# Improvement Action Plan

## Healthcare Improvement Scotland and the Mental Welfare Commission for Scotland: Unannounced Safe Delivery of Care Inspection and Visit to Child and Adolescent Mental Health Service Inpatient Units.

Royal Hospital for Children and Young People – Melville Unit, NHS Lothian 12-16 May 2025

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

**NHS board Chair**

Signature: _____

Full Name: Professor John Connaghan

Date: 11/06/26

**NHS board Chief Executive**

Signature: _____

Full Name: Professor Caroline Hiscox

Date: 11/06/26

| Ref: | Domain | Action Planned | Timescale to meet action | Responsibility for taking action | Progress | Date Completed |
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| **Part 1 - The Metal Welfare commission will review the content and time frames of the actions outlined in part 1 of the improvement action plan.** | | | | | | |
| MWC 1 | The practical application and safe use of proportionate restraint as a last resort is a significant issue at the Melville Unit. Based on observation of practice, the impact on young people, the lack of detailed anticipatory care plans, incomplete recording of details post event and completion of the electronic incident reporting system, the approach to restraint in Melville Unit requires further enquiry and improvement by the service. | 1.1 Request amendment to the electronic incident reporting system (Datix) categories to offer an alternative to current 'Violence & Aggression' categorisation to allow for planned restraint for treatment. | 30 October 2025. | CAMHS General Manager. | Discussions with other inpatient CAMHS units to consider if a common data set could be created across Scotland, next meeting held 30 October 2025.<br>V&A data on IPU reported quarterly to REAS SMT.<br>10 Jun 26 - Amendments made to Datix to allow discrimination between planned NG feeding and V&A incidents.<br>Full revision of Datix categories is dependent on MWC publishing the proposed categories for restraint and restrictive practice measures. NHS Lothian CAMHS is working with MWC on this. Meeting was held with other Scottish CAMHS units on 20 May 26 and a further is planned for 17 Jun 26. | 30/10/2025<br>Complete<br>Complete |
| | | 1.2 Develop an audit tool to monitor compliance with recording distress preferences in MH PCCP in EPR. | 31 December 2025. | CAMHS Consultant Nurse. | *Monthly audits of quality and compliance to Melville SMT have been introduced, with feedback loop to clinical teams and escalation to CAMHS SMT if <85% compliance.<br>*First audit complete and shared at IPU DM and with the IPU SCN & CN Team. Audits are ongoing as a continuous process.<br>* Grid of audits will assist in outlining the audit cycle including actions.<br>* Scrutiny of audits and EPR are under review, MDT person centred care planning group meeting monthly | Complete [Dec 2025] |
| | | 1.3 Training and guides for staff around care planning for distress preferences / restraint to be developed and integrated in to care pathway. | 31 December 2025. | CAMHS Consultant Nurse. | Training guides developed in collaboration with REAS Clinical Educators and IPU NQNS. This has been shared with the SCN & CN Team.<br>YP fill out checklist re distress preference/ restraint as part of NG SOP<br>Work is continuing with this, 5/2/26. Audits have been completed and will be repeated.<br>Guidelines are on intranet. | Complete [Dec 25] |

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| MWC 2 | Nasogastric tube feeding under restraint requires further enquiry and improvement by the service to ensure best practice is being followed and young people are given every opportunity to retain decision making as per best practice guidelines. | 2.1 Develop a SOP for Nasogastric Tube Feeding Standard Operating Procedure. | 31 November 2025. | IPU Consultant Clinical Psychologist. | SOP approved at REAS SLT 16/03/26, after some amendments. | Complete: [signed off March 2026] |
| | | 2.2 Develop educational resources to support NG feeding SOP with engagement and feedback from CYP. | 31 December 2025. | IPU Consultant Clinical Psychologist. | Educational resources developed.<br>Baseline data established; early evidence of reduction in NG feeding under restraint with outputs included in a paper: results are positive. | Complete Dec 25 |
| | | 2.3 Deliver staff training on SOP and evaluate staff confidence pre/post with aim of 90% staff receiving training. | 31 March 2026. | IPU Consultant Clinical Psychologist. | CPD started on 5/3/26.<br>50% of training completed (10/05/2026) further training completed w/c 11/5/26. | Complete |
| | | 2.4 Reduce NG feeding under restraint by 80% by 31 May 2026 (this is an improvement aim). | 31 May 2026. | IPU Consultant Clinical Psychologist. | Training and wide-ranging QI project has been carried out, data confirms reduction in NG feeds under restraint. Reported to REAS CGAG every 6 months. | Complete |
| | | 2.5 Develop Quality Improvement plan to address Continuous Intervention (CI) activities. | Mapping completed by 01 December 2025. | Service Director. | In progress - REAS-wide working group set up; presentation completed; to be delivered to staff on Melville Unit.<br>CAMHS team to work within the existing process in the meantime to improve consistency in following the process.<br>Melville team represented on wider REAS group leading on this programme.<br>Multidisciplinary training in CAMHS being carried out to enable staff to undertake CIs. Link with person centred care plans PCCP (upskilling nursing staff on PCCP work) and MDT approach.<br>Include OT. | Complete [Dec 2025] |
| | | 2.6 Test advanced care planning helping CYP make decisions for their future care & advanced statements. | Pilot in progress. | CAMHS Consultant Nurse. | In progress – Advanced statements are discussed at ward round and this should be documented.<br>Currently testing care planning with Tier 4 CAOT community team and planned to scale up to other community teams if successful.<br>Plans to develop routine promotion of AS in T3 community teams in future. | Complete |
| | | 2.7 Ensure all children and young people (CYP) are offered independent advocacy at key points in their care | 31 October 2025. | CAMHS General Manager. | Admission checklist updated to include advocacy offer. Staff reminded via safety huddle to offer independent advocacy at other key points. | Partly complete. |

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| | | journey (e.g. admission, post-MDT review, before significant treatment decisions) and record advocacy discussions clearly in the electronic patient record. | | | Core process in place – Oct 2025.<br>Audit tool still in development.<br>Audit tool in development to capture documentation of advocacy discussions. Audit to be completed.<br>Information on Padlet, white board, admission checklist.<br>Audit completed and evidence provided. Actions following audit to be discussed with clinical team.<br>Audit tool in development to capture documentation of advocacy discussions in EPR. | Audit tool will be completed by end June 2026 |
| | | 2.8 Undertake a qualitative review of a sample of records to assess how effectively family perspectives, updates and shared decisions are captured. | 01 November 2025. | CAMHS Nurse Consultant. | Scoping of note content completed. Quality of documentation reviewed.<br>Revised guidance on care plans for families developed.<br>Audits completed; areas for improvement identified and remedial actions taken. | Complete [Nov 2025]. |
| | | 2.9 Develop guidance for staff on high-quality narrative recording that reflects collaborative practice. | 01 December 2025. | CAMHS Nurse Consultant. | Will be developed from audit results. | Complete [February 2026] |
| MWC 3 | Authority to treat young people should be in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003. Lawful practice and understanding of roles and responsibilities has yet to be embedded at Melville Unit with no evidence of managerial oversight or action progressing following recommendations previously made by the Commission. This is an area which requires further enquiry and improvement by the service. | 3.1 Continue existing systems of governance around authority to treat. | Ongoing. | Chief Nurse. | A system has been in place since May 2025, for ensuring authority to treat is monitored. This has been supplemented by additional scrutiny.<br>• Charge Nurse checks the compliance with daily checks every week.<br>• Physicians Associate, overseen by Consultant Psychiatrist, will provide weekly full audit of compliance with legal authority to treat procedure.<br>Hardcopies of legal paperwork are held in the dispensary for medications and treatment room for NG Feeds. Registered nurses check these are up to date daily before administration of treatment. | Complete |
| MWC 4 | The issue of concerning multidisciplinary team dynamics has been a long-standing known issue at Melville Unit. Our direct observation and feedback given to us evidence that little progress | 4.1 Evaluate the impact of interventions introduced previously using a short survey to capture staff experiences. | Baseline data collated by 31 October 2025; evaluation report by | CAMHS General Manager. | Work on team dynamics which started in August 2024 was completed in September 2025. | Completed: Evaluation report : 30 Apr 2026. |

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| | has been made. This is an area which requires further enquiry and improvement by the service. | | 30 April 2026 and release of iMatter scores due June 2026. | | MDT meetings have been redesigned to support attendance and clearer MDT decision making<br><br>AMBIT framework is being implemented and staff are being trained and the approach used at MDT meetings.<br><br>Team to use a staff climate safety tool to provide the baseline information.<br><br>MH Nurse Director is working with the team on this, QR codes available for staff. Use this as evidence.<br><br>A short survey / focus group process to capture staff experiences six months post-implementation in progress – review and development of evaluation report by 30 April 2026, with iMatter results pending due annual release in June 2026 and will inform next-stage evaluation. | iMatter scores: Jun 2026.<br>Baseline data collected Oct 2025. |
| | | 4.2 Offer team members opportunity to attend external Psychological Safety professional development training e.g. 'Civility Saves Lives' . | 01 February 2026. | CAMHS General Manager. | Support from Organisational Development department has been identified to deliver sessions to the team. OD team have a planned approach through engagement with Melville Senior Team and are now engaging with local team leads (24/3/26).<br><br>Sessions are booked in May and June 2026 | Complete |
| MWC 5 | There appeared to be a disconnect between what activities were reportedly said to be available and the experience of young people particularly in the evenings and at weekends. Some young people explained that this failure in provision meant they spent too much time thinking their own "thoughts." | N/A | N/A | N/A | This finding is covered by HIS requirement in part two of the report at domain 4.1 (4). | N/A |
| MWC 6 | The quality of care planning, associated documentation and inclusion of parents/relatives remain an area that has yet to develop as recommended by the Commission previously. | N/A | N/A | N/A | This finding is covered by HIS requirement in part two of the report at domain 4.1. (5), 4.1(6) and domain 6(11). | N/A |
| MWC 7 | Communication with young people and their families is an area highlighted for further improvement. | N/A | N/A | N/A | This finding is covered by HIS recommendation in part two of the report at domain 4.1(1) and requirement 4.1(5). | N/A |
| MWC 8 | The maintenance of the environment to ensure staff and patient safety. | N/A | N/A | N/A | This finding is covered by HIS requirement in part two of the report at domain 4.1(8). | N/A |

| Part 2 - Healthcare Improvement Scotland will review the content and time frames of the actions outlined in part 2 of the improvement action plan. | | | | | | |
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| HIS 1 | NHS Lothian must ensure enough staff are on duty who are trained in restraint to respond to staff personal alarms at all times. | 1.1. Set minimum compliance threshold for restraint training at 85% and audit quarterly. | 01 November 2025. | CAMHS General Manager. | Review of initial professions showed over 80% of nursing staff and psychology completed high-level restraint training in October 2025. Monthly oversight at CAMHS SMT and reported quarterly to REAS H&S meeting. Future booked training for all staff is also available.<br><br>Staff training in restraint at 98% on 18/03/26 | Complete [Nov 2025] |
| | | 1.2 Augment existing organisational alarm response SOP by developing guidance specifically for CAMHS. | 01 November 2025. | CAMHS General Manager. | Appendix to REAS alarm SOP defines roles and responsibilities across MDT staff for entire process of responding to alarms and restraints documented in SOP. | Complete |
| HIS 2 | NHS Lothian must ensure all staff who administer rapid tranquilisation have completed intermediate life support training. | 2.1 Review training needs for and make appropriate provision of ILS for staff working within the in-patient unit. | 01 November 2025. | CAMHS General Manager. | Current compliance mapping shows BLS training up to date for all staff.<br><br>All Charge Nurses received ILS training. The service is assured by having an ILS trained Charge Nurse on each shift in addition to having rapid access to a resuscitation team we will be able to identify and manage physically deteriorating patients. Training complete May 2026<br><br>The use of the post administration rapid tranquilisation 'canned text' (TRAK patient record system short-code), will ensure physical checks are completed, recorded and concerns responded too. | Complete [May 2026] |
| HIS 3 | NHS Lothian must ensure timely review and implementation of lessons learned from reported incidents including significant adverse events. | 3.1 Undertake themed reviews of Datix and SAE reports relating to Melville Unit on a quarterly basis. | 31 January 2025. | CAMHS General Manager. | High level data shared quarterly re MH QI team. Presented at REAS Clinical Governance meeting<br><br>Local review of Datixes by Charge Nurse to assess quality and actions.<br><br>Feedback to nursing and MDT team through team meetings.<br><br>Consultant Psychologist producing themed review around restraints for NG feeding.<br><br>Themed review from DATIX still to be completed, not possible within this period but is planned.<br><br>Local Datix review by Charge Nurse to assess quality and actions; feedback through team meetings. | Partly complete.<br><br>Themed review to be completed by 01 July 2026 |

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| | | | | | Consultant Psychologist producing themed review around restraints for NG feeding. | |
| HIS 4 | NHS Lothian must ensure meaningful activity is consistently provided, including evenings and weekends and that activity plans are completed and updated in care plans. | 4.1 Deliver an expanded range and availability of activity for patients into evening and over weekends. | 31 January 2025. | CAMHS Consultant Nurse. | 1 of 2 Therapeutic Activity Manager (TAM) recruited to manage programme of activity and meet with YP to agree personised activities. They work closely alongside OTs. Second TAM post started April.<br>Second TAM appointed and due to start end April 2026.<br>More extensive programme for weekdays, including evenings. YP do individual planning for weekend activities. Evidenced by people's care plans and progress notes<br><br>Leads meeting every 4 weeks until end of 2025 to develop new programme plan, with focus on out of hours/weekends activities to start 2026.<br>Activity timetables are shared in communal area, given to YP and uploaded to Padlet. Activity CPs are improving, increased canned text use.<br><br>All CYP have a timetable of meaningful activity, uploaded to Padlet, given to young people in shared in ward area.<br>This started in January but is well developed, close to completed. | Complete. |
| | | 4.2 Develop Refresher Sessions for all nurses to develop and enhance their skills working therapeutically with CYP individually and in groups. | 01 October 2025. | CAMHS General Manager. | Complete - Mandatory/Refresher Sessions for all nurses to develop and enhance their skills working therapeutically with CYP individually and in groups set up across October 2025 to January 2026. This has been shared as evidence with MWC. | Complete |
| | | 4.3 Develop an automated report providing audit of what activity is being offer to CYP. | 01 October 2025. | CAMHS General Manager. | Report of activities offered to patients and what is being accepted by CYP recorded in daily notes using search for canned text "activity" for review by OT s to support care planning. | Complete |
| HIS 5 | NHS Lothian must ensure effective communication with families and young people including care planning, meal plans, passes and any restrictions put in place. | 5.1 Audit current use of keyworkers' weekly on parent/carer contact phone call with patient consent recording on EPR using canned text for parent/carer engagement. | 01 November 2025. | CAMHS General Manager. | Automated weekly report developed to give rapid weekly feedback started August 2025.<br><br>Audit shared with all Melville staff and at Development group + QI pin board<br><br>Evidence suggests that this is improving | Complete [August 2025] |

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| | | 5.2 Develop leaflet providing information (including Family and Carer Quick Guide to meal plans) on Padlet to be provided at admission and within Electronic Patient letter for parents to have access to IPU information. | Complete. | CAMHS Consultant Nurse. | Complete – provided evidence to MWC of current digital information and leaflets and mealtime guides held within the digital Information Pack for Parents, Carers and Guardians for IPU Welcome Pack & Resources. | Complete [May 2025]. |
| | | 5.3 Provide written information to CYP prior to and following meetings. | In progress – to conclude 31 December 2025. | CAMHS Consultant Nurse. | A quality improvement project has been established to ensure proactive contact and effective information sharing with YP & Families & Carers.<br>YP submit questions to MDT ward round.<br>All YP and families are offered a feedback meeting after MDT Ward Round, documented in TRAK. | Complete [January 2026] |
| HIS 6 | NHS Lothian must ensure that all documentation is accurately and consistently completed and reviewed. This includes activity plans, nasogastric bolus charts, and risk assessments. | 6.1 Develop, implement and audit IPU Nursing Record Keeping Guidance. | 01 February 2026. | REAS Chief Nurse. | Record Keeping Guidance developed Aug–Sept 2025.<br>'NG SOP' signed off, which notes documentation associated with NG feeds.<br>Weekly documentation review process is being tested and will be shared once validated.<br>Supervision template under revision to include sample note audits.<br>Development Day presentation took place 27 October 2025.<br>In progress - Draft Record Keeping Guidance developed Aug–Sept 2025 and currently under review. Weekly documentation review process live. Supervision template under revision to include sample note audits. Development Day presentation scheduled for 27 October 2025.<br>1st December; Record keeping guidance (that aligns with the YPs IPU pathway has been developed in collaboration with NQNs and shared with the IPU SCN &CNs. The Consultant Nurse presenting to the SCN and CNs the YPs pathway and the CNs role in overseeing this on 9th December. The REAS Clinical Education Team will also be attending on the 9th to present on REAS Nursing Record Keeping Standards.<br>Holding nurses accountable for professional standards, capability issue and use available tools for audit Inc. MEG audits. | Complete. |

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| | | | | | LACAS lead is doing training with CNs and how to run reports. Person doing the audit has to understand where the risk is identified.<br>Senior Practice Development Nurse is working with staff to improve consistency of record keeping. Nurse manager working with nursing staff to improve record keeping.<br>Routinising the standard of documentation and make links to decision making and better patient care.<br>Education and training, mentoring and support then follow up. | |
| HIS 7 | NHS Lothian must ensure all environmental risks are identified, and risk assessed to mitigate potential risks arising from the physical environment. | 7.1 Maintain proactive environmental risk management through the Melville Unit Environmental Group. | SLWG in place and meeting monthly. | Melville Unit Environmental SLWG - Clinical Nurse Manager, with Estates, Equans (private firm that manages hospital building), Senior Charge Nurse and Service Manager. | Group active and meeting monthly. Environmental tracker live and under review; initial actions logged and in progress. Compliance with H&S regulations mapped for next meeting.<br>Key risks addressed:<br>Main doors replaced<br>Wall protection in situ in most bedrooms<br>Intensive nursing suite requires additional work but has been in continuous use until 26/2/26. Work now commenced. | Complete [August 2025] |
| HIS 8 | NHS Lothian must ensure the care environment is consistently maintained to ensure staff and patient safety including timely reporting of maintenance requests. | 8.1 Remind staff of their ongoing responsibility to environmental maintenance and safety assurance. | 31 October 2025. | Site Director. | All maintenance issues logged on the live action tracker and assigned for follow-up within agreed time frames.<br>Equans and Estates teams attend monthly SLWG to review outstanding items and agree completion dates. | Complete [24/2/26] |
| HIS 9 | NHS Lothian must ensure the safe disposal of sharps. | 9.1 Review of sharps management across Site & staff reminded of requirements to monitor compliance through local safety brief and IPC walk-round. | May 2025. | Chief Nurse. | A single non-compliance was observed by HIS; all other SICPs fully compliant. Action was taken immediately following inspection to remind staff and to verify closure of sharps bins. | Complete [Oct 25] |
| HIS 10 | NHS Lothian must ensure completion of the staffing level tool as part of the common staffing method. | 10.1 Use the Common Staffing Methodology (CSM) to review staffing requirements. | Ongoing annual review cycle. | REAS Chief Nurse. | The Staffing Review in 2025 applied the CSM, escalation and governance to secure additional staffing for the unit.<br>NHS Lothian will continue to use the CSM annually and at key change points to ensure safe staffing levels are maintained. | Complete [Oct 25] |

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| HIS 11 | NHS Lothian must ensure that young people and their families are involved in planning their care and that this is clearly documented including regular one to ones. | 11.1 Development of templates co-designed with YP to be used in advance of weekly meetings | Ongoing. | CAMHS Consultant Nurse. | Templates shared with MWC in part of evidence.<br>Evidence around care planning and standards is addressed in Nursing Record Keeping Guidance, alongside person centred 'What Matters to You' documentation<br>Audits of care planning are now carried out regularly and are available as evidence. | Complete [Dec 25] |
| | | 11.2 Development of quarterly "Melville Carers & Parents Bulletin" sharing what is going on in the ward & developments shared five times a year, every quarter and Christmas. | Ongoing. | CAMHS Consultant Nurse. | Has started, Autumn Bulletin shared with MWC as evidence | Complete [Dec 25] |
| HIS 12 | NHS Lothian must ensure necessary medication is available in an emergency. | 12.1 All required emergency medications are in stock and regularly checked. | Ongoing, occurs weekly. | CAMHS General Manager. | CNM will oversee a weekly medication stock check and restocking process, with any shortages escalated to the REH Pharmacy Team. Weekly checklist has been redesigned.<br>Pharmacy to provide quarterly oversight and advice as part of governance assurance. | Complete [Dec 25] |
| HIS 13 | NHS Lothian must ensure any outstanding improvement actions highlighted within the Royal College of Psychiatry Quality Network for Inpatient CAMHS (QNIC) internal audit are actioned. | 13.1 Conduct an internal review of the QNIC Standards. | 31 January 2026. | CAMHS General Manager. | Internal review completed. Some issues outstanding: these are detailed along with mitigations in summary review document. | Complete |
| HIS 14 | NHS Lothian must ensure adequate provision of a full range of dietary options. | 14.1 Review current catering provision. | 31 December 2025. | CAMHS General Manager. | Initial scoping of current menu completed by due date.<br>New menus will be in circulation in September 2026 including vegan options with greater choice available prior to the new menus.<br>List of snacks available to YP in between meals and out of working hours. | In progress |