Huntercombe Hospital - Stafford

Quality Report

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

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

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

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

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

Overall summary

The Care Quality Commission (CQC) carried out a responsive inspection of Huntercombe Hospital Stafford on the 08 July 2016 to ensure effective safeguarding processes were in place. This followed the CQC issuing a warning notice on 19 May 2016 to the hospital managers requiring them to introduce an effective system and provide staff with training around safeguarding.

We found:

- Significant improvement in staff training and knowledge about recognising and reporting potential abuse
- Managers had introduced systems to quickly identify and act on any concerns about abuse.
- Hospital managers were taking an active role in the daily review of incidents and the clinical management of risk across the site.

However:

Summary of findings

- Only one third of ward staff were aware of systems for raising urgent safeguarding concerns out of hours.
- Ward meetings did not have systems embedded to ensure concerns were reported and actions were followed up consistently.

Summary of findings

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Background to Huntercombe Hospital - Stafford

Huntercombe Hospital-Stafford was a child and adolescent mental health service (CAMHS) for 39 young people of both genders aged 8 to18 years. The hospital can also admit detained patients.

Huntercombe Hospital-Stafford was divided into three separate wards; Hartley, Thorneycroft and Wedgewood wards.

- Hartley ward was a Psychiatric Intensive Care Service (PICU) providing 12 beds for male and female patients. The PICU unit at Stafford offers inpatient care to young people suffering from mental health problems who require specialist and intensive treatment to address their needs. The team is led by a consultant child and adolescent psychiatrist and further supported by a team of nurses, therapy and support staff. The unit is a locked secure unit, which means that people who are admitted are not allowed to leave or enter the building unless they have authorisation from doctor and the staff are aware of what they are doing. All patients on the PICU are detained under the Mental Health Act (1983). This unit had been closed following concerns raised about patient safety following the CQC's comprehensive inspection in May 2016.
- Thorneycroft ward was a general CAMHS acute assessment unit with 12 beds for young people aged 12-18 years. The young people treated in this unit had a range of diagnoses from psychosis and bipolar disorder to depression and deliberate self-harm. The team was led by a child and adolescent psychiatrist. Occupancy levels were capped at a maximum of eight children or young people at the time of this inspection. This was because of ongoing concerns about safety at the hospital and was under ongoing review by NHS England and the service provide in liaison with the CQC and Local authority.
- Wedgewood ward has 15 beds and provides a specialist eating disorders service. The young people treated on the eating disorders unit have a diagnosis of Anorexia Nervosa, Bulimia Nervosa, or other similar eating disorders. The team is led by a consultant child and adolescent psychiatrist. Occupancy levels were capped at a maximum of twelve children or young people at the time of this inspection. This was because of ongoing concerns about safety at the hospital and was under ongoing review by NHS England and the service provide in liaison with the CQC and Local authority.

The CQC registered Huntercombe Hospital - Stafford to carry out the following services/activities:

- Accommodation for persons who require nursing or personal care
- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures

The hospital did not have a manager registered with the CQC in post at the time of the inspection. A new hospital director had taken up post on the 04 July 2016 and was to register.

The CQC last carried out a comprehensive inspection of the site in May 2016 and a responsive inspection in April 2016. The inspection in April 2016 had identified the need for urgent action on safeguarding. The inspection in May 2016 found the service to be inadequate overall and led to the CQC putting the hospital in special measures. This inspection was a focused inquiry to determine if improvement had been made in improving safeguarding knowledge and procedures.

Our inspection team

Team leader: Michael Fenwick

The team that inspected the service comprised four CQC inspectors and one inspection manager.

Summary of this inspection

Why we carried out this inspection

We carried out an unannounced, focused inspection at Huntercombe Hospital Stafford on 28 April, 29 April and 04 May 2016. This inspection was responsive to information we received in a whistleblowing alert on 27 April 2016.

That inspection found that the hospital managers had failed to maintain an effective safeguarding system at the hospital. This included a failure to provide information to external organisations such as the local authority and CQC that are required by law.

It also found that staff knowledge of and training in safeguarding procedures were inadequate.

The CQC issued a warning notice to the provider requiring them to improve the situation by becoming compliant with Regulation 13, section (1) (2) (3), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 24 June 2016.

Consequently, the hospital managers provided the CQC with an action plan about how they would achieve compliance. The CQC and representatives of NHS England met with the providers weekly to review the progress of this plan and other areas of concern.

The CQC made an unannounced inspection on the 8 July 2016 to for assurance that improvements had been made. This report contains the findings of that inspection.

How we carried out this inspection

To fully understand the issues of concern that were raised the inspection team:

- reviewed the clinical records for all patients looking for evidence of capacity or competency assessments to consent to treatment
- spoke with the social worker and one ward manager
- spoke with one consultant psychiatrist
- spoke with the Information and Compliance Officer
- spoke with one nurse, four support workers, a dietician, art therapist and housekeeper on Wedgwood ward
- spoke with two nurses, five support workers and two other staff on Thorneycroft ward
- spoke with three young people on Thorneycroft ward
- attended the morning handover meetings on both wards and the hospital wide daily management meeting
- examined minutes and other documents relating to safeguarding and clinical governance inside the hospital.
- looked at safeguarding training rates for clinical staff and hospital staff as a whole
- spoke with the local safeguarding team leader and Local Authority Designated Officer (LADO)
- spoke with commissioners at NHS England and the local police liaison officer.

What people who use the service say

- During this inspection, we spoke to three of the eight young people on the acute assessment ward, Thorneycroft ward.
- These young people spoke more positively about the care they were receiving than when spoke to the CQC during previous interviews. They described an understanding of how to make complaints both internally to the provider and externally to agencies such as the CQC if they felt they needed or wished to.
- They were also aware of advocacy services attending the hospital regularly and their role in supporting the young people.
- The young people we spoke to stated they received debriefs after incidents involving restraint.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found:

- Safeguarding training had been provided to all hospital staff and that 86% of core clinical ward staff were now trained.
- There had been an increased use of the electronic incident reporting system by all grades of staff.
- Management had introduced flow charts and examples of safeguarding concerns and grading to promote reporting.
- Out of hours contact protocol for reporting concerns to senior staff on call was in place.
- There were daily ward reviews of incidents with full multidisciplinary team involvement.
- The hospital managers led a daily hospital wide review of safety incident and clinical progress. These meetings were fully documented and reviewed incident reports from both wards.

However:

- None of five the staff we interviewed on Wedgewood were aware of how to escalate urgent safeguarding concerns out of hours. On Thorneycroft, four out of seven staff knew how to do this.
- No records of agreed actions were kept for review at the ward level morning meetings.

Are services effective?

We found:

- Staff were assessing young people's competency and capacity appropriately. This provided assurance that young persons' rights to make decisions were being respected.

However:

- We found consent forms from parents sought for naso-gastric tube feeding on admission were still in place.
- We heard continued concerns from the Local Authority about the hospitals timeliness and accuracy in reporting incidents despite some improvements.

Are services caring?

We found:

- Patients spoke more positively about the care they were receiving.

Summary of this inspection

- Patients received debriefs after the use of restraint.
- Advocacy was active on wards and engaged with the young people.

Are services responsive?

We found:

- Patients we spoke to knew how to make a complaint
- Patients knew about the CQC and local authority as points for raising concerns.

Are services well-led?

We found:

- The morale and confidence of staff in the use of incident reporting systems and their effectiveness had increased.
- Staff felt informed about changes and we saw evidence of regular communication by management through meetings, newsletter and emails.
- Teams were being supported in change and new developments through away days

However

- The management structure was still unsettled with new roles and responsibilities not yet well understood.
- Staff did not feel involved in the development of services and action plans

Detailed findings from this inspection

Mental Health Act responsibilities

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

Child and adolescent mental health wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are child and adolescent mental health wards safe?

Safe Staffing

- During our inspection, we found a greater awareness amongst staff of the guidance around the use of restrictive practices. On both wards, staff were aware of the need to provide support to young people following the use of restraint and that the use of restrictive practices could be potentially considered abuse.
- The number and type of restrictive practices (restraint, use of rapid tranquilisation etc.) used on each ward was now reviewed weekly in the multi-disciplinary team meeting.

Assessing and managing risk to patients and staff

- Safeguarding training had been offered to all staff on site at Level 3 Safeguarding for Children. Eighty six percent of nursing and support workers were up to date with this training as compared to 44% when the CQC issued the warning notice on the 19 May 2016.
- Level 3 safeguarding training had also been undertaken by other staff at the hospital. We found that 12 out of 15 of the therapy team (80%), 13 out of 15 of support service staff (87%), two out of four of the permanent medical staff (50%) and all nine of the teaching staff had completed the required training at the time of this inspection.
- Medical staff, the hospital social work team and senior managers were also booked to undertake further Level 4 Safeguarding training in August 2016.
- Positive behavioural support (PBS) training was being introduced to the service. Staff use this framework to understand the meaning of behaviour for an individual and the context in which the behaviours occur. This understanding assists staff to design more supportive environments and to better support individuals in developing skills that will improve their quality of life.

Reporting incidents and learning from when things go wrong

- Staff we spoke with during inspection were confident in knowing how to report incidents. In addition to general safeguarding training, the hospital managers had introduced a pathway for staff to follow when reporting safeguarding concerns.
- We found that staff were confident and competent in explaining safeguarding and how to report concerns. However, personal responsibility was felt only to extend to reporting concerns to the next level of staffing for example the nurse in charge of the shift.
- Flowcharts and briefings had been provided to identify staff responsibilities and give examples of potential abuse. However, we found that not all staff were aware of these protocols despite them being prominently displayed on the wards.
- Statutory notifications to the CQC had increased, were timely and corresponded with notices provided to the Local Authority (LA).
- Progress of Section 47 investigations (Child Protection Enquiry) remained a concern for the LA lead. However, there had been some improvement in communication and access to evidence.
- We found that the backlog of non-investigated/open incidents on the incident reporting system had significantly reduced since introducing the new system of review.

Child and adolescent mental health wards

- Consultant psychiatrists we spoke to were clear about their role in leading on review of incidents at multi-disciplinary meetings. The hospital social worker was also more confident of the revised system.
- Hospital managers had introduced a two-tiered clinically led management approach to incidents.
- First level: Monday through to Friday morning meetings on each ward take place to discuss and review information from the previous 24 hours. This approach ensured follow up to incidents, increased body maps and debriefs offered to the young people and staff involved in incidents. Incident reporting was also reviewed in this meeting forum.
- We found on one ward that not all concerns discussed in the clinical nurse handover were brought to this meeting. No minutes were taken and action points not followed through from the previous days meeting.
- Second level: Monday through to Friday hospital senior management team meetings occur, ward representatives and multi-disciplinary senior management attend. The previous day's minutes and actions were discussed and updated; safeguarding was an agenda item as was the review of incidents and daily ward updates. This meeting had a positive impact and was seen as overseeing ward level decisions and gaining consistency and accuracy in reporting and documenting incidents.
- No routine had been established as to how the findings and action from this senior management meeting were fed back into ward meetings on a daily basis. Continuity of individuals between the two meetings was relied upon. Ward staff were not aware of the senior management team meeting and its role.
- The hospital had developed a monthly governance cycle to take a higher level view of incidents and review trends.
- We found Local Authority safeguarding reports had been made within the required timescale of 48 hours. Out of hours contact with the Emergency Duty Team (EDT) had also been promoted for urgent concerns.
- Support materials had been developed to support the on call manager overnight and at weekends. These packs included copies of the relevant pathways about recording incidents and the obligation to report externally to the local authority, police, NHS England and CQC as required.
- However we found that none of the five staff interviewed on Wedgewood knew of the new out of hours reporting system. Four out of seven staff on Thorneycroft could refer to new protocol. Proportionately this meant two thirds of all staff interviewed and all staff on one ward did not know how to urgently report a safeguarding incident outside of normal working hours. The potential impact was to delay the investigation of any alleged abuse.
- A monthly dashboard had been developed which detailed the frequency and category of incidents. This was discussed at the newly established clinical risk governance group and shared with ward staff by circulation of its minutes.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Multi-disciplinary and inter-agency team work

- Multi-disciplinary team (MDT) members attended daily handover meetings in addition to the regular clinical MDT meetings to ensure consistent review of incidents and communication of agreed actions.
- Hospital managers had held meetings with the local authority designated officer for safeguarding children (LADO) to discuss ongoing protocols for their involvement.
- Managers had also made contact with the local police to proactively engage local agencies that support the hospital.
- However, the local authority safeguarding manager had concerns that not all required notifications were being made in a timely fashion. Hospital staff were not always allowing investigating social workers access to care plans, risk assessments and the young people involved for interview. Huntercombe managers had been informed of these concerns at a strategy meeting on the 22 June 2016 at the hospital and at provider engagement meetings, with the CQC and NHS England during June.

Good practice in applying the Mental Capacity Act

- Staff were assessing young people's competency and capacity appropriately. This provided assurance that young persons' rights to make decisions were being

Child and adolescent mental health wards

respected. However, we found consent forms from parents sought for naso-gastric tube feeding on admission were still in place instead of sought at times when clinically required.

Are child and adolescent mental health wards caring?

The involvement of people in the care they receive

- The young people we spoke to during inspection described an understanding of how to make complaints both internally to the provider and externally to agencies such as the CQC if they felt they needed or wished to.
- We heard from young people on Thorneycroft ward that advocacy workers visited the ward each Thursday and Friday. Staff on the ward could put calls through to advocacy at the request of a young person at other times.

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

Listening to and learning from concerns and complaints

- During our inspection, we saw evidence that staff were receiving feedback and outcomes form complaints and investigation. One nurse on Wedgwood ward reported that she had received a letter concerning an investigation she was involved in. The letter contained learning points and advice on how to handle similar events in the future.

Are child and adolescent mental health wards well-led?

Good governance

- Since our initial visit, senior hospital managers with the support of corporate directors have prioritised training for staff in skills and knowledge to maintain safety on the wards. The organisations commercial director had led weekly updates and review of progress against an action plan agreed with NHS England and CQC.
- There had been significant change in the management structure since our last inspection. Given this, it was felt to still be new and not fully established, with new roles and responsibilities not yet well understood by all staff.

Leadership, morale and staff engagement

- Staff we spoke to told us that they felt informed about changes through regular management communication via meetings, newsletters and email and supported through recent team away days. However did not feel involved in the development of services and action plans.
- From speaking with staff during our inspection, staff described increased confidence in the incident reporting systems and their effectiveness

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff are aware of the new protocols and arrangements for support out of hours to escalate urgent safeguarding concerns.

Action the provider SHOULD take to improve

- The provider should ensure robust governance structures are in place to monitor and record the completion of agreed actions within clinical review / handover meeting forums.
- The provider should ensure that parental consent is not sought for naso-gastric tube feeding on admission but instead at the appropriate time when clinically required.
- The provider should provide all the required reports to the Local Authority in a fully detailed and timely manner and fully support investigating social workers in their duties.
- The provider should clarify and communicate the revised management structures to all staff.
- The provider should develop a range of mechanisms to promote the involvement of staff in the development of services and action plans.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services and others were not protected from the risk of abuse as the provider failed to operate an effective system to prevent report and investigate immediately any allegations. This was a breach of Regulation 13 (1) (2) (3)