Priory Healthcare Limited

# The Priory Hospital Roehampton

## Inspection report

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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 | Inspected but not rated |
| Are services safe? | Inspected but not rated |
| Are services effective? | Inspected but not rated |
| Are services caring? | Inspected but not rated |
| Are services responsive to people's needs? | Inspected but not rated |
| Are services well-led? | Inspected but not rated |

# Summary of findings

## Overall summary

Priory Hospital Roehampton provides inpatient child and adolescent mental health services. The service provides mental health care and treatment for children and young people aged between 12 and 18.

We did not re-rate the overall service following this inspection. It remained good overall. At our inspection in April 2021 we rated the domain of safe as requires improvement. We rated effective, caring, responsive and well-led as good.

This was a focused inspection that covered specific aspects of safe, effective, caring, responsive and well-led. We undertook a short announced focused inspection of this service due to the increase in the number of self-harm incidents reported to the CQC by the provider and to follow up on the actions taken by the service to address the breach of regulation from our previous inspection.

The service had made many improvements since our last inspection in April 2021, but further work was needed to fully address the breach of regulation and to ensure that improvements were embedded and sustained.

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. There was now a clinical psychologist, deputy ward manager and ward consultant for Lower Court. Managers ensured that these staff received training and supervision. The ward staff worked well together as a multidisciplinary team.

The ward environments were safe and clean.

Staff assessed and managed risk well. They minimised the use of restrictive practices and had arrangements in place for safeguarding.

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed.

They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.

Staff treated patients with kindness and respect.

The service was well led. Governance processes had been strengthened and mostly operated effectively and performance and risk were managed well.

Staff feedback was positive, they reported that morale and the culture within the service were improving. Staff felt respected, supported and valued. They could raise any concerns without fear and reported that their concerns were taken seriously. Leaders were visible in the service and approachable for patients and staff.

However:

# Summary of findings

Whilst the service had a robust improvement plan for the recruitment, retention and development of qualified, non-qualified and therapy staff, there was still a significant use of agency staff. Vacancy rates for nurses and the use of agency staff were slowly reducing.

Not all agency staff were aware of the potential environmental risks. The quality of induction for agency staff was not consistent across the service. Not all agency staff had a full understanding of safeguarding in relation to children and young people. Agency staff who were not registered nurses did not have the opportunity to routinely access and review patient records. Regular agency staff did not receive supervision.

Regular staff meetings and debriefs following incidents on Lower Court did not take place.

Systems to ensure that learning from incidents were not fully developed to ensure that learning was fully embedded.

The care pathway on Lower Court was not clear. The service had commenced a strategic review of the CAMHS service.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| Child and adolescent mental health wards | Inspected but not rated  | Overall summary is on page 2 |

# Summary of findings

## Contents

# Summary of this inspection

## Background to The Priory Hospital Roehampton

The Priory Hospital Roehampton is an independent hospital that provides care and treatment for people with mental illness. The hospital provides inpatient child and adolescent mental health services on Lower Court and Richmond Court. Lower Court provides care and treatment for up to 12 children and adolescents experiencing an acute episode of mental illness. Richmond Court provides care and treatment for up to six patients. Both wards accept both male and female patients.

The service is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act

The last inspection of this service was in April 2021. We rated the service overall good. We rated the domain of safe as requires improvement. We rated effective, caring, responsive and well-led as good. We found one breach of regulation. This was in relation to regulation 12 (safe care and treatment).

This was a focused inspection carried out in response to a number of notifications received by CQC which indicated that there were risks to patient safety and to check on improvements made since our last inspection. We inspected both wards providing inpatient child and adolescent mental health services and looked at elements of the domains safe, effective, caring, responsive and well-led.

There was a registered manager in post.

**What people who use the service say**

We spoke with seven patients and two carers.

Patients reported that permanent and regular agency staff understood their individual needs. They told us that this was not the case with ad-hoc agency staff who mainly covered night duty. Patients described these staff as not understanding boundaries and what support was required when they were distressed.

Patients told us that the therapies programme had improved and staff supported them with their education.

We received mixed feedback from carers. One carer told us that communication on Lower Court could be improved, another carer told us that staff on Richmond Court kept them up to date about the care and treatment of their family member.

## How we carried out this inspection

During this inspection we carried out the following activities:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients

# Summary of this inspection

- spoke with seven patients who were using the service and two carers or family members of patients who were using the service. Interviews with carers were completed by telephone. Our final carer interview was on 11 February 2022
- spoke with the hospital director, director of therapies, director of workforce, director of clinical operations and medical director for specialist services
- spoke with 16 other staff members: including consultant psychiatrists, nurses, occupational therapists, healthcare assistants, clinical psychologist and therapies lead
- attended and observed one situation report meeting
- attended and observed a staff meeting on Richmond Court
- looked at four care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

**Inspection Team**

The inspection was carried out by two inspectors, an inspection manager, a specialist advisor and an expert by experience.

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 to improve**:

The service must continue to ensure that persons providing care and treatment to young people have the competence, skills and experience to do so safely. They must continue to recruit and retain staff and ensure that all agency staff are fully inducted, understand risk and safeguarding. (Regulation 12(1)(2)(c)).

**Action the service SHOULD take to improve:**

- The service should consider giving agency staff access to patient records.
- The service should consider providing supervision to regular agency staff.
- The service should ensure that regular staff meetings and debriefs take place.
- The service should ensure that care pathways are clear and meet the needs of people using the service.
- The service should continue to develop systems from learning from incidents so that learning is embedded and repeat incidents reduced.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Child and adolescent mental health wards** | Inspected but not rated | Inspected but not rated | Inspected but not rated | Inspected but not rated | Inspected but not rated | Inspected but not rated |
| **Overall** | Inspected but not rated | Inspected but not rated | Inspected but not rated | Inspected but not rated | Inspected but not rated | Inspected but not rated |

Inspected but not rated

# Child and adolescent mental health wards

| | |
|---|---|
| Safe | Inspected but not rated |
| Effective | Inspected but not rated |
| Caring | Inspected but not rated |
| Responsive | Inspected but not rated |
| Well-led | Inspected but not rated |

## Are Child and adolescent mental health wards safe?

Inspected but not rated

**Our rating of safe stayed the same. We did not inspect the whole of safe during this inspection and therefore did not rate the key question.**

### Safe and clean care environments

**All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. However, not all staff knew about potential ligature anchor points on the ward.**

### Safety of the ward layout

All wards were clean, well equipped, well furnished, well maintained and fit for purpose. Since our last inspection Lower Court had been redecorated.

Staff carried out regular checks of the ward environment on each shift and removed or reduced any risks identified.

The ward layouts did not allow staff to observe all areas, but staff used regular observation in line with patients' risk assessments to mitigate the risks. The service had closed circuit television (CCTV) throughout the wards and recorded any activity taking place. Cameras in bedrooms could be activated if the young person was presenting a high risk after consent had been sought from the parent or carer of the young person.

Staff mitigated the risks to keep patients safe. Staff said each patient and their belongings were risk assessed for items that could be used to create a ligature. Staff were aware of personal items that could create potential ligatures, understood the ward's ligature response protocols and knew the location of the ward's ligature cutters. However, not all staff knew about potential ligature anchor points on the ward. Some agency staff had not seen the ward's ligature map and were unaware of the potential environmental ligature risks.

### Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. Each ward had dedicated housekeeping staff.

Staff followed infection control policy, including handwashing. Staff were aware of service's infection control policy and followed infection control principles including the use of personal protective equipment.

Inspected but not rated

# Child and adolescent mental health wards

## Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Clinic rooms were organised, clean and tidy. Staff checked, maintained, and cleaned equipment. Staff ensured that equipment was correctly calibrated.

## Safe staffing

**The service had enough nursing and medical staff and received basic training to keep people safe from avoidable harm. However, whilst progress had been made with recruiting staff, nurse vacancies remained high. Not all agency staff had a full induction.**

## Nursing staff

At our inspection in April 2021, we found the service did not employ sufficient nursing staff and relied on agency staff to maintain safe levels of staffing. We also found that staff did not have the competence, skills and experience to care for patients safely. At this inspection we found some improvements.

The service's vacancy rates had improved since the last inspection in April 2021. Vacancy rates for nursing staff were reducing slowly. At the time of our inspection RMN vacancies were at 50% on Lower Court and 40% RMN vacancies on Richmond Court. Since our inspection a deputy ward manager had been appointed and in post to Lower Court. Plans were in place for 85% of health care assistants to be permanent or bank by the end of March 2022.

The service had clear processes in place to ensure all shifts were covered. The service management team and workforce coordinator reviewed and discussed staffing twice a day. The workforce coordinator managed bank and agency bookings and oversaw staff rotas. They worked with the ward managers to ensure additional staff were booked in advance to support ward activities. Where possible they requested bank and agency staff familiar with the service.

Leaders were proactively working on staff development, retention and succession planning for the service. This involved a strong commitment to the support of learning and development of staff. There were now specific career pathways within the service for the development of ward managers and lead nurses. A proposed career pathway for health care assistants was in the process of being signed off by the service's senior leaders. Senior managers had also reviewed the service's pay scales and upwardly adjusted staff's salaries to ensure a pay system that was fair. The majority of nursing staff received two pay raises to bring all staff in line with the new pay scales. The service had also been able to recruit an additional 18 registered nurses from the agency onto their bank system.

Between August 2021 to January 2021, a total of 2323 shifts were covered by bank and agency staff on Lower Court. 459 shifts were for registered nurse staff and1864 shifts for non-registered staff. The registered nurse shifts were covered by agency locum nurses who were very familiar with the ward. The service had employed additional non-registered agency staff during this period to offer extra support in response to rising acuity. All staff reported that there had been increased acuity and most patients required enhanced observations.

Between August 2021 to January 2021, a total of 937 shifts were covered by bank and agency staff on Richmond Court. 337 shifts were for registered nurse staff and 600 shifts for non-registered staff.

Overall staff feedback was positive. They reported that the senior leadership team had made improvements to staffing since the last inspection, they described regular agency and bank staff being booked to ensure consistency in care. Staff also reported that work had been undertaken to improve recruitment, pay, retention and career progression.

There was still a significant use of bank and agency staff whilst the service was recruiting permanent staff. Although managers requested staff familiar with the service, staff and patients said unfamiliar agency staff did at times cover shifts. Patients on Lower Court reported that this was mainly at night and that this led to new agency staff not fully understanding their needs. They told us that consistent care was important for their safety and wellbeing.

The service had an induction programme in place for all staff including bank and agency staff. However, not all agency staff had a full induction. We saw that competency checklists had been completed for new agency staff working on the ward. Staff said the quality of staff inductions was not consistent across the service. This meant that staff may not have fully understood the service and patients' need before starting their shift. The service had carried out a strategic review on Lower Court ward and plans were in place to increase supernumerary time for new staff from one to two weeks. Permanent staff reported that they had undertaken a comprehensive induction before working on shift.

Managers supported staff who needed time off for ill health. Staff said their managers were understanding and supportive when managing ill health.

The ward managers could adjust staffing levels according to the needs of the patients. Managers could increase the number of staff on the ward if there was a high level of acuity or there were patients assigned to enhanced observations.

### Medical staff

Managers could call locums when they needed additional medical cover. Staff reported there was always sufficient medical cover and a doctor available to go to the ward quickly in an emergency, for example, to support patients during and after physical interventions. Since our last inspection the service had recruited a new medical director for CAMHS and specialist services, they were also the consultant for Richmond Court and a full-time consultant psychiatrist to Lower Court.

### Mandatory training

Staff had completed and kept up to date with their mandatory training. The average mandatory training rate for permanent staff was 75% for Lower Court and 89% for Richmond Court. There was a cross site plan running until the of April 2022 to deliver all mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received emails and text message prompting them to complete their training when their training was up for renewal. Training for agency staff was provided by their agencies. This included adult and children safeguarding, health and safety, and de-escalation training.

### Assessing and managing risk to patients and staff

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

### Assessment of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident.

Inspected but not rated

# Child and adolescent mental health wards

## Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff confirmed that patient risks were discussed and reviewed at each handover meeting, daily site meeting and the weekly ward round. This included discussions on patient progress and changes to individual risk following incidents. These meetings enabled staff to focus on the current risks and review how effective management and mitigation plans were working. All staff were aware of the services observation policies and levels of enhanced observations.

Staff could observe patients in all areas of the wards and followed procedures to minimise risks where they could not easily observe patients. Staff completed security and environmental checks regularly to ensure areas of the ward did not contain risks.

Staff followed the services policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff conducted patient, belongings, and room searches in twos and documented them.

## Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

There were 271 episodes of physical interventions between 1 August 2021 and 31January 2022 on Lower Court. These involved nine patients and were mainly to prevent self-harm incidents. One hundred of these incidents related to one patient.

There were 19 episodes of physical interventions between 1 August 2021 and 31January 2022 on Richmond Court. These involved five patients.

Between 1 August 2021 and 31January 2022 there were 48 incidents of rapid tranquilisation on Lower Court. There were no incidents of rapid tranquilisation on Richmond Court. All episodes of restraint were reviewed at the learning lessons committee to ensure that best practice had been followed and any learning shared with the wider ward team.

## Safeguarding

**Staff had training on how to recognise and report abuse and they knew how to apply it. Most staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. However, not all agency staff had a full understanding of safeguarding in relation to children and young people.**

Staff had training on how to recognise and report abuse, and they knew how to apply it. Ninety-two percent of permanent staff had completed safeguarding training on Lower Court and 100% of staff on Richmond Court. However, not all agency staff had a full understanding of safeguarding in relation to children and young people. This meant that some staff may not always recognise children and young people at risk of or suffering harm and therefore fail to raise safeguarding concerns when needed. All staff were aware of the service's safeguarding protocols and knew who the safeguarding leads were. Staff were comfortable in raising any safeguarding enquiries with managers and safeguarding leads.

Inspected but not rated

# Child and adolescent mental health wards

The service maintained a safeguarding log which tracked each safeguarding incident, reports to the local authority safeguarding team and immediate actions to safeguard the individual. The service had completed a safeguarding audit, where actions were identified a named staff member was allocated to address these. All actions were rated red, amber or green and signed off when completed.

### Staff access to essential information

**Agency staff who were not registered nurses did not have access to patient records.**

Staff recorded Information on the electronic patient record. Most information needed to deliver patient care was available to staff when they needed it and was in an accessible form. However, agency staff who were not registered nurses did not have the opportunity to routinely access and review patient records. This meant that agency staff relied on communication at handover meetings for information and updates on patients' needs, risk, individual care and support approaches and safeguarding concerns. This also meant that agency staff unfamiliar with the ward may not fully understand individual patient's needs, risks and individual approaches to care and support them. For example, some staff were unaware of a patient's care and support around health eating and meal planning.

### Track record on safety

There had been 22 serious incidents reported since May 2021. Most of these related to absconding and ligature incidents.

### 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, staff were not regularly debriefed and supported after some serious incidents. Further work was needed to develop systems to learn from incidents and to embed this.**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents thoroughly.

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

Managers investigated incidents and shared lessons learned with the whole team and the wider service. Both ward managers attended the learning lessons committee and sub-committee.

Learning from incidents was cascaded by ward managers through team meetings and nurse meetings. Where staff are not able to attend meetings, lessons learnt were shared via email. Staff also received a monthly e-learning bulletin which detailed learning from incidents within the wider Priory group. However, whilst the service had rolled out processes to review and check learning from incidents, this was not yet fully embedded in the service.

There was evidence that changes had been made as a result of feedback, for example a gate had been installed between the two wards following a number of young people absconding when returning from school, accessing the main hospital building or ground leave. Staff also identified individual changes to patient care because of learning from incidents, for example the review or use of a headboard for a patient who self-harmed through head banging.

Inspected but not rated

# Child and adolescent mental health wards

Staff on Lower Court reported that managers did not always debrief and support staff after incidents. Staff said that debrief after incidents rarely occurred. This meant that staff as a team were not able to reflect, learn and review feedback from incidents. Larger incidents were sometimes discussed but details of these were not recorded. Staff were able to approach managers and discuss incidents on a one to one basis if they wanted.

## Are Child and adolescent mental health wards effective?

Inspected but not rated

**Our rating of effective stayed the same. We did not inspect the whole of effective during this inspection and therefore did not rate the key question.**

### Assessment of needs and planning of care

**Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed.**

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a care plan for each patient that met their mental and physical health needs. Staff regularly reviewed and updated care plans when patients' needs changed.

### Best practice in treatment and care

**Staff provided a range of treatment and care for patients based on national guidance and best practice.**

The multidisciplinary team provided care and treatment to meet patients' physical, psychological, social, mental and spiritual care needs. These interventions were in line with National Institute for Health and Care Excellence (NICE) guidance. The service had a timetable of therapy-based groups that young people could engage with such as art therapy, yoga, dialectical behaviour therapy (DBT), baking skills, equine and pet therapy. Young people could attend education classes at the on-site school. Where patients were not able to go to school, teachers carried out education sessions on the ward. Other interventions offered included family therapy and one to one clinical psychology.

Staff took part in clinical audits and managers used results from these audits to make improvements. Assurance processes supported managers in auditing care records. Ward clerks completed a daily patients' records checklist and raised any issues with staff directly if there are any information missing or needing update. The multidisciplinary team also reviewed and updated patient's records at each clinical round and ward round. The service's senior management team also conducted a monthly random audit of a different ward each month focusing on patient documentation, staffing levels and the ward environment. In addition to this, the director of quality fully audited the service every six months. Audit results were shared and discussed at the service's clinical governance meetings where follow up action were assigned if required.

### Skilled staff to deliver care

**The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers provided an induction programme for new staff. Managers supported staff supervision, however agency staff did not receive supervision and staff did not attend regular team meetings.**

Inspected but not rated

# Child and adolescent mental health wards

At our inspection in April 2021, the ward teams did not include a clinical psychologist. At this inspection we found improvements. The service had employed a locum clinical psychologist since September 2021 for both wards. There was on-going recruitment to fill the clinical part time psychologist role on Richmond Court. The role involved strengthening the service therapeutic processes, delivering dedicated one to one sessions with patients, supporting the delivery of group sessions, conducting assessment such as autism and functional assessments of behaviour, supporting positive behavioural support and developing and reviewing positive behavioural observation charts.

The clinical psychologist also worked with the staff team on upskilling and development in areas such as autism awareness and mental capacity and how this relates to children and young people. This included a dedicated one-hour slot each week for bite size training, case formulation and review of care plans and complex cases with staff.

The service had ongoing recruitment for a family therapist for Lower Court. Where patients required family therapy this was arranged with the family therapist on Richmond Court. The service had also recruited two new social workers to join the MDT.

The service's senior managers had worked with managers to ensure permanent staff received regular, constructive supervision of their work. The service had identified that supervision compliance was low in the October 2021, with an average supervision rate of between 40% and 60%. By setting supervision as a priority and ringfencing supervision time the service was able to increase the average supervision rate to 90% by December 2021. Staff said they were able to discuss their wellbeing, personal and professional development and to reflect on and learn from practice. However, regular agency staff did not receive any supervision. This meant that agency staff did not have a dedicated space to discuss their wellbeing and reflect on their practice.

Managers did not ensure staff attended regular team meetings on Lower Court. Staff meetings did not regularly occur. Although staff meetings were planned, staff said these were often cancelled due to staff supporting patients, particularly when acuity on the ward was high. When team meetings were cancelled, they were not rescheduled. This meant that staff did not have a dedicated space to discuss learning from incidents, safeguarding, complex cases and general ward and service updates and development.

## Are Child and adolescent mental health wards caring?

Inspected but not rated

**Our rating of caring stayed the same. We did not inspect the whole of effective during this inspection and therefore did not rate the key question.**

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

We observed staff treating patients with kindness and respect. They respected patients' privacy and dignity. Patients reported that permanent and regular agency staff understood their individual needs. They told us that this was not the case with adhoc agency staff that mainly covered night duty. Patients described these staff as not understanding boundaries and what support was required when they were distressed.

## Are Child and adolescent mental health wards responsive?

Inspected but not rated

# Child and adolescent mental health wards

Inspected but not rated

**Our rating of responsive stayed the same. We did not inspect the whole of effective during this inspection and therefore did not rate the key question.**

## Access and discharge

**It was not clear how the care pathway on Lower Court was tailored for individual patients. As a result, there was a risk that patients admitted to the ward may not have their needs met and having excessive lengths of stay.**

The care pathway on both wards was based on the National Institute for Health and Care Excellence's and the Quality Network Inpatient CAMHS guidance. However, it was not clear how the care pathway on Lower Court was implemented to support patient admissions. For example, it was not clear how it was tailored to meet individual needs and if the care approach differed between patients with different needs i.e. patients with neurodevelopmental conditions compared to patients with psychiatric conditions. This meant that the staff were at risk of delivering a generic care approach that did not always meet patients' needs. This also created a risk of patients being admitted who were not suitable for the ward with staff unable to meet patients' needs. At the time of the inspection the service that two placements that were not suitable for the ward. They had stayed in the service for over a year. The service managers were working with commissioners to identify suitable alternative placements.

Senior managers had already identified this as an area of improvement for the service. A strategic review of both wards had commenced. Plans were in place to ensure the care pathways on Lower Court and Richmond Court are tailored to meet the needs of individual patients and in line with best practice guidance. For Lower Court the strategic review also included a review of the service level agreement with commissioners.

The service was responsive to the needs of the patients and staff on the wards. Admissions to Lower Court had been temporarily suspended due to the high levels of acuity. The service had recommenced admissions and all referrals were triaged to ensure that the individuals needs could be met safely.

## Facilities that promote comfort, dignity and privacy

At our last inspection we recommended that the service provide food to meet the needs and preferences of the patients. At this inspection we found improvements had been made. Any concerns relating to food were raised with the ward manager and at the community meeting. Meeting minutes demonstrated that any concerns raised where shared with the catering team such as the availability of gluten and vegan meals.

At our last inspection we recommended that the garden was made safe and fencing improved so that patients could have unrestricted access to the garden. At this inspection the service had made improvements. The fence height had been increased and anticlimb paint on the walls. Astroturf was in place and plans were in place for the patients to have a mural. Individual risk assessments were carried out when patients wanted to access the garden.

Inspected but not rated

# Child and adolescent mental health wards

## Are Child and adolescent mental health wards well-led?

Inspected but not rated

**Our rating of well-led stayed the same. We did not inspect the whole of well-led during this inspection and therefore did not rate the key question.**

### 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 patients and staff.**

Leaders had the skills, knowledge and experience to perform their roles. They understood the issues, priorities and challenges the service faced and managed them. They could explain clearly how the teams were working to provide high quality care.

Leaders were committed to the ongoing improvement of the service and had a clear vision of how the service could continue to develop and improve. Leaders were able to explain their focus on staff development and retention to maintain a strong workforce for the service.

Leaders were visible in the service, approachable and accessible for patients and staff. Staff reported they could raise any concerns they had with them.

Leadership development opportunities were available, including opportunities for staff below team manager level.

### Culture

**Staff felt respected, supported and valued. They could raise any concerns without fear.**

Staff felt positive and proud about working for the service and their team. Staff said the team was supportive of one another and they felt able to raise issues or concerns without fear of retribution.

At our last inspection some staff reported that concerns they raised were not listened too, and they felt unsupported and not valued. At this inspection we found improvements. Staff at all levels felt supported by their line managers and the provider's senior leadership team. The hospital director had implemented regular drop in forums and breakfast meetings where staff could meet and raise any concerns regarding the hospital with senior staff. These sessions were also used to inform staff about changes and developments at the hospital. Staff reported that their views and opinions would be listened to and acted on. They described that communication and staff wellbeing initiatives had improved. No incidents of bullying, harassment or discrimination were reported on the wards during the inspection.

Staff reported the morale on the wards was improving and that senior leaders were working to improve staffing, retention and the strategic direction of the CAMHS service. Leaders were visible in the service and approachable for patients and staff.

All staff reported that their team colleagues showed a strong desire to work towards quality improvement and provide a positive experience for all patients.

Inspected but not rated

# Child and adolescent mental health wards

## Governance

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

The hospital director and senior leadership team were aware of areas where improvements could be made and were committed to improving care and treatment for patients. They knew that improvements in the service needed to be embedded and sustained.

Since our last inspection, governance systems have been reviewed and strengthened to include more patient involvement. Patients now attended a part of the clinical governance meeting. Whilst these changes were positive, they were still not fully embedded.

Governance and performance monitoring arrangements were in place to support the delivery of the service, identified risk and monitored the quality and safety of service provision. There were systems and procedures to ensure that the wards were clean and safe. There were sufficient staff on duty to meet the assessed needs of patients safely and additional staff could be rostered if needed. Work was progressing to recruit permanent qualified and nonqualified staff and reduce the use of agency staff. A strategic review of the CAMHS service had begun. Arrangements were in place for incidents to be reviewed, learning identified and to share learning from incidents. However, whilst the service had rolled out processes to review and check learning from incidents, this was not yet fully embedded in the service. For example, the service had not developed systems to look at incidents month on month, track trajectory, dig deeper into themes and carry out an audit or review to ensure that learning has been embedded.

## 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 an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Leaders were aware of the main risks in relation to the service they were providing and demonstrated a good understanding of how to improve performance. The hospitals risk register was reviewed at the monthly clinical governance meeting, any updated actions added. The highest risks related to Covid vaccinations, staff recruitment, turnover, patient acuity on Lower Court and recruitment of therapists.

### Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The service had a dashboard that held key data about the service. This included key information such as incident reporting, staffing, complaints and training.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The service did not ensure that persons providing care and treatment to young people have the competence, skills and experience to do so safely. (Regulation 12(1)(2)(c)) |