hand hygiene." This meant staff were not following the policy and were putting young people at risk. CQC had received two notifications from the service regarding young people alleging to be injured by staff with long nails during physical intervention. The PPE audit did not identify this risk.

Seclusion rooms

The seclusion rooms allowed clear observation and two-way communication on Wizard House and Buttercup wards however, the intercom was not working on Primrose and Mulberry wards. This meant that staff and children and young people using the seclusion room would need to communicate through the glass in the locked door.

They had a toilet and a clock.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Equipment had been included for paediatrics following actions from an organisational whistle blower. However, the resuscitation policy provided following the inspection had not been revised to include paediatric specific guidance which was one of the actions following the whistleblowing.

Staff checked, maintained, and cleaned equipment. All equipment was calibrated and maintained apart from the blood glucose monitors. Once we raised this with the service, they took appropriate action and arranged for the process to calibrate the equipment and shared this with senior leaders too.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep children and young people safe. However, the use of bank and agency staff ensured this.

The service had reducing vacancy rates for support workers. Vacancy levels were;

- Buttercup 2
- Mulberry 4.5
- Primrose 9.3
- Wizard 1.5

The service had increasing vacancy rates for registered nurses at Mulberry ward and decreasing vacancy rates on the other wards. There were no vacancies on Buttercup and the provider had over recruited registered nurses. Vacancy levels on the other wards were;

- Mulberry 0.8
- Primrose 1.8
- Wizard 0.9

The service had increasing rates of bank and agency staff with 941 shifts covered by agency staff in May 2022 and 1055 shifts covering by bank staff in May 2022.

Managers tried to request bank and agency staff that were familiar with the service. We saw processes for identifying regular staff with the agencies and they prioritised offering shifts to regular staff. Young people told us they tried to do this, but this was not always possible, and staff worked on the wards who did not know the young people well. Young people told us this happened more at night.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The security team provided an induction to all agency staff and records showed when this had been completed. Staff also completed an induction checklist with an experienced team member who did this alongside a tour of the ward. We saw the completed induction checklists which were signed by both staff. Bank staff also completed all of the mandatory training within the service.

Managers supported staff who needed time off for ill health. Staff followed the sickness absence policy.

Requires Improvement

Child and adolescent mental health wards

Levels of sickness were reducing on all wards except Primrose. Average sickness levels for the last year was Buttercup 6%, Mulberry 9%, Primrose 9% and Wizard 11%.

Managers did not always accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Staff told us additional staff were requested via the staffing team if enhanced observations were required or escorts which required additional staff. We reviewed the staff allocation sheets for the first week of May 2022 and found on Buttercup ward, 11 occasions where staff were on enhanced observation of more than two hour duration. The nurse in charge conducted 2:1 observations for more than two hours duration on two occasions. This meant the registered nurse was not able to perform their nursing duties or respond as required during this time. On Mulberry ward, there were seven occasions of staff conducting observations for more than two hour duration and one shift where there was one registered nurse and there should be two. On Primrose ward there was four occasions of staff conducting enhanced observations for more than two hours duration. This meant there were not enough staff to ensure staff had breaks in line with best practice guidance between observations. National institute for health and care excellence guidance (NICE) NG10 states “Ensure that an individual staff member does not undertake a continuous period of observation above the general level for longer than 2 hours.”

The ward manager could adjust staffing levels according to the needs of the children and young people.

Children and young people had regular one to one sessions with their named nurse.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed. Leave may have been rearranged or delayed but no incidents of cancelled leave were recorded within the service.

The service had enough staff on each shift to carry out any physical interventions safely. Staff responded from other wards too.

Staff shared key information to keep children and young people safe when handing over their care to others. We reviewed handover records and saw that risk and incidents were included as part of this.

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. Speciality Doctors provided the first level of on call and then the consultant psychiatrists provided the second level of on call.

Managers could call locums when they needed additional medical cover. There was one vacancy for a consultant psychiatrist within the service and their role was being covered by a locum.

Managers made sure all locum staff had a full induction and understood the service before starting to work at the service.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. All courses were above 90% compliance apart from BLS which was 70% and records showed staff were booked to complete this in June and July 2022. Medicines management was 84% and clinical supervision was 87%.

Requires Improvement

Child and adolescent mental health wards

The mandatory training programme was comprehensive and met the needs of children and young people and staff. Training included autism awareness and risk training including self-harm and ligature.

Managers monitored mandatory training and alerted staff when they needed to update their training. They could access the training levels on the system, and we saw staff allocated to complete training that were due for refreshers.

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. The ward staff had regard to Mental Health Unit (Use of Force) Act 2018 and its guidance and complied with requirements.

Assessment of children and young people risk

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk was also discussed at the daily handover meetings and each young person was rag rated. The senior nurse on site, provided a summary for each ward for each shift to the members of the multidisciplinary team and the ward managers. This included incidents that had happened during the shift, action taken and any young person on enhanced observations and any safeguarding concerns. This meant staff knew which young people were presenting as higher risk and the information was shared within the daily morning multidisciplinary meeting.

Staff used a recognised risk assessment tool. The service used the START assessment of risk, areas of risk considered were risk of violence to others, suicide, self-harm, self-neglect, substance misuse, unauthorised leave and victimisation. There were also risk management plans in place for the young people whose records we reviewed.

Management of children and young people risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Risks were shared at the ward handover and the daily managers morning meeting to ensure there were enough staff to meet the needs of young people and be able to respond to incidents if needed. How to support young people was included in the care plans and one page profiles.

Staff identified and responded to any changes in risks to, or posed by, children and young people. This was reviewed twice daily on the ward and handed over to colleagues at handover.

Staff followed procedures to minimise risks where they could not easily observe children and young people. This included enhanced observations.

Staff followed the providers policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards including the requirements of the Mental Health Unit (Use of Force) Act 2018 and its guidance. The restraint and violence reduction policy had been updated to include the recently implemented legislation. There was a poster explaining blanket rules, restrictive practices and bedtimes aimed at young people. The service used the Department of Health and Social care's easy read guidance to explain the legislation to young people.

Requires Improvement

Child and adolescent mental health wards

Use of restrictive interventions

Levels of restrictive interventions were reducing for all wards except Buttercup. Physical intervention figures for the wards for the last 12 months were;

- Buttercup 454
- Mulberry 1017
- Primrose 739
- Wizard 370

Records showed that there was one young person on each ward who required high levels of physical intervention. This included young people who head banged and had sustained a previous injury and were at higher risk of injury. Their care records guided staff to intervene earlier due to their increased risk.

Staff attempted 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. However, five young people told us they felt staff intervened too quickly to restrain them. Another five young people said the intervention from staff including as and when required medicines helped and that staff understood their background and some reasons for their behaviour.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. We reviewed records and they met best practice requirements.

When a child or young person was placed in seclusion, staff kept clear records and followed best practice guidelines. We reviewed two seclusion episodes and found the records met the Mental Health Act requirements.

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

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff compliance was 98% at the introductory level training and 100% compliant at level 3.

Staff kept up-to-date with their safeguarding training.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. There was a family room just off reception which was used for visitors with children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding log which included all alerts and progress made. This was reviewed weekly at the safeguarding meeting which was chaired by the head of social work.

Staff access to essential information

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

Children and young people notes were comprehensive, and all staff could access them easily. The majority of information was held on the electronic record system. Observations were in paper and included communication summaries and one page profiles to assist staff to know how best to support children and young people.

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

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

Records were stored securely. Paper records were stored in locked offices and electronic records required individual staff log ins and were password protected.

Medicines management

The service used systems and processes to safely prescribe, administer and record medicines. However, they did not store all medicines safely. 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 and recording medicines. However, staff did not label individual young people's medicines safely. Medicines for individuals, for example, inhalers, creams and eardrops were not labelled. This meant staff did not know who the medicine was for and it could be given to the wrong young person which posed an infection control risk. There were four examples on Buttercup ward, two examples on Mulberry ward and several on the other two wards.

We discussed this with the pharmacist who used an electronic system to record their visits, actions and feedback on actions. It showed that on a "dialogue" on the system in September 2021, there was an action for Mulberry inhalers to be labelled and the response from the ward manger was that they had emailed the nurses. Although that request may have been met, this did not change practice as we found medicines which were not labelled.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. This happened within ward rounds.

Staff followed current national practice to check children and young people had the correct medicines. There was one young person who was on a high dose of antipsychotic medicine and they had a care plan in relation to this, including the review of physical health and possible side effects. There was also a high dose antipsychotic procedure in place for staff to follow.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Information was shared from the provider and within medical meetings.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed children and young people safety incidents well. Staff recognised incidents and reported them 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 used the electronic incident management system, we saw incidents were recorded in a timely detailed manner.

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

Staff reported serious incidents clearly and in line with provider policy.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, however families said to us that they did not get the investigation report or learning for lower levels incidents that did not meet the threshold of the duty of candour.

Managers debriefed and supported staff after any serious incident. The psychology department were also involved in facilitating debriefs.

Managers investigated incidents. However, causes and contributory factors were not always identified for example, one young person gained access to a blade in a pencil sharpener via an online shop. Actions were identified however no root causes or contributory factors were identified. This meant learning may not always be identified and changes in practice implemented to benefit others.

Staff received feedback from investigation of incidents, both internal and external to the service. Lessons learnt from across the provider were discussed at team meetings, divisional clinical and operational governance committee, local and regional clinical governance meetings. This meant learning was shared from different services to avoid a reoccurrence.

Staff met to discuss the feedback and look at improvements to children and young people's care. Incidents were discussed at the ward round, which was multidisciplinary and changes in care were agreed as a team.

There was evidence that changes had been made as a result of feedback. Following an incident where an agency member of staff used an incorrect holding technique, the service introduced a new role of safety interventions champion on each ward.

Requires Improvement

Child and adolescent mental health wards

Managers shared learning about serious incidents with their staff and across the service. This included monthly lessons learnt bulletins which were from the provider so learning from other services was shared. Lessons learnt bulletins included the recommendation and how staff practice had changed. The team brief was also shared with staff and this included the organisational update too.

Are Child and adolescent mental health wards effective?

Good

We rated it as good.

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.

We reviewed 17 care records. Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The GP visited regularly, there were physical health nurses available to support and the speciality doctors led on the physical health needs of young people.

Staff developed a comprehensive care plan for each child or young person that clearly identified their mental and physical health needs. Areas included personal needs, communication and social needs, mental health needs, life skills, education, restrictions, potential risk, physical health and safeguarding. Records included one page profiles, which were a person centred brief document including the young person’s photograph and how best to support them, which was helpful for staff that were not familiar with the service.

Staff regularly reviewed and updated care plans when children and young people's needs changed.

Care plans were personalised, holistic and recovery-orientated.

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. Plans identified the needs of children young people clearly and ensured that they had good access to a wide range of therapies and 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 comprehensive access to a range of care and treatment however there had been changes in workers for young people, due to not having a full complement of multidisciplinary team members.

There was a part time family therapist who could only support a limited amount of families and records showed lengthy gaps between appointments.

There was a vacancy for an occupational therapist, activity facilitator and a social worker on Mulberry ward.

Primrose ward had a vacancy for a consultant, there was a locum in place. They had vacancies for an occupational therapist, psychologist and social worker.

Buttercup ward had a vacancy for a social worker, a locum was in post.

Six family members told us their loved one had not been able to access the therapy they needed. This meant young people could not access the psychological therapy, assessment and continuity of multidisciplinary input they needed to progress in their recovery. Six family members were concerned about the lack of psychological input their loved one was receiving.

Feedback from young people and family members prior to the inspection and during the inspection was that there were high numbers of male staff on observations on the female wards. We reviewed staff rotas and staff allocations for Buttercup and Mulberry wards and found that male staff were allocated to 2:1 observations, however they were conducting 2:1 observations with the female staff and there were not two male staff conducting observations at the same time. On Buttercup ward, there was a young person in the Mulberry seclusion room on 1:1 observations and male staff conducted these for four hours on 2 May 2022.

Staff delivered care in line with best practice and national guidance. (from relevant bodies e.g. NICE) including the self-harm guidance of collaborative risk assessment. Young people told us, and records showed that the risk assessments and management plans were personalised, dependant on risk and other health needs. Where there were regular psychologists working on the wards, they offered several therapies including compassion focused therapy and dialectal behavioural therapy.

Staff identified children and young people's physical health needs and recorded them in their care plans.

Staff made sure children and young people had access to physical health care, including specialists as required. However, families told us that the service were not proactive with pursuing aid and adaptions for young people, for example hearing aids when damaged.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration. The menu was a rolling four week menu, including vegetarian, vegan and healthy food options.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. Young people had access to the gym and outdoor space.

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 the GAP (global assessment of progress) which was reviewed on admission, discharge and at governance meetings. Staff reviewed the progress made with young people and the models of care which had recently been introduced to the service to identify which stage of the recovery they were on.

Staff used technology to support children and young people. Young people, following risk assessment had access to mobile phones and tablets. Ward rounds and care programme approach(CPA) meetings took place virtually which meant family members and care coordinators could attend without the distance challenges.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Ward managers audited other wards for COVID 19 environmental audits monthly. There were two quality improvement projects; one on Buttercup to reduce the length of stay and one on Mulberry ward to reduce the number of physical interventions.

Managers used results from audits to make improvements. The use of physical interventions on Mulberry ward had reduced and was continuing to reduce following the implementation of the quality improvement project.

Skilled staff to deliver care

The ward teams did not include or have access to the full range of specialists required to meet the needs of children and young people on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service did not have a full range of specialists to meet the needs of the children and young people on the ward. There were vacancies for a lead social worker and social worker, two occupational therapists, a psychologist and a consultant psychiatrist. However these posts had been recruited to. There was a locum consultant and a locum social worker covering two wards. Psychologists from the neighbouring adult service had been providing some support to the wards however, due to changes in staff, young people were not receiving continuity of care. However, there were two speech and language therapists within the service, providing assessments, input into the positive behaviour support planning process and reasonable adjustments to ensure information was accessible for young people. We saw accessible mood cards in place, to help young people communicate how they were feeling and communication grab sheets for staff to know how best to communicate with young people.

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. Bank and agency staff now accessed autism training. The recruitment agreement with agencies included the training requirements which aligned with the providers mandatory training.

Managers gave each new member of staff a full induction to the service before they started work. There was an induction policy in place and a corporate induction for bank and permanent staff which was three weeks duration and included an introduction to the service, health and safety, mental health awareness, physical intervention, security, professional boundaries, spending time on the ward, BLS, service user engagement and eLearning.

Managers supported staff through regular, constructive appraisals of their work with 97% completed.

Managers supported staff through regular, constructive clinical supervision of their work with 89% compliance for clinical supervision and 93% for managerial supervision. The supervision policy included frequencies of supervision with clinical supervision monthly and managerial three monthly.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Managers tried to offer a couple of meetings a month at different times to try to engage with both shift codes. For staff that could not attend the meetings, minutes were emailed to them.

Managers made sure staff received any specialist training for their role. The service was supporting five autistic young people. They provided autism training at level one, which was eLearning with 93% compliance and level two, which was face to face learning with 66% compliance. The courses were interactive and informative.

Managers recognised poor performance, could identify the reasons and dealt with these. Examples included concerns about agency staff practice, which had been fed back to the agency and resulted in staff not working at the service.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit children and young people. There were vacancies within the multidisciplinary team which meant children and young people had gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. Meetings took place weekly, however the frequency that each young person was discussed depended on the ward. For example, young people on Wizard house were reviewed weekly as it was a general ward with shorter length of stays and the low secure ward staff discussed young people monthly. Staff also held care plan review meetings to discuss the documentation and goal setting. We observed five ward rounds for Primrose, Buttercup and Mulberry wards. Young people completed my say forms prior to the meeting with requests and their view of how they were doing which were discussed within the meetings. Medicine was discussed and staff explored if young people understood what medicines they were on and why. Families, commissioners, and other members of the multidisciplinary teams were involved in the meetings.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. We reviewed handover records and found they were detailed and included observation levels, leave, risk rating, restrictions, presentation, incidents, meaningful activity, physical health and positive words.

Staff were implementing safe wards and some elements of that were visible in the wards, including picture boards at the ward entrance with the pictures of staff members and their roles, positive words and inspirational thoughts for the day were visible on Mulberry ward.

Ward teams had effective working relationships with other teams in the organisation. We saw staff interacting with the catering department and examples of staff moving wards to assist other wards that were short staffed.

Ward teams had effective working relationships with external teams and organisations including care coordinators, local GPs and acute hospitals.

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. Mental Health Act awareness training compliance was 100%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. There was a team of Mental Health Act administrators at the hospital.

Staff 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. Policies included the segregation policy which had been reviewed to include the Use of Force Act too.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. Information on the advocate and how to contact them was displayed in the wards. Young people told us the advocates visited the wards regularly.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time.

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.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children 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. Mental Capacity Act training compliance was 100%.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. There was also a policy in place regarding information sharing with parents and carers.

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. The speech and language therapists provided information in alternative formats that were accessible for the young person.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision.

Requires Improvement

Child and adolescent mental health wards

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. Examples included a young person's dietary intake.

Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations.

Staff knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this. This was included in the Mental Capacity Act and advanced decisions guidance.

Are Child and adolescent mental health wards caring?

Good

We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for children and young people. We saw staff talking to young people in quiet areas of the ward. Our short observation for inspection (SOFI) observations on Mulberry ward showed staff were showing warmth, collaboration, acknowledgement, acceptance, genuineness and facilitation, all of the interactions were positive. On Wizard House staff were validating to the young people, respectful and acknowledging, all of the interactions were positive. However, on Buttercup ward staff were talking about their personal lives and ignoring the young person they were supporting on four occasions although the other 13 interactions were positive, including staff showing warmth, acceptance, respect, acknowledgement and facilitation. The service had a professional boundaries policy and professional boundaries training was included as part of the induction, the training stated that staff should "Never- discuss your personal life, your personal health (mental, physical emotional) with service users." This meant staff were not following this on Buttercup ward.

Staff gave children and young people help, emotional support and advice when they needed it. We observed staff playing cards with young people, doing arts with young people and chatting with young people. Staff explained to young people why they couldn't have access to certain items, for example pencil sharpeners.

Staff supported children and young people to understand and manage their own care treatment or condition. The service had recently introduced the models of care to the service with phase 1 -assessment and engagement, phase 2 - formulation and treatment and phase 3 - transition and discharge. Young people were able to tell us where they were on their recovery journey in relation to the model of care.

Staff directed children and young people to other services and supported them to access those services if they needed help.

Requires Improvement

Child and adolescent mental health wards

Children and young people said staff treated them well and behaved kindly, particularly the regular staff that they knew well. Young people said for some of the staff who were not regularly on their ward, including bank and agency staff, they were not as responsive to their needs.

Staff understood and respected the individual needs of each child or young person. One page profiles were in place for each young person and a communication grab sheet which were an abbreviated version of their positive behaviour support plan. These documents provided staff with a person centred resource of how best to support them.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people.

Staff followed policy to keep children and young people's information confidential. Staff allocation sheets used initials so that personal data was not shared. Staff who were carrying out the general observations had the observation file that they kept with them at all times. Young people's records were either stored electronically on the electronic record which required a password to access or were in a locked room, including the clinic and staff office.

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. Young people told us how they were shown around the ward, introduced to other young people and were told about the running of the ward and what to expect.

Staff involved children and young people and gave them access to their care planning and risk assessments. A welcome booklet had been created however, this was not up to date and did not include the change in bed numbers on Wizard House or information about how to complain.

Staff made sure children and young people understood their care and treatment (and found ways to communicate with children and young people who had communication difficulties). The speech and language therapists adapted information to make it more accessible for young people with communication needs, including use of symbols and plain English.

Staff involved children and young people in decisions about the service, when appropriate. In the community meetings young people contributed to the ideas for venues for community leave.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. Weekly community meetings took place and monthly people's council meetings. Both young people and staff attended the meetings, young people had an opportunity to share their views and experiences and create actions. This included discussing staffing, activities, repairs and ensuring staff were aware of observation levels of young people.

There had been a survey conducted between March 2020- April 2021, there was an action plan created and progress had been made with the actions. Actions included a pay review, training refreshers, review support for international staff, promote the freedom to speak up guardian role and refurbish the staff rooms and toilets.

Requires Improvement

Child and adolescent mental health wards

Staff supported children and young people to make decisions on their care. Young people completed My Say forms before their ward rounds and staff discussed their requests in the meetings and gave answers to the requests including the reason for their decision making. Young people attended their ward rounds if they wanted to and they were included and consulted in changes in their care.

Staff made sure children and young people could access advocacy services. Information was on display on the wards and young people told us they accessed the service.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. A carers welcome booklet had been created with useful information for carers including restricted and banned items, visiting arrangements and advocacy information.

Staff helped families to give feedback on the service. Parent and carer forums were held monthly on Mulberry and Buttercup wards, topics included clinical models of care, medication and side effects, role of occupational therapy and psychology, complaints and compliments, safeguarding and restricted Items. Within the forums people were asked what is going well? and what is not going well/what can we do better? Feedback from families resulted in an action plan. The forums had been held over virtual means, this meant families who lived a distance away could attend. Wizard House and Primrose ward were planning on trying to re-introduce these forums too as they had been tried unsuccessfully previously.

Staff gave carers information on how to find the carer's assessment. Staff also told families how they could apply for the reimbursement of travel costs if eligible.

Are Child and adolescent mental health wards responsive?

Good

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. As a result, children and young people did not have to stay in hospital when they were well enough to leave.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to.

The service had several out-of-area placements. Families we spoke to had to travel for several hours to visit their loved one. We saw examples of young people being transferred to a hospital closer to home when a bed became available.

Managers and staff worked to make sure they did not discharge children and young people before they were ready. Regular reviews took place and the models of care helped to identify young people's recovery journey and when they were ready for discharge.

When children and young people went on leave there was always a bed available when they returned.

Children and young people were moved between wards during their stay only when there were clear clinical reasons, or it was in their best interest. Examples included young people who may have deteriorated, moving from Wizard House the general acute ward to Primrose, the PICU.

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

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. Mulberry ward had one delayed discharge due to difficulties finding a move on placement for the young person. Wizard House had one delayed discharge however, a placement had been identified.

Children and young people sometimes had to stay in hospital when they were well enough to leave. This was usually because an appropriate community placement could not be identified.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. This was discussed in ward rounds and at care programme approach reviews.

Staff supported children and young people when they were referred or transferred between services. Information was shared with services and staff explained to young people what would be happening and would support with the transfer too.

The service followed national standards for transfer.

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 with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Young people told us the food was not good quality and children and young people could not make hot drinks and snacks at any time.

Each or young person had their own bedroom, which they could personalise. We saw examples of personal belongings in young people’s rooms. Some young people had put their preferences on their bedroom doors to communicate with staff.

Children and young people had a secure place to store personal possessions. Storage was available in their rooms and they also had security cupboards to secure store restricted items.

Staff used a full range of rooms and equipment to support treatment and care. A gym was available for staff to support young people to use. Staff received a gym induction at the staff induction, to ensure they could support young people to use the equipment safely. Wards had activity rooms for arts and crafts and a sensory room with light projectors and interactive features which all wards had allocated time to access. Occupational therapy kitchens enabled young people to develop their cooking skills and prepare meals. There was the communal treetops area off the ward with pool tables and seating which young people could access with staff.

Areas of the wards had chalked sections to enable inspirational quotes, plans, activities and creative art to be displayed.

Primrose ward had their notice boards and artwork damaged and removed from the walls, this meant the ward was very bare. The ward manager explained the plans of more sturdy wall coverings and art that were going to be installed.

On Buttercup ward we saw, and young people told us that the sensory room was decorated in a childlike manner, the dining room was quite sparse and unwelcoming.

The service had quiet areas and a room where children and young people could meet with visitors in private. There was a family room just off reception and this could be booked for visits. There were spaces on the ward that could also be used for visiting.

Children and young people could make phone calls in private. Young people had their own mobile phones, subject to a risk assessment. We saw the majority of young people with access to their phones.

The service had an outside space that children and young people could access easily. Young people had to ask staff to facilitate outside access, mainly due to observations.

Children and young people could not make their own hot drinks and snacks, they asked staff to facilitate this. There was a water cooler on each ward however, cups were not available next to the unit and young people had to ask staff for a cup on Buttercup and Mulberry wards due to the risk. However, on Primrose ward, young people could make drinks and snacks if risk assessed as safe to do so. Young people could access the occupational therapy kitchen on Wizard House.

The service offered a variety of food. Eight of the 19 young people we spoke to said the food was unhealthy, with chips available at most meals. Two young people on Wizard House had found ants in their food. Young people also said there was limited vegetarian and vegan food choices. We reviewed the menus and found the menu included vegetarian, vegan and healthy food options. Chips were not served with every meal.

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, work, and they supported them. There was a school within the service which young people with leave went to. For those young people who were very unwell or did not have leave, the education team visited the ward to offer education to young people. The teaching staff liaised with the education in the home area for young people and arranged for them to sit their GCSEs if they were of the age.

Staff helped children and young people to stay in contact with families and carers. Staff rang families daily to provide an update on their loved one's day and update on any incidents and progress made. However, some young people had declined for families to receive regular updates. For young people over the age of 16, if they were deemed to have capacity to make that decision, then the staff respected this. If there was any occasion where staff went against a young person's wishes, this was done in their best interest.

Families visited their loved one, this usually took place in the family visiting room, of if the young person had leave, the young people also went out with family.

Young people kept in contact with family via their mobile phones too and could use video calling too.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. At times, the dynamics of the wards meant that young people had disagreements, staff tried to manage this by mediation and discussions during the community meetings regarding expectations.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The wards on the ground floor were accessible to people with mobility difficulties, and there was a lift to the upstairs wards.

The speech and language therapists has developed communication aids for young people who found it difficult to communicate verbally at times, these included symbols, talking mats, easy read medicines information, easy read mental health awareness information including anxiety, depression and social stories to help explain how to respond in certain situations,

Communication grab sheets were in place which included how people communicated, how people made choices and decisions, important thing people should know and how to help the person.

The accessible information standard applies to people who have information or communication needs relating to a disability, impairment or sensory loss. This includes learning disability and autism. The requirements are that staff should identify people with information or communication needs, record the needs, flag the needs on the system to alert other staff, share the information with other health and social care services and then meet their needs. Although the service had developed a variety of communication methods to support young people and had created communication grab sheets, the elements of the accessible information standard were not recorded within the care record.

An LGBTQ+ group had been set up for young people to explore their sexuality, learn about the history and ask questions. This group was open to people who identified as LGBTQ+ and their allies.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain. Information was on display on the ward and resources were available to print off for the different needs of young people.

The service had information leaflets available in languages spoken by children, young people and the local community. Information was in English, the young people at the inspection spoke English. The service had access to translation services to support families with reports written in their own language, and interpreters available for ward rounds and CPAs.

Managers made sure staff, children and young people could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. The menus showed a variety of dishes with food from different origins.

Children and young people had access to spiritual, religious and cultural support. There was a multifaith room and faith leaders could visit the service as required. Young people could also access places of worship if their leave allowed.

Requires Improvement

Child and adolescent mental health wards

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.

Children, young people, relatives and carers knew how to complain or raise concerns. However, four of the 19 young people did not know how to complain to the service.

The service clearly displayed information about how to raise a concern in children and young people areas. How to complain information was displayed including contact details for the CQC, there were easy read versions of the complaints policy available and leaflets about complaints and compliments.

Staff understood the policy on complaints and knew how to handle them. There was a complaints department who investigated and oversaw complaints, young people received an outcome letter at the conclusion of the complaint.

Managers investigated complaints and identified themes. The service had a complaints log which recorded the number and nature of the complaints, the outcome, recommendations and whether the complaint was upheld or not. This meant the service had good oversight of complaints.

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 did not share feedback from complaints with staff. We reviewed team meeting minutes and found that they did not include complaints. The complaints policy stated, “The learning outcomes from complaints, will also be shared at staff meetings.” This was not happening. However, complaints were discussed at the Forestwood governance meetings and the regional operations governance meeting.

The service used compliments to learn, celebrate success and improve the quality of care. Compliments were recorded by number and nature. Minutes showed these were shared with staff at team meetings.

Are Child and adolescent mental health wards well-led?

Requires Improvement

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.

Leaders provide clinical leadership. The registered manager was visible within the service and was a strong responsive leader. However, Buttercup did not have a ward manager and there was a team leader acting up into the role. Mulberry’s ward manager was leaving to manage a new service. This meant there were gaps within the leadership of the wards although staff acting up were in the process of shadowing experienced managers.

Requires Improvement

Child and adolescent mental health wards

Most leaders had the skills, knowledge and experience to perform their roles. The registered manager and ward managers of Wizard House and Primrose had worked at the service for several years and had attended several training courses and peer support in relation to leadership and management.

The organisation has a clear definition of recovery and this is shared and understood by all staff. The models of care had been introduced and they had been tailored to the type of service, there were versions for the low secure wards and acute and PICU services. Staff and young people were becoming more familiar with these and they were referred to in ward rounds and reviews.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Daily morning meetings took place with the ward managers, consultants and members of the multidisciplinary team. Ward managers updated on the previous 24 hours within their ward, incidents and events that had happened, challenges and how they were going to address them. Others present in the meeting offered support, including in relation to staffing.

Leaders were visible in the service and approachable for children and young people and staff. The registered manager was very visible on the wards and staff and young people told us that the hospital director also visited the wards. Leaders attended the people's council where young people had the opportunity to feedback directly to them.

Vision and strategy

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

Staff know and understand the vision and values of the team and organisation and what their role is in achieving that. The providers values were; care, respect, empower, trust and integrity. These were interwoven through the organisational induction. Any behaviours that fell short of the values were addressed with staff and concerns were discussed at team meetings.

All staff have a job description, we reviewed four staff personnel files and they all had the required recruitment checks completed.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Discussions took place at team meetings and governance meetings. Updates were provided with changes to the neighbouring services that were based on the same site.

Staff could explain how they were working to deliver high quality care within the budgets available. Budgets were discussed at the divisional clinical and operational governance meeting which the hospital director attended, challenges highlighted were the high use of agency staff.

Culture

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

Staff felt respected, supported and valued. Staff we spoke to felt supported and valued, they were positive about career progression. A staff survey had been completed however, this incorporated the other two services on the site.

The staff were mainly positive and satisfied however, some staff were experiencing stress at work, this related to staffing challenges and dynamics of young people and their family circumstances. Additional supervision and reflective practice had been offered to staff. Recruitment was underway for vacancies. The service offered peer support from staff who were trained in trauma risk management and sustaining resilience at work. There was a national lead to oversee the roll out and leads in the North, Midlands and South. The provider was developing resources for staff to promote the service and explain the support available.

A review of the exit interviews for the last 12 months of staff leaving the service showed the highest reason for people leaving as better pay and conditions. The service had improved the pay and conditions in the last six months. The next highest reason was the role being unsuitable, the recruitment process had changed to ensure that staff had previous experience of working in the sector to be shortlisted. The meant the service were listening to feedback from staff to try to improve staff retention and staff's employment experience.

The provider recognised staff success within the service – for example, through staff awards. Star of the week was awarded to a staff member and a young person, this was agreed in the community meetings.

Staff told us they felt valued at a team level, however, did not always feel valued by the organisation..

Staff felt positive and proud about working for the provider and their team.

Staff appraisals included conversations about career development and how it could be supported.

The service responded proactively to bullying and harassment cases. Staff we spoke to had not experienced any bullying or harassment.

Staff had access to support for their own physical and emotional health needs through an occupational health service. This included access to a GP 24/7, employee assistance programme and wellbeing portal.

The staff survey did monitors morale, job satisfaction and sense of empowerment however this was at a site level and included the other two service. The next staff survey was going to be completed at a location level.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES) were reviewed however this was at provider level. Members of the multidisciplinary team told us they had progressed in their role at the service and had access to leadership and development training. For support workers, there were senior support worker roles that they could progress to and for registered nurses, they could progress to team leaders.

Teams worked well together and where there were difficulties managers dealt with them appropriately. Observations of staff interactions was that they were working well as a team, supporting each other, staff were confident at approaching others for support. Staff responded to incidents on other wards.

Governance

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

The governance policies, procedures and protocols did not ensure that actions identified by the pharmacist's audit were implemented and sustained in relation to the labelling of young people's medicines.

Requires Improvement

Child and adolescent mental health wards

The oversight of the service did not ensure that the wards were well maintained and received regular deep cleans.

Staff had not implemented recommendations from reviews of deaths, incidents, complaints, whistle blowing's and safeguarding alerts at the service level. The service had not ensured that the recommendations from the provider level whistle blowing regarding paediatric resuscitation were fully implemented.

The service had ensured that they were complying with the Mental Health Unite (Use of Force) Act 2018.

The service had not ensured that staff were following the dress code and professional boundaries policies.

There was a clear framework of what must be discussed at a facility, team or directorate level in team meetings to ensure that essential information, such as learning from incidents was shared and discussed. However, findings and learning from complaints was not discussed at team meetings.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. Care records were completed to a high standard. Staff complied with COVID 19 IPC guidance in relation to wearing of masks, these were audited.

Data and notifications were submitted to external bodies and internal departments as required. Statutory notifications were received regularly from the service for reportable incidents. The service informed commissioners of relevant incidents too.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the children and young people. Regular updates were provided to home teams and commissioners and they were involved in the young people's reviews.

The service has a whistle blowing policy in place which staff were aware of.

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.

There was a clear quality assurance management and performance frameworks in place that were integrated across all organisational policies and procedures.

Staff maintained and had access to the risk register at facility or directorate level. Staff at facility level could escalate concerns when required. There was a service level risk register which ward managers could contribute to. Risks included use of restraint, poor response from staff on response, high agency use, with actions of how to address these. This meant the service were aware of some of the concerns we had about the service.

Staff have the ability to submit items to the provider risk register. Risks were escalated to a senior level at the divisional clinical and operational governance meeting where the corporate risk register was discussed.

Staff concerns matched those on the risk register. In relation to staffing and high levels of agency use. Also, the response from staff to support other wards during an incident.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

The service monitored sickness and absence rates. These were reviewed at a ward level and ward managers took appropriate action with the support of human resources. Information was also held at a service level. The last three year's absence was severely affected by COVID19.

Where cost improvements were taking place, they did not compromise children and young people's care. Budgets were discussed at the divisional clinical and operational governance meeting, an area of focus was the reduction of agency staff, this would also benefit the young people by having more consistency. The provider had improved the terms and conditions of employment for permanent staff with the aim of improving staff retention and the interest in applying for permanent roles.

Information management

Staff engaged actively in local and national quality improvement activities.

The service used systems to collect data from facilities and directorates that were not over-burdensome for frontline staff. Information was extracted from incident reporting systems and electronic care records.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, ward staff were responsible for answering the phones and if they were supporting people on the ward, this meant calls may be unanswered which was feedback re received from a few families.

Information governance systems included confidentiality of children and young people records. There was information sharing policies and procedures in use too.

Ward managers had access to information to support them with their management role. This included information on the performance of the service, staffing and children and young people care. They could access all electronic systems and the handovers were saved on the computer system too.

Information was in an accessible format, and was timely, accurate and identified areas for improvement. Ward improvement plans had been developed for Mulberry regarding reducing restraints and increasing activities in an evening and a weekend. Primrose had a ward improvement plan to focus on the recruitment of a full multidisciplinary team, reducing restraints and increasing activities in an evening and a weekend.

Staff made notifications to external bodies as needed. This included statutory notifications to CQC.

All information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it. Paper records were stored in locked offices and access to computers and electronic record systems required passwords.

The service had developed information-sharing processes and joint-working arrangements with other services where appropriate to do so. This included the local authority and LADO (Local authority designated officer) for safeguarding purposes and commissioners and home teams regarding progress with young people.

The service ensured service confidentiality agreements were clearly explained including in relation to the sharing of information and data. Polices were available and conversations took place with families to explain the young person's decision.

Requires Improvement

Child and adolescent mental health wards

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.

Staff, children and young people and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, newsletters and so on. Externally there was a website and internally there was an intranet for staff to access. Staff received the team brief which was a service update and lessons learnt bulletins which was from the provider level and included learning from other locations too.

Children and young people had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Young people attended the community meetings on the ward and people's council for the service and questionnaires were completed annually however, these were not at service level. One to one discussions also took place between young people and staff. Young people also gave feedback to the independent advocate who raised this with the service on their behalf. This meant young people had a variety of ways of giving feedback.

Carers had the opportunity to feedback on Mulberry and Buttercup wards at the carer's meetings, however these did not take place on Wizard House and Primrose. Families told us they had not been asked for feedback about the service unless it was within the young people's reviews. This meant that families were not actively involved in providing feedback for all wards.

Children and young people and staff could meet with members of the provider's senior leadership team and governors to give feedback. This happened at the people's council meetings.

Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch. There was a Greater Manchester CAMHS Lead Provider Collaborative who was the main contact for the service in relation to commissioning.

Learning, continuous improvement and innovation

The organisation encouraged creativity and innovation to ensure up to date evidence based practice is implemented and imbedded. However, due to vacancies for members of the multidisciplinary team this was not fully imbedded.

The service assessed quality and sustainability impact of changes including financial.

All staff have objectives focused on improvement and learning. This was as part of their supervisions and appraisals.

The service had a staff award/recognition schemes. Young people were involved in identifying the star of the week.

Mulberry, Buttercup and Primrose wards were accredited by the Quality Network for Inpatient CAMHS, managed by the Royal College of Psychiatrists. The accreditation meant that the wards were deliver care that met best practice. The accreditation process includes an external review of care and treatment by a panel of experts within CAMHS on the young people's experience, parents and carer's engagement, environment and staffing requirements. All wards had participated in the annual Quality Network for Inpatient CAMHS reviews in 2021.

Wizard House had completed a peer review with Quality Network for Inpatient CAMHS in 2022 in preparation for applying for accreditation. This meant the ward were striving to deliver care that met best practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Individual medicines were not labelled in line with legislation. This may lead to misadministration or infection.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The environment was not clean and well maintained and damage to the environment was not addressed promptly.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Governance processes did not ensure that actions from investigations were fully implemented. For example, the service did not have in use the up to date policy and related practice regarding paediatric resuscitation. Managers did not ensure that staff followed policies in relation to dress code and professional boundaries. Managers did not ensure that actions following medicines audits were fully imbedded and sustained.