St Andrew's Healthcare - Children and Adolescents Mental Health Service

Quality Report

FitzRoy House and Smyth House
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

The Child and Adolescents Mental Health service is now based in Smyth House, a refurbished building situated on St Andrew's Healthcare Northampton site. Smyth House has three ten bedded wards.

At the time of inspection, the service was still based in Fitzroy House and we inspected seven wards. We completed a follow up visit to Smyth House and inspected one ward. Further details can be found later in the report.

This service was last inspected in December 2019. The service was rated inadequate overall and continued to be in special measures which they were placed in July 2019. We issued an urgent Notice of Decision under section 31 of the Health and Social Care Act 2008, imposing conditions on the provider. We told the provider it must make immediate improvements to ensure young people were kept safe through ensuring staff only use approved restraint techniques, that seclusion practice complies with the Mental Health Act, that incidents are investigated in a timely manner, that safety checks and observations are carried out robustly and that staff treat young people with kindness and adopt practices that are least restrictive and not punitive. In addition, we told the provider it must ensure it fosters a positive culture and that the service is overseen by effective leaders who have appropriate processes in place to always ensure oversight of the service.

At this inspection we rated St Andrew's Healthcare Child and Adolescents Mental Service as **requires improvement** because:

- Whilst the service had made several improvements senior leaders had not yet achieved consistency of standards across all wards. Governance processes and aspects of practice were inconsistent across all wards and not yet fully embedded.
- There were inconsistencies in safety practices across the wards. Staff on Meadow, Maple, Brook and Bracken wards (four out of eight wards) did not always ensure a safe environment. On Maple and Bracken ward we found plastic rubbish liners in children and young people's toilets which could be used to self harm. We did not find this issue on the remaining six wards. Five staff across Meadow, Brook and Bracken wards did not wear protective masks correctly and we identified issues relating to infection risks for two young people on Acorn and Berry wards. However, we raised this with the ward manager who implemented new infection control processes for both young people whilst we were on site.
- Not all staff managed risks to children and young people and staff effectively. Staff on Bracken, Brook and Maple wards did not always follow the provider's policy and procedures on the use of enhanced support when observing children and young people assessed as being at higher risk harm to themselves or others. This was managed effectively on all other wards. We found one example of staff observing the same young person for 11 hours of their shift on Brook ward. Staff routinely observed for periods of four hours and above on Brook ward. Staff did not always record children and young people's presentations and risk factors correctly on Bracken and Maple wards. The provider reported 249 incidents of children and young people self harming, across seven wards, whilst on enhanced observations between 1 May 2020 and 31 August 2020.
- Levels of staff restraint of children and young people, including prone restraint and use of rapid tranquillisation had increased on Acorn, Meadow and Maple wards since the last inspection, although had reduced more recently. Staff on Maple ward did not always follow National Institute of Clinical Excellence guidance or the providers policy when using rapid tranquillisation. In one example they did not monitor a young person's physical health after rapid tranquillisation. We did not find this issue on the remaining seven wards.

Summary of findings

- Not all staff followed systems and processes when safely prescribing, administering, recording and storing medicines. There was missing medication on Brook ward. Staff had not always recorded medicine fridge temperatures on Bracken and Maple ward. Staff had not disposed of expired medical equipment on Maple and Bracken wards.

However:

- The provider had made a number of improvements that we told it needed to be made following our inspection in December 2019. There were new hospital leaders in place who had taken action to change the culture of the service and staff reported a shift to people taking responsibility and raising issues in an open and honest way. Leaders displayed the values of the service and ensured staff worked with children and young people in ways which were supportive and not punitive. We saw an overall improvement in seclusion and restraint practice, safeguarding investigations and staff had stopped using punitive language in children and young people's records. Leaders implemented new governance systems, improved their processes and acted to address poor staff conduct quickly.
- Generally, we found that staff went the extra mile for children and young people; carers told us staff hired a soft play centre out of hours for a young person's birthday and staff supported a young person to cook with his mum via video calls during the coronavirus pandemic. Staff treated children and young people with kindness, dignity and respect on seven of the eight wards inspected. We observed positive and relaxed interactions between staff and children and young people. We observed care delivered by staff that demonstrated staff knew the needs of the children and young people on the ward. Young people told us staff were kind and supportive and good at helping them stay calm. Carers spoke positively about staff and told us staff supported them to keep in contact with their relative throughout the coronavirus lockdown.
- Staff involved children and young people and their carers in their treatment and care. The service placed strong emphasis on children and young people's feedback about the new wards and made changes to plans throughout the transformation process to meet their requests. Staff encouraged children and young people, and their carers to be partners in their care through co-production work and monthly carer's meetings. The service trained carers in trauma informed care to deliver training to staff through sharing their experiences as a parent. Staff described this as "powerful, thought-provoking and extremely insightful".
- Staff provided a wide range of care and treatment interventions suitable for the children and young people on the wards. The interventions were those recommended by, and delivered in line with, guidance from the National Institute of Health and Care Excellence. Interventions included a full therapy programme and the use of recognised rating scales to assess and record severity and outcomes.
- Staff and children and young people had access to an extensive range of rooms and equipment to support treatment and care. Children and young people had access to the provider's school for educational activities. Staff ensured that children and young people had access to appropriate spiritual support. The service had a multifaith area and access to chaplaincy support, which included access to leaders from different religions including Christianity, Islam and Wicca.
- The teams included, or had access to, the full range of specialists required to meet the needs of children and young people on the ward. Staff had the right experience, qualifications, skills and knowledge to meet the needs of the children and young people. Teams held regular and effective multidisciplinary meetings.
- The service supported learning, continuous improvement and innovation. The service published research into dialectical behaviour therapy outcomes and adverse childhood experiences in relation to the impact of physical health on mental health. The provider set up a developmental trauma centre with the aim of being a centre of excellence for trauma informed care.

On this inspection we found that the service made enough improvements and we are lifting the hospital from special measures.

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

Summary of findings

Contents

Requires improvement

St Andrew's Healthcare - Children and Adolescents Service

Services we looked at
Child and adolescent mental health wards; Wards for people with learning disabilities or autism;

Summary of this inspection

Background to St Andrew's Healthcare - Children and Adolescents Mental Health Service

St Andrew's Healthcare Child and Adolescents Mental Health service registered with the CQC on 11 April 2011. The service has a registered manager and a controlled drug accountable officer. The Child and Adolescents Mental Health service is now based in Smyth House, a refurbished building situated on St Andrew's Healthcare Northampton site. The service was based on seven wards in Fitzroy House at the start of the inspection and moved to three wards in Smyth House during the inspection process. Smyth House offers sensory rooms, music and arts rooms, a gym, gardening areas and outside space (courtyards). The service offers education opportunities through St Andrew's school, which is Ofsted registered and rated as outstanding. The other registered locations at Northampton are Men's services, Women's services and Neuropsychiatry services.

St Andrew's Healthcare also deliver services in Birmingham and Essex.

St Andrew's Healthcare Child and Adolescents Mental Health service in Smyth House has three wards and is registered to accommodate 30 children and young people. At the start of the inspection the service was operating seven wards in Fitzroy House. There were 21 children and young people using the service when we inspected.

We inspected the following wards at Fitzroy House:

- Acorn, bespoke service for one young person.
- Berry, bespoke service for one young person.
- Bracken, a ten bedded medium secure ward for males with learning disability.
- Brook, a ten bedded low secure ward for males with learning disability.
- Maple, a ten bedded low secure ward for females with complex mental health needs.
- Marsh, a ten bedded low secure ward for males with complex mental health needs.
- Meadow, a ten bedded low secure ward for females with complex mental health needs.

We inspected the following ward at Smyth House:

- Seacole, a ten bedded mixed gender low secure ward.

We planned to visit the other two wards in Smyth House (Stowe, a ten bedded mixed gender low secure ward and Sitwell, a ten bedded medium secure ward for males with learning disability). The visit ended earlier than planned due to a young person presenting with coronavirus symptoms requiring the inspection team to leave the service.

St Andrew's Healthcare Child and Adolescents Mental Health service has been inspected 12 times.

St Andrew's Healthcare Child and Adolescents Mental Health 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

This service was last inspected in December 2019. The service was rated inadequate overall and continued to be in special measures. The service was rated inadequate for safe, requires improvement for effective, inadequate for caring, good for responsive and inadequate for well led.

We found issues of immediate concern during the December 2019 inspection and issued an urgent Notice of Decision under section 31 of the Health and Social Care Act 2008, imposing conditions on the provider. These concerns related to breaches of the following regulations:

- Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safe care and treatment.
- Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safeguarding service users from abuse and improper treatment.
- Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Good governance.

We found that the provider made improvements to the service since the last inspection. We found some issues

Summary of this inspection

relating to the safe and well led key questions and have issued requirement notices in relation to these. Details can be found in the requirement notices section of the report.

Our inspection team

The team that inspected the service comprised two CQC inspection managers, five CQC inspectors, three specialist advisors including a doctor, a nurse and a social worker, and two carer experts by experience.

Why we carried out this inspection

We completed a comprehensive inspection of this service to check on improvements made following it being rated inadequate and continuing in special measures in December 2019.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

During the inspection visit, the inspection team:

- visited all seven wards that were open at Fitzroy House and one ward at Smyth House following the service move, looked at the quality of the ward environment and observed how staff were caring for children and young people;
- spoke with nine children and young people who were using the service and reviewed two comments cards;
- spoke with 12 carers;
- spoke with the clinical director, head of operations, head of nursing, specialist nurse, quality lead and managers for all wards;
- spoke with 35 other staff members; including doctors, nurses, occupational therapists, psychologists, healthcare assistants, social workers, speech and language therapists, education staff, administrators, physical healthcare staff and technical instructors.
- reviewed closed circuit television footage of incidents and restraint;
- attended and observed three episodes of care, one community meeting, one daily multi disciplinary meeting and one clinical governance meeting;
- looked at 13 care and treatment records of children and young people and 11 seclusion records;
- carried out a specific check of the medication management on all wards;
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with nine children and young people and received written feedback from two comments cards.

Children and young people said they felt safe and supported. They said most staff treated them well and were good at de-escalation.

They told us that staff only used restraint when necessary and used it respectfully and with skill.

Most children and young people said they were involved in their care and treatment, involved in co-production and that their families were involved.

Children and young people spoke highly of the physical healthcare team.

However, three young people told us there were not enough staff and this impacted on them being able to do activities and access their bedrooms. Two young people told us the food was of poor quality. One young person said staff had not listened to him when he was feeling mentally unwell and asking for support and subsequently an incident occurred.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- There were inconsistencies in safety practices across the wards. Staff on Meadow, Maple, Brook and Bracken wards (four out of eight wards) did not always ensure a safe environment. On Maple and Bracken ward we found plastic rubbish liners in children and young people's toilets which could be used to self harm. These were removed as soon as we told the ward managers about this. We did not find this issue on the remaining six wards. Five staff across Meadow, Brook and Bracken wards did not wear protective masks correctly and we identified issues relating to infection control risks for two young people on Acorn and Berry wards. However, we raised this with the ward manager who immediately implemented new infection control processes for staff to follow.
- Not all staff managed risks to children and young people and staff effectively. Staff on Bracken, Brook and Maple wards did not always follow the provider's policy and procedures on the use of enhanced support when observing children and young people assessed as being at higher risk harm to themselves or others. We found one example of staff observing the same young person for 11 hours of their shift on Brook ward. Staff routinely observed for periods of four hours and above on Brook ward. Staff did not always record children and young people's presentations and risk factors correctly on Bracken and Maple wards. The provider reported 249 incidents of children and young people self harming whilst on enhanced observations between 1st May 2020 and 31st August 2020. However, this was a reduction since the last inspection and when incidents occurred the provider reviewed the prescribed observation levels for individual young people, updated risk assessments and management plans and increased support where needed.
- Levels of restraint, prone restraint and rapid tranquillisation increased since the last inspection on Meadow, Maple and Acorn wards. The service reported a spike in April 2020 which they attributed to significant change experienced by children and young people. This included government imposed coronavirus restrictions and the planned move to new wards. However, this had reduced more recently. Staff on Maple ward

did not follow National Institute of Clinical Excellence guidance or the providers policy when using rapid tranquillisation in one example, where they did not monitor a young person's physical health after rapid tranquillisation.

- Not all staff followed systems and processes when prescribing, administering, recording and storing medicines. On Brook ward there were four doses of diazepam missing. Staff had consistently recorded medicine fridge temperatures on Bracken and Maple ward. Staff had not disposed of expired medical equipment on Maple and Bracken wards. Emergency drugs were not available on Brook ward; however, this was mitigated by access to emergency drugs on the other wards.
- Staff on Meadow did not always complete daily safety nurse checks and security checks. Staff on Marsh ward had not signed all emergency bag checks. We did not find these issues on the remaining six wards.
- Staff had not always followed the Mental Health Act Code of Practice in relation to seclusion documentation on two wards. We found missing information in three of eleven records reviewed. Examples included two seclusion episodes on Bracken ward with no seclusion care plans and one episode of 70 minutes on Brook ward with no reviews recorded.

However:

- Staff on Marsh, Acorn, Berry and Seacole wards ensured they cared for children and young people in safe environments. These wards assessed and maintained the ward environment to minimise risk to children and young people. All staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. Managers displayed a ligature heat map on every ward which identified high risk areas. The service had enough nursing and support staff on all wards to keep children and young people safe. On Marsh, Acorn, Berry and Meadow wards staff completed observations in line with the providers policies and procedures. Staff on Marsh, Acorn, Berry and Meadow wards managed medication safely and all wards, except for Maple, followed the correct procedures for the administration of rapid tranquilisation, including checking children and young people's physical health after the event.
- The service made improvements in how staff managed times when children and young people required seclusion. Staff ensured children and young people had immediate access to mattresses, chairs and blankets unless it was assessed as unsafe for the individual. Staff worked with children and young

Summary of this inspection

people to end seclusion at the earliest opportunity and managers reviewed records of seclusion to assure themselves this was happening. Seclusion rooms and extra care suites on all wards met the Mental Health Act Code of Practice.

- Staff across all wards completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed these regularly.
- The service had enough nursing and support staff on all wards to keep children and young people safe.
- The service effectively managed safeguarding through support and training for staff and had made improvements in completing timely investigations, which identified any lessons to be shared with staff. Staff had positive relationships with the local authority.
- The service proactively reduced the number of restrictive practices. All wards had restrictive practice logs, which evidenced staff and children and young people discussed any restrictions in place. The provider held monthly 'proactive and positive care' meetings, which reviewed the use of restrictive practices.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive mental health assessments for children and young people and developed care plans to meet identified needs. These included 'Positive Behaviour Support' (PBS) plans for all children and young people and Structure, Positive approach, Empathy, Low arousal, Links (SPELL) plans. Staff created holistic, personalised and recovery orientated plans. Staff updated care plans when necessary.
- Staff provided a range of care and treatment interventions suitable for the children and young people on the ward. The interventions were those recommended by, and delivered in line with, guidance from the National Institute of Health and Care Excellence. Interventions included a full therapy programme and the use of recognised rating scales to assess and record severity and outcomes.
- The teams included, or had access to, the full range of specialists required to meet the needs of the children and young people on the ward. As well as doctors and nurses, teams included or could access occupational therapists, technical instructors, physiotherapists, clinical psychologists, social workers, pharmacists, speech and language therapists and dieticians. Staff had the right experience, qualifications,

Summary of this inspection

skills and knowledge to meet the needs of the children and young people. Teams held regular and effective multidisciplinary meetings as evidenced in the meetings we observed.
- Staff supported children and young people to access physical healthcare support from the provider's physical healthcare team. The provider allocated one nurse practitioner to the service who provided wound care, diabetic reviews, naso-gastric feeds, asthma support, vaccinations and all physical health checks.

However:

- Staff did not always complete children and young people's physical health assessments on admission. Staff on Meadow ward had not completed physical health assessments for two young people on admission, with no explanation recorded.
- Staff did not always attend shift handovers on time, we reviewed 34 handover audit records completed between June and September 2020. Auditors recorded 26 staff as being late to handover and five staff as not attending, with no explanation recorded. Staff raised concerns that the 15 minutes allocated to handovers would not be sufficient once the wards were full.

Are services caring?

Good

We rated caring as **good** because:

- Children and young people described staff 'going the extra mile' for example, carers told us staff hired a soft play centre out of hours for a young person's birthday and staff supported a young person to cook with his mum via video call.
- Staff generally treated children and young people with kindness, dignity and respect on seven of the eight wards inspected. We observed positive and relaxed interactions between staff and children and young people. We observed care delivered by staff that demonstrated staff knew the needs of the children and young people on the ward.
- Carers spoke positively about staff, describing them as "lovely", "supportive", "encouraging", "professional", "fabulous" and "fantastic". Carers told us staff supported them to keep in contact with their relative throughout the coronavirus lockdown.
- Staff involved children and young people and their carers. Children and young people were involved through co-production work and implemented changes at the new service, for example choosing furniture that was homely and

Summary of this inspection

safe. A young person spoke to the board of trustees about co-production at the service. Carers attended monthly carer's meetings and felt empowered to raise issues and reported they felt listened to.
- Carers told us about their involvement in trauma informed care training through sharing their experiences as a parent. Staff described this as "powerful, thought-provoking and extremely insightful".

However:

- Staff on Meadow ward did not always treat children and young people with kindness, dignity and respect. We reviewed a seclusion record when staff failed to respond to a young person's request to use the toilet for at least 45 minutes. We found an example of staff using inappropriate language in a young person's record.
- Carers reported inconsistencies in communication with staff on Bracken, Meadow and Maple wards.

Are services responsive?

Good

We rated responsive as **good** because:

- Staff and children and young people had access to an extensive range of rooms and equipment to support treatment and care. This included activity rooms, games rooms and courtyards on each ward. Within the secure perimeter of the building there were family visiting rooms, numerous sports facilities, an animal courtyard, a tranquillity garden, a horticultural garden, sensory rooms, music, art and craft rooms, a hairdresser, a café, social areas, therapy kitchens and a multifaith area. Smyth House replicated the provision of rooms and equipment available at Fitzroy House on a smaller scale. The lead occupational therapist presented a paper to the provider's board to ensure the sensory facilities and animal courtyard provided at Fitzroy House were included in the new service.
- Children and young people had access to the provider's school for educational activities. Each child or young person had an individualised timetable to meet their needs. Education staff ensured all children and young people had an education, health and care plan in place and liaised with the young person's home area local authority to monitor and review. Children and young people were also able to access the provider's on site light industry workshop.

Summary of this inspection

- Staff ensured that children and young people had access to appropriate spiritual support. The service had a multifaith area and access to chaplaincy support, which included access to leaders from different religions including Christianity, Islam and Wicca.

However:

- Children and young people reported, in the most recent satisfaction survey (2019), that they were not confident that complaining made a difference. Only 24% of children and young people who complained thought it made a difference.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- Managers had not ensured the practice across all wards was of a consistent standard, demonstrated by discrepancies in medication management, observations of children and young people, completion and quality of seclusion records and ward safety checks. Whilst the issues identified did not relate to all wards, they did relate to issues identified at the inspection in December 2019.
- Whilst the service had made improvements, particularly relating to previous issues that affected children and young people's experience, treatment and upholding dignity and human rights, senior leaders had not yet achieved consistency of standards across all wards.
- Findings in the safe key question demonstrated that managers did not have clear oversight and assurance across all wards and this was yet to be embedded in practice.

However:

- The provider made improvements in other areas that we raised as areas of concern at the previous inspection. The provider had made management changes, new leaders implemented actions to change the culture of the service and staff reported a shift to people taking responsibility and raising issues in an open and honest way. Leaders displayed the values of the service and ensured staff worked with children and young people in ways which were supportive and not punitive. We saw an overall improvement in seclusion and restraint practice, safeguarding investigations and staff stopped using punitive language in children and young people's records. Leaders implemented new governance systems, improved their processes and acted to address poor staff conduct quickly.

Summary of this inspection

- Local and provider level leaders were visible on wards and approachable. The service leadership team attended ward team meetings and executives visited the wards: including the chief executive and deputy chief executive working shifts as healthcare assistants.
- The service provided a clear framework of what must be discussed at a ward, team or directorate level in team meetings to support essential information, such as learning from incidents and complaints, being shared and discussed.
- The service supported learning, continuous improvement and innovation. The service published research into dialectical behaviour therapy outcomes and adverse childhood experiences in relation to the impact of physical health on mental health. The provider set up a developmental trauma centre with the aim of being a centre of excellence for trauma informed care.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

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.

As of 31 August 2020, 89% of the workforce in this service received training in the Mental Health Act. The training compliance reported during this inspection was lower than the 95% reported at the last inspection.

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. We received feedback from the advocacy service as part of the inspection. Advocacy continued to be offered throughout the coronavirus pandemic through a mixture of remote working and attending in person. Advocates attended community meetings, hospital managers hearings and children and young people's care reviews via video conferencing. Advocates offered drop-in sessions over the phone and on site.

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

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

The service accommodated one informal young person at the time of the inspection. Staff implemented the correct processes and safeguards to support this young person whilst they remained on the ward.

The provider monitored compliance with the Mental Health Act through regular audits, including checks of every seclusion episode. Staff adherence to the Mental Health Act significantly improved since the last inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

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

As of 31 August 2020, 89% of the workforce in this service received training in the Mental Capacity Act which was slightly lower than at the previous inspection.

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 if they did not have the capacity to do so. We reviewed records which evidenced capacity being discussed, assessed and recorded. Staff on Marsh ward used social stories to support children and young people's

understanding in relation to the service move. Staff on Marsh completed a care plan to support a young person to make informed decisions about their take away consumption following an increase in weight.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Pharmacy staff completed an audit regarding recording children and young people's consent on the provider's electronic medication administration system. The service scored 33% compliance; local leaders were acting by ensuring ward doctors recorded consent correctly.

Staff understood how to support children under 16 years 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 years and where to get information and support on this.

Requires improvement

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

Staff completed and regularly updated thorough risk assessments of all ward areas.

Staff could not observe children and young people in all parts of the wards; however, staff were aware of blind spots and mitigated these through observations.

Maple ward recently changed to a mixed sex ward, following consultation with children and young people who expressed this as a preference as it reflected normal life. The service was compliant with guidance in relation to mixed sex wards, with separate bedroom areas and a female only lounge.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. Managers displayed a ligature heat map on each ward which identified high risk areas.

Children and young people had nurse call alarms in their bedrooms.

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff isolated and tested children and young people for COVID-19 infection following home leave or leave to potential new placements. Staff reported that the general hospital usually returned results within nine hours of the test being submitted.

Staff reported that the provider kept them informed through daily updates throughout the coronavirus pandemic. We reviewed clear, detailed information and guidance that the service provided to staff. Staff were provided with personal protective equipment.

We inspected five seclusion rooms at the service. Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. A checklist, for staff to check the furnishings, was available outside the seclusion rooms. However, on Meadow ward staff had not always signed and dated the checklists.

Extra care suites met the requirements of the Mental Health Act 1983 Code of Practice for caring for children and young people in long term segregation. For example, young people in long-term segregation had access to a lounge, bedroom with en suite facilities (including a toilet, hand-basin and shower) and secure area in which they could access fresh air. Young people chose whether to personalise their extra care areas, in line with their individual risk assessments.

Clinic rooms were fully equipped, with accessible resuscitation equipment.

However, we found staff using plastic bin liners in toilets and bathrooms on Maple and Bracken wards. Plastic bin liners should not be used in children and young people's areas due to the risk of using them to self harm. These were removed as soon as we told the ward managers about this.

Staff did not always follow infection control policy. We observed closed circuit television footage of five staff not wearing masks correctly (three on Meadow, one on Maple and one on Brook) as required by coronavirus procedures. The provider advised that staff have since been informed if they do not wear personal protective equipment as required there will be a disciplinary note put on their file. The provider had issued a weekly newsletter in September 2020 reminding staff of the legal requirement to wear masks correctly and that disciplinary action would be taken if staff did not. Staff did not manage infection risks in relation to the care of two young people in long term segregation. However, we raised this with the ward manager who implemented new infection control processes for both young people whilst we were on site.

Staff did not always complete emergency bag checks in line with the provider's policy and procedures. On Marsh ward staff had not signed the checks for three weeks in June and two weeks in July.

Staff had not disposed of expired medical equipment on Maple and Bracken wards. We found 30 out of date blood collection bottles on Bracken and numerous out of date items on Maple including blood collection bottles, pipettes, infusion sets, tongue depressors, hazmat suits, dressings and face shields.

Safe staffing

The service had enough nursing and support staff to keep children and young people safe for most shifts.

The provider booked in more staff than required and reported 112% of shifts were covered by staff across the service from 1 June 2020 to 31 August 2020. This was based on safe staffing figures. The provider used a staffing tool that sets out a requirement for safe staffing numbers and optimum staffing numbers. The optimum numbers include staffing numbers required to provide a full therapeutic timetable. Of the shifts filled, 20% were filled by qualified staff and 80% by unqualified staff.

However, staff on Maple and Bracken wards reported regularly working below optimum numbers, which impacted on children and young people's access to activities and leave. We reviewed Bracken team meeting minutes from August 2020 which stated the ward was 'constantly working below numbers which impacts on service users being able to do activities.

During our site visit on the 8 September 2020, we noted six staff on duty on Maple ward. The planned number for this day was nine staff (eight as per establishment and one to support a young person's discharge). The shift planner for the day also detailed six staff being on duty. We reviewed meeting minutes for Meadow ward in July 2020 which described difficulties with having enough staff on the ward to meet the needs of children and young people and resulted in an incident where there were only three staff on the ward and children and young people were not kept safe.

Most children and young people had staff to escort them on community leave (under section 17 of the Mental Health Act 1983 leave). Of 1007 planned leaves, between 1 June 2020 and 31 August 2020 six were cancelled; five for clinical reasons and one due to insufficient staff (on Maple ward).

This service reported a vacancy rate for all staff of 8% as of 31 August 2020. This was lower than the rate reported at the last inspection of 18% (as of 31 July 2019).

This service reported an overall vacancy rate of 10% for qualified staff as of 31 August 2020.

This service reported an overall vacancy rate of 7% for unqualified staff.

The provider employed their own bank staff (employed by the provider on an as and when required basis), referred to as 'WorkChoice' staff. The service provided the following information in relation to bank staff: "We have not shown WorkChoice numbers separately from those staff on a fixed working pattern because our WorkChoice staff moved from working as part of a centralised staffing service to being part of the service in February 2020. They are therefore inducted, supervised, managed, and trained alongside the rest of their CAMHS colleagues. As we move from fixed A&B shifts to a more flexible approach, the lines between "permanent" staff working a flexible shift pattern and a WorkChoice member of staff who might be doing as many shifts are becoming increasingly blurred."

In the same period, agency staff covered 5% of available shifts for staff. This was a reduction from the 11% reported at the last inspection.

The main reasons for bank and agency usage for the wards were to provide enhanced support to children and young people, cover staff vacancies and sickness.

Ward managers could adjust staffing levels daily to take account of children and young people's needs. When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. When agency and bank nursing staff were used, they received an induction and were familiar with the ward. We observed that a qualified nurse was present in communal areas of the wards during our inspection.

Due to the reduction in bed numbers, staff numbers significantly decreased. Service leaders reduced overall staff numbers from 312 to 139 between May 2020 and September 2020.

Managers supported staff who needed time off for ill health.

Staffing levels allowed children and young people to have regular one-to-one time with their named nurse.

Staff received and were up to date with appropriate mandatory training. Overall, staff in this service had undertaken 94% of the various elements of training that the provider set as mandatory. There were no mandatory courses with a compliance rate below 75%.

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

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

Assessing and managing risk to patients and staff

The provider made improvements to ensure staff followed the provider's policy on the use of enhanced support, including a new policy, training and regular audits. However, we found examples on three wards where staff did not always follow the provider's policy and procedures on the use of enhanced support when observing children and young people assessed as being at higher risk harm to themselves or others. We found issues on three of the eight wards visited.

On Brook ward, staff care planned for two young people to be observed by the same staff for longer than two hours continuously. We found examples of staff observing the same young person for 11 hours of their shift. Staff routinely observed for periods of four hours and above. This is not in accordance with the providers policy and does not adhere to guidelines by the National Institute for Health and Care Excellence (NG10). Staff completing extended periods of enhanced observations may be less likely to maintain the levels of concentration required to maintain safety. However, the provider advised this approach was care planned and the deviation from policy agreed with the policy owner.

Staff did not always record their observations of children and young people correctly on Maple and Bracken wards. This meant that staff may not have accurate risk information to support the assessment of children and young people. On Maple ward staff recorded on two dates in September 2020 that a young person was settled and stable with no risk factors. However, for the same dates staff recorded on the electronic record incidents of restraint and rapid tranquillisation being administered. On Bracken ward we reviewed observation records for two young people on enhanced support and staff did not detail their mood and presentation.

Staff did not always keep children and young people safe from harm whilst on enhanced observations. The provider reported 249 incidents of children and young people self harming whilst on eyesight or arm's length observations between 1 May 2020 and 31 August 2020. 87 incidents occurred whilst children or young people were on arm's length observations with the remaining 152 on eyesight observations. Meadow reported the highest number at 75 incidents (64 on eyesight observations and 11 on arm's length). Bracken reported the least with 38 (ten on eyesight observations and 28 on arm's length). However, this was a reduction since the last inspection. The provider advised that the purpose of enhanced observation is not always to prevent self harm, but to intervene quickly.

Staff did not always complete safety checks in line with the provider's policy and procedures on one ward. This potentially exposed children and yougn people to identifiable risks. We reviewed a week of daily safety nurse checks and security checks on Meadow ward. We found four days when the safety nurse checks had not been recorded and two days when staff had not recorded daily security checks.

Staff completed risk assessments for each child and young person on admission, using a recognised tool, and reviewed these regularly.

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

The provider made changes to reduce the use of blanket restrictions. All wards had restrictive practice logs, which evidenced staff and children and young people discussing any restrictions in place. We reviewed minutes of ward based daily multi-disciplinary meetings which evidenced active discussions in relation to risks and restrictions, for example, individual dynamic risk assessments about children and young people's access to courtyards, bathrooms and making hot drinks. The provider held monthly 'proactive and positive care' meetings, which reviewed the use of restrictive practices.

The provider had taken action to address concerns from the previous inspection relating to staff using inappropriate restraint techniques. Any incidents involving staff use of inappropriate restraint were reported and investigated. We reviewed 16 incidents of restraint on closed circuit television footage that had taken place in August and September 2020. We identified one restraint of concern which evidenced staff dragging a young person for a few seconds when they lifted her feet off the ground. Staff already referred this incident to the local authority designated officer, and it was being investigated. We identified two restraints that posed a potential risk to children and young people due to staff not keeping control of the situation and one where excessive numbers of staff were involved. However, we observed positive de-escalation and team work by staff and staff demonstrating least restrictive practice throughout the other restraint incidents reviewed. There was one brief moment of prone restraint that staff had not recorded on the incident report, however staff appropriately managed this.

Levels of restraint increased since the last inspection on Acorn, Marsh and Meadow wards. The provider reported 1,166 incidents of restraint from 1 March 2020 and 31 August 2020 on 26 children and young people. This equated to an average of 44 restraint incidents per person. This was an increase since the last inspection when 2,266 incidents of restraint from 1 February 2019 to 31 July 2019 were recorded for 85 children and young people. This equated to 26 restraint incidents per person. The service reported a spike in April 2020 (532 incidents) which they attributed to the impact of coronavirus restrictions and the planned service move. Staff provided additional interventions to support children and young people and the incidents decreased. Meadow ward reported the highest number of restraints at 719, followed by Maple with 247. Restraint figures for August 2020 were 170 incidents of restraint on nine young people.

The provider reported 132 episodes of prone restraint (face down) between 01 March 2020 and 31 August 2020. Meadow reported the most with 84, followed by Maple with 20. The most common reason recorded for prone restraint was 'patient position' (57). This equated to an average of 11 prone restraints per person. This was an increase since the last inspection when the provider reported 232 incidents of prone restraint from 1 February 2019 to 31 July 2019. This equated to an average of three per person. Prone restraint figures for August 2020 were 18 incidents of prone restraint on six children and young people.

Staff on Maple ward did not follow National Institute of Clinical Excellence guidance or the provider's policy when using rapid tranquillisation. We reviewed records for a young person following staff administering rapid tranquillisation. Staff had not recorded the time of administration and had not recorded any post administration physical health monitoring. Staff advised there were no forms for the observation of physical health post rapid tranquillisation. Staff had not completed National Early Warning Score or Paediatric Early Warning System charts and there was no evidence of a doctor's review of the young person's health. Senior ward staff advised that staff did not routinely complete monitoring of physical health following rapid tranquillisation. Children and young people were at risk of developing physical health concerns that staff would not identify.

The service reported 92 incidences of rapid tranquillisation on nine different children and young people from 1 March 2020 to 31 August 2020. Meadow reported the highest number at 55, followed by Maple with 35. Bracken and Acorn reported no incidences. This was an increase since the last inspection when the provider reported 39 prone restraints that resulted in rapid tranquillisation.

The service reported use of mechanical restraint for one young person on Meadow ward. Staff had fully involved the young person who expressed this was their preference. Staff were authorised at board level to use emergency restraint belts for a child or young person as a last resort intervention to keep them safe and reduce the length of time in restraint. Staff consulted outside the ward multi disciplinary team to ensure that the use of mechanical

restraint was the least restrictive option to keep the young person safe. We reviewed evidence that the use of mechanical restraint for this young person was subjected to additional board level scrutiny and was under continual review.

The service reported 152 episodes of seclusion between 1 March 2020 and 31 August 2020, the most on Meadow (65), followed by Brook (34). The service reported a spike in April 2020 (53 incidents) which they attributed to young people becoming unsettled due to coronavirus restrictions and the planned service move. Staff provided additional interventions to support children and young people and the incidents decreased. This was a significant decrease since the last inspection when the provider reported 582 episodes of seclusion from 1 February 2019 - 31 July 2019.

We reviewed 11 seclusion records. The seclusion records met most of the requirements of the Mental Health Act 1983 Code of Practice. On Maple ward we reviewed a seclusion record where staff had not completed a body map of the young person despite them punching walls, picking wounds and headbanging. Staff on Maple secluded a young person without a clear rationale as the young person changed herself into strong clothing, walked herself into seclusion, was calm and complied with all staff requests. Staff recorded the young person as calm for the duration of the seclusion, from 21:16 to 22:45 hours. Service leaders told us they discussed this seclusion incident with the team. However, we were not provided with any evidence of this.

On Brook ward staff secluded a young person for 70 minutes in the day area of the extra care suite. Staff had not recorded the rationale for this, their review or that they had informed the necessary parties. Staff did not record their rationale for termination. On Bracken ward staff had not recorded a rationale for not allowing a young person to have clothes in one record; in another record staff had not completed a seclusion care plan.

The wards in this service participated in the provider's restrictive interventions reduction programme. Staff told us that they would use de-escalation methods before resorting to restrictive interventions and children and young people confirmed this. Staff told us about different de-escalation methods they would try, for example, weighted blankets and use of ice cubes to distract children and young people from self harm urges to avoid using restrictive interventions.

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

Staff had appropriately recorded six episodes of long-term segregation of children and young people, between 1 March 2020 and 31 August 2020, two on Brook ward and one each on Bracken, Maple, Fern (now closed) and Marsh.

The provider ensured children and young people had access to education when in long term segregation. We spoke with a teacher, who talked to us about bespoke education programmes for children and young people in long-term segregation.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. All staff completed level one safeguarding children and adults training and 91% of staff completed level three safeguarding children and adults training. The service recently introduced specific safeguarding supervision for all staff after identifying an increase in safeguarding incidents as a result of unprofessional conduct.

The service made progress in ensuring investigators completed detailed safeguarding investigations in a timely manner. We reviewed investigations for six safeguarding incidents that occurred between June 2020 and August 2020. Investigators completed their investigations within 28 days for five cases. Investigators involved children and young people, in some cases using advocacy and staff that knew the children and young people well to help with this. Investigators made recommendations for learning and actions from the incidents. We also saw evidence that local leaders took appropriate disciplinary action against staff following incidents of unsafe or unprofessional behaviours.

The service lead social worker met with the local authority safeguarding representative weekly to review safeguarding cases.

Social workers, allocated to individual wards, were responsible for raising safeguarding alerts during normal office hours. Outside of these hours staff would report incidents to the local authority duty worker.

The service had a named child protection lead and managers displayed this information on the wards.

Requires improvement

Child and adolescent mental health wards

Staff followed safe procedures for children visiting the ward. There were visiting areas located outside of the wards which staff used to facilitate families visiting with children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The service reported 80 safeguarding incidents between 1 March 2020 to 31 August 2020. Meadow ward reported the highest number at 40, followed by Maple with 12 and Marsh with 10. Of these, 49 were referred externally.

Staff access to essential information

Staff used an electronic record system for children and young people's records, with some records also available in paper format, for example, positive behaviour support plans.

All information needed to deliver care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form.

Medicines management

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. On Brook ward there were four doses of rectal diazepam missing. Staff last checked on 5 September 2020 and signed as present. On Bracken ward staff did not complete the controlled drugs register correctly. Staff made changes to dates and amounts and not initialled. Staff had not always recorded medicine fridge temperatures on Bracken and Maple ward, we found three days missing over three months on Bracken and two days missing in August on Maple. Staff on Maple recorded the fridge temperature above the accepted limit of eight degrees Celsius on four days in July and August 2020 but had not taken action to rectify. Children and young people were at risk of receiving medication that would not work as effectively.

Emergency drugs were not available on all wards. There was no adrenaline medication in EpiPen's on Maple ward despite staff recording during routine stock checks that it was. However, adrenaline was available in vials and the provider advised there was a national shortage of EpiPen's at the time of the inspection. Staff were able to access emergency medications on other wards.

Staff reviewed medicines regularly and provided specific advice to children and young peoples and carers about their medicines.

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

The service had systems to ensure staff knew about safety alerts and incidents.

Decision making processes were in place to ensure staff did not control children and young people's behaviour by excessive and inappropriate use of medicines.

Staff reviewed the effects of each medication on children and young people's physical health according to National Institute of Clinical Excellence guidance, except for rapid tranquilisation monitoring on Maple ward.

Track record on safety

Between 1 September 2019 and 31 August 2020 there were seven serious incidents reported by this service. Willow and Marsh reported two each, with Acorn, Fern (now closed) and Meadow all reporting one.

Three were serious incidents of child and young person self harm, two were physical aggression and violence, one was young person's sexual activity and one related to security.

The number of serious incidents reported during this inspection was lower than the 31 reported at the last inspection.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported all incidents that they should report. Leaders ensured incidents were investigated in a timely manner.

Staff understood the duty of candour. They were open and transparent and gave children, young people and their families a full explanation when things went wrong. This was confirmed by carers we spoke with.

We reviewed an incident where a nurse administered the wrong medication to a young person. The nurse immediately explained what happened to the young person, apologised, sought advice, reported appropriately and reflected. There was no harm to the young person.

Requires improvement

Child and adolescent mental health wards

Staff received feedback from the investigation of incidents, both internal and external to the service. Feedback was provided in team meetings, supervisions and via 'red top alerts', which were emailed to all staff across the organisation. Examples included a young person breaking a laundry basket and secreting the sharp pieces of plastic. Staff at the service changed the laundry baskets.

We reviewed investigation reports that evidenced changes and learning, for example, reviewing closed circuit television footage with staff to help improve their practice when responding to an incident.

Managers acted following the previous inspection to make changes to improve the safety of the service. This included a review of the handover process and regular audits to ensure all risk information was being handed over.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff assessed the mental health of all children and young people on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff did not always complete physical health assessments on admission. Staff on Meadow ward had not completed physical health assessments for two young people on admission. Children and young people were at risk of their physical health needs not being met. Staff on other wards completed physical health assessments on admission for records reviewed.

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

Staff developed 'Positive Behavioural Support' plans with children and young people on all wards. These were personalised, holistic and recovery-orientated. Plans included specific interventions individualised to meet individual needs, examples included creating a 'den' in the sensory room. Staff demonstrated good knowledge of Positive Behavioural Support' plans and interventions to support individual, for example, use of sensory box, use of ice, coloured rice and weighted blankets.

Staff developed 'SPELL' plans (Structure, Positivity, Empathy, Low arousal, Links) on Brook and Acorn wards. These were plans designed specifically to support children and young people with autistic spectrum disorders. The plans were very detailed and included positive approaches and expectations, warning signs and self-regulation.

Staff regularly reviewed and updated care plans when the needs of children and young people changed.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the children and young people on the wards. The interventions were those recommended by, and delivered in line with, guidance from the National Institute of Health and Care Excellence.

A trauma informed care model underpinned the service provision. The provider advised "trauma informed care is a system development model grounded in and directed by a complete understanding of how trauma exposure affects people's neurological, biological, psychological and social development. The main principles are that everyone feels connected, informed, valued and hopeful about recovery, the connection between childhood trauma and psychopathology is known and understood by all staff and that staff work in mindful and empowering ways with all stakeholders to promote and protect the autonomy of the individual. Trauma informed care services ask what happened to you? Rather than what is wrong with you?" The trauma informed treatment pathway was guided by Goldings pyramid of need ensuring interventions were based on psychological need/priority for the children and young people at that time.

Staff completed trauma screenings and assessments with children and young people. Staff used the University of California, Los Angeles brief screen for child/adolescent trauma and post-traumatic stress disorder (2020). Staff completed the following trauma assessments: The University of California, Los Angeles Post Traumatic Stress Disorder Reaction Index for DSM-5 Child/Adolescent Self Report; the University of California, Los Angeles Post Traumatic Stress Disorder Reaction Index for DSM-5: Parent/Caregiver Report; Child and Adolescent Needs

trauma comprehensive; Child and Youth resiliency measure-revised (2018); - Difficulties in Emotional Regulation Scale Short Form (2015) and Beck Youth inventories.

Other interventions included a full dialectical behavioural therapy programme, cognitive behavioural therapy, behavioural family therapy, sensory integration, 'reinforce appropriate implode disruptive' approach, transition to the family environment therapy, work on psycho-social skills, autism groups, cognitive development and 'Playfulness, Acceptance, Curiosity and Empathy' therapy.

National Institute of Health and Care Excellence recommends trauma focused cognitive behavioural therapy for children and young people with post traumatic stress disorder. Over the last year all psychologists undertook continuing professional development to ensure they were up to date with current practice guidance, this included attendance at conferences and online courses. The service completed a National Institute of Health and Care Excellence audit on post-traumatic stress disorder at the end of last year.

Following feedback from children and young people, the lead occupational therapist put forward a case to the board of trustees for animal therapy to continue at the new service. Animal therapy provided part of the service pre-vocational / work rehabilitation pathway, was part of the trauma informed care model using non-talking therapies for children and young people that do not feel safe and struggle to trust staff initially, helped improve children and young people's motivation and engagement in meaningful activity, was used as part of exposure work, as part of sensory integrations, and to provide a connection to home.

The service included an Ofsted registered school, rated as outstanding, which provided educational and vocational opportunities to children and young people. These included General Certificates of Secondary Education, A levels, access courses, the Duke of Edinburgh award, citizenship activities and access to work experience. The school supported children and young people to gain qualifications, despite the limitations imposed by the coronavirus pandemic. The service reported 36 children and young people gained qualifications, including GCSE's in Maths, English and Biology.

The service accessed physical healthcare support from the provider's physical healthcare team. The provider allocated one nurse practitioner to the service who provided wound care, diabetic reviews, naso-gastric feeds, asthma support, vaccinations and all physical health checks, for example, blood tests and swabs etc.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration. There were children and young people with 'disordered eating', some of which required nasogastric feeds at times. There were staff trained to provide nasogastric feeds. Nasogastric feeds consist of delivering liquid nutrients through a tube passing through the nose and into the stomach.

Staff supported children and young people to live healthier lives through healthy eating advice and support to access physical activities. Staff supported children and young people to cook healthy versions of their favourite takeaways.

Staff used recognised rating scales to assess and record severity and outcomes. These included Health of the Nation Outcome Scales for Children and Adolescents, the Short Term Assessment of Risk and Treatability, Structured Assessment of Violence Risk in Youth and Children's Global Assessment Scale, Difficulties in Emotional Regulation Scale Short Form, Strengths and Difficulties Questionnaire and Friends and Family Test.

Staff used technology to support children and young people effectively. Examples included use of digital devices to access internet based programmes to access mindfulness and relaxation sessions. Staff supported children and young people to use video conferencing facilities to attend co-production meetings. One staff, who had to self isolate due to coronavirus, continued to provide therapy to a young person via video conferencing. Another young person struggled to meet with people face to face, so the psychologist provided therapy via video conferencing, which reduced their anxieties.

Staff participated in clinical audits, including audits of enhanced support, general observations, National Institute of Health and Care Excellence guidance, seclusion, long term segregation, care plans and safeguarding. We reviewed evidence in team meeting minutes of outcomes and actions from audits being discussed and implemented.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of children and young people on the ward. As well as doctors and nurses, teams included or could access occupational therapists, technical instructors, physiotherapists, a sports and exercise therapist, clinical psychologists, social workers, pharmacists, speech and language therapists and dieticians.

Staff had the experience, qualifications, skills and knowledge to meet the needs of the children and young people on the ward.

Managers provided new staff with appropriate induction. All staff attended a two day corporate induction followed by a service specific induction. The service induction programme was spread over three to six months and included the following topic areas; A 'keeping everyone safe' session and a children and young people and carers session (devised, produced and facilitated by children, young people and carers), nursing staff and medical staff attended a full day on Immediate Life Support and how to recognise the deterioration in a child or young person; unqualified staff completed the Care Certificate within the first three months of employment, and were supported by a workplace mentor.

Managers supported staff through regular, constructive appraisals of their work, 96% of staff received an appraisal within the last 12 months.

Managers supported staff through regular, constructive clinical supervision of their work. The service reported a clinical supervision compliance rate of 85% between 1 March 2020 and 31 August 2020.

The service reported a management supervision compliance rate of 91% between 1 March 2020 and 31 August 2020.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We reviewed minutes of 52 meetings between April and September 2020. Meetings were well attended, and managers provided staff with relevant information.

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

Managers made sure staff received any specialist training for their role. The service reported an additional 73 specialist training opportunities that staff had undertaken in the past 12 months, the most popular were Cyber Security Awareness, National Early Warning Score, Fire Safety Awareness, Search training, Enhanced Support, Trauma Informed Care Training, SPELL Structure, Positive approach, Empathy, Low arousal, Links Training, Clinical Supervision, Safe Medication Management, Nutrition and Wellbeing. We reviewed 84 staff evaluation forms completed between December 2019 and August 2020 following trauma informed care training, all were positive about the training and described how it would help them in their role in relation to use of language, sensory strategies and understanding the impact of adverse childhood experiences.

Two staff attended a conference facilitated by an external disability rights campaign organisation on Positive Behaviour Support. The aim was to ensure Positive Behaviour Support plans were compliant with guidance. Several changes were made to Positive Behaviour Support plans with further improvements planned as part of the embedding Positive Behaviour Support in line with trauma informed care.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers gave examples of using the provider's human resources processes to manage performance and conduct issues.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. We observed one ward based daily multidisciplinary meeting and reviewed ten sets of minutes from ward based daily multidisciplinary meetings. Staff discussed each child and young person in detail including concerns and plans for the day, reviewed the daily planner and staff numbers. Education staff were integrated with the ward teams, with a teacher based on each ward and attending multidisciplinary meetings. Teachers provided education and activities on the ward as well as in the school.

Staff shared clear information about children and young people and any changes in their care. Staff completed handovers in line with the provider's policy and procedures. We reviewed handover records for the past two months on Brook, Bracken, Maple and Marsh wards and staff completed detailed records. However, staff did not always attend handover on time. The service ward

managers and senior nurses completed weekly observations/audits of each other's ward handovers once a week to ensure staff were completing them correctly. We reviewed 34 audit records completed between June and September 2020. Auditors recorded 26 staff as being late to handover and five staff as not attending.

The service allocated 15 minutes for staff handovers. Staff were concerned this would not be enough time when they have ten children and young people on the ward and were worried that they may have to work late to ensure an effective handover takes place.

Ward teams had effective working relationships within the service and with external agencies, including local authorities and commissioners.

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.

As of 31 August 2020, 89% of the workforce in this service received training in the Mental Health Act. The training compliance reported during this inspection was lower than the 95% reported at the last inspection.

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. We received feedback from the advocacy service as part of the inspection. Advocacy continued to be offered throughout the coronavirus pandemic through a mixture of remote working and attending in person. Advocates attended community meetings, hospital managers hearings and children and young people's care reviews via video conferencing. Advocates offered drop in sessions over the telephone and on site.

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

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician 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 detention papers and associated records correctly and staff could access them when needed. Records reviewed confirmed this.

The service accommodated one informal young person at the time of the inspection. Staff implemented the correct processes and safeguards to support this young whilst they remained on the ward.

The provider monitored compliance with the Mental Health Act through regular audits, including checks of every seclusion episode. Staff adherence to the Mental Health Act significantly improved since the last inspection.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to young people 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 the five principles.

As of 31 August 2020, 89% of the workforce in this service received training in the Mental Capacity Act. The training compliance reported during this inspection was lower than the 95% reported at the last inspection.

Requires improvement

Child and adolescent mental health wards

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 they did not have the capacity to do so. We reviewed records which evidenced capacity being discussed, assessed and recorded. Staff on Marsh ward used social stories to support children and young people to understand the service move. Staff on Marsh completed a care plan to support a young person to make informed decisions about their takeaway consumption following an increase in weight.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve. Pharmacy staff completed an audit regarding consent on the provider's electronic medication administration system. The service scored 33% compliance; local leaders were acting by discussing with ward doctors.

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 16 to 18 and where to get information and support on this.

Are child and adolescent mental health wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

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

Staff treated children and young people with kindness, dignity and respect on Acorn, Berry, Bracken, Brook, Maple, Marsh and Seacole wards. We observed positive and relaxed interactions between staff and children and young people.

We heard examples of staff going the extra mile, for example, carers told us staff hired a soft play centre out of hours for a young person's birthday. This young person struggled to go out and their family reported that he had a great time. We were told about staff supporting a young person from Ireland who loved cooking with his mum. Staff set up video calls with their mum and they would cook the same meals together over the call.

We observed care delivered by staff that demonstrated staff knew the needs of the children and young people. On Marsh ward we observed staff responding quickly and discreetly to a young person's request to have support from his mum via video call in a difficult situation.

Staff ensured the impact to children and young people caused by disruption of the service move was minimised.

We observed staff on one ward discussing a young person who was transitioning in a respectful and appropriate manner.

We found evidence in team meeting minutes where managers proactively challenged staff to reflect on the language they used in records. For example, reminding staff not to use the word 'prompt' but use encourage or support. Leaders advised staff to consider how the child, young person or their family would want it to be written.

Staff supported children and young people to understand and manage their own care, treatment or condition.

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. However, two young people told us that some staff were not supportive and could be rude.

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 information confidential.

However, staff on Meadow ward did not always treat children and young people with kindness, dignity and respect. We reviewed a seclusion record when staff failed to respond to a young person's request to use the toilet for at least 45 minutes. We found one example of medical staff misgendering a young person in their admission notes. However, the provider advised that this was part of an entry prefaced with 'report copied from referral form' received from the patient's previous clinical team. We found an example of staff using inappropriate language in one young person's record. However, the provider took swift action to investigates and undertake formal disciplinary measures.

Involvement in care

Staff involved children and young people and gave them access to their care planning and risk assessments.

Staff made sure children and young people understood their care and treatment. They ensured that children and young people had easy access to independent advocates.

Staff involved children and young people in decisions about the service, when appropriate. The provider set up co-production meetings attended by children, young people and staff. We reviewed minutes of six co-production meeting minutes from March 2020 to September 2020. Children, young people and staff, including local leaders, attended. The agenda included staff training (and children and young people's involvement with this), service development, review of policies and procedures and restrictive practice. We also reviewed a co-production report following feedback from children and young people about the new service. There were examples of changes made to the new service following their feedback. These included changes to lighting, purchasing furniture from a supplier identified by a young person and bringing the animals to the new service. We reviewed examples of co-produced work including a contract for children and young people to have mobile phones, a draft welcome booklet and ward leaflet. A young person spoke to the board of trustees about co-production at the service and the provider's involvement lead shared the service's co-production work with the provider's other locations as an example of how it should be done.

Staff introduced children and young people to the ward and the services as part of their admission. Children and young people were involved in staff recruitment, including being part of the selection panel and writing questions. One young person told us about their work experience in the human resources department.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. The service held daily community meetings (huddles) on wards with children and young people. We observed a community huddle that estates staff attended. Estates staff updated participants on progress with works on the new wards. Staff gave children and young people the opportunity to feedback and share any anxieties. Estates staff advised they will be around the day before and during the move for any help or advice. Staff gave children and young people a choice in the order they will move. We observed good involvement of children and young people and positive interactions.

We reviewed the results of the most recent survey completed in 2019. Positive feedback included 86% of children and young people reporting being involved in reviews of their care and treatment. The service received negative feedback in relation to children and young people's complaints not making a difference. The provider implemented an action plan in response with "an overarching aim to increase the attendance at forums and involvement groups and to identify different ways of involving young people from across the wards. It is through these groups that we will continue to plan improvements based around children and young people's experience."

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

Staff made sure children and young people could access advocacy services, including throughout the coronavirus pandemic.

Most carers we spoke with gave positive feedback about the service. We spoke with twelve carers. All carers spoke positively about staff, describing them as lovely, supportive, encouraging, professional fabulous and fantastic. Carer's described how staff involved them in changes to the service. Carers had no concerns about the number of staff. Most carers were confident in the care and treatment offered, were involved in care plans and were invited to care reviews. Carers told us staff supported them

to keep in contact with their relative throughout the coronavirus lockdown. Carers reported that their relatives were supported to access education, with lessons being tailored to meet individual needs.

Carers told us about their involvement in trauma informed care training through sharing their experiences as a parent. Staff described this as "powerful, thought-provoking and extremely insightful".

The service facilitated monthly carers meetings. Staff held these on a Saturday to enable more carers to attend. We reviewed minutes of carers meetings from March to August 2020. From April 2020 staff held meetings virtually due to coronavirus restrictions. Carers attendance varied between two and four carers per meeting. There was evidence of discussions in relation to carers being involved in staff training and staff seeking carers views on how communication could be improved. Carers we spoke with were positive about the monthly carers group and felt empowered to raise issues and reported they felt listened to.

The service provided travel bursaries to help families with cost of travelling to visit their relative. Staff hosted welcome meetings with families following new admissions.

There was a carers centre located on site.

However, not all carers were involved in care plans and some were not aware of the care and treatment provided. Most carers reported a lack of consistency with communication. Two carers raised concerns that they did not feel safe in the visiting rooms as there was no easy way to contact staff when their relative became distressed. Carers reported that sometimes staff offered a personal alarm, but not always. One carer told us they had to shout down the corridor for help on one occasion. Two carers on Bracken ward told us they had not been given full information about incidents involving their relative and that managers had not listened to them.

Are child and adolescent mental health wards responsive to people's needs?
(for example, to feedback?)

Good

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.

The service was in the process of changing from a nationally commissioned service to a combination of one nationally commissioned ward and two locally commissioned wards. The provider had worked closely with commissioners to ensure the changes made to the service were in line with identified Children and Adolescents service needs.

The service reported an average occupancy rate of 62% between 1 September 2019 and 31 August 2020. This was due to the provider proactively deciding to reduce their beds and reduce risks.

There was always a bed available when children and young people returned from leave.

The service reported 12 internal transfers between 1 September 2019 and 31 August 2020. Staff had transferred four children and young people as part of the wards merging, staff transferred five children and young people to rehab wards as their recovery progressed, staff moved one young person due to a decline in their mental state and one young person moved to another ward as they were over 18 years and now an adult.

When staff moved or discharged children and young people, this happened at an appropriate time of day.

Staff completed discharge plans for children and young people. Staff were supporting one young person's transition process by working alongside staff from their next placement.

The service reported 22 delayed discharges between 1 September 2019 and 31 August 2020. Marsh reported the highest with six, followed by Acorn and Bracken with four each. The most common reason for the delay was "awaiting further non-acute NHS care" (11), followed by "housing - supported accommodation" (three), followed by "awaiting care coordinator allocation" (two), "awaiting community equipment/adaptations" (two) and "awaiting MOJ [Ministry of Justice] agreement/permission" (one). The service did not provide a reason for four of the delayed discharges. The service engaged in a weekly teleconference

Access and discharge

with NHS England and home area commissioners to discuss any delayed discharges and transition blockages in the service and worked to resolve these issues and escalate matters.

Staff supported children and young people during referrals and transfers between services – for example, if they required treatment in an acute hospital.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward/service supported treatment, privacy and dignity. Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.

Staff and children and young people had access to the full range of rooms and equipment to support treatment and care. This included activity rooms, games rooms and courtyards on each ward. Within the secure perimeter of Fitzroy House there were two gyms, a large sports hall, an outdoor multi sports area, an outside gym area, an animal courtyard, a tranquillity garden and a horticultural garden. In addition to two sensory rooms, a music room, an arts studio, a craft room, a hair salon, a café, a social area with a pool table, three therapy kitchens, a multi-faith area (including a wudu for bathing), and treatment rooms. Educational facilities included a science room with a viewing laboratory which enabled children and young people to view teachers performing science experiments safely.

Smyth House replicated the provision of rooms and equipment available at Fitzroy House on a smaller scale. The lead occupational therapist presented a paper to the provider's board to ensure the sensory facilities and animal courtyard provided at Fitzroy House were included in the new service. In addition, children and young people with the required leave would be able to access additional sports facilities, including a swimming pool, in a building located next door to Smyth House.

Children and young people had their own bedrooms, which they personalised.

Children and young people had somewhere secure to store their possessions.

Each ward had a quiet room and meeting rooms located just outside the main ward area that staff used to facilitate family visits.

Each ward had a phone room where children and young people could make phone calls. There were also additional phones located in the meeting rooms just off the wards, which children and young people could also use.

Each ward had an outside courtyard area that provided access to outside space.

Staff assessed children and young people's access to hot drinks at an individual level. The new wards included a hot drinks station. There were cold drinks dispensers in the lounge areas.

Children and young people had their own snack boxes and could request snacks at any time.

Patients' engagement with the wider community

Staff facilitated young people's access to high quality education throughout their time on the ward.

Children and young people had access to the provider's school for educational activities. Each person had an individualised timetable to meet their needs. There was a specially designed classroom for children and young people with autistic spectrum disorders. The room had individual workstations, clearly labelled items and social areas to encourage interaction.

Children and young people were able to access the provider's on site light industry workshop.

Staff supported children and young people to access a variety of on site and leave activities, although this had been reduced over recent months due to coronavirus restrictions. Staff recently supported children and young people on trips to theme parks.

Staff supported children and young people to maintain contact with families through visits and video conferencing.

Meeting the needs of all people who use the service

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

Requires improvement

Child and adolescent mental health wards

The service made adjustments for children and young people with a disability – for example, by ensuring disabled people's access to premises and by meeting children and young people's specific communication needs. The provider equipped wards with assisted bathrooms. Staff ensured all children and young people had an education, health and care plan in place. These were overseen by education staff who liaised with the young person's home area local authority to monitor and review. Where appropriate education staff maintained contact with the home area school. On Brook ward staff were trained in Makaton and used social stories and 'now and next' to support communication. Staff used easy read pictorial representations to support one young person's communication needs. We observed good use of pictorial signs and pictorial activity planners on Acorn and Berry wards.

Managers ensured that staff and children and young peoples had easy access to interpreters and/or signers.

Staff offered children and young people a choice of food to meet the religious and cultural dietary requirements. This included vegetarian, vegan, halal and kosher meals.

Staff ensured that children and young people had access to appropriate spiritual support. The service had a multifaith area and access to chaplaincy support, which included access to leaders from different religions including Christianity, Islam and Wicca.

Staff were supporting a number of transgender young people during our visit. Staff completed training and accessed support from specialist organisations to support children and young people with lesbian, gay, bisexual and transgender needs.

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 the wider service.

The service reported 42 complaints received over the past 12 months (1 September 2019 to 31 August 2020). Of these, three were still active with two being investigated as serious incidents. Meadow received the highest number of complaints with 12, then Marsh with seven and Maple with six.

The common themes for complaints were staff attitude/ behaviour (14), restrictive practice (10), staff competence (three).

No complaints were referred to the ombudsman.

The provider reported they adopted a new approach to focus on the performance around a complaint rather than the outcome of whether it is upheld or not. Emphasis was on the learning from complaints and what change and quality improvement had been made as a result of the feedback received through concerns and complaints.

Children and young people spoken with told us they knew how to complain. However, the service completed a survey in 2019 and only 24% of children and young people who complained thought it had made a difference. The provider had a complaints team, which children and young people could contact directly from the telephones on the wards.

Staff spoken with knew how to handle complaints appropriately.

Managers provided feedback about complaints in team meetings.

The service reported 48 compliments received over the past 12 months (01 September 2019 to 31 August 2020). Maple received the highest number of compliments with 10, then Marsh and Brook with eight each. Compliments included thanks to staff for giving up their own time to take a young person to a concert, the young person reported that they really enjoyed it. There were numerous compliments from relatives thanking staff for the care and treatment provided to their loved one and from recently discharged young person expressing thanks for the progress and positive difference the service had made to their lives. There were also compliments received from external professionals relating to well-planned and successful discharges, high quality trauma informed care plans and "astonishing" progress staff were making with complex children and young people.

Are child and adolescent mental health wards well-led?

Requires improvement

Leadership

Requires improvement

Child and adolescent mental health wards

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

The provider made progress in addressing the issues we found at the previous inspection. The provider made management changes, implemented new governance systems, improved their processes and acted to address poor staff conduct to ensure they had the right staff working in this service. However, the new systems and processes were not yet consistent and embedded. They acted to reduce the service from 110 to 30 beds as part of their management of risk. Human resources staff supported managers to reduce their staffing numbers to meet the requirements of the new service. We reviewed the process used and found it to be detailed and robust to ensure staff with the right values will be working in the new service. Leaders involved children and young people in interviewing staff for key roles, for example, ward managers.

The provider recently changed the structure of their services. The Child and Adolescent Mental Health Service was one 'division' instead of two 'integrated practice units'. A new leadership team was in place following this change. Staff described the new leaders as open, honest and approachable. Local leaders attended daily ward meetings and rotated attendance at the service out of hours.

Local and provider level leaders were visible on wards and approachable. We saw evidence in minutes of the service leadership team attending ward team meetings and of provider executives visiting the wards, including the chief executive and deputy chief executive working shifts as healthcare assistants.

Leadership development opportunities were available, including opportunities for staff below team manager level. One ward manager told us they completed a master's degree accredited by a recognised management institution.

Vision and strategy

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

The provider's senior leadership team successfully communicated the provider's vision and values to the frontline staff in this service, we found a significant improvement in these values being embedded in staff practice, for example, progress notes written in a professional, non judgemental manner.

The provider's vision was to Transform Lives Together. The values which underpin this vision and strategy were: Compassion: Be supportive; understand and care for our patients, their families and all in our community. Accountability: Take ownership; be proactive, be responsible, do what you say you will do. Respect: Act with integrity; be real, be open, be honest. Excellence: Innovate, learn and deliver; whatever you do, do it well.

Local leaders mapped changes in the service to the provider's values:

Compassion: Trauma informed care, debriefs/reflective practice, focus on staff well-being.

Accountability: Senior leadership team, safety culture, closer integration between health & education staff.

Respect: Co-production and patient involvement, patient access to mobile phones, continual review of language used.

Excellence: Adopting 'Safewards', right sizing and re-design of the service, merging wards.

Ward managers told us they have autonomy within a structure of accountability.

Some staff reported that the changes to the service had taken place without consultation. Senior and local leaders advised that they had to decide changes quickly to ensure the service made the required improvements to deliver safe, effective, compassionate treatment and to continue operating. Staff across all levels acknowledged that the previous service was too big and impossible to staff without heavy reliance on agency. We received a mixed response from staff in relation to communication about the changes; some staff said this was very good, others reported it wasn't enough. Healthcare assistants told us they felt they were kept out of the loop by senior managers. Some staff reported having input into the design of the new building. Some staff did not know where they were going to be working or if they even had a job once the wards moved.

Culture

Requires improvement

Child and adolescent mental health wards

Most staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Leaders implemented actions to change the culture of the service. Local leaders told us that they were taking action to move from a custodial form of care to a compassion driven model. This included changing the language used in children and young people's records and supporting staff to understand the link between the language used and how staff cared for children and young people. Following an audit of clinical records, the service developed a training pack for all staff to improve the quality, objectivity and use of language within the children and young people's records. Local leaders removed the previous separate shift patterns and staff worked on a flexible basis across days and nights. Local leaders told us that staff perception of why changes were made was gradually changing from "because the CQC have told us to" to making changes because it is the right thing to do. Staff reported a shift in culture to staff taking responsibility and raising issues in an open and honest way.

Most staff felt respected, supported and valued. We reviewed the most recent staff survey completed 2019. The provider wide engagement was 68% and the service engagement score was 60%, this was a 3%-point improvement compared with 2017.

The areas that saw the largest improvements in the service, compared with 2017 were:

- Flexibility (+10% points)
- Authority to take action (+10% points)
- Accountability for ethical behaviour (+9% points)

Areas that had declined since 2017 were:

- Physical working environments 46% (-7% points)
- Bureaucracy 25% (-6% points)
- Work-life balance 54% (-5% points)

Staff reported that managers supported them well and they were confident to raise concerns. There were different channels staff were able to use to raise concerns. Outside of line manager support, these included 'Speak Up Guardian' champions and access to a 'safecall' phone number, where staff could raise concerns anonymously. We reviewed 'safecalls' received from the service between the 1 June 2020 and 31 August 2020. Staff made five calls in total relating to; staff not wearing personal protective equipment correctly, staff inappropriate comments to children and young people and staff allowing children and young people to hold keys, staff playing inappropriate games with children and young people and lack of seclusion facilities in Smyth House. Local leaders acted to address all concerns raised including reporting to the local authority safeguarding team, disciplinary action, improved communication, increased training and mitigations to reduce risks.

Managers identified poor performance and dealt with it, with support from the provider's human resources team.

Staff appraisals included conversations about career development and how the provider could support this. The provider supported healthcare assistants to train as registered mental health nurses.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. The provider facilitated an Inclusion Steering Committee and employee support groups for black, Asian minority ethnic; lesbian, gay, bi-sexual and transgender plus; disability and a support group for women. Each group has an executive as their sponsor. The provider ran several key children, young people and staff events including St Andrews Pride, Mental Health Awareness Week and Black History Month.

Occupational health services and a trauma nurse supported staff physical and emotional health needs. The provider invested in a programme of support to promote staff well-being.

The provider recognised staff success within the service through staff awards. The provider issued awards based on their values on a monthly and quarterly basis, which then culminated in an organisation wide annual awards ceremony for the overall winners.

Governance

Findings in the safe key question demonstrated that managers did not have clear oversight and assurance across all wards and this was yet to be embedded in practice.

Requires improvement

Child and adolescent mental health wards

Whilst the service had made improvements, particularly relating to previous issues that affected the experience of children and young people, treatment and upholding dignity and human rights, senior leaders had not yet achieved consistency of standards across all wards.

Managers had not ensured the practice across all wards was of a consistent standard, demonstrated by discrepancies in medication management, observations of children and young people, completion and quality of seclusion records and ward safety checks. Whilst the issues identified did not relate to all wards, they did relate to issues identified at the inspection in December 2019.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

The provider introduced a new clinical governance framework from June 2020. The provider supported the implementation with a series of workshops delivered by the chief executive, deputy chief executive and medical director for leaders of each division, From July 2020 wards should be holding clinical governance meetings as per the provider's clinical governance manual. However, managers had not followed the new agenda for the ward team meeting minutes reviewed. The provider advised this had not been 100% consistent and where gaps have been identified they were working with wards to ensure this happened.

Wards held daily multi-disciplinary meetings which linked into daily service level meetings. We reviewed minutes of ten multi-disciplinary meetings and minutes of ten corresponding daily service level meetings. The meetings followed a set agenda and there was evidence of issues raised in the ward meetings being escalated and discussed at service level.

We observed one clinical governance meeting for the service. The team discussed staffing, risks, seclusions, restrictive practice, training, co-production, friends and family feedback, new coronavirus restrictions, feedback from community meetings, complaints/compliments and linked discussions to CQC key questions.

The provider gained assurance through peer reviews, pharmacy checks, ward manager checks, long term segregation and enhanced support divisional reviews, monthly executive '15 step' walk arounds on wards; monthly areas of focus- based on CQC key questions, quality team visits, focused areas of practice and quality improvement projects.

Staff implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Examples included changes made to the management of safeguarding within the service.

Management of risk, issues and performance

Ward managers told us they could add items to the service or organisational risk register.

The service risk register reported 21 risks. These included two very high risks (clinical variation and CQC ratings impact) and nine high risks. Each risk included mitigating actions, with details of the person(s) responsible for ensuring the actions were taken. Clinical variation was included on the provider wide risk register.

Staff concerns matched those on the risk register.

The service had business continuity plans to manage emergency situations, for example, adverse weather events or a flu outbreak. The service ordered flu vaccinations for all children and young people and was running flu vaccination campaign to raise awareness and educate them.

Where cost improvements were taking place, they did not compromise the care of children and young people. Changes to the service had been made with quality as a priority over making cost savings.

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 provider used systems to collect data from wards that were not over burdensome on staff.

Staff had access to the equipment and technology they needed to do their work.

The provider used a 'patient safety dashboard', managers used this to review incidents, use of restrictive interventions and to help identify themes.

Requires improvement

Child and adolescent mental health wards

The provider used key performance indicators to support managers to gauge the performance of their teams, including compliance with training, supervision and reduction in restrictive interventions.

Staff made referrals to the local authority safeguarding team and notifications to CQC as required.

Engagement

Staff had access to up to date information about the work of the provider through the intranet, emails and newsletters.

Local leaders introduced weekly service newsletters for staff from July 2020 onwards, following feedback from staff asking for regular updates. Leaders issued the weekly newsletter each Thursday with two video calls scheduled for Friday (one at 06:30 for night staff and one at 14:00) for staff to ask any questions of the local leadership team. We reviewed nine newsletters issued between July and September 2020. Leaders provided clear communication for staff with updates on changes taking place.

Children, young people and their carers had opportunities to feedback about the service through questionnaires and meetings. The provider employed a dedicated involvement lead to oversee this work.

Staff had opportunities to meet the providers senior leadership team through 'drop in' sessions.

Senior leaders engaged with external stakeholders, for example NHS England and clinical commissioning groups.

Learning, continuous improvement and innovation

Managers offered staff the opportunity to give feedback on services and input into service development.

The service had been working with external partners, including NHS trusts with outstanding ratings to help the service improve.

The chief executive provided a quality lead to help local leaders put quality into practice. This involved putting together an action plan involving all the staff. Part of the role was offering staff a safe space where they could share concerns about all the changes. The quality lead facilitated workshops with doctors, ward managers and lead clinicians. Other aspects included ensuring all staff had the right support and training to do their job. The quality work was underpinned by co-production with children, young people, carers and staff. Practical changes included changing meeting times and agendas, ensuring staff were confident to deliver and receive de-briefs following incidents and implementing assurance processes, for example, peer reviews.

Innovations were taking place in the service. The provider implemented continuing quality improvement. The service introduced the 'safewards' approach as its first continuing quality improvement project. This approach aims to reduce conflict and containment on mental health wards. Continuing quality improvement workshops took place on each ward at the service in June 2020.

The service published research into dialectical behaviour therapy outcomes and adverse childhood experiences in relation to the impact of physical health on mental health.

The provider had set up a developmental trauma centre with the aim of being a centre of excellence for trauma informed care.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff undertaking patient observations do so in line with their policy and procedures and that all patient observations are recorded in line with provider's policy. (Regulation 12 (2)).
- The provider must review incidents of patients self harming whilst on enhanced observations and take action to reduce the number of incidents. (Regulation 12 (2)).
- The provider must review the use of restrictive interventions and take action to reduce the use of restraint, prone restraint and rapid tranquillisation. (Regulation 12 (2)).
- The provider must ensure staff follow systems and processes when safely prescribing, administering, recording and storing medicines and equipment. (Regulation 12 (2)).
- The provider must ensure that all young people have appropriate physical health checks following rapid tranquillisation medicines. (Regulation 12 (2)).
- The provider must ensure that documentation is always completed in line with that required by Mental Health Act Code of Practice for young people in seclusion. (Regulation 12 (2)).
- The provider must ensure robust governance and clear oversight across all wards to ensure consistency of good practice is embedded. (Regulation 17 (1) and (2)).

Action the provider SHOULD take to improve

- The provider should ensure all staff treat all patients consistently with kindness, respect and dignity. (Regulation 10).
- The provider should ensure that all staff follow infection prevention and control policies and procedures. (Regulation 12).
- The provider should ensure staff complete safety checks in line with policies and procedures. (Regulation 12).
- The provider should ensure staff complete physical health assessments for all patients on admission. (Regulation 12).
- The provider should ensure sufficient staff on all shifts to keep patients safe. (Regulation 18).
- The provider should consider ensuring staff attendance at handovers.
- The provider should consider reviewing the time allocated to complete handovers to ensure it is sufficient.
- The provider should consider improving staff communication with carers.
- The provider should consider reviewing the response to patient complaints to increase patients' confidence in the process.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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