Huntercombe (No 12) Limited

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Insufficient evidence to rate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Huntercombe Hospital - Maidenhead provides specialist child and adolescent mental health inpatient service (CAMHS), including psychiatric intensive care for young people.

Following this inspection, we served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action. We told the provider that we were considering whether to use our powers to urgently suspend, impose variation or remove their registration. The effect of using Section 31 powers is serious and immediate. The provider was told to submit an action plan within 5 days to address concerns about poor care and treatment on two of the wards.

We also issued a Warning Notice under Section 29 of the Health and Social Care Act 2008, telling the provider they must ensure that a Positive Behaviour Support (PBS) approach is embedded across the hospital, to enable an effective response to young people whose behaviour poses a challenge and risk to themselves, others and service, and that this must be achieved by 31 January 2020.

We have rated the service as inadequate overall and placed it in special measures. This means that the provider must make the required improvements otherwise we will take further enforcement action. The service will be subject to close scrutiny and monitoring.

Our rating of this service went down. We rated it as inadequate because:

- On two of the three wards we inspected (Severn and Thames), young people did not receive safe care that met their individual needs. We found young people did not receive person centred care. We found minimal evidence of clinical formulations being made, despite some young people experiencing long and highly restrictive admissions. Staff did not appear to be using a Positive Behaviour Support ('PBS') informed approach, despite us telling the provider it must use these at the previous inspection in 2019. PBS is an evidence based and person-centred approach to supporting patients who behave in ways which pose risk and challenges to themselves and others.
- On Severn and Thames wards, staff did not follow safe systems and processes to prescribe, administer, record and store medicines. Prescribing was not always in line with national guidance. Staff did not record the reasons why some medicines were prescribed for some young people outside of licensed or best practice guidance, and the hospital lacked the required peer review process to review these prescribing practices. Young people did not have personalised care plans to support them or staff to manage agitation or distress without the use of medicines. Staff appeared to use medicines to manage young people's agitation and distress, without ensuring that less restrictive and more therapeutic options were consistently provided. We observed several young people on Seven and Thames ward that appeared over sedated due to effects of prescribed medication.
- Staff did not robustly assess young people's mental capacity or Gillick competency which is the legal framework used to decide whether a child, under 16 years of age, is able to consent to their own treatment. We were unable to find evidence that staff routinely reviewed consent during a young person's admission. We found incomplete or contradictory Mental Health Act 1983 consent to treatment paperwork. We found incidents where staff had administered medicines without young people's consent or legal authorisation in place. We found young people were not regularly referred to the second opinion appointed doctor (SOAD) service, who safeguard the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting.
- Staff did not effectively monitor young people's physical health. Staff did not consistently follow the providers policy, or best practice guidance, when monitoring young people's physical health following giving rapid tranquilisation.

paediatric early warning (PEWS) charts used by staff to assess and monitor young people's physical health had been introduced but had not been used correctly. At the last inspection we told the hospital it must use nationally recognised early warning assessment and monitoring methods (e.g. PEWs) for all young people. Staff reviewed the effects of regular medications on each patient's physical health but did not always record the effects of rapid tranquilisation for a minimum of two hours as required by national guidance and service policy.

- On Thames and Seven ward young people and their families were not involved in care planning or risk assessment. Care plans lacked personalisation. Young people did not have copies of their care plans. Parents told us they felt their knowledge of their child's needs and risks, and their views, were ignored by staff. Parents told us they felt concerned this had led to less effective and potentially harmful care being provided to their child.
- Risk assessments were not up to date or sufficiently detailed. Patients did not have risk management plans. On Thames and Seven ward records showed staff relied on restrictive interventions such as sedating medications, increased nursing observations, and restricted access to items within the ward environment, without evidence of considering person-centred or less restrictive alternatives.
- Although a new senior team had been appointed, governance processes had not been operating effectively, which prevented the issues we found in care and treatment from been identified or addressed by the provider organisation. Issues of concern raised at the previous inspection, that we told the provider they must address, had not improved. The hospital lacked robust governance and assurances processes to ensure risk assessments, risk management plans and care plans were consistently completed, sufficiently detailed, and were regularly updated and reviewed across the wards. Issues with the safe storage and management of medication in clinic rooms on the PICU wards had not been identified by the hospital governance systems.
- There was a lack of robust oversight and assurance by Huntercombe senior leaders. Therefore, they had not picked up poor care at the hospital and acted to make improvements in a timely manner.

However:

- The provider had recently recruited a new Hospital Director, Head of Nursing, Head of Quality and Quality Manager. The new managers had the skills, knowledge and experience needed to perform their roles, and had identified the need for improvements at ward level. In response to the concerns which were identified during this inspection, the new management team developed a comprehensive action plan with clear timescales to address our concerns about patient safety and wellbeing.
- The new managers showed a good understanding of the service they managed and were visible in the service and approachable for patients and staff.
- While a significant number of the registered nursing staff were from agencies, all agency staff received the same induction, training and supervision as permanent employees, and most were on long term agreements.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Inadequate 	Our rating of this service went down. We rated it as inadequate because:

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 60 bed independent hospital. It provides specialist mental health services for adolescents and young people from 12 to 25 years of age and is registered to treat young people who are detained under the Mental Health Act 1983. It also treats young people who are admitted informally. Huntercombe delivers specialised clinical care for young people of all genders requiring CAMHS, including 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. Where appropriate the young people have access to the hospital grounds and local community facilities.

The hospital consists of four wards.

• Kennet ward provided eating disorder services and had 20 beds.

• Tamar ward provided tier four CAMHS general adolescent services and had 11 beds.

• Thames ward had 14 beds and provided psychiatric intensive care services (PICU).

• Severn ward had 15 beds and provided psychiatric intensive care services (PICU).

We undertook an unannounced, focussed inspection of Huntercombe Hospital, Maidenhead because we had received information which raised concerns about the safety and quality of the service. These concerns included the frequency of incidents of deliberate self-harm, staff whistleblowing about working practices, and complaints from parents of young people at the hospital about the quality of the care and communication with the staff.

The hospital was previously inspected in June 2019 and rated as Good overall. We rated the effective key question as requires improvement, all other key questions were rated as Good. Following the 2019 inspection, we told the provider that they **must** take the following action:

- The provider must ensure that training levels for all staff in the Mental Health Act exceeds 75%. This had been achieved.
- The provider must ensure that the Paediatric Early Warning System (PEWS) is used correctly and consistently across the wards, to monitor changes to young people's physical health. This had not been achieved, although we noted some improvement in the three wards that we inspected.
- The provider must ensure that a positive behaviour support approach is embedded across the hospital, to enable an effective response to young people whose behaviour poses a challenge to the service. This had not been achieved at this inspection

Summary of this inspection

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 team that inspected the service comprised three inspectors, one mental health act reviewer, a pharmacy inspector, one head of inspection, three specialist advisors and an expert by experience.

On the 19th of November 2020 our on-site inspection activity comprised:

- Visits to three wards (Kennet, Thames and Severn), where we observed patients interacting with staff and inspected clinic rooms and areas where medication was stored
- Interviews with the hospital director, head of nursing and quality, newly appointed head of nursing and quality and compliance manager
- Interviews with 16 patients
- Interviews with four parents of young people currently being treated at the hospital
- Interviews with ward staff, including three ward managers, a clinical nurse specialist, five support workers, three nurses, a dietician and assistant dieticians, three doctors, and a youth engagement practitioner
- Reviewed eight care records, and six medication charts in detail
- Observed a care planning approach (CPA) meeting

We also reviewed information provided by the service, including:

- Incident data for four weeks prior to the inspection, including serious incidents and incidents where young people were restrained by staff
- Complaint data for four weeks prior to the inspection
- The service's medicines management policy and recent clinical audit reports
- Training, supervision and appraisal data

We also reviewed feedback information we held about the service from patients, parents, staff and stakeholders, including three parents who made contact with us to share concerns about their children's care in the weeks prior to the inspection.

We returned to the service on the 3rd December to gather further evidence, specifically focussed on the use of medicines on the PICU wards, Thames and Severn. At this visit we reviewed care records of 15 young people, including prescribing care plans, medication charts, minutes of review meetings and behaviour support plans.

Areas for improvement

Following this inspection, we served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action. We told the provider that we were considering whether to use our powers to urgently suspend, impose variation or remove their registration. The effect of using Section 31 powers is serious and immediate.

The provider was told to submit an action plan within 5 days to address the following:

Summary of this inspection

1. Ensure that all young people receive safe care to meet their individual needs that is individually assessed, and care planned.

2. Ensure that staff are trained in Positive Behaviour Support and the Positive Behaviour Support approach is implemented across both PICU wards.

3. Ensure that all known risks and identified risks are recorded, and appropriate action is taken to mitigate the risk and that this is recorded in the risk management plan for all young people.

4. Ensure that all young people on the PICU wards have their medication reviewed by a consultant independent of the Maidenhead site.

5. Ensure that all young people on the PICU wards have their capacity or competence to consent to medication in line with the Mental Health Act 1983 / Mental Capacity Act 2005 reviewed by a consultant independent of the Maidenhead site.

6. Ensure that all young people on the PICU wards are reviewed to establish whether they have validly consented to their medication as certified on form T2 including consent to IM medication.

We also served a warning notice under Section 29 of the Health and Social Care Act 2008. The provider was failing to comply with Regulation 12, (2) (c), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We told the provider they must ensure that a positive behaviour support approach is embedded across the hospital, to enable an effective response to young people whose behaviour poses a challenge to the service, and that this must be achieved by 31 January 2020.

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

The provider **must** ensure that there are robust governance and assurances processes in place to ensure risk assessments, risk management plans and care plans are completed, updated and regularly reviewed. These processes must include oversight from senior organisational leadership that connect the hospital to the wider governance structures. (Regulation 17 of the Health and Social Care Act 2008 (RA) Regulations 2014; Good governance).

The provider **must** ensure that the Paediatric Early Warning System (PEWS) is used correctly and consistently across the wards, to monitor changes to young people's physical health (Regulation 12 of the Health and Social Care Act 2008 (RA) Regulations 2014; Safe care and treatment).

The provider **must** ensure that good systems and processes to safely administer, record and store medicines are in place on all wards. (Regulation 12 of the Health and Social Care Act 2008 (RA) Regulations 2014; Safe care and treatment).

The provider **must** ensure effective governance systems are in place to ensure systems and processes to safely administer, record and store medicines are operating effectively. (Regulation 17 of the Health and Social Care Act 2008 (RA) Regulations 2014; Good governance).

Action the provider SHOULD take to improve

Summary of this inspection

The provider **should** ensure that staff supervision takes place within the 42 day period described in the hospital policy (Regulation 12 of the Health and Social Care Act 2008 (RA) Regulations 2014; Safe care and treatment).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Inadequate	Requires Improvement	Requires Improvement	Insufficient evidence to rate	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Insufficient evidence to rate	Inadequate	Inadequate

Inadequate

Child and adolescent mental health wards

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Insufficient evidence to rate
Well-led	Inadequate

Are Child and adolescent mental health wards safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

- Staff on the two PICU (psychiatric intensive care unit) wards did not assess and manage risks to young people and themselves well, and did not follow best practice in anticipating, de-escalating and managing challenging behaviour. We found that the staff approach to risk management relied heavily on medication and observation. Risk assessments had been marked as having been reviewed recently, however, content in some instances referred to initial period following admission, despite the patient having been admitted for some time. Young people did not appear to be involved in risk assessment, risk management or care planning development. We found no evidence of involvement of families in care planning and risk assessment, even where in one instance a specific family communication care plan was in place. Most young people did not have a risk management care plans, those that did were generic.
- Prescribing on the two PICUs was not always in line with national guidance and there was no peer review process in place to ensure it was in the best interests of the patients. We were concerned that medication was being inappropriately used to manage aggression and distressed behaviour, without personalised support plans to address the causes of the distress. This is a practice we describe as chemical restraint. All of the ten prescribing records we reviewed on the PICU wards on our second visit found antipsychotic medicines prescribed without a clearly documented diagnosis, rationale or care plan developed by the multidisciplinary team. Care plans did not show that other interventions were tried before the use of regular antipsychotic medicines to control aggressive behaviour, and there were no recorded plans for stopping treatment. Antidepressants were prescribed to young people with no current recorded diagnosis of depression. We noted some young people appearing drowsy and sedated. Three young people were prescribed a medicine to aid sleep that is not licensed for children under 18.
- Antipsychotic medicines were widely prescribed to young people to treat agitation and distress, with no recorded plans for reviewing or stopping treatment. 'When required' medicines were used to control behaviour and we saw two examples where the number of doses administered in 24 hours was more than the prescribed amount. Staff prescribed rapid tranquillisation without the appropriate Mental Health Act consent to treatment form in place.
- Staff on the two PICUs did not make regular records, in line with national guidance, of the reasons for continuing or stopping medicines including regular antipsychotics and 'when required' medicines. Young people's carers told us they were not given clear advice about why medicines were prescribed and what to expect.

- Physical health checks were made before antipsychotic medicines were prescribed and at intervals during use, however staff did not always complete records of physical health monitoring for a minimum of two hours following the use of rapid tranquillisation in line with national guidance and hospital policy. Records for one young person showed they were monitored for ten minutes on two occasions, and for 20 minutes on a third occasion
- Capacity or competency to consent to treatment was not robustly assessed or clearly recorded. There was limited evidence that capacity or competency had been reviewed. Consent forms used to record consent to treatment under the Mental Health Act (1983) were incomplete and contradictory, and recorded consent in a way that precluded the oversight of a second doctor (SOAD).
- The hospital admitted young people with autistic spectrum disorder (ASD), however the ward environments were not adjusted to meet their needs, in particular those with sensory needs. There was an acknowledgement by staff that the ward environments could be especially stressful for these young people, due to noise and unpredictability. Staff commented that this contributed to distress for these patients, which in turn led to increased incidents and increasingly restrictive interventions, including increased levels of medication, increased use of PRN medication and physical restraint. PRN (pro re nata) refers to medicine which is not scheduled but administered when required.
- The service did not have good systems and processes to safely administer, record and store medicines. In one clinic room, we found expired and un-labelled over-the-counter (OTC) medicine belonging to young people on the counter top, with a bag of prescribed medicine belonging to a young person who had been discharged. Staff were unsure about where the medicines needed to be, and when. This placed young people at risk of avoidable harm through errors in the administration of medicine.
- On the two PICUs, books used to record and monitor controlled drugs and drugs liable for misuse were not filled with names of drugs kept in the cupboard, or the names of young people and the doses prescribed. Individual pages often failed to give details of drugs carried and number of next page. Records being inaccurately maintained by staff could prevent staff from knowing what medicines should be in stock, or if they had been misused.
- On Severn Ward, in the clinic room, we found two over filled and open sharps bins with broken glass ampoules and needles on the top of the lid. This presented a risk of injury and infection to staff. This was addressed immediately by the ward management. We found cleaning items located in the same cupboard as meal replacement drinks and sterile tongue depressors, including lime scale remover, room and fabric refresher, and spirit cream cleaner. These materials could pose risk to young people's physical health if confused with other items. We saw an epi-pen adrenaline auto injector wrapped in paper towel next to the taps at the hand-washing sink, and were told by staff that they did not know how long it had been there. This indicated that clinic room checks and audits were not being carried out frequently or effectively.
- The stock medication cupboard was disorganised with no clear system for storing drugs, for example, to readily locate different items according to their purpose. The cupboard also contained a bottle of shampoo. We found expired items, including a box of blood ketone strips and two epi-pens. The drug cupboard, containing medication in daily use, was also disorganised. We found bottles of in-use laxative medication unlabelled and dirty. The emergency drug box was not clean or fit for purpose. Staff told us that dispensing drugs could be challenging as a result of lack of organisation in the cupboard.
- The lead was missing from the portable suction machine and suction catheters had expired in 2019 and Jan 2020. Two oxygen tanks were under a shelving unit in the nursing office and both had a thick covering of dust. Other physical health monitoring equipment was stored in the nursing office. The pulse oximeter, sphygmomanometer, blood glucose monitoring kit, blood pressure cuffs and thermometer were dusty when touched and it was not possible to identify when they were last cleaned or calibrated.
- Ward areas were not all clean, well maintained, well-furnished and fit for purpose. We found dried blood stains on the wall in a room on Severn ward which staff told us was used for family visits and sometimes de-escalation support for young people. Young people on Kennet ward also told us that sometimes it took staff a long time to clean up blood stains on walls, that occurred when a patient had harmed themselves by head banging.

Inadequate

Child and adolescent mental health wards

- The décor on the PICU wards was very tired, and communal areas of the ward did not have natural light, although staff acknowledged that the effects of lockdown has disrupted the redecoration and maintenance of the wards and the new hospital redirector had included refurbishment of the wards as part of a high level improvement plan.

However

- When we returned to the hospital for the second unannounced site visit on the 3 December 2020 and found the clinic rooms on the two PICUs were clean and well organised, and medicines were being stored appropriately.
- In response to our concerns about the use of medicines on the PICUs, the provider carried out reviews and audits of all patient's prescribing and quickly established a new medical peer group and risk and incident learning group.
- The service had robust measures in place to manage the risk of Covid 19 across the site. A recent outbreak of on Tamar ward had been successfully managed by the hospital, with young people supported to self-isolate, and no spread of the infection to any of the other three wards. At the time of the inspection there were no confirmed cases on the site.
- The service had enough nursing, medical and support staff cover. When additional staff cover was required to allow increased observation levels for patients, staff were able to move between wards. The leadership team were working to reduce the use of agency staff, but ensured that where agency staff were used that they had received the same level and standard of induction training as permanent staff. The majority of agency staff were on long term agreements, in some cases for a number of years, and so were familiar with the wards.
- The clinic room on Kennet ward was found to be well ordered and clean. Staff kept appropriate records which showed regular checks took place to monitor the fridge temperatures for the safe storage of medicines. Emergency equipment and medicines were stored on the wards in the nurses' offices.
- On Kennet ward, staff assessed the physical and mental health of all young people on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. The Clinical Nurse Specialist (CNS) told us that physical health monitoring is regularly updated.
- On Kennet ward, staff used systems and processes to safely prescribe, administer, record and store medicines. Care records showed and young people told us that staff gave young people good information about medicines. Prescription charts had patient consent forms that had been completed appropriately.
- Across the three wards we visited we found that incident records showed that during we found that during incidents staff used restraint only after attempts at de-escalation had failed.

Are Child and adolescent mental health wards effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff did not develop individualised care-plans. On the two PICUs we found minimal evidence of clinical formulations being made despite long admissions, and of the two formulations we found, both were no longer relevant or up to date.
- We found evidence on the two PICUs of copying and pasting within care plans which resulted in errors like incorrect young people's initials being used. Care plans were written with "I" statements despite referring to nursing goals and written in nursing language with no obvious involvement with the young person. There was no record of young people having been offered or provided with copies of their care plans.
- On the two PICUs care plans were not holistic and recovery-oriented. We found minimal evidence of personalised work by nursing, occupational therapy or psychology to develop coping skills. Some groups were available on the wards,

Inadequate

Child and adolescent mental health wards

however care records frequently showed young people consistently declining to participate with no recorded exploration as to why or what alternatives could be offered. Where we found detailed therapeutic assessments, for example, from psychology and occupational therapy, there was no evidence that his work had been used to guide or develop the young person's treatment plan.

- While we found evidence of multidisciplinary discussions in patient review meetings, the emphasis was predominantly on incidents. However, content in some instances referred to initial period following admission, despite the young person having been admitted for some time.
- Young people on the two PICUs did not appear to be involved in the care planning development, and we found no evidence of involvement of families, even where in one instance a specific family communication care plan was in place.
- Staff did not carry out structured evaluation of their approach or use an appropriately detailed outcome measuring tool. Staff carried out a HONOS (Health of the Nation Outcome Scales) questionnaire on admission, however this was not repeated regularly and so could not be used to evaluate care. Some young people had an RCADS (Revised Children's Anxiety and Depression Scale) score noted on their records, but these were also not repeated and were without any commentary as to how the score was reached.
- On Severn ward 51% of staff supervisions were in date, and on Thames ward 78% of supervisions were in date. Two new ward managers had been appointed in the month prior to the visit, and both were aware that this was an area that required urgent redress.

However

- The ward teams included access to occupational therapy and psychology. These staff delivered group sessions and some activities for young people. We saw that some young people were attending groups in DBT (Dialectical-behavioural therapy), Progress, and Mindfulness. Youth engagement practitioners were also present on the ward. Young people had access to good school facilities.
- All staff completed mandatory induction training prior to working on the wards, which included PRICE (Protecting Rights in a Caring Environment). We saw evidence that staff needed to demonstrate competency in this technique before being permitted to carry out physical restraint.
- PRICE trainers had recently been recruited from within the staff team and were in the process of being based on the wards, to improve practice by supporting staff to develop and maintain their skills in the approach.

Are Child and adolescent mental health wards caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement because:

- Young people described variable experiences of the staff who cared for them, with several commenting that agency staff and night staff were less kind and understanding of their needs. Some told us that staff did not seem to understand young people, or their needs around self- harm and eating disorders.
- Feedback from parents about the service was mainly negative. One guardian we spoke with praised the hospital and felt that their young person was getting the help they needed. However, six of the seven parents we interviewed described feeling unhappy and concerned for the safety of their young people. Parents described difficulties getting feedback about their child's treatment and progress, finding it hard to get through to the wards on the telephone, and delays in being informed about incidents.

Inadequate

Child and adolescent mental health wards

- Some parents described a serious lack of trust in staff, having been given inconsistent information about their young person following incidents in which they were harmed, or giving examples of their young person's information being confused with another patient. Several parents described the atmosphere on the PICU wards as "oppressive" and "traumatising", and two linked the ward environment to self -harming behaviours and attempts to abscond.
- Four parents expressed concern about the level and type of medication their child was receiving and said that their views had not been taken into account by the service. Five parents were concerned that their young people were not receiving therapeutic care, and felt that their mental health problems had significantly worsened during their stay at the hospital. This was especially the case for parents of young people with a diagnosis of autistic spectrum disorder, who felt that the staff's lack of understanding of their condition would trigger incidents that could have otherwise been avoided.
- In the weeks prior to the inspection, two parents complained that visits were cancelled at very short notice due to staff being too busy to facilitate them. Some parents described feeling desperate for their young people to leave the hospital, as they did not feel that they were safe.
- We saw care on the wards being provided in ways that compromised young people's privacy and dignity. Staff carried out observations with young people in their beds, for example, with doors propped open leaving them visible to staff and other young people passing by.
- Care records showed limited evidence that staff involved young people in care planning and risk assessment, or actively sought their feedback on the quality of care provided.

However

- The majority of ward staff we interviewed spoke of the young people they cared for with compassion and respect, and several expressed a commitment to improve the service and make it a healthier and more recovery focussed environment.
- Some young people spoke positively about staff, saying they treated them with dignity and respect.
- We observed some positive interaction between staff carrying out enhanced observations with some young people, engaging them in games and friendly conversations.
- Senior managers had identified the need to improve communication with parents, and this formed part of a high level improvement plan that the newly appointed hospital director shared with us. A key function of the newly created head of quality and patient experience role was to develop systems for engaging parents in the child's care.
- Young people had access to independent advocates, and contact details were displayed clearly on the ward.

Are Child and adolescent mental health wards responsive?

Insufficient evidence to rate

This was a focused inspection we did not gather sufficient evidence to form a judgement of this domain.

Are Child and adolescent mental health wards well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate because:

Inadequate

Child and adolescent mental health wards

- Although a new senior team had been appointed, and begun addressing quality issues, our findings from the other key questions demonstrated that governance processes did not yet operate effectively at ward level. The concerns we found in care and treatment, including the use of medication, had not been identified or addressed by the provider organisation. Issues of concern raised at the previous inspection, that we told the provider they must address, had not improved.
- There was a lack of robust oversight and assurance by Huntercombe senior leaders. Therefore, they had not picked up poor care at the hospital and acted to make improvements in a timely manner.
- Turnover of staff at senior level within the hospital and the organisation appeared to have prevented improvement measures initiated at the time of the last inspection from being followed through. Staff told us that staff wellbeing initiatives like "Joy in Work" had ceased, and that a capital investment programme to improve the physical environment had been halted. Senior managers explained that this had in part been due to the coronavirus pandemic, as large non-essential meetings had been put on hold and non essential visits by contractors had been cancelled.
- Managers told us that systems for monitoring levels of supervision, appraisal and mandatory training at ward level were not accessible to them. Senior managers told us they had access to this information and were providing monthly snapshots to the wards in order to monitor compliance.
- The hospital had not carried out an in-depth patient experience survey for over three years and did not have a system for engaging with and gathering feedback from parents and stakeholders.
- The case management system used to manage patients' documentation and contemporaneous notes did not hold all patient information. Some information was stored on the shared network drive, and some in hard copy. This made some information difficult for staff to locate and therefore use effectively.

However

- The hospital director, quality manager, and interim head of nursing and quality had recently been appointed and had developed a comprehensive improvement plan that addressed a number of the safety concerns. Changes had recently been made to the leadership structure to improve the standard of care at the service. This included separation of the existing head of nursing and quality role into two separate posts. The first of these roles was a head of quality, improvement and patient experience, with a governance role that included oversight of the Mental Health Act processes, incidents, and risk. The second was a head of nursing role, with a very recent appointee with experience in CAMHs hospitals. This newly formed team showed insight into the impact that the high turnover of senior staff had had on the quality of care at the hospital, in particular the two PICU wards, and had a clear vision for creating stability. They had begun consulting with external stakeholders and carrying out their own observations at ward level and identified areas of concern that included the management of incidents, medicines management, and length of stay on the PICU wards. These areas were addressed in the quality improvement action plan that was overseen by the new hospital director. The new hospital director described having support from senior leaders within the parent organisation to make changes to improve patient safety, with a focus on reducing the number of incidents.
- The new leadership team and new chief executive officer (CEO) provided the action plan requested in our Section 31 Letter of Intent and acted promptly to begin making improvements. This included ensuring that all patients on the PICU wards had their care and treatment reviewed, arranging training in PBS to be rolled out across the site, and ensuring that consent to treatment was re-assessed and appropriately recorded. The organisation agreed that the case management system be upgraded to allow for better record keeping and analysis of data including incidents.
- The leadership team had agreed new systems with the new commissioning stakeholders to support quality improvements across the hospital. This included plans to have commissioning case managers based on the wards on a weekly basis to oversee individual patients' care, PRICE (protecting rights in a caring environment) trainers based on the wards.

Inadequate

Child and adolescent mental health wards

- The head of nursing chaired a daily site meeting attended by all senior staff and ward managers, to identify staffing shortfalls and other areas where wards may need support. These meetings always included a “heat map” of risks to identify which wards were experiencing challenges. Senior managers were also attending handovers on the wards to hear staff concerns and develop more direct oversight and had begun holding steering groups with key multidisciplinary team professional groups.
- At ward level, two new ward managers had been appointed for each of the PICU wards. Both were less than one month in post at the time of the inspection and had identified concerns about the quality of care and the impact of reduced management cover in the period prior to their arrival.
- Staff generally described feeling respected, supported and valued by their immediate line manager.
- The provider had carried out a staff survey in the month prior to the inspection.
- Staff had gathered patient feedback about ward round meetings in the month prior to the visit, and the introduction of patient experience surveys was included in the improvement plan that had been developed by the new hospital director.
- The hospital had an assertive recruitment drive in progress, with 48 new support workers in the vetting process towards filling 96.2 full time equivalent vacancies.
- The hospital had a programme for recruiting and training their own nurses, and supported preceptorship.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider **must** ensure that there are robust governance and assurances processes in place to ensure risk assessments, risk management plans and care plans are completed, updated and regularly reviewed. These processes must include oversight from senior organisational leadership that connect the hospital to the wider governance structures. The provider **must** ensure effective governance systems are in place to ensure systems and processes to safely administer, record and store medicines are operating effectively.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider **must** ensure that the Paediatric Early Warning System (PEWS) is used correctly and consistently across the wards, to monitor changes to young people's physical health. The provider **must** ensure that good systems and processes to safely administer, record and store medicines are in place on all wards.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	S29 Warning Notice The provider was failing to comply with Regulation 12, (2) (c), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was an absence of a consistent and evidence based approach to supporting young people who present with very distressed behaviour that poses a risk to themselves and others. Positive Behaviour Support (PBS) had not been implemented and was not being used in the care of young people who would benefit from this approach in line with national guidance (Department of Health, Positive and Proactive Care: reducing the need for restrictive interventions, 2014; NICE Guideline 10, Violence and aggression: short-term management in mental health, health and community settings, 2015; Mental Health Act Code of Practice, 2015 - Chapter 26, Safe and therapeutic responses to disturbed behaviour.) Following the 2019 inspection, we told the hospital that they must take the following action and served a requirement notice as detailed below: The provider must ensure that a positive behaviour support (PBS) approach is embedded across the hospital, to enable an effective response to young people whose behaviour poses a challenge to the service. The provider is required to address the breach described above the by 31st January 2021.