Huntercombe Young People Ltd

Huntercombe Hospital Maidenhead

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Huntercombe Hospital Maidenhead is a specialist child and adolescent mental health inpatient service (CAMHS).

This is the first time we have rated this service since it was taken over by a new provider, Huntercombe Young People Ltd.

We rated it as requires improvement because:

- We saw that many improvements had been made at the hospital since it has been taken over by a new provider on 5 March 2021 and at our previous inspection on 18 March 2021.
- The provider had recruited a new senior leadership team at the hospital. These leaders had the skills and experience needed to drive forward the required improvements at the hospital. Despite only being in post a short amount of time we saw that they had already had a positive impact and begun to move forward with changes in a structured way to ensure the changes made were sustainable.
- Managers had begun to embed a positive behaviour support (PBS) approach to care at the hospital. This had a positive impact on young people's care and treatment and we received positive feedback from young people and staff about this improved approach. Young people felt more involved in their care.
- Staff morale had improved since the previous inspection. Staff were optimistic about the future of the hospital under the direction of the new senior leadership team.
- The hospital was cleaner and brighter than at our previous inspections.
- The use of restrictive interventions had reduced on three out of four wards.
- Young people had up to date risk assessments in place with clear plans for managing identified risks.

However:

- Staff working with young people with eating disorders had not all received relevant training to equip them sufficiently to care for young people as effectively as needed. Meal support training was offered to staff on Kennet ward but not staff on Thames ward. An eating disorders e-learning course was available however this was not mandatory. This meant that staff who had not undertaken this course lacked an understanding about how to support young people with eating disorders and therefore young people did not always receive adequate support at mealtimes.
- Several staff involved in assisting young people with nasogastric feeding told us that they did not feel adequately supported to undertake this role effectively.
- Young people did not always receive the therapeutic intervention required to support them adequately. Young people had to wait a long time to access one to one therapy with appropriately trained therapists. The hospital had struggled to recruit therapy staff, hence there were very few of these available to support the therapeutic interventions required.
- Tamar ward required modification to ensure it met the needs of young people. It was located over two floors which made observation difficult. There was a lack of communal space and the corridors were very narrow which meant it was difficult for people to pass one another safely. There were also issues with the sound and ventilation on the ward.
- The room used to undertake nasogastric feeds on Thames ward was hot and unpleasant.
- The communal space on Kennet ward was too small to accommodate the 20 young people cared for on the ward.
- The hospital had a high vacancy rate for registered nurses.
- Staffing across the hospital was inconsistent, with the same number of doctors, administrative staff and youth engagement practitioners allocated to a 20 bedded ward as a 10 bedded ward.

Summary of findings

- Less than half of staff had received an annual appraisal in the last year.
- Some mandatory training courses had low compliance. These included managing medications (60%) and sepsis awareness (56%).
- Documentation and incident reports lacked sufficient detail to clearly portray what had happened during an incident. For example, not detailing the actions taken by staff to try and de-escalate a young person prior to restraining them.
- Although frequency of communication with relatives had improved, there were still inconsistencies in communication and relatives did not always feel listened to by staff.
- The ligature audit for Severn ward did not include mitigation plans for all identified risks.

Following our inspection we served a warning notice under Section 29 of the Health and Social Care Act 2008. The provider was failing to comply with Regulations 12 (2) (c), Safe care and treatment, 15 (1) Premises and equipment and 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider that they must become compliant with these regulations by 10 September 2021.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Huntercombe Hospital Maidenhead

Huntercombe Hospital Maidenhead is a specialist child and adolescent mental health inpatient service (CAMHS). It is a 59 bed independent hospital, however is currently only able to admit 50 patients due to conditions imposed on it's registration by CQC. It provides specialist mental health services for adolescents and young people from 12 to 18 years of age. The hospital delivers specialised clinical care for young people requiring inpatient CAMHS, including psychiatric intensive care and eating disorders.

The hospital and its surrounding grounds are within a rural setting and are situated near a town with easy access to transport links and shops. Young people are supported in their education via the hospital school which is rated good by Ofsted. Where appropriate the young people have access to the hospital grounds and local community facilities.

The hospital consists of four wards:

• Kennet ward provides eating disorder services and has 20 beds.

• Tamar ward provides tier four CAMHS general adolescent services and has 10 beds.

• Thames ward has 14 beds and provides psychiatric intensive care services (PICU), however is currently only able to admit 10 patients due to conditions imposed on it's registration by CQC.

• Severn ward has 15 beds and provides psychiatric intensive care services (PICU), however is currently only able to admit 10 patients due to conditions imposed on it's registration by CQC.

Huntercombe Hospital Maidenhead is registered to provide the following regulated activities;

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

• diagnostic and screening procedures

• treatment of disease, disorder or injury.

At the time of the inspection there was no registered manager. However, the new hospital director had submitted an application to CQC to fulfil this role and was pending approval. The hospital director started in post the week prior to the inspection.

Huntercombe Hospital Maidenhead had previously been inspected in November and December 2020 under its previous ownership. At that inspection we rated the hospital inadequate overall and placed it into special measures. However, when a new owner takes over a hospital or service the hospital/service is considered as if it were a completely new service. It would therefore be inappropriate for the rating to be carried over.

This is the first time we have rated this service under its new ownership.

On 5 March 2021 the hospital was registered under a new provider, Huntercombe Young People Ltd.

Summary of this inspection

We carried out a focused inspection of the hospital on 18 March 2021 and some of the concerns we had about the hospital under its previous ownership about the quality of care were still evident. We therefore served the provider with a notice of decision under Section 31 of the Health and Social Care Act 2008, imposing a condition on its registration, which took effect from 25 March 2021. The condition means that the provider must seek written permission from the Care Quality Commission before admitting or readmitting young people to Severn or Thames wards psychiatric intensive care wards (PICUs), and must not admit any more than 10 young people on each ward until further notice. The condition remains in place.

We also served a warning notice under Section 29 of the Health and Social Care Act 2008 as we judged that the provider was failing to comply with Regulation 17(1), Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider did not have in place:

• robust governance and oversight of the review of care to ensure it was fit for purpose and any improvements to the quality of care for young people could be made;

• robust governance and oversight of the management of incidents, including safeguarding incidents;

• a holistic, proactive and preventative approach to care (such as positive behavioural support (PBS) in line with national best practice and guidelines);

• a least restrictive approach to care, in line with national best practice and guidelines;

• an approach to care on the PICUs that was in line with National Minimum Standards for PICUs.

However, on this inspection (14, 15 and 29 July 2021) we found that the provider had met the requirements of the warning notice (detailed above) served following the inspection on 18 March 2021.

What people who use the service say

Young people told us that overall staff were kind and treat them with dignity and respect. They told us that staff engaged with them much more that they had previously and that they feel there have been improvements at the hospital over the last few months. However, young people on Kennet ward told us that they did not receive adequate support at mealtimes and that staff often made unhelpful and inappropriate comments about food. They also told us that it could be difficult to get attention from staff if they were not on one to one observations and that they had to wait a long time for one to one therapy.

How we carried out this inspection

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

The inspection team comprised four inspectors, two inspection managers, the head of hospital inspection for the region, two specialist advisors and an expert by experience.

Summary of this inspection

On 14 and 15 July 2021 the inspection team visited Thames, Severn and Tamar wards and carried out the following activities:

- Reviewed the environment of the wards and observed how staff were interacting with and caring for young people
- Spoke with five young people
- Spoke with 11 relatives
- Interviewed members of the senior leadership team including the hospital director, head of nursing, head of quality, head of therapies, head of education and site services manager
- Spoke with 24 other staff including support workers, senior support workers, nurses, assistant psychologists, youth engagement practitioners, practice education facilitators, consultant psychiatrists, associate specialists, a pharmacist and ward managers
- Reviewed 15 care records and 16 prescription charts
- Reviewed six observation records
- Observed three patient review meetings
- Observed a site operations meeting

There was a COVID outbreak on Kennet ward at this time and so we returned to inspect this ward on 29 July 2021. At this inspection we carried out the following activities:

- Reviewed the environment of the ward and observed how staff were interacting with and caring for young people
- Spoke with seven young people
- Spoke with five staff members including a youth engagement practitioner, a doctor, an administrator, a senior support worker and the interim ward manager
- Reviewed six care records, six observation charts and 17 prescription charts

We also reviewed a range of information provided by the service, including:

- Policies and procedures
- Minutes from a range of meetings including staff meetings, governance meetings and patient review meetings
- Incident and complaints data
- Training, supervision and annual appraisal data

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

Following our inspection we served a warning notice under Section 29 of the Health and Social Care Act 2008. The provider was failing to comply with Regulations 12 (2) (c), Safe care and treatment, 15 (1) Premises and equipment and 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We told the provider that they must become compliant with these regulations by 10 September 2021.

Please also see the section about breaches of Regulations and the Enforcement Action.

Action the service MUST take to meet the requirements of the warning notice:

- The provider must ensure that staff working with young people with eating disorders have the appropriate training and skills to do so (Regulation 12 (2) (c)).

Summary of this inspection

- The provider must ensure that adequate support is given to young people with eating disorders at mealtimes (Regulation 12 (2) (c)).
- The provider must ensure that staff supporting young people with nasogastric feeding receive appropriate support (Regulation 12 (2) (c)).
- The provider must ensure that the ward environments are suitable to meet the needs of young people and that there are sufficient communal spaces on the wards for young people to use (Regulation 15 (1)).
- The provider must ensure that there are enough suitably qualified and competent therapy staff to provide a range of therapeutic interventions to meet the needs of young people (Regulation 18 (1)).
- The provider must ensure that there are sufficient staff members of all disciplines on the wards to meet the needs of the young people (Regulation 18 (1)).

Action the service MUST take to improve:

- The provider must ensure that all staff are offered an annual appraisal (Regulation 18 (2) (a)).
- The provider must ensure that staff are up to date with their mandatory training (Regulation 18 (2) (a)).
- The provider must ensure that the ligature audit for Severn ward is updated to include mitigation plans for all identified risks (Regulation 12 (2) (b)).
- The provider must ensure that records are adequately updated and that incidents which are reported include all relevant information about what action was taken (Regulation 17 (2) (c)).

Action the service SHOULD take to improve:

- The provider should consider lengthening the amount of time allocated to handover.
- The provider should consider reviewing the effectiveness of the communication with relatives.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards safe?

Requires Improvement

We rated safe as requires improvement.

Safety of the ward layout

The ward environments were not always safe, well maintained or fit for purpose. However, the hospital was clean.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff completed daily security checklists. Ward managers then completed weekly audits to ensure these checks had been completed. The site services manager completed daily walk arounds on the wards to look for environmental risks and to speak to young people and staff about any potential maintenance issues. Staff also utilised maintenance books to record any issues that required fixing. These were reviewed daily by the maintenance team.

Some ward areas required significant improvement to ensure they were suitable to meet the needs of young people. Tamar ward was located in a converted stable barn over two floors making it difficult to observe young people. The corridors were very narrow, making it difficult for people to pass one another. There were two corridors for females, however only one of these had toilet facilities meaning that young people on the other corridor did not have a toilet close to their bedrooms. We also identified problems with sound on Tamar ward, for example young people who became distressed could clearly be heard in other areas of the ward which could have an impact on other young people on the unit. There was also a lack of ventilation on the ward which young people told us was intolerable in the warm temperatures. Staff had obtained fans for them to use however there were not enough of these for everyone.

Staff could not observe young people in all parts of the wards. Kennet and Tamar wards had lots of blind spots. Staff mitigated this risk using staffing and observation. CCTV was also used in communal areas on all wards. On Thames, Tamar and Severn wards the footage was viewable from the nursing office. On Kennet ward managers were trialling a Care Protect system where footage is monitored by external clinicians who contact the ward staff if they have any concerns.

Tamar, Thames and Severn wards accepted young people of any gender. Kennet ward only accepted females. The wards that accepted young people of different genders complied with guidance on mixed sex accommodation.

There were potential ligature anchor points in the service. Staff knew about any potential ligature anchor points and mitigated the risks to keep young people safe. Staff had completed ligature audits on all wards. On Severn, Thames and Kennet wards these had all been reviewed within the last 12 months. The Tamar ligature audit had not been reviewed since May 2020. Staff on Tamar ward showed us the most recent ligature audit they had access to which was dated 2019. The audits showed that ligature risks would predominantly be managed by individual risk assessment and staff observation. On Severn ward the ligature audit had recently been updated to include the new zen room which was a quiet place for young people to use. However, the audit had lots of gaps in other areas where ligature risks had been identified but there was no mitigation plan documented.

Staff had easy access to alarms and young people had easy access to nurse call systems. Bedrooms had an alarm call button for young people to summon assistance from staff. Staff carried portable alarms on their person.

Maintenance, cleanliness and infection control

The feeding room on Thames ward was hot and unpleasant. When we returned on the second inspection date we saw that some changes had been made to the feeding room on Thames ward, including obtaining a new chair. Managers had also ordered a mindfulness board and arranged for air-conditioning to be installed.

Staff made sure the premises were clean. Cleanliness throughout the hospital had improved since our previous inspection.

Staff followed infection control policy, including handwashing. Staff completed monthly hand hygiene audits. The results from June 2021 showed that all staff audited complied with requirements.

Seclusion room

The seclusion room on Severn ward allowed clear observation and two-way communication. It had a toilet but did not have a clock. Staff told us that a clock would be placed within view of the room should it be used.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment. Staff completed weekly clinic room audits and an external pharmacist completed a monthly audit. However, we found that some medicines were overstocked. For example, on Severn ward there was lots of a particular type of medicine kept in stock even though no young people were currently prescribed this. On Severn ward we also found a box of forceps which had a date that had expired and that the sharps bin was not signed or dated.

Safe staffing

The service had a high vacancy rate for nursing staff. Shifts were covered by agency staff, a number of whom had worked at the hospital on a long-term basis. These agency staff knew the young people and received basic training to keep people safe from avoidable harm. However, there were times that agency staff who had little experience of working at the hospital were used to cover shifts

Nursing staff

Requires Improvement

Child and adolescent mental health wards

The service had enough nursing and support staff to cover all the shifts; with many shifts being covered by agency staff. However, some staff told us they felt over-stretched, especially when staff were on annual leave. Young people and staff told us that section 17 leave was sometimes cancelled due to a lack of staff and young people told us that, if they weren't on enhanced observations, it could be difficult find a member of staff when they needed to talk as all staff were often allocated to undertaking close observations. Young people had raised the issue of lack of staff to take them out in a recent community meeting. Relatives told us that they often had to call the wards several times before staff answered the phone.

The service had high permanent staff vacancy rates. The vacancy rate for registered nursing staff was 40%. Managers told us about a number of initiatives they were using to try and recruit more nurses, including recruiting registered general nurses with experience working with young people, launching a "grow your own" programme to support healthcare assistants to pursue nurse education and linking in with local universities so that student nurses could carry out placements at the hospital.

The service had high rates of bank and agency nurse usage. Between 31 May and 27 June 2021 53% of nursing shifts at the hospital had been covered by agency staff.

The service had lower rates of bank and agency support worker usage. Between 31 May and 27 June 2021 19% of support worker shifts had been filled by agency staff.

Where bank and agency staff were used, managers requested staff familiar with the service. Forty-seven percent of nursing vacancies were covered by staff who held long-term locum contracts which helped to ensure consistency with staffing. Some young people told us that some of their favourite staff were agency staff. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had reducing turnover rates. Turnover rates had reduced from 8.5% in May 2021 to 3.8% in June 2021. Levels of sickness had remained at 10% over the last three months. This had been impacted by COVID-19 isolation.

Managers utilised a staffing grid to calculate the number and grade of nurses and support workers for each shift. The ward manager could adjust staffing levels according to the needs of the young people. For example, managers increased the number of support workers on a shift to ensure there were enough staff to cover enhanced observation levels.

Young people had a named nurse and a named support worker. Young people did not always have regular one to one sessions with their named nurse. An audit completed by staff on Tamar ward showed that in the week prior to the inspection a random sample of five young people all had a one to one session with their named nurse. However, the same audit on Kennet ward showed that none of the five young people in the sample had a one to one session that week.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep young people safe when handing over their care to others. However, not enough time was allocated to handover. On Kennet ward 15 minutes was scheduled for handover, which was insufficient time for staff to discuss all that was required about the care of the 20 young people. Staff told us that this always overran.

Medical staff

The service had enough day time and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was a consultant psychiatrist and an associate specialist allocated to each ward. There was an out of hours on call rota with an associate and a consultant doctor always being available.

Mandatory training

Staff kept up to date with most of their mandatory training courses. Data from June 2021 showed that 83.7% of staff were up to date with their mandatory training, although the the provider's target compliance rate was 90%. Some staff told us that it was difficult to find the time to complete their mandatory e-learning training due to other demands on the wards. Attendance at some training courses fell substantially below this target. These included managing medications (60%) and sepsis awareness (56%).

The mandatory training programme did not cover all the training the staff required to ensure they could meet the needs of the young people. Staff working with young people with eating disorders on Kennet and Thames wards did not receive sufficient training for this aspect of their role. Only 33 out of 172 eligible staff on Thames and Kennet wards had attended a four-hour eating disorder teaching session delivered by a clinical psychologist and the head of therapies. Staff on Kennet ward completed meal support training led by a dietician but 10 out of 82 staff had not completed this. This training was not available to staff working on Thames ward although they cared for several young people who required specialist support because of their eating patterns and associated thoughts and risks.

Assessing and managing risk to young people and staff

Staff assessed and managed risks to young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. **Staff used restraint only after attempts at de-escalation had failed.**

Assessment of young person risk

Staff completed risk assessments for each young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed risk assessments which had evidence of involvement from the multidisciplinary team and young people.

Management of young person risk

Staff knew about any risks to each young person and acted to prevent or reduce risks. We reviewed records which showed that all young people had up to date risk assessments in place, with clear plans for how to manage identified risks. Staff identified and responded to any changes in risks to, or posed by, young people.

Observation levels were increased to mitigate risk. We reviewed observation records for six young people who were on eyesight or arms' length observations and these were all completed to a high standard. They were sufficiently detailed and included the reason for observation, details of any relevant risks and details of how often staff should change over. Staff did not usually observe the same young person for more than two hours, however, where they did there was a clear care plan and rationale in place for this. The observation records we reviewed were all signed and dated, and observations were reviewed daily by the multi-disciplinary team. This helped to ensure that young people were not subject to prolonged periods of enhanced observation where this was no longer necessary. However, some young

people told us that the rationale for why observation levels had changed was not always communicated to them. Staff worked with young people to develop crisis plans if they were going on home leave. These were then shared with families and local community teams. Throughout our inspection we observed staff assigned to young people's observations interacting with them – they were laughing, chatting and playing games with young people.

Staff followed policies and procedures when they needed to search young people or their bedrooms to keep them safe from harm. Young people had search care plans in place. Staff routinely searched bags when young people returned from leave but did not routinely conduct personal searches.

Use of restrictive interventions

Levels of restrictive interventions were reducing on three out of four wards. Data from January to May 2021 showed that the number of restraints used on Thames, Severn and Kennet wards had reduced. The number of restraints on Tamar ward had increased from 39 in January 2021 to 62 in May 2021. On Kennet and Thames wards the main use of restraint had been to enable nasogastric feeding.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained young people only when these failed and when necessary to keep them or others safe. Staff we spoke with were able to give examples of strategies from young people's positive behaviour support (PBS) plans that they would use to try and de-escalate situations.

Safeguarding

Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. There was a safeguarding lead for the hospital.

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

Most staff kept up to date with their safeguarding training. Training data from June 2021 showed that 90.8% of staff had completed safeguarding vulnerable adults training and 87.4% of staff had completed safeguarding children training. The provider's target rate for percentage of staff to complete these was 90%.

Staff could give clear examples of how to protect young people from harassment and discrimination.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with knew who the hospital safeguarding lead was. Managers told us they were in the process of identifying safeguarding champions for the wards to further support staff.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

Young peoples' notes were comprehensive and all staff could access them easily.

Requires Improvement

Child and adolescent mental health wards

When young people transferred to a new team, there were no delays in staff accessing their records as all wards used the same system.

Records were stored securely. All electronic information was only accessible via password protected systems. Any paper files were stored in locked nursing offices.

Track record on safety

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them, although these sometimes lacked detail. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave young people honest information and suitable support.

Staff knew what incidents to report and how to report them. All staff received training in how to use the provider's incident reporting and management system. However, some of the reports and documentation about incidents that we reviewed lacked sufficient detail to explain exactly what had taken place.

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

Staff understood the duty of candour. They were open and transparent and gave young people and families a full explanation if and when things went wrong. Families told us that they were kept updated following any incidents and that this had improved over the last few months.

Managers debriefed and supported staff after any serious incidents. However, this was not always documented. Staff told us that debriefs usually took place after an incident. Staff involved in restraining young people for nasogastric feeding on Thames ward told us they would appreciate more support after having to undertake feeds and then support young people in recovering after the feeds. They told us they felt under a lot of pressure with the number of young people they had to support in this way alongside providing care to the other young people on the ward.

Staff received feedback from investigation of incidents, both internal and external to the service. Most staff we spoke with were able to give examples of lessons learned from incidents within the hospital and some staff were aware of lessons learned from incidents at other hospitals run by the provider. Managers shared lessons learned bulletins with staff via email and kept copies of these in the nursing offices. This had improved since our previous inspection.

Staff met to discuss the feedback and look at improvements to young peoples' care. Managers attended daily site meetings where incidents from the previous day were discussed. Some staff we spoke with told us that they felt more involved in the incident process now, and that they felt confident to question why incidents escalated and identify solutions to prevent them happening again, rather than simply reporting incidents and not receiving any feedback.

Managers shared learning with their staff about incidents that happened elsewhere. For example, we saw that a lessons learned bulletin from May 2021 included information about an incident which had happened at another location so that all staff across all the provider's services could learn from this. Details of any patient safety alerts sent via the central alerting system were also included in regular bulletins to staff.

Are Child and adolescent mental health wards effective?

Requires Improvement

Child and adolescent mental health wards

Requires Improvement

We rated effective as requires improvement.

Assessment of needs and planning of care

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

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

Young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Vital observations were checked at least once a day on Thames, Severn and Tamar wards and at least twice a day on Kennet ward.

Staff developed a comprehensive care plan for each young person that met their mental and physical health needs. Managers had identified that young people had a lot of different care plans, sometimes more than ten, and so were trialling a new care plan structure where young people had four or five care plans focusing on key areas such as keeping well, safe, connected and healthy.

Staff regularly reviewed and updated care plans when young peoples' needs changed.

Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for young people based on national guidance and best practice; however young people had to wait a long time to access these. They ensured that young people had good access to physical healthcare. They also participated in clinical audit. Staff did not routinely use outcome measures.

Staff provided a range of care and treatment suitable for the young people in the service. They provided cognitive behaviour therapy (CBT), dialectical behaviour therapy (DBT), mindfulness and mentalization-based therapy (MBT). However, young people had to wait a long time to access some therapies. The waiting time for psychology and family therapy was up to six weeks. There was only one occupational therapist covering the site who had a caseload of 12 young people with complex needs.

Staff delivered care in line with best practice and national guidance. For example, staff on Kennet ward used the Maudsley Family Based Treatment Model for anorexia.

Staff identified young peoples' physical health needs and recorded them in their care plans. Staff assessed physical health needs as part of the admissions process. Staff completed paediatric early warning system (PEWS) observations once a day for young people on Thames, Severn and Tamar wards and twice a day for young people on Kennet ward. We reviewed PEWS charts on Thames and Kennet wards. On Thames ward these were all completed accurately. On Kennet ward there were three instances where a higher score had been indicated and it was not documented whether this had been escalated and what action had been taken. Staff assured us that action had been taken.

Requires Improvement

Child and adolescent mental health wards

Staff made sure young people had access to health care, including specialists as required. A GP visited the hospital weekly and a speech and language therapist was contracted to offer three assessments per month. Young people were supported to attend appointments with other healthcare specialists as required.

Staff met young peoples' dietary needs and assessed those needing specialist care for nutrition and hydration. Young people on Kennet ward were assessed by a dietician during the first week of their admission.

Staff used the Health of the Nation Outcomes Scales for Children and Adolescents (HoNOSCA) to monitor outcomes for young people. Progress against young person and carer identified goals was monitored through patient review meetings.

Staff took part in clinical audits and they had a schedule for completing these. The pharmacist carried out regular audits including of emergency drugs and rapid tranquilisation. Feedback from audits was passed to managers who used results to make improvements.

Skilled staff to deliver care

Access to some members of the multidisciplinary team was limited due to staffing vacancies. Managers did not ensure they had staff with the range of skills needed to provide high quality care and did not ensure staff were offered the relevant support to help them to succeed in their roles. Managers provided an induction programme for new staff.

The service had access to a full range of specialists. However, there were too few of them to adequately meet the needs of the young people on the wards. At the time of the inspection there was one full time clinical psychologist and 0.6 WTE counselling psychologist in post. The Quality Network for Inpatient CAMHS (QNIC) standards recommend that CAMHS wards have one clinical psychologist per 12 young people. Similarly, there was only one occupational therapist available to deliver therapy. QNIC standards also recommend one occupational therapist per 12 young people. This is likely to have impacted on the progress of the young people and contributed to the long length of stay for some young people at the hospital. Managers told us that the waiting time for therapy was up to six weeks. A psychologist and an occupational therapist had recently left the hospital and managers were in the process of recruiting to these posts. An art therapist had just been recruited to cover maternity leave and planned to offer both group and individual sessions. There was one full time family therapist for the hospital and they were trying to recruit to two systemic practitioner posts. Systemic practitioners have completed training in family and systemic therapy to an intermediate level but are not yet fully qualified family therapists.

Managers did not always ensure staff had the right skills, qualifications, experience and competence to meet the needs of the young people in their care. Some staff we spoke with raised concerns that the people who had been recruited into support roles at the hospital did not have the relevant skills and experience. Some staff were concerned that some of the support staff did not understand professional boundaries. We saw evidence that managers were taking action to address this. Managers had also worked with staff to implement a positive behaviour support (PBS) approach to care on Thames ward. This was also starting to be rolled out on Severn and Tamar wards with plans for Kennet ward to implement this shortly. Staff we spoke with were very engaged with this and gave positive feedback about the training they had received and the impact it had on reducing incidents and starting to improve quality of life for young people. Young people told us that PBS had encouraged staff to be more engaged. The PBS plans we reviewed on Thames ward were very comprehensive and clearly focused on wellbeing and recovery.

Requires Improvement

Child and adolescent mental health wards

Staffing across the hospital was inconsistent, with the same number of doctors, administrative staff and youth engagement practitioners allocated to a 20 bedded ward as a 10 bedded ward. Staff on Kennet ward told us that they felt very stretched.

Managers gave each new member of staff a full induction to the service before they started work. The induction period for new staff was three weeks which consisted of two weeks classroom-based learning and a week where they were supernumerary on the wards. They then received a further ward-based induction and were required to complete a number of e-learning modules. Staff told us the induction helped them to prepare for the work they were doing.

Managers did not support all staff through regular, constructive appraisals of their work. Forty percent of staff had received an appraisal in the last year, which is well below the provider's compliance target of 90%.

However, managers supported staff through regular, constructive clinical supervision of their work. Nurses and support workers told us that they received supervision once a month and records showed that 85.6% of staff had received supervision in June 2021. Managers had access to a dashboard which showed when supervision for staff members was due. Consultant psychiatrists received group supervision monthly with the medical director and other doctor grades received weekly supervision from a consultant psychiatrist.

Managers did not ensure that all staff received the relevant specialist training for their role. Staff working with young people with eating disorders on Kennet and Thames wards did not receive sufficient training for this aspect of their role. Only 33 out of 172 eligible staff on Thames and Kennet wards had attended a four-hour eating disorder teaching session delivered by a clinical psychologist and the head of therapies. Staff on Kennet ward completed meal support training led by a dietician but 10 out of 82 staff had not completed this. This training was not available to staff working on Thames ward although they cared for several young people who required specialist support because of their eating patterns and associated thoughts and risks. An e-learning course titled "eating disorders: anorexia and bulimia" was available to staff to complete, however, at the time of the inspection this was not mandatory for staff working with young people with eating related problems. When we highlighted this to the hospital director he immediately made this training mandatory and made arrangements for staff to undertake this.

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

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit young people. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss young people and improve their care.

Staff made sure they shared clear information about young people and any changes in their care, including during handover meetings. However, only 15 minutes was allocated for handover on Kennet ward so this frequently overran.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. Staff invited community team members to attend monthly care programme approach (CPA) meetings. Staff told us that they had a good working relationship with colleagues at their local accident and emergency department, and that hospital staff were planning to deliver a presentation to these staff around working with young people with mental health conditions.

Requires Improvement

Child and adolescent mental health wards

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain young peoples' 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. Ninety percent of staff were up to date with their Mental Health Act training.

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 administrator was and when to ask them for support.

Young people had easy access to information about independent mental health advocacy. Advocacy posters were displayed on the wards and young people we spoke with were aware of these. These included photos of the advocates.

Staff explained to each 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 young peoples' notes each time. On Kennet ward all young people who were detained had been read their rights four days prior to the inspection and this was clearly documented.

Staff tried to ensure young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. However, some young people, staff and relatives told us that leave was sometimes cancelled due to a lack of staff.

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

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

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

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

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Eighty-five percent of staff were up to date with their Mental Capacity Act training.

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

The service conducted an annual audit to monitor how well it followed the Mental Capacity Act.

Requires Improvement

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards caring?

Good

We rated caring as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated young people with compassion and kindness. They mostly understood the individual needs of young people and supported them to understand and manage their care, treatment or condition. However, staff lacked understanding around working with young people with eating disorders.

Staff were discreet, respectful, and responsive when caring for young people. Staff gave young people help, emotional support and advice when they needed it. We saw lots of examples of staff caring for young people in a compassionate manner during our inspection. We witnessed staff reassuring young people, laughing with young people appropriately, engaging young people in games and utilising the outside space. Staff were much more engaged with young people than we had seen during our previous inspections.

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

Most young people said staff treated them well and behaved kindly. The majority of the relatives we spoke with also gave positive feedback about the way staff treated young people. However, some young people on Kennet ward felt that a punitive approach was taken to nasogastric feeding. They told us that staff said “support stops when you leave the dining room” and that staff did not speak to them while they were being fed. We discussed this with managers who explained that it is common practice for staff not to speak to young people while they are being fed. However, it is important that young people feel they are being supported during what is likely to be a distressing intervention.

Staff mostly understood and respected the individual needs of each young person. However, some young people we spoke with on Kennet ward told us that staff lacked understanding of eating disorders and that the support they received during mealtimes was variable. Young people worked with the dietician to create a list of “do’s and don’ts” for staff to follow at mealtimes, however, they told us staff do not always read these and therefore make inappropriate comments during mealtimes. They had also raised this issue in a recent community meeting. This could impact on a young person’s recovery.

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

Staff followed policy to keep young peoples’ information confidential.

Requires Improvement

Child and adolescent mental health wards

Involvement in care

Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that young people had easy access to independent advocates and to child helplines.

Involvement of young people

Staff introduced young people to the ward and the services as part of their admission. Staff gave young people an information pack on admission which contained key information. Managers were in the process of developing 'pen profiles' with some brief information about staff members to help young people get to know staff.

Staff involved young people and gave them access to their care plans and risk assessments. All the care plans we reviewed indicated that young people had been offered a copy. Most young people we spoke with told us they had been involved in their care planning.

Staff made sure young people understood their care and treatment and supported them to make decisions about their care. Most young people we spoke with told us they understood their care and treatment. Some young people said it wasn't always clear why decisions had been made, for example why their observation levels had been changed or why they were no longer offered meal support.

Staff involved young people in decisions about the service, when appropriate. For example, managers had consulted young people regarding how to improve the feeding room on Thames ward.

Young people could give feedback on the service and their treatment and staff supported them to do this. Staff on each ward ran weekly community meetings which were an opportunity for young people to give feedback or suggestions on anything that could be improved. We reviewed minutes from the community meetings which included an update on any action taken regarding suggestions made in the previous meeting. Young people on Tamar and Kennet wards were invited to participate in a patient engagement group and staff had displayed some of the suggestions and details of action taken on a "you said, we did" board on Kennet ward. However, some of the suggestions related to "enjoying food" and "baking" which were not appropriate for Kennet ward. This had led to some of the young people on Kennet ward becoming distressed. We reported this to managers who acknowledged the error and took prompt action to remove the inappropriate content and apologise to the young people.

Staff made sure young people could access advocacy services. Advocates visited the hospital weekly. Posters were displayed on the wards which young people were aware of.

Involvement of families and carers

Staff informed and involved families and carers.

Relatives told us that frequency of communication had improved since the previous inspection. However, they said the quality of information and ways of communicating could still be better. Staff worked with young people and their families to develop communication care plans, as appropriate. Staff involved families in care and treatment planning, but some relatives told us that they did not always feel listened to by staff. Relatives also expressed concern with miscommunication at the hospital and different staff telling them different things, for example, some staff would allow

Requires Improvement

Child and adolescent mental health wards

three people to visit but others only allowed two. Relatives told us that they were kept informed about any incidents that took place and they were invited to attend Care Programme Approach and Patient Review Meetings. When we reviewed care records we saw that young people had specific "parent" care plans and there was evidence that these had been co-produced with relatives.

Staff encouraged families to give feedback on the service. Managers had tried to contact each family to seek feedback and received 41 responses. The key themes identified from the feedback were that relatives desired clearer communication, earlier engagement from the care team, a single point of contact and to be considered a valued and knowledgeable partner in their relative's care.

Managers were aware that involvement of family members and carers still required improvement and had devised a number of initiatives to try and help address this. One initiative was to invite a parent of a young person to deliver a session to new staff as part of their induction. The first session had taken place just prior to the inspection and staff gave excellent feedback about how powerful and thought-provoking it was. Managers were also in the process of adapting a questionnaire for parents to complete on admission to gather information about young people's usual daily routine and likes and dislikes.

Staff signposted families to their local CAMHS services for peer support but were also planning to start offering parent workshops and family information days.

Are Child and adolescent mental health wards responsive?

Requires Improvement

We rated responsive as requires improvement.

Access and discharge

Some young people had excessive lengths of stay at the hospital, particularly on the PICUs.

Managers regularly reviewed length of stay. However, some young people had been at the hospital far longer than recommended. For example, some young people on the PICUs had been there over a year. This was not in line with National Minimum Standards for Psychiatric Intensive Care Units for Young People (2015) which states that CAMHS PICUs are intended for short stays of up to six weeks. Staff were actively working with the Provider Collaborative to try and source suitable placements to move young people on.

Managers and staff worked to make sure they did not discharge young people before they were ready. When young people went on leave there was always a bed available when they returned.

Young people were moved between wards during their stay only when there were clear clinical reasons, or it was in their best interests. For example, some young people had been moved from Kennet ward to Thames ward when they needed to be nursed in a more secure environment.

Discharge and transfers of care

Requires Improvement

Child and adolescent mental health wards

The service had a high number of delayed discharges. At the time of the inspection there were six delayed discharges due to suitable onward placements not yet being identified for young people or them having been accepted but there being no bed available. Managers monitored the number of delayed discharges every week.

Communication around discharge could be improved. Relatives told us that discharge did not always occur as planned which led to their loved ones becoming upset.

Facilities that promote comfort, dignity and privacy

Young people did not always have sufficient privacy on the wards. Some young people shared bedrooms and there were limited quiet areas for privacy. The food was adequate.

Young people on Thames, Tamar and Severn wards had their own bedrooms. Some of the bedrooms on Kennet ward required young people to share a bedroom with another young person. Staff told us that this was risk assessed. Young people we spoke with told us that they did not mind sharing a bedroom, some said they preferred to share. Where young people did share bedrooms this was with another young person of a similar age to them. During our first visit on 14 and 15 July 2021 we found that young people on Thames ward were unable to control the vistamatic panels on their bedroom doors meaning they could not close the screen if they wished to have privacy. When we returned for our second visit on 29 July 2021 this had been resolved so young people could utilise the privacy element of the screen with staff being able to override this. During our first visit some of the bedrooms on Tamar ward did not have curtains, however these had been put up prior to our second visit.

Young people had a secure place to store personal possessions. On Kennet ward lockers were available for young people to store their possessions. Staff kept keys for the lockers in the nursing office. Young people could request staff open lockers for them and access was supervised.

The service had rooms where young people could meet with visitors in private, however did not have enough quiet spaces for young people to use. For example, on Kennet ward the only communal space was the lounge which was very busy and loud. A zen room had recently been set up on Severn ward which was a quiet sensory space for young people to use, however we found this to be bright and stark. Managers were in the process of looking at whether the brightness of the lights could be reduced.

Young people could make phone calls in private.

The service had an outside space that young people could access easily. Access to the garden was timetabled, however, young people could also request additional access outside of these times. We observed lots of young people utilising the outside space during our inspection.

The service offered adequate food and catered to the dietary needs of young people. Staff changed menus quarterly and sought feedback from young people.

Young peoples' engagement with the wider community

Staff supported young people with activities outside the service. Although there was access to high quality education, attendance rates were poor.

Staff made sure young people had access to opportunities for education. There was a school on-site at the hospital, however attendance was poor, with absence rates ranging from 17-41%. School staff emailed attendance statistics to ward managers each week. Young people told us that staff encouraged them to attend school and activities did not take

place during school hours in order to encourage young people to attend. School staff ran a session for new staff during induction to promote the importance of education. The school was to begin offering an arts award from the next academic year and also planned to invite more external speakers in once lockdown restrictions eased, which they hoped would encourage more young people to attend.

Staff helped young people to stay in contact with families and carers. All wards provided iPads which young people could use to video call their loved ones. However, young people on Kennet and Tamar wards told us that this was difficult due to poor or broken Wi-Fi connections.

Staff encouraged young people to develop and maintain relationships both in the service and the wider community. The youth engagement practitioners arranged outings for young people and young people were encouraged to pursue activities they enjoyed in the community, for example attending local farms or going to the cinema.

Meeting the needs of all people who use the service

Staff helped young people with communication, advocacy and cultural and spiritual support.

Not all of the wards were accessible for disabled people. Severn and Thames wards were but Tamar and Kennet wards were not.

Staff made sure young people could access age appropriate information on treatment, local services, their rights and how to complain.

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

Young people had access to spiritual, religious and cultural support. Staff displayed leaflets about various groups in reception.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously and investigated them appropriately.

Young people, relatives and carers knew how to complain or raise concerns. Some of the relatives and young people we spoke with told us they had raised concerns which had been promptly addressed.

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

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints but did not identify themes. The service had received 11 complaints since April 2021. Of these one was upheld, four were partially upheld, two were not upheld and four were still being investigated. We saw evidence that managers reviewed and responded to complaints and that complaints were discussed in governance meetings, however there was no evidence that themes from complaints had been identified.

Staff knew how to acknowledge complaints and young people received feedback from managers after the investigation into their complaint.

Requires Improvement

Child and adolescent mental health wards

Are Child and adolescent mental health wards well-led?

Requires Improvement

We rated well-led as requires improvement.

Leadership

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 young people and staff.

Despite only being in post a few days and weeks at the time of the inspection the impact that the new senior leadership team had made was very clear to see. Staff we spoke with told us that they were optimistic about the new leadership team at the hospital. They told us that leaders were now a visible presence on the wards and that they were available to offer support and guide staff through the changes needed to improve the care provided at the hospital. They told us that the new senior leadership team genuinely cared about staff and young people, and that they were open to creative solutions to try and aid young people with their recovery. Although staff felt the change in leadership was positive, they did also acknowledge that this was the third change in leadership in a short amount of time and that it had been difficult to constantly adjust to new ways of working.

Vision and strategy

Staff were aware of the provider's vision and values.

Managers displayed posters about the aims and values of the service on the wards. Staff we spoke with were aware of these and how they impacted on their day to day work.

Culture

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.

Overall, staff morale had increased since our previous inspection. Most of the staff told us they felt supported and valued in their work. Staff told us that it no longer felt like there was a hierarchy on the wards and that senior colleagues were very approachable and always made time for them. However, two staff members told us that while they felt confident to raise concerns, they feared that they would not be handled in a confidential manner.

Ward managers displayed whistleblowing posters in the nursing offices. This included contact details for an external organisation staff could raise concerns with privately and confidentially if they wished to do so.

Governance

Our findings from the other key questions demonstrated that governance processes still required improvement.

Requires Improvement

Child and adolescent mental health wards

We saw evidence of where decisions had been made but the detail had not been recorded in the relevant documentation. For example, discharge plans had been agreed and documented in CPA minutes but discharge plans had not been updated; incidents had been reported but lacked sufficient detail to give a clear picture of the events that had taken place. We reviewed PEWS charts which showed that it was not always documented that concerns had been escalated, despite staff telling us that this was the case.

Each ward had a monthly governance meeting which fed into the monthly hospital-wide governance meeting. Managers kept an action log to record any actions identified from governance meetings, including details of which staff member was responsible for ensuring it was complete. This was reviewed at every meeting to ensure adequate oversight. The central quality team also provided managers with weekly oversight reports looking at incidents and a breakdown by category so that themes and trends could be identified.

Managers had a risk register and held monthly meetings to review this.

The new senior leadership team had clear plans in place to improve the governance arrangements and oversight at the hospital. This included implementing a PBS steering group, quality briefings around reducing restrictive practice and quality improvement projects.

Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Quality and innovation

Staff engaged in national quality improvement activities.

Staff on Kennet ward participated in the Quality Network for Inpatient CAMHS (QNIC) programme managed by the Royal College of Psychiatrists.

Managers had signed up to pilot Safewards on Severn and Tamar wards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The ligature audit on Severn ward did not include a mitigation plan for all identified risks.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not ensure that records were adequately updated and that incidents which were reported included all relevant information about what action was taken.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure that staff were offered an annual appraisal or that they were up to date with their mandatory training.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	S29 Warning Notice **Regulation 12 (2) (c), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** • The provider did not ensure that staff working with young people with eating disorders had the appropriate training and skills to do so. • The provider did not ensure that adequate support was given to young people with eating disorders at mealtimes. • The provider did not ensure that staff supporting young people with nasogastric feeding received appropriate support. **Regulation 15 (1), Premises and equipment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** • The provider did not ensure that the ward environments were suitable to meet the needs of young people or that there were sufficient communal spaces on the wards for young people to use. **Regulation 18 (1), Staffing, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** • The provider did not ensure that there were enough suitably qualified and competent therapy staff to provide a range of therapeutic interventions to meet the needs of young people. • The provider did not ensure that there were sufficient staff members of all disciplines on the wards to meet the needs of the young people.