Active Young People Limited

Ivetsey Bank Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Ivetsey Bank Hospital, formerly known as Huntercombe Hospital Stafford, is a child and adolescent mental health service for 37 male and female children and young people aged 12 to 18 years. At an inspection in October 2021 this service was placed into special measures as we found the service to be inadequate overall. We inspected again in September 2022 and found some improvements. However, we again inspected in November 2022 based on concerns that were raised with the CQC. We issued a Warning Notice to ensure that our immediate concerns were addressed and the service remained in special measures.

At this inspection, we found the service had made improvements against the Warning Notice, however we did identify other areas of concerns and have taken further enforcement action. The service remains in special measures.

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

Staff were not always following the Rapid Tranquilisation policy; physical healthcare observations were not always completed after rapid tranquilisation was used.

Staff were not always managing young people's physical health needs. Paediatric early warning scores (PEWS) were not always completed correctly, and staff recorded repeated entries of 'refused' for weeks at a time without escalation to the multi-disciplinary team.

There were gaps in electronic records and it was difficult to access young people's records.

Young people told us staff did not offer debriefs after incidents had occurred.

Young people did not receive weekly one to one sessions with their named nurse.

Young people did not receive 25 hours of therapeutic intervention each week in line with NHS England guidance

Staff did not always manage dynamics between young people within the wards; young people said this made them feel unsafe.

Families and young people raised concerns about the lack of experience of some staff working on Wedgewood specialist eating disorders unit.

Staff did not always respect a young person's preferred name and pronoun on Wedgwood.

Staff did not regularly check emergency equipment was in working order.

Young people did not have regular access to outside space.

Young people and family did not always feel involved in their care.

However:

Summary of findings

Staff now completed body maps after incidents where young people had sustained injuries after incidents of restraint. Staff now completed neurological observations after incidents of headbanging.

Staff now updated risk plans after incidents.

The provider ensured young people were given to opportunity to raise sexual safety concerns with the police and staff raised these with the local authority for external investigation.

The provider now ensured staff received training workshops on safeguarding and boundaries and used specifically developed crib sheets to identify potential safeguarding concerns.

Closed Circuit Television (CCTV) footage reviewed showed staff applied least restrictive principles when restraint was required to maintain safety.

Staff now completed personalised positive behavioural support plans for young people with a dual diagnosis of autism, which meet the guidance within the Mental Health Act 1983: Code of Practice. Closed Circuit Television reviewed showed staff followed positive behavioural support plans to de-escalate incidents when they occurred. The provider had recruited a full-time psychologist to work on site at the hospital. The provider ensured young people who had a preferred gender of staff delivering care were receiving this. Staff received a written handover for each shift and this information was included.

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 Ivetsey Bank Hospital

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

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

Ivetsey Bank Hospital consists of 3 wards: Hartley, Thorneycroft and Wedgewood.

Hartley ward is a psychiatric intensive care unit (PICU) providing 12 beds. The PICU offers care to children and young people suffering from mental health problems who require specialist and intensive treatment. There is an additional bed in the extra care area which is attached to the ward. The extra care area is used for young people who require long term segregation to manage their care needs. This area was in use at the time of our inspection.

Thorneycroft ward is a general child and adolescent mental health (GAU) unit with 12 beds for young people aged 12 to 18 years. The children and young people treated there have a range of diagnoses from psychosis and bipolar disorder to depression.

Wedgewood ward is a specialist eating disorder unit (EDU), which provides services for 12 children and young people. The children and young people treated here have a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or other disordered eating conditions.

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

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

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury

We previously inspected the service in November 2022. At that inspection, we undertook an unannounced focussed inspection following concerns raised around patient safety of the following key questions:

• Are services safe?

• Are services caring?

• Are services well-led?

We rated the service as inadequate for providing safe and well led services, and requires improvement for providing caring services.

We rated the service as inadequate overall and served 4 Warning Notices for breaches of Regulations 9,12,13 and 17 in December 2022.

Summary of this inspection

At this inspection we carried out an unannounced comprehensive inspection and reviewed progress made within the Warning Notices served to the provider at the previous inspection. We visited the site between 6 and 7 June 2023 and inspection activity continued until the 16 June 2023, when we returned to review further Closed Circuit Television evidence.

What people who use the service say

We spoke with 11 children and young people who use the service and 9 family members and carers:

Young people told us they did not have enough access to fresh air, and this was due to a lack of staff to escort them off the ward. They said they did not receive weekly one to one sessions with their named nurse, and they did not receive debriefs from staff following incidents, including incidents of restraint.

Young people on Thorneycroft said they sometimes felt unsafe due to poorly managed dynamics between them.

Young people and their families said there was not enough access to therapeutic interventions, and they said staff were not always experienced in treating eating disorders on Wedgewood ward.

Families said they did not always receive feedback after raising a complaint, and they were not routinely invited to attend multi-disciplinary team meetings and when they tried to join remotely it was difficult to participate.

However, the young people said some staff were kind and engaged in activities with them and most families said they felt their young person was safe.

How we carried out this inspection

This inspection was an unannounced, comprehensive inspection.

We were on site for 1 day, telephone interviews with staff and analysis of data and information sent to us by the provider was reviewed in the week following inspection.

Our inspection team comprised 2 inspectors, a specialist advisor nurse and an expert by experience, this is a person with lived experience or who has cared for someone with experience of using a child and adolescent mental health service (CAMHS).

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information. During the inspection, the inspection team:

- visited all 3 wards and the extra care area, looked at the quality of the environment and observed how staff were caring for children and young people
- spoke with 11 children and young people who were using the service
- spoke with 9 family members and/or carers of children and young people using the service
- spoke with the matron, a doctor, and ward managers for 2 wards
- spoke with 12 other staff members including, nurses, support workers and therapists
- looked at 8 care and treatment records of children and young people
- looked at 11 prescription cards

Summary of this inspection

- carried out observations on all 3 wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

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

Action the service MUST take to improve:

- The provider must ensure Rapid Tranquilisation policy is followed, and that physical health observations are monitored following administration of sedative medications. (Regulation 12 (2)(b))
- The provider must ensure Paediatric Early Warning Score (PEWS) are monitored and recorded in accordance with young people's care plans, and where clinically indicated. (Regulation 12 (2)(b))
- The provider must ensure young people are offered debriefs following incidents. (Regulation 12 (2)(b))
- The provider must provide sufficient therapeutic intervention to meet young people's needs in line with nationally recognised guidance. (Regulation 9 (1))
- The provider must ensure young people admitted to Thorneycroft have regular access to outside space, that this is included within risk assessments and care plans with regard given to those with informal status, in line with the requirements of the Mental Health Act. (Regulation 12 (2)(b))
- The provider must ensure systems are in place for checking emergency equipment are followed and completed by suitably qualified staff. (Regulation 17 (2)(b))
- The provider must ensure the interim electronic record system is fit for purpose, with a robust plan to transfer records stored within the interim system into care notes. (Regulation 17 (1))

Action the service SHOULD take to improve:

- The provider should ensure that young people's gender and pronoun preferences are respected at all times, including in care records. (Regulation 9)
- The provider should ensure family members and carers feel involved in the child or young person's care and treatment. (Regulation 9)
- The provider should ensure families and young people are receiving timely feedback from complaints that are made. (Regulation 17)
- The provider should continue to take measures to ensure young people do not feel unsafe due to bullying and intimidation. (Regulation 12)
- The provider should audit its offer to young people of one to one weekly sessions with their named nurse. (Regulation 9)
- The provider should review the content of its eating disorder mandatory training, and how this is embedded within the service. (Regulation 18)

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Child and adolescent mental health wards

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

Is the service safe?

Requires Improvement

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

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. However, some staff were not following infection and prevention control measures. Staff did not always check emergency equipment and emergency use drugs or check and clean clinic equipment.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. A staff member was allocated at the start of the shift to complete environmental and security checks. Ward managers were alerted to any concerns raised. Maintenance attended where required.

Staff could observe children and young people in all parts of the wards. Blind spots on ward areas were mitigated using convex mirrors or through enhanced observations. Hartley and Thorneycroft had Closed Circuit television in use, Wedgewood did not have access to Closed Circuit television. Hartley unit also had an enhanced visual technology system in place for 2 of the bedrooms, to assist in enhanced monitoring.

The ward complied with guidance and there was no mixed sex accommodation. All 3 wards had single sex bedroom corridors and separate bathrooms.

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

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe.

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

Requires Improvement

Child and adolescent mental health wards

Maintenance, cleanliness, and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. This was an improvement since the last inspection.

Staff made sure cleaning records were up-to-date and the premises were clean. All wards had undergone a schedule of deep cleaning since the last inspection, including bedrooms. Daily cleaning checks were completed. Audits were in place to monitor the cleanliness of the service.

Staff did not always follow infection control policy, including handwashing. Some staff were not adhering to 'bare below the elbows' according to monthly audits in February and March 2023. Staff were compromising the provider's infection prevention and control measures in place to prevent the spread of pathogens. The audit identified 2 actions; staff were to receive education on the principles of hand hygiene and warning letters if required. The May 2023 audit of hand washing was incomplete, 9 staff were assessed but none were audited for bare below the elbow. However, the audit summary reported staff still needed more awareness regards bare below the elbow.

Seclusion room

The Seclusion room allowed clear observation and two-way communication. It had a toilet and a clock. Staff used a projector so young people could watch films projected on to the wall whilst in seclusion.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs, however staff did not always check these regularly. Staff on Thorneycroft were not checking emergency equipment and medicines daily as required, there were 3 days missing in April 2023 and 2 days missing in May 2023.

Clinical tests, such as urinalysis sticks, were all in date, an improvement from the previous inspection.

Safe staffing

The service mostly 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.

Staff were supported by a buddy system and the service provided guidance for buddies. The provider recruited staff through an international scheme. These staff were offered a financial package which included 3 months accommodation and a welcome food package for one week.

The service had reducing vacancy rates for healthcare assistants (HCA) but not nursing staff.

Five nurses had been recruited in the past 6 months. The HCA vacancy rate reduced over 6 months from 61% of substantive posts recruited to in December 2022 to 81% of staff in post in May 2023. The service recruited 77 HCA in the past 6 months with a further 20 substantive staff to start post in July and August. However, the nurse vacancy rate had not improved over 6 months, in December 2022 substantive nurse vacancies were 57% compared to 53% in May 2023.

The service did not have a reducing rate of bank and agency nurses, but did have a reducing rate for HCAs. The service had recruited 4 cohorts of international nurses and HCAs started at the service recently. Most HCA shifts were completed by permanent staff. For example, in May 2023 permanent HCAs covered 78% of overall staffing, 4% were bank staff and agency 17%. However permanent nurses covered 55%, 1% were bank nurses and 44% were agency. Young people were familiar with most agency staff as they were block booked and well known to the service.

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

In the 12 months prior to the inspection HCA turnover was 23%, for nurses it was 27%.

Managers supported staff who needed time off for ill health.

Levels of sickness remained the same. From January to March 2023 nurse sickness levels were 6% and HCA was 9%. For April and May 2023, the nurse sickness rate was 8% and HCA was 9%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift.

Ward managers could adjust staffing levels according to the needs of the children and young people.

Children and young people did not always have regular one to one sessions with their named nurse. Staff told us one to one sessions should take place at least weekly however that this was not met currently. Five young people said they did not get regular one to one time with their named nurse. Agency staff who were well known to the service acted as named nurse to young people. Young people were not having focused therapeutic interaction with their named nurse impacted collaborative care planning and identifying goals. A ward manager told us this was difficult to audit with the current care record system not being able to filter searches.

Children and young people rarely had their escorted leave cancelled, however they said there were not always enough activities. Seven young people on Wedgewood said there were not enough activities on the ward. Leave was not cancelled because of staffing. Four young people on Thorneycroft said there were not enough activities and opportunities to access to fresh air. Staff were required to escort young people from the first floor down into the gardens and there was not always enough staff on shift to do this. A system was in place for young people to gain access to their own fob following a risk assessment, however in 6 months prior to the inspection, no young person had access to a fob, including those who were informal. However, 2 young people on Hartley said there were enough activities, one spoke highly of the occupational therapy team, saying they were proactive in helping them build up skills and were visible on the unit. During the inspection we saw activities taking place in the gardens and basketball area.

The service had enough staff on each shift to carry out any physical interventions safely. There were enough staff supporting young people and each other during the 10 incidents we reviewed on CCTV.

Requires Improvement

Child and adolescent mental health wards

Staff shared key information to keep children and young people safe when handing over their care to others. We observed handovers to be thorough, the written handover report was detailed. Staff had a 'must go through' list at the start of each handover which included themes from incidents, audits, and security prompts. Handovers also included the young person's preferred pronoun, gender preference for staff completing observations, current risks, and MDT care plan.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

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

Each ward had a consultant and associate specialist doctor.

Mandatory training

Staff had mostly completed and kept up-to-date with their mandatory training.

Staff compliance rates for mandatory training varied. Overall rates within the service for basic life support and immediate life support, datix (incident reporting), PRICE (physical intervention), safeguarding level 3 adult and children, and patient search were over 80%. Four staff were trained to safeguarding children level 4. However, fire evacuation and safety, moving and handling were below 75% for the service. Supportive engagement and therapeutic observation was mandatory however only 24% of staff had completed this on site, with the lowest compliance on Wedgewood at 10%. Six young people on Wedgewood said not all staff interacted with them when they were distressed. Two families said interaction from staff was not consistent. Only 69% of staff completed eating disorders training. The service told us moving and handling compliance was low due to a change in its requirement, and supportive engagement and therapeutic observation had only recently been added to the mandatory training programme and sessions for staff had been booked.

The mandatory training programme was comprehensive and met the needs of young people and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Bank staff were included in mandatory training. Mandatory training figures were discussed in senior governance meetings.

Assessing and managing risk to children and young people and staff

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

Assessment of patient risk

Requires Improvement

Child and adolescent mental health wards

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff updated risk assessments after incidents. Positive Behavioural Support (PBS) plans were in place for young people with autism. This was an improvement from the last inspection.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Zero tolerance care plans for certain types of deliberate self harm were in place, where young people had caused significant injury to themselves previously. Staff were aware of which young people had zero-tolerance care plans in place, and the interventions required to keep the young person safe. However, we reviewed CCTV for a young person with a zero tolerance care plan and staff did not implement this care plan to prevent the young person from head banging, putting the young person at risk of harm.

Staff identified and responded to any changes in risks to, or posed by, children and young people.

Staff could observe children and young people in all areas of the wards.

With the exception of one occasion staff followed trust policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. On one occasion a young person brought contraband items on to the ward which they used to harm themselves. However, following this incident staff updated the young person's risk assessment to include searching on return from leave. We did not see evidence of any other similar incidents.

Use of restrictive interventions

Levels of restrictive interventions were not reducing.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. However, the provider's April 2023 quarterly audit raised concerns that not all restrictive interventions were risk assessed and did not include multidisciplinary team involvement. It also raised concerns that debriefs were not being documented. There were no actions identified from this audit.

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

Staff made attempts 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. Hartley reported 264 restraints in May 2023, which was an increase, compared to February 2023, which had the lowest number of restraints in 6 months at 117. Thorneycroft reported 57 restraints in May 2023, which was an increase compared to February 2023, which had the lowest number of restraints at 8. Wedgewood reported 102 restraints in May 2023, compared to January 2023 which had the lowest number of restraints at 68. Ten incidents were reviewed on CCTV, staff worked hard to engage with young people when they were distressed and de - escalated incidents using interventions in PBS plans. During one incident staff used a visual communication prompt to deescalate an incident of self-harm, which the young person responded positively to. When staff had to use restraint, it was in line with the service's policies and procedures. Six young people told us they did not receive debriefs after incidents which included restraint, a focus group of 7 young people on Wedgewood reported they did not receive debriefs and a group of 3 young people on Thorneycroft also reported they did not receive debriefs after incidents.

Requires Improvement

Child and adolescent mental health wards

Staff did not always follow National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Young people's physical health observations were not always monitored post administration of rapid tranquilisation. In the 6 months prior to our inspection, rapid tranquilisation was used the most in May 2023 at 32 times and the lowest at 7 times in January 2023. This was highest on Hartley, at 28 times. On Thorneycroft, rapid tranquillisation was used the most in May at 4 times and not used for the previous 4 months. On Wedgewood, it was used once in March in 6 months. We reviewed 3 out of the 4 incidents of rapid tranquillisation on Thorneycroft and found that staff did not monitor physical observations on 2 occasions as per provider policy and in accordance with NICE guidelines. Managers identified this in a quarterly internal audit completed in January 2023, physical observation monitoring charts reviewed had incomplete observations recorded with no comment to indicate why there were missing checks and signatures. Managers did not set actions from this audit.

When a child or young person was placed in seclusion, staff kept clear records and mostly followed best practice guidelines. Staff used seclusion infrequently, once in February 2023, twice in April 2023 and once in May 2023. We reviewed a seclusion episode from April 2023. Nursing staff, MDT and the consultant reviewed the seclusion in a timely manner following the Mental Health Act Code of Practice and their own policy. However, seclusion was not terminated until more than 15 hours after the young person was described as settled in presentation. Managers reviewed this seclusion and noted reviews were completed on time but did not comment on the potential missed opportunities to end seclusion earlier.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was put in long-term segregation. There was a young person in the extra care area at the time of inspection. This had been independently reviewed by another service within the local provider collaborative. Discharge meetings involving other stakeholders had been set up.

Young people and staff discussed restrictive practice in weekly community meetings.

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 followed crib sheets that had been developed by the service social work team. Staff we spoke with were aware of how and when to raise a safeguarding. Staff made 12 referrals to the LADO (local authority designated officer) during the period of January to March 2023, for incidents meeting the threshold for referral.

Staff kept up-to-date with their safeguarding training, 96% of staff completed up to level 3 safeguarding training for children and adults. Four staff were trained to level 4, with a further 4 members of staff booked to do this training. Incidents flagged as having potential safeguarding concerns had increased from 21 in December 2022 to 100 in February 2023, governance minutes said this was related to increase in training and better awareness from staff.

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. However, 5 young people reported they had felt unsafe due to poorly managed dynamics on the ward. Senior managers had identified bullying and negative dynamics between young people as a theme to safeguarding incidents over the past 6 months.

Requires Improvement

Child and adolescent mental health wards

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

Staff had reported 66 incidents related to sexual safety incidents in 6 months, 12 met the threshold for external referral. These included 6 allegations related to staff, none were accepted by the local authority for investigation. Young people been offered support to contact the police, one accepted support, the police investigated and closed. The service reviewed its internal referral system and saw an increase in referrals of incidents related to safeguarding due to this.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Service staff had regular engagement meetings with the LADO and a site visit was being arranged. Senior leaders reviewed CCTV where appropriate and made referrals to the local authority for external investigation. At the time of inspection there were 3 open section 47 Child Protection Enquiries, none related to hospital care.

Managers took part in serious case reviews and made changes based on the outcomes. Senior leaders met monthly for a safeguarding meeting. Themes were discussed and a rag rated action plan produced.

Staff access to essential information

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

Patient notes were not comprehensive and staff could not access them easily. The electronic records system had not been working since August 2022. This was beyond the provider's control and was an issue with the care notes system and had effected other hospitals across the Country. Staff were recording entries on a network drive; however, these entries were not locked and notes were not in chronological order. Managers told us it was difficult to complete audits on the existing system as it could not search and filter. It was also difficult to access historical records when external providers were completing assessments.

Medicines management

The service used systems and processes to safely prescribe, administer, and record medicines. Staff did not always review 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 always store medicines in line with the provider's policy. Some medicines needed to be stored in a refrigerator as they could break down and become less effective at room temperature. Staff were not always completing daily checks of clinic refrigerator temperatures. Hartley had gaps in recording for 13 days in April 2023 and 1 day in May 2023. Wedgewood missed 1 day of recording in May 2023.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines.

Staff followed current national practice to check the young people had the correct medicines.

Requires Improvement

Child and adolescent mental health wards

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Medicines were discussed monthly in governance meetings. Quarterly audits and medication management meetings took place led by medics and attended by nurses. The pharmacist presented the quarterly audits and actions were rag rated and dated for completion. However, an audit of high dose anti-psychotics had been a rolling action from March 2022 and was not completed until April 2023.

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

Staff did not always review the effects of each child or young person's medication on their physical health according to NICE guidance. Rapid tranquillisation policy was not always followed. Staff did not always complete the monitoring document following the administration of rapid tranquillisation medicines. In 2 out of 3 incidents reviewed, staff did not complete physical health checks in line with policy and current national guidance.

Track record on safety

Reporting incidents and learning from when things go wrong.

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service, however they did not always involve families and children and young people in these investigations. 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 had received additional training on reporting incidents related to sexual safety. Governance minutes reported an increase in staff reporting incidents related to this. Sexual safety incidents were discussed in monthly safeguarding meetings with senior leads.

We reviewed 10 incidents from the reports through to CCTV. No disproportionate use of force was observed. This was an improvement from the last inspection.

We reviewed 23 incidents related to self-harm. Staff completed body maps and neurological observations following these incidents. We saw staff completing neuro-observations whilst observing CCTV. This was an improvement from the past inspection.

Staff raised concerns and reported incidents and near misses in line with provider policy. Incidents were discussed in handover and daily operational meetings with senior leaders and the MDT. Senior staff used CCTV to investigate incidents and complaints when needed. Incident data was discussed monthly in Clinical Governance meetings, themes and trends on each ward were discussed.

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

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave children, young people, and families a full explanation if and when things went wrong. In 6 months, there had been 45 incidents that met the threshold for Duty of Candour. The main theme was self-harm incidents, which accounted for 49% of all incidents.

Requires Improvement

Child and adolescent mental health wards

Managers investigated incidents thoroughly. However, children, young people and their families were not always involved in these investigations. Governance minutes reported this was inconsistent and that families were not always updated.

Managers debriefed and supported staff after any serious incident.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff received bulletins on a bi-monthly basis, including examples of good practice regarding patient safety and experience. Staff participated in lessons learnt sessions that were held monthly and available to all staff. Four staff said debriefing sessions took place following incidents to support understanding and learning. Incidents were reported in written handovers and included for 2 weeks to ensure all staff were aware.

Staff met to discuss the feedback and look at improvements to patient care. Managers and senior leaders attended monthly governance meeting which included a review of incident and safeguarding themes.

There was evidence that changes had been made as a result of feedback. Manager identified inappropriate boundaries between staff and young people by observing CCTV. Managers put in place boundary workshops, 4 sessions had taken place in April and May 2023.

Managers shared learning with their staff about never events that happened elsewhere. The director of quality for Active Care Group had set up good practice workshops across the area.

Is the service effective?

Requires Improvement

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. While staff developed individual care plans which included multidisciplinary discussion they were not regularly reviewed during their time on the ward. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after.

Children and young people had their physical health assessed soon after admission, however this was not regularly reviewed during their time on the ward. Staff did not always complete Paediatric Early Warning Scores (PEWS) correctly. We reviewed 8 records, 5 were poorly completed or documented 'declined'. There were repeated entries of young people having 'refused' monitoring to take place for weeks at a time without this being discussed in MDT, care planned

for, or included in a PBS plan. Nurses were allocated PEWS to complete daily and physical health monitoring was recorded on the written handover. Managers did not always audit physical healthcare quarterly as scheduled; the last audit was completed in February 2023 and was next due for completion in May, however this was missing. The audit did not include escalation for when young people refused physical health monitoring.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs.

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

Care plans were personalised, holistic and recovery-orientated. Occupational therapists developed sensory profiles for young people assessed as needing these.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for children and young people based on national guidance and best practice. They did not always ensure that children and young people had good access to physical healthcare and support 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 did not always provide a range of care and treatment suitable for the children and young people in the service. Three families and 7 young people said access to therapeutic intervention was limited. Two staff members also reported this. Service specifications for CAMHS services from NHS England states that all young people must receive 25 hours of therapeutic intervention is they are not in full time education. Young people did not receive 25 hours of therapeutic intervention. Individual hours of therapeutic intervention was poor; young people on Hartley received 5.2 hours each, Wedgewood 7.4 hours each, Thorneycroft 5.9 hours each. The service reported that this was related to vacancies within the therapy department, and the current electronic system not capturing when engagement had happened. Wedgewood was slightly higher as they had a family therapist in post, which was in line with best practice and national guidance for specialist eating disorder units.

Staff did not always make sure children and young people had access to physical health care, however they did have access to specialists as required. Young people were registered with a local GP who attended the site weekly. Meeting young peoples' physical healthcare needs was the provider's number one objective in their Quality Strategy 2023-2026. The provider had an action plan in place to meet this priority.

Staff met children and young people's dietary needs, and assessed those needing specialist care for nutrition and hydration. Wedgewood was a specialist eating disorders unit and staff supported Hartley in providing care for young people with an eating disorders diagnosis whose distress required the environment of a Psychiatric Intensive Care Unit (PICU).

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 a yoga teacher and a personal trainer who delivered physical education.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes.

Requires Improvement

Child and adolescent mental health wards

Staff used technology to support children and young people. A visual technology system was in place in 2 bedrooms to monitor and observe young people which supported staff to keep young people safe.

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. The service had a programme of audits.

Managers used results from audits to make improvements. For example, pharmacy audits identified levels of cleanliness had reduced in clinical areas. Governance minutes stated managers introduced clinic leads to oversee the improvements in this area. No concerns were identified in this area during our inspection.

Skilled staff to deliver care

The ward teams did not always 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 access to a full range of specialists to meet the needs of the children and young people on the ward. The provider recently recruited a psychologist to deliver sessions on site, there were 2 vacant posts for full time psychologists. This was an improvement from the last inspection. There were vacancies for 2 for family therapists. Wedgewood had a family therapist in post. One young person spoke highly of the occupational therapy team and their efforts to support their discharge into the community with the development of independent living skills. However young people and families reported they did not get enough therapeutic input. One family said they were concerned about discharge, and deterioration that might occur on home due to the lack of psychological input received on the ward.

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.

Agency staff were included in mandatory training, this was a 2-day face to face training. The training schedule included fire safety, therapeutic observations, eating disorder and meal support, safeguarding, infection prevention and control, positive behavioural support, searching and ligature risks.

Managers gave each new member of staff a full induction to the service before they started work. New staff had a 3-week face to face induction. This included the above sessions and educational sessions specifically for Hartley as PICU, Thorneycroft as GAU and Wedgewood as an eating disorder unit. Staff also received training on basic life support, PEWS and moving and handling. Shadow shifts were incorporated into this induction. PRICE training was also included for restraint and de-escalation.

Managers supported staff through regular, constructive appraisals of their work. Appraisals were on an 8-week rolling programme. During March to April 2023, Thorneycroft achieved 96% compliance, Hartley 98%, and Wedgewood 100%. Clinical staff achieved a 92% overall rate. During April to May 2023, Thorneycroft was 86%, Hartley was 97% and Wedgewood was 98%. All clinical staff achieved an overall rate of 87%.

Requires Improvement

Child and adolescent mental health wards

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Managers supported medical staff through regular, constructive clinical supervision of their work. Staff completed supervision on an 8-week rolling programme. During April to May 2023 the supervision rate for Hartley was 81%, Thorneycroft was 86%, and Wedgewood 95%. Clinical staff achieved an overall staff rate of 95%. During March to April 2023, all clinical staff achieved 91%, Thorneycroft was 93%, Wedgewood 90% and Hartley 100%.

While most managers ensured staff attended regular team meetings or gave information from those they could not attend. Staff on Hartley said they did not have regular team meetings in place.

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

Managers had not made sure staff received all specialist training for their role. For example, only 69% of staff had completed training for people with eating disorders.

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

Although 2 young people said they had seen staff sleeping whilst on observations, managers took prompt action to address this issue. Senior leaders developed a 4-point audit which was completed nightly by the nurse in charge. In addition, CCTV observations were conducted to ensure supportive observations were being carried out as prescribed. This CCTV review totalled 6 hours, 3 of which were taken from night shifts. Managers took action to address issues identified with staff sleeping on observations including no longer booking specific bank and agency staff and informing the agency. Managers also took action against 6 permanent staff which included letters of concern, additional supervision, monitoring, a change of shift pattern (moved to days and placed on restricted overtime), and completion of observation knowledge assessments.

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. Young people and external teams were invited to MDT meetings. However, 4 families said they were not routinely invited to MDT meetings and when they did attend the conference line was often difficult to hear and made it difficult to contribute. Families said they often had a separate call after the ward review had taken place.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. The written handover document was detailed.

Ward teams had effective working relationships with other teams in the organisation. Managers said they completed audits for other wards to encourage openness and avoid closed cultures.

Ward teams had effective working relationships with external teams and organisations. Discharge meetings were set up for young people with complex or delayed discharges which involved multiple organisations.

Requires Improvement

Child and adolescent mental health wards

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 training was mandatory, Hartley achieved 100% compliance for level 2 training, Thorneycroft achieved 89% for level 1 and Wedgewood 94% for level 1.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

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.

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. Posters were displayed in ward areas of who their advocate was and how to make contact.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, the information was repeated as necessary every 4 weeks and recorded clearly in the child or young person's notes each time. The Mental Health Act administration team audited this. Staff were making additional efforts with young people who had specific communication needs, according to the audit in February 2023.

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

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

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

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

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

Managers and staff did not always make sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The provider had not identified that the young people who were informal and admitted to Thorneycroft ward could not have access to the outside space easily, and in line with the requirements of the Mental Health Act.

Requires Improvement

Child and adolescent mental health wards

Good practice in applying the Mental Capacity Act

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the 5 principles.

Mental capacity act training was mandatory as e-learning. Hartley reported 94% compliance, Thorneycroft 81% and Wedgewood 98%.

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

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

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

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

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered their wishes, feelings, culture, and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

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

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

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.

Is the service caring?

Requires Improvement

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

Requires Improvement

Child and adolescent mental health wards

Kindness, privacy, dignity, respect, compassion, and support

Staff mostly treated children and young people with compassion and kindness. They respected children and young people's privacy and dignity. They usually 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. Young people were mostly complimentary of staff.

However, 5 young people on Thorneycroft said they did not always feel safe on the ward due to poorly managed dynamics between young people. Staff tried to address this issue through community meetings that included an item called ward dynamics as a rolling agenda item. Senior managers discussed this issue in their team meetings, and in one instance a young person who said they felt unsafe was placed on observations whilst the social work team worked with the perpetrator.

Staff usually gave children and young people help, emotional support and advice when they needed it. We saw staff engaging with young people during our inspection. Whilst viewing closed circuit television footage we saw how staff worked hard to verbally de-escalate young people in distress. However, 5 young people said there were often staff members on shift who they did not know, and who did not always interact with them. Two staff members said not all staff had the confidence to verbally deescalate an incident. To address this issue managers told us a de-escalation skills group had been put in place to improve staff's knowledge, understanding and skills to de-escalate heightened emotional reactions, and the Protecting Right in a Caring Environment (PRICE) trainer was also attending night shifts to support staff and embed skills.

Staff supported children and young people to understand and manage their own care treatment or condition. Young people were encouraged to attend ward review meetings.

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

Children and young people said most staff treated them well and behaved kindly towards them. However, 7 young people and children told us staff did not always understand and respect their individual needs. During a focus group on Wedgewood 7 young people said staff were not always compassionate when they were distressed.

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 patient information confidential.

Involvement in care

Staff involved children and young people 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

Requires Improvement

Child and adolescent mental health wards

Staff introduced children and young people to the ward and the services as part of their admission. Young people had designed the welcome leaflet.

Staff involved children and young people and gave them access to their care planning and risk assessments. Receiving copies of care plans was a rolling agenda in the community meeting, with escalation to the nursing team if a young people had not received an updated copy that week.

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.

Staff involved children and young people in decisions about the service, when appropriate. Children and young people could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held weekly and the children and young people contributed to activity and menu planning. The young people chaired this meeting.

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

Staff made sure children and young people could access advocacy services.

Involvement of families and carers

Staff did not always inform and involve families and carers appropriately.

Staff did not always support, inform, and involve families or carers. Staff communication with families and carers was mixed, 5 families and carers said they received good communication whilst 3 said they did not.

Staff did not always help families to give feedback on the service. Four families and carers said they were not invited to attend weekly ward review but did receive a phone call afterwards. Two families said the conference line the service used was difficult to hear and contribute through.

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

Is the service responsive?

Requires Improvement

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

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. However, children and young people did sometimes have to stay in hospital when they were well enough to leave.

Requires Improvement

Child and adolescent mental health wards

Managers regularly reviewed length of stay for children and young people, however they did sometimes have to stay in hospital when they were well enough to leave. Managers put in place regular discharge meetings with external teams to support discharge of young people, and involved the provider collaborative where required.

The service had low out-of-area placements. Managers worked with case managers for young people out of area to support discharge. The service had 10 out of area young people at the time of inspection.

Managers and staff worked to make sure they did not discharge children and young people before they were ready.

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. This was in discussion and agreement with the young person's case manager.

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 stay in hospital was longer than expected. Managers knew which wards had the longest admissions and took action to reduce them.

The service had 17 people whose stay in hospital was longer than expected in the past 6 months. Four young people were out of area and waiting for repatriation to their local area.

Young people with autism had scheduled Care, Education and Treatment reviews (CETR) to support with discharge planning. These reviews are carried out by an independent panel of people, an expert by experience, a clinical expert, and the commissioner. They make recommendations about the safety, care and treatment of people and aim to reduce the amount of time people spend in hospital. Staff were following the recommendations made.

Children and young people sometimes had to stay in hospital when they were well enough to leave as there were limited community options for young people to step down to.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. Staff wrote service specifications for young people who were ready for discharge, these were shared with community providers to ensure they understood the person's current needs and history.

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity, and privacy

Requires Improvement

Child and adolescent mental health wards

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy, and dignity. Each child and young person had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy and the food was of good quality. However, bedrooms did not have en-suite bathrooms, not all children and young people could make hot drinks and snacks. Free access to outside areas was not considered for children and young people who were admitted informally.

Each or young person had their own bedroom, which they could personalise. Staff and young people were co-producing the environment and weekly community meetings included a 'glamour your manor'. Separate lockers were available for secure items that required staff supervision. While bedrooms did not have en-suite facilities, separate male and female bathrooms and toilets were available across the wards.

Children and young people had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care.

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

Children and young people could make phone calls in private.

The service had an outside space that children and young people could access, young people had access to a basketball court and we saw this was frequently used. However, Thorneycroft was located on the first floor, and the young people said it was difficult to have regular access to fresh air as there was not always the staff to take them down to the gardens.

Managers said there was a policy in place for young people to gain access to a fob key which would allow them in and out of the unit. However, in 6 months no young person had gained access to a fob key. While managers had provided a guide for staff to follow, the document did not include consideration for those informally admitted.

Not all children and young people could make their own hot drinks and snacks. While the young people on Thorneycroft ward could make their own hot drinks and snacks, and were not dependent on staff, those on Wedgewood ward had structured times for meals and snacks, due to the nature of the eating disorder model of care. The young people on Hartley ward did not have access to the kitchen to make their own drinks and were dependent on staff. Staff explained this was due to the nature of risk within the PICU environment.

The service offered a variety of good quality food.

Children and young people's engagement with the wider community

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

Staff made sure children and young people had access to opportunities for education and work, and supported them. Children and young people attended in-house school sessions throughout the day. Young people were able to progress with their educational needs as teachers had good links with the children and young people's community schools. During our inspection we observed a young person being supported to sit their GCSE exam. Staff helped children and young people to stay in contact with families and carers.

Requires Improvement

Child and adolescent mental health wards

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. The MDT individually risk assessed children and young people to access the community and they were encouraged to participate in community activities outside of the hospital. For example, one young person said staff supported them to attend the job centre as they were preparing for discharge.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. A lift was available for access to Thorneycroft ward which was on the first floor.

Written handovers included young people's preferred gender and pronoun. However, we were told staff on Wedgewood were not always respectful of young people's preferred name and pronouns.

Staff made sure children and young people could access age appropriate information on treatment, local services, their rights and how to complain. Young people designed posters which were displayed across the wards with information about activities.

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

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

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people.

Children and young people had access to spiritual, religious, and cultural support.

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, however families and carers did not always receive feedback and outcomes following their complaint

Children, young people, relatives, and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. The service had had 18 complaints in 6 months which had been investigated. Senior management team meetings identified themes to complaints, for example, in May 2023 leaders reported a theme of attitudes and behaviours from staff towards young people. The management team addressed this with a letter to all staff about behaviours and completed a survey with young people and staff to explore culture and trauma informed responses. Lessons learnt were shared through senior management team meetings.

Requires Improvement

Child and adolescent mental health wards

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

Staff knew how to acknowledge complaints however, young people and their families did not always receive feedback and outcomes from managers after investigations into their complaint.

The service used compliments to learn, celebrate success and improve the quality of care. Weekly community meetings included a positive 'shout out' from young people to staff.

Is the service well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders mostly 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.

Leadership posts were not always filled. While the quality and compliance officer post had been recruited to the new post holder had not yet started. The hospital director post had become recently vacant, as was the medical director post. The ward manager post on Wedgewood was also vacant. There was a gap in some scheduled audits, feeding back of complaints to families and oversight of the therapeutic programme offered to young people. However, the core service matron had been in post 6 months and was available for young people to speak with. The matron was visible on the wards engaging with young people and staff. Managers said they were supported by senior management within the Active Care Group who had stepped in to ensure leadership of the site.

Managers met daily for operational meetings. Managers had clinical governance meetings monthly and supported each other in reviewing CCTV and conducting audits.

Although the senior management team met monthly, 1 staff member said they did not know who the senior management team was as it changed regularly.

Leadership courses were offered including a Level 7 Senior Leader Apprenticeship which was a 2 year course for those working in senior roles.

Vision and strategy

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

Vision and values were part of the induction for new starters. Staff told us they were displayed on computer screen savers.

Requires Improvement

Child and adolescent mental health wards

Active Care Group had launched a new intranet site across its services to share information across the group.

Culture

Staff 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 had a positive 'shout out' from young people in community meetings.

International staff told us how they had been supported throughout the process of leaving their homes to join the service. They said the service had supported with accommodation, food vouchers and transport to work. They said the service had offered them training to meet the needs of the young people and keep them safe. They said teams on the wards were supportive.

Governance

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

We had inspected this location 4 times since 2020. The provider had not improved consistently during this time and it had remained in special measures. During this inspection, the provider had made improvements against the Warning Notice issued in December 2022, however we identified other areas of concern and took further enforcement action.

The provider's systems in place did not ensure children and young people had their therapeutic intervention. We were informed by young people, their relatives, and a therapist that these interventions were not taking place. The audits were unclear, and records were inconsistent making it difficult to evidence whether the interventions had taken place as agreed.

Governance systems had not identified that staff were not monitoring children and young people's wellbeing after the administration of rapid tranquilisation medications.

Systems in place had not ensured that Paediatric Early Warning Signs (PEWS) were monitored, recorded and action taken when clinically indicated, in accordance with children and young people's care plans.

There was no system in place to ensure that children and young people admitted to Thorneycroft had regular and frequent access to outside space and that this was included within risk assessments and care plans with regard given to those with informal status, in line with the requirements of the Mental Health Act.

The provider had not identified that their system that was in place for checking emergency equipment was not followed and completed by suitably qualified staff.

Managers had not identified that a young person had remained in seclusion for longer than necessary following a review.

Requires Improvement

Child and adolescent mental health wards

There was a set agenda for clinical governance meetings which reviewed and updated the quality action plan for the service. The meeting covered issues related to safety including regulatory compliance, safeguarding and incidents, how effective the service was and patient experience.

Senior management team meetings also followed a set agenda and covered training, staffing and agency use, complaints and lessons learnt.

Management of risk, issues and performance

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

The electronic system for recording and storing young people's notes was still not working after a major incident that had impacted other hospitals. Young people's records could not be easily accessed and audited.

We asked the provider to submit a report on progress being made to reinstate the electronic recording system, and ensure the interim system is fit for purpose, with a robust plan to transfer records stored within the interim system.

The service had an up-to-date risk register.

The health and safety team shared a bulletin of lessons learnt across the group every quarter. This also included examples of good practice and performance.

Engagement

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

The service worked closely with its provider collaborative. Senior leaders with the provider collaborative had been on site, with plans made to return.

Learning, continuous improvement and innovation

Staff engaged actively in local quality improvement activities. Governance minutes had identified boundaries between staff and young people to be a repeated area for improvement. Workshops had been put in place with high staff turn out to address this.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service was not operating effective systems or following processes established to ensure compliance with the requirements of the regulations Governance systems, including audits, were not operated effectively to continually assess, monitor and improve the quality and safety of the services provided The service did not have an audit system in place to monitor whether the service was providing young people with 25 hours of therapeutic intervention each week.

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 The service was failing to provide care and treatment in a safe way to young people as staff were not following best practice when administering rapid tranquillisation Young people were placed at risk as physical health needs were not adequately monitored by staff Young people were at risk because the service failed to ensure equipment was safe to use. Young people admitted to Thorneycroft must have regular access to outside space, that this is included within risk assessments and care plans with regard given to those with informal status, in line with the requirements of the Mental Health Act.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider must provide sufficient therapeutic intervention to meet young people's needs in line with nationally recognised guidance