Huntercombe Hospital - Stafford

Quality Report

Ivetsey Bank,
Wheaton Aston,
Stafford
ST19 9QT
Tel:01785 840000
Website:http://huntercombe.com/our-centres/the-huntercombe-hospital-stafford

Date of inspection visit: 30, 31 January and 1 February 2017
Date of publication: 16/05/2017

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

Ratings

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

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

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

Summary of findings

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

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

Overall summary

The chief inspector of hospitals is recommending that Huntercombe Hospital Stafford comes out of special measures. We previously inspected the service in May 2016 where we rated the service as inadequate in each domain; safe, effective, caring, responsive and well-led and as inadequate overall.

When CQC inspected again in February 2017, we found that the provider has made improvements to the quality and safety of care provided. We have rated caring as good. The safe, effective, responsive and well-led domains have been rated as requires improvement..

During this most recent inspection, we found that the services had addressed the majority of issues that had caused us to rate the service as inadequate overall at the May 2016 inspection. They were now meeting Regulation 9, 10, 11, 15, 17 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We have rated Huntercombe Hospital Stafford as requires improvement because:

- We found blanket restrictions in place that were not justified by individual risk assessment or proportionate to potential risks. These limited the independence of the young people at the hospital. Young people were restricted in their access to bathrooms, bedrooms, use of a telephone, the internet and access to outside space.
- The provider had failed to update their policy on rapid tranquilisation in line with guidance issued by the National Institute for Health and Care Excellence in April 2015. This had been a requirement at our previous inspection to ensure safe prescribing for young people in the care of the hospital.
- The hospital was not able to provide a full range of psychological therapies to meet all the needs of the young people in their care in line with NICE guidance.

However:

- Managers had introduced training in positive behavioural support to reduce the dependency of staff on restraint and other restrictive practices when managing behaviours that challenge.
- Senior staff reviewed incidents daily and shared lessons learnt with staff.
- Staff fully assessed and monitored the physical health care needs of young people in their care.
- Care planning reflected the views of young people and care notes were kept securely and up to date
- Managers had introduced a new system for clinical governance that was comprehensive and provided assurance to the Huntercombe Group nationally of the safety of the hospital.
- Following the CQC placing the hospital in special measures local managers and directors of the national group had listened to staff in a series of away days to review the events that had led to that judgement. Managers had committed to an ongoing programme of meetings and actions to engage staff in the future development of the hospital. There were regular forums to hear the views of young people with regard to their care and the hospital's improvement plan.

Summary of findings

Contents

Summary of this inspection

Page

Background to Huntercombe Hospital - Stafford 5

Our inspection team 6

Why we carried out this inspection 6

How we carried out this inspection 8

What people who use the service say 8

The five questions we ask about services and what we found 10

Detailed findings from this inspection

Mental Health Act responsibilities 13

Mental Capacity Act and Deprivation of Liberty Safeguards 13

Overview of ratings 13

Outstanding practice 30

Areas for improvement 30

Action we have told the provider to take 31

Requires improvement

Location name here

Services we looked at
Child and adolescent mental health wards

Summary of this inspection

Background to Huntercombe Hospital - Stafford

Huntercombe Hospital-Stafford is a child and adolescent mental health service (CAMHS) for up to 39 young people of both genders aged 8 to18 years. The hospital can admit young people who are detained under the Mental Health Act.

The hospital is divided into three separate wards; Hartley, Thorneycroft and Wedgewood wards.

- Hartley ward is a Psychiatric Intensive Care Service (PICU) providing 12 beds for male and female young people. The PICU unit at Stafford offered inpatient care to young people suffering from mental health problems who require specialist and intensive treatment to address their needs. The team was 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 admitted were not allowed to leave or enter the building unless they had authorisation from a doctor and the staff are aware of what they are doing. All young people on the PICU were detained under the Mental Health Act (1983). The Huntercombe Group had closed the unit following concerns raised about patient safety following the CQC's comprehensive inspection in May 2016 and remained closed at the time of this inspection.
- Thorneycroft ward is a general CAMHS acute assessment unit with 12 beds for young people aged 12-18 years. The young people treated in this unit have a range of diagnoses from psychosis and bipolar disorder to depression and deliberate self-harm. A consultant child and adolescent psychiatrist lead the team. 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. This is under ongoing review by NHS England and the service provide in liaison with the CQC and local authority. At the time of this inspection, there were nine young people on the ward.
- 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. A consultant child and adolescent psychiatrist leads the team. 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. At the time of this inspection, there were seven young people on the ward and one on home leave.

A school on site provided education for the young people in the care of the hospital. The Office for Standards in Education regulates the school. They last inspected the school in March 2016 rating it as good.

The CQC registered Huntercombe Hospital - Stafford to carry out the following regulated 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 this inspection. A new hospital director had taken up post on the 04 July 2016 and was in the process of registering.

A responsive inspection of the hospital in April 2016 had identified the need for urgent action on safeguarding. That inspection led to the CQC issuing a warning notice for urgent improvement in safeguarding arrangements at the hospital which was assessed at a responsive inspection in July 2016. We found that the necessary improvements had been made within the timescales of the warning notice..

The CQC last carried out a comprehensive inspection of the site in May 2016and found the service to be inadequate overall. This led to the CQC putting the hospital in special measures in August 2016. The

Summary of this inspection

organisation took a decision to close the Psychiatric Intensive Care Unit after this inspection and all young people were moved to alternative services by early June 2016.

Because of the CQC placing this service unit into special measures, regular meetings were arranged to discuss immediate risk management and a programme of improvement. These engagement meetings involved staff from CQC, local authority, NHS England (the service commissioner) and the provider.

The CQC, NHS England and The Huntercombe Group maintained a schedule of weekly then monthly engagement meetings from the end of May 2016. Senior management staff from the organisation, the relationship holder and the inspection manager from the CQC and representatives of NHS England attended these meetings. Through these regular meetings, the CQC closely monitored ongoing risk and of improvements leading up to this inspection.

..

Our inspection team

Our inspection team was led by:

Team Leader: Michael Fenwick, Hospital Inspector (mental health) Care Quality Commission

The team that inspected the service comprised three CQC inspectors, a CQC inspection manager and a variety of specialists. This included a specialist advisor who was a social worker with experience in child and adolescent mental health services (CAMHS) and an expert by experience who was the parent of a young person who had used CAMHS inpatient services.

Why we carried out this inspection

We undertook this inspection to find out whether Huntercombe Hospital Stafford had made improvements to their child and adolescent mental health wards and psychiatric intensive care units since our last comprehensive inspection of the trust in May 2016.

When we last inspected the trust in May 2016, we rated child and adolescent mental health wards and psychiatric intensive care units as **inadequate** overall. We rated the child and adolescent mental health wards and psychiatric intensive care units service as inadequate for safe, effective, caring, responsive and well-led. This led to the CQC placing hospital into **special measures**. The special measures process is designed to ensure a timely and coordinated response where we judge the standard of care to be inadequate.

Following the May 2016 inspection, we told the provider it must take a series of actions to improve the service related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 9 Person-centred care:

- The provider must ensure that care plans and risk assessments are completed and regularly reviewed, holistic, patient centred and recovery focussed
- The provider must ensure that care records are maintained securely, accurate, complete and contemporaneous.
- The involvement of carers and family in young person's care must be improved and communication maintained between multi-disciplinary meetings. practice

Regulation 10 Dignity and respect

- The provider must improve the arrangements for protecting the privacy and dignity of young people in shared bedrooms and shared facilities on the wards.

Regulation 11Need for consent

- The provider must ensure that the staff use the proper legal authority to assess the ability of young people to consent to treatment and the ability of young people under 16 to have the capacity to consent recognised.

Regulation 12 Safe care and treatment

Summary of this inspection

- The provider must ensure that emergency equipment is ready and safe to use through regular checks and testing.
- The provider must ensure the management of aggression and use of restrictive practices are in line with the least restrictive principle, monitored and subject to a reduction strategy.
- The provider must provide physical health care monitoring (on admission and following restraint) and to meet the specific needs of eating disorder young people as routine practice on all wards.
- The provider must provide sufficient, appropriate and coordinated therapeutic activities and access to psychological therapies must be available on all wards
- The provider must ensure that clinical policies are reviewed and updated in line with national policy and guidance e.g. NICE on rapid tranquillisation

Regulation 15 Premises and equipment

- The provider must ensure that entry to the hospital is controlled and patient safety maintained by following a process of security checks on visitors, staff and young people at the point they enter and leave the hospital.
- The provider must ensure the security of medicines and clinical equipment is controlled with a dedicated key rather than allow access though overrides and universal keys.
- The provider must ensure the integrity of the fire alarm system to maintain the safety of people at the hospital.

Regulation 17 Good governance

- The provider must bring policies into line with the revised Mental Health Act Code of Practice to ensure staff are following best practice and protecting young people when using restrictive practices.
- The provider must ensure that an annual environmental risk assessment is carried out and mitigation of risks identified
- The provider must ensure there is learning from incident reports and that lessons are shared across the hospital and organisation
- Hospital managers must meet their obligations under the Children Act and bring reporting procedures to the standards outlined in the Local Safeguarding Children Board.

Regulation 18 Staffing

- The provider must ensure that mandatory training levels are addressed in order for staff to gain the skills and knowledge required to care for the patient group.
- The provider must ensure that supervision and appraisal of staff is addressed and are carried out at intervals in accordance with the organisation's own policy and that there is system for the induction of all new staff and support/preceptorship for newly qualified professional staff in line with requirements of their professional regulator.
- The provider must ensure that staff are skilled in and have adequate knowledge of local safeguarding procedures.
- The provider must ensure that ward environments are compliant with standards relating to mixed gender accommodation.
- The provider must ensure that staffing levels are sufficient to enable safe, effective and high quality care.
- The provider must ensure that specialist training for naso-gastric tube feeding is delivered to all applicable staff
- The provider must ensure that out of hours medical cover for the hospital includes access to psychiatric specialists at all times.

Because of these breaches, the CQC placed Huntercombe Hospital Stafford in special measures in August 2016. The organisation took the decision to voluntarily close the Psychiatric Intensive Care Unit at this time and all young people were moved to alternative services. Admissions to the other two wards were capped in agreement with NHS England in order to allow improvements to take place.

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from young people.

During the inspection visit, the inspection team:

- visited Thorneycroft and Wedgewood wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for young people;
- spoke with four young people who were using the service;
- spoke with five carers of young people at the hospital;
- spoke with the hospital director and acting managers for each of the wards;
- spoke with four staff nurses, six healthcare support workers, two psychology assistant and the medical team on the wards ;
- spoke with two occupational therapist, psychologist, activity workers and the three members of the hospital social work team;
- spoke with three teachers from the education department;
- spoke with the governance and quality lead and two members of their team;
- held a focus group with ten therapy staff;
- received feedback about the service from NHS England and local authority safeguarding team;
- spoke to the Mental Health Act administrator;
- spoke with the generic advocate and the independent mental health advocate (Mental Health Act);
- spoke with the Director of Quality and Commercial Director for The Huntercombe Group
- attended and observed two hand-over meetings and two multi-disciplinary meetings;
- looked at thirteen care and treatment records of young;
- carried out a specific check of the medication management on two wards;
- looked at a range of policies, procedures and other documents relating to the running of the service; and
- reviewed a plan to re-open the psychiatric intensive care unit (Hartley ward) by the end of February 2017with local hospital managers and NHS England.

What people who use the service say

Two young people on Wedgewood said that doctors had given them choices about medication and leaflets about this and their rights. They had been unhappy that they had so many different doctors and nurses in such a short space of time. Parents supported these concerns around the turnover within the medical team and subsequent inconsistencies in treatment and approach.

The main concern was that they felt frustrated by some of the restrictions on the ward as there didn't always seem to have a rationale behind them. Two young people, interviewed separately, said that the ward "felt like a prison" because of the number of locked doors. They especially disliked having to be let into their bedrooms by staff. They also disliked the closed blinds on the nurses' office which they said were always shut. One young person said the blinds made them feel like "us and them".

The young people were confused about changing restrictions on the ward and how staff communicated these to them. One young person told us that the ward manager had said the bedrooms could stay unlocked but then other staff kept them locked anyway. Another restriction that caused frustration was that staff only allowed young people to use their mobile phones after 5pm for a limited time. One young person told us how

Summary of this inspection

she would prefer to speak or text her family at times she required support and felt this coping strategy was frustrated by restrictions on access to phones and a lack of privacy to use them.

Young people on Thorneycroft told us that the staff were caring. One young person felt the environment to be more restrictive than similar units they'd been admitted to. The lack of access to outside space was their main concern. They had also been frustrated by the lack of a prayer mat and copy of the Quran to support their religious obligations. There was no dedicated faith room available on the ward.

Another young person told us about being subject to restraint. They reported staff had talked to them throughout, explaining what was happening and debriefed them afterwards.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:'

- We found that blanket restrictions were in place on both wards. Doors were locked; access to telephones and the internet was limited. Staff controlled access to outside space and bedrooms restricting the liberty of all young people on the wards.
- There remained a significant level of vacancies in qualified nursing and staff to deliver psychological therapies. Managers had mitigated the shortage of nursing staff through the block booking of agency nurses. However, this adversely affected the effectiveness of building teams and the continuity of care.

However:

- Emergency equipment was safe to use and subject to regular checks and testing. All staff were aware of its location and we saw evidence of regular drills to maintain skills and effectiveness of training in life support skills.
- Mandatory training levels in key areas such as safeguarding and life support skills, had risen to 90% giving staff the skills and knowledge required to maintain the immediate safety of young people.
- We found that senior staff reviewed incidents daily and regularly shared lessons learnt with staff.

Are services effective?

Requires improvement

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

- The service was not able to offer the full range of therapies recommended by the National Institute for Health and Care Excellence. Therapy staff as a group remained without a clear leadership structure and uncoordinated within the hospital.
- Only 58% of eligible clinical staff were up to date with Mental Health Act training.
- The Huntercombe Group assessment form for mental capacity omitted the diagnostic test of capacity required to make a valid assessment. Other information incorrectly denied the rights of a Gillick competent young person to refuse treatment.
- The provider had not implemented clinical policies in line with the revised Mental Health Act code of practice.

However:

- Staff fully assessed and monitored physical health care needs.

Summary of this inspection

- Multi-disciplinary team meetings were inclusive of young people and their carers, responsive to need and very well documented.
- The uptake of online training in the Mental Capacity Act had substantially increased.
- Care planning reflected the views of young people and staff kept care notes up to date and stored them securely.

.

Are services caring?

Good

We rated caring as **good** because:

- Young people reported that they found staff to be caring and supportive.
- Most young people felt staff treated them with dignity and respect.
- Staff shared care plans and information with young people and involved them in their ongoing development. Young people held copies of their own care plans.
- Carers told us that they felt that staff involved them in discussions about care decisions and kept them up to date with any changes.
- Managers had positively engaged with the views of young people through regular weekly community meetings and a monthly survey of the young persons' views on their care.

However:

- One young person told us that staff sometimes used language that was not appropriate to their age and stage of development.

Are services responsive?

Requires improvement

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

- Access to outside space remained dependent on the ability of staff to accompany the young person.
- Young people and carers told us that activities were often subject to cancellation at short notice. Young people had raised cancellations and a lack of options as problems at community meetings and in two cases formal complaints.
- Privacy to make phone calls and limited access to a phone was a common concern for young people on both wards.
- One young person told us of delays in being able to attend to his religious obligations due to a lack of equipment and scripture.
- A lack of space on Thorneycroft ward meant that on site visiting was still limited to meeting rooms off the ward.

Summary of this inspection

- Managers had improved visiting arrangements at the hospital and visitors could now visit young people directly on Wedgewood ward.

However:

- Young people on Thorneycroft now had free access to drinks and healthy snacks.
- Managers had improved visiting arrangements on Wedgwood ward and visitors could now visit young people directly on the ward.
- The number of complaints had reduced and between October and December 2016 managers had closed all complaints within the local target timescale.

Are services well-led?

Requires improvement

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

- There remained a significant gap in ward management and clinical leadership on the wards. Leadership at the hospital was due to change again and these instabilities could impact on the confidence of staff in the process of change. Staff believed that stable leadership was a key factor in maintaining safety at the hospital.
- Therapy staff as a group felt that they lacked leadership and a voice within the hospital and as a resource for recovery, they lacked co-ordination. Significant vacancies remained in staff able to deliver some specific psychological interventions recommended in national guidance for the treatment of young people.

However:

- Staff were more confident about the local leadership and future of the hospital. Morale was high within ward teams and individual teams.
- Local managers had introduced new systems for clinical governance that were comprehensive and provided ongoing assurance to the Huntercombe Group nationally of the safety of the hospital.
- Local managers and directors of the wider organisation had listened to staff in a series of away days to review the events that led the CQC to place the hospital in special measures. There was an ongoing programme of meetings and actions to engage staff in the future development of the hospital.

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.

- The responsible clinician undertook the medical scrutiny of the medical recommendations of detained young people on admission. They completed a form used to evidence the completeness of the recommendations, for all the detained young people this had been completed. Out of hours, qualified nursing staff undertook the receipt and scrutiny of documents.
- The hospital managers employed a full time Mental Health Act administrator based at the hospital. The role covered receipt and administrative scrutiny of documents, ensuring leave authorisation are current and completed properly, uploading documents on to care notes, systems in place to alert the Responsible Clinician (RC) of consent to treatment rules and expiry of sections and nursing staff of section 132 reading of rights to young people.
- The Mental Health Act administrator also arranged tribunals and managers panel hearings. Where a patient had not submitted an appeal the Mental Health Act administrator had a system in place to ensure a reminder was sent for an automatic referral to the tribunal service. Staff on the wards knew how to contact the Mental Health Act administrator for help and advice.
- Leave was authorised through a standardised system, staff recorded any specific conditions. At each multidisciplinary meeting leave was discussed and granted on the basis of a risk assessment.
- The ward staff completed a specific form for young people taking external leave; this recorded a description of the patient, their destination and a risk assessment. On return from leave, staff recorded how the patient's leave went.
- There was an inconsistent approach amongst nursing staff regarding leave on Wedgewood ward, where a patient required the use of restraint to administer treatment via a nasogastric tube. Some staff felt this should not prohibit a patient's leave and allowed young people to go out. Whereas others felt, leave could not take place.
- The Mental Health Act administrator provided a document to family and carers regarding leave, this included information about what leave is, the conditions and the importance of returning on time from leave. During our visit, there were no young people absent without leave or missing. In the previous twelve months until the end of January 2017 there had been one incident of a detained young person leaving the grounds without authorisation. They returned to the hospital within an hour of their leaving accompanied by staff.
- On our previous inspection, we found a very limited number of staff trained in the Mental Health Act. Training had been limited amongst clinicians to medical and qualified nursing staff. Only 30% of that group were up to date in their training in May 2016. Managers had expanded training to all clinical staff and we found on this inspection that 58% of eligible staff were now up to date with their Mental Health Act training. Managers informed us all staff would now receive mandatory training in the Act. However, the Huntercombe Group had not implemented policies relevant to restrictive and other clinical practices in line with the revised Code of Practice until the week of our inspection. Managers had not planned how they would implement these new policies and when staff would receive training about how these changes would affect practice. The Mental Health Act administrator had a slot within the staff induction programme to ensure new staff understood their role and responsibilities in regard to the Act.
- Staff provided all treatment for detained young people under an appropriate legal authority. Where young people were being treated on statutory treatment forms known as T3, they were kept with the medication cards.
- Records showed that staff made both informal and detained young people aware of their rights. Where young people were detained under the powers of the Mental Health Act, they were informed of their rights on

a monthly basis, this included a verbal explanation and written information. The Mental Health Act administrator sent a reminder to the ward staff regarding section 132 rights. This ensured young people received an explanation on a regular basis. Staff provided informal young people with an information leaflet detailing their rights.

- Detention paperwork was available for inspection; this included the Approved Mental Health Professional (AMHP) reports. It was in good order and easy to locate in all the files.
- The Mental Health Act co-ordinator completed regular audits on the accuracy and completeness of section 17 leave, section 132 (rights), capacity/competence forms, treatment and use of the independent Mental Health Act advocate. These audits were reviewed at the monthly integrated governance meetings.
- The wards had access to two advocacy services. One service provided advocacy support to all young people; however, where issues related to detention staff made referrals to an independent mental health advocate service. Staff had displayed posters for both services around the ward that included a photo of the advocates.
- Both advocacy services felt young people were aware of their legal status on the ward, whether this was informal of a section of the Mental Health Act. Where young people lacked the capacity to understand the role of the advocacy service, the multidisciplinary team would assess whether the patient would benefit from the support of an advocate and make a referral accordingly.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff trained in the Mental Capacity Act via an e learning module and 85% of staff were up to date with their training.
- There was a policy available to inform staff of the requirement s of the Mental Capacity Act including the provisions of the Deprivation of Liberty Safeguards (DoLS).
- The wards used the same consent to treatment forms for young people under the age of 16 and for those aged 16 and over. However, the form omitted the diagnostic test required by the Mental Capacity Act (MENTAL CAPACITY ACT). The assessment of mental capacity is a two stage process, including the diagnostic test and functional test. Before you can assess whether a patient meets the functional test, the diagnostic test has to be completed. The lead consultant psychiatrist had raised this issue with the Huntercombe Group medical director. However, at the time of our inspection no action had been taken centrally to correct the form.
- Staff understood the principles of the MENTAL CAPACITY ACT in supporting young people to make their own decisions. Given the age group of the young people at the hospital if they were unable to make a decision for themselves staff could, on some issues, consult their parents for an opinion and if appropriate consent.
- We found staff to have a good understanding of the Mental Capacity Act's definition of restraint covering the use or threat of the use of force to make someone do something they are resisting, or restrict a person's freedom of movement, whether they are resisting or not. Staff had not fully understood this definition on our previous inspection.
- There was no regular review or audit of the use of the Mental Capacity Act in place at the hospital
- On our May 2016 inspection, we had found staff on Wedgewood ward were assessing the ability of young people under 16 to consent to treatment using the test for mental capacity. This was an inappropriate use of the Mental Capacity Act which does not apply to under 16s when considering their ability to consent. Staff on the ward, including medical staff, did not recognise the difference between establishing evidence of mental capacity and the concept of Gillick competency. Gillick competency is a test in medical law to decide whether a child younger than 16 is competent to consent to

medical examination or treatment without the need for parental permission or knowledge. Children must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions.

- We required the provider to ensure that the staff used the proper legal authority to assess the ability of young people to consent to treatment following our May 2016 inspection. On this inspection, we found staff were aware of the difference between Gillick competence (in the case of children under 16) and mental capacity (in the case of young people 16 and over). When staff admitted young people to the ward, they documented depending on their age their capacity or competence to consent to admission.
- We reviewed a flowchart regarding competence, capacity and consent displayed the in the nursing office. However, this was not correct. The flowchart stated "people with Gillick competence can consent to treatment but not refuse it". This was incorrect; a patient who is Gillick competent can refuse treatment. However, we did not find any evidence that staff had disregarded a Gillick competent child's refusal of treatment. Managers agreed to correct this misinformation.

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

Safe and clean environment

- Dedicated reception staff controlled entry and exit to the hospital. They understood the security safety measures required and checked the identification of all external visitors. They issued keys and alarms only to staff and visitors approved by the estates manager or hospital director. They also reminded staff and visitors on the need to store any restricted items in lockers provided in the reception area. The hospital had three wards split between two buildings. At the time of this inspection, entry to each building operated from the central reception and security point.
- Thorneycroft and Hartley wards shared a similar layout, two separate floors in the same building. Hartley ward remained closed to admission during this inspection and we did not inspect it, but managers had made us aware of a programme of environmental improvements they were putting in place before it could be re-opened. Wedgewood ward had two floors and was housed in an older building than the other two wards. Bedrooms were located on the first floor for all young people. Social facilities, the nursing office and clinic rooms were on the ground floor. When a young person was using an upstairs room, a worker was always with them. We found other potential ligature points on Wedgewood ward which we highlighted to managers for immediate action. There were also potential safety risks with unprotected mirrors on Thorneycroft ward. Managers agreed to review these risks immediately and update their internal ligature risk assessments.
- The layout of the bedrooms on Wedgewood meant that although there were separate washing facilities for the young men and young women, the females would have to pass the male rooms to reach the toilets and showers. On Thorneycroft staff asked young women to sleep in a bedroom on the male corridor when female beds were fully occupied. This meant they had to walk through communal areas and past male rooms to use female toilets and bathrooms. Where a young woman might sleep on the male side of Thorneycroft, staff had supported them through additional levels of staff observation of the corridor. No young women were sleeping on the male side of Thorneycroft ward at this inspection and all the young people on Wedgwood were female.
- Emergency equipment was in good order, staff were aware of location and we saw evidence of regular checks and drills to practice its use. Clinic rooms on both wards were clean and well equipped, with evidence of cleaning schedules and checks on the cleanliness of equipment were up to date.
- There was no seclusion room in use at the hospital following the closure of Hartley ward. Managers told us it had been refurbished before re-opening to meet the requirements of the Mental Health Act code of practice
- We found the clinical areas to be clean and furnishings well maintained. We discussed cleaning routines with domestic staff on both wards. They were aware of the potential risks of cleaning materials being used in

deliberate self-harm and took precautions to always lock things away when not in use. We reviewed cleaning records and found them to be up to date and verified that the environment was regularly cleaned.

- Staff followed infection control procedures and were aware of the need to maintain good hand hygiene.
- We found that a series of environmental risk assessments had been completed, for instance in areas such as water management and legionella testing.
- There was no nurse call system available to young people in the bedrooms and communal areas on Thorneycroft ward. Staff felt that they would be able to hear young people calling for help as staff were routinely available in corridors. However, there was a non-vocal young person on the ward who could not be able to summon help in this way. We asked managers to consider how they could support this young person in order to alert staff to any urgent need and to develop a clear system that helps all young people to alert staff in an emergency. Staff members on both wards carried personal alarms that they could activate in case of any concerns. The alarm system would then identify their location to other staff allowing them to attend and support them as soon as possible.

Safe staffing

- Each ward had a whole time equivalent (WTE) of 11 nurses and 25.7 nursing assistants. There were 18 WTE nurse vacancies overall; 4.5 on Wedgewood; 2.5 on Thorneycroft and 11 vacancies being recruited to prior before the planned reopening of the psychiatric intensive care unit. The three vacant ward manager posts were also being advertised
- There were 15.4 WTE vacancies for nursing assistants across the hospital with 6.7 vacancies for Wedgewood and 8.7 vacancies being recruited to prior before the planned reopening of the psychiatric intensive care unit
- Both wards had been making use of block booked agency qualified nurses working full time for the previous five months.
- In the three months prior to the inspection, all shifts had been filled to at least the level of staffing planned. In part, this was because of the availability of extra nursing assistants because of the closure of the psychiatric intensive care unit.
- The staff sickness rate was 3.9% in the 12-month period to January 2017. For the same period, the staff turnover rate was 55.3%. This high turnover reflected the impact of the imposition of special measures on the hospital with staff resigning or being removed from posts
- Managers used a bespoke Huntercombe Group tool to estimate staffing levels. The tool relied on clinical judgement to estimate the number of staff required in relation to the number of young people on the ward, levels of clinical observation and clinical need.
- We looked at staff rotas for three months up to January 2017. Staffing levels were maintained to at least the levels planned on all shifts in the last three months to the end of January 2017.
- Agency staff were given a tour of the ward to familiarise them to its layout and an explanation of the emergency response procedures, including the location of resuscitation equipment.
- With two qualified nurses working each shift, staff were able to spend more time in the communal areas of the ward supporting other staff and had time to spend with individual young people in one to one sessions.
- Young people and their parents complained that planned ward activities and outings were frequently cancelled due to lack of staff. Community meeting minutes reflected these concerns and recorded staff notifying young people of cancellations in the week ahead due to staff shortages. Managers did not keep an ongoing record of activities offered, their take up and any cancellations.
- There were enough trained staff available on each ward at all times to carry out physical interventions.
- Managers had arranged an on call rota for consultant and junior doctors at the hospital to be available by phone and attend the hospital in an emergency. In January 2017 this arrangement was being replaced by the use of an off-site on-call system maintained by another provider. The rota of on-call medics included consultant psychiatrists as well as GPs whose staff already used to manage physical health problems. Junior doctors at the hospital continued to support an on call rota whilst nursing staff developed confidence in using the new system.
- In May 2016, only nine out of 120 eligible staff were up to date in their basic life support training in our visit in May

2016. We highlighted that lack of training in the management of emergency physical health through basic and intermediate life support skills could put young people at significant risk. We asked the managers to improve mandatory training levels in order for staff to gain the skills and knowledge they needed.

- Managers made basic life support an immediate focus for training following that inspection and the vast majority of staff were up to date by the end of July 2016. On this inspection, 89% of staff were up to date with basic life support training and 100% of nursing staff were trained in intermediate life support. The quality team at the hospital had also reinforced the classroom teaching with regular resuscitation and emergency drills throughout the hospital. As a result, we had confidence, following this visit, that staff would manage a physical health emergency in a timely and effective manner.
- Mandatory training rates had also increased in fire safety, restraint and use of care notes to levels of 90% or above. However, managers had not improved all areas of mandatory training. Staff training rates in manual handling, record keeping and care planning, and clinical risk assessment all fell below 75%.

Assessing and managing risk to young people and staff

- There had been no incidents of long term segregation or seclusion in the six months prior to 31 Jan 2017. Staff did not use seclusion on the two wards we inspected. A seclusion room was available on site and had been refurbished as part of the preparation for the re-opening of the psychiatric intensive care unit.
- There were 622 episodes of restraint in the six months between July and December 2016; these were highest on Wedgewood ward. Staff used restraint on 396 episodes out of the total to support naso-gastric tube feeding of young people to maintain their physical well-being. There had been no reported prone restraints. When restraint was being used it was appropriate as a last resort and carefully managed and documented. Staff provided support for young people following an episode of restraint. On Wedgewood ward, where restraint could be routinely required to feed a young person, we found that staff tried to reduce the amount of time they would need to hold a young person for by thorough preparation including discussions with young people about the procedure.
- We looked at eight care and treatment records of young people on Wedgewood and five on Thorneycroft ward. We found that risk assessments were up to date and comprehensive and included physical health risks and linked to positive behavioural support plans. Staff on the wards had a good knowledge of the individual risk of the young people they looked after and the approach they may make to them if they were distressed.
- Staff undertook a risk assessment of every patient on admission and updated this regularly and after every incident. We observed that staff in the regular multidisciplinary team meetings routinely reviewed and updated risk assessments. The daily morning meeting of senior clinical staff also reviewed and updated risk assessments following any incidents.
- There were a number of blanket restrictions in place on the wards including staff limiting the use of mobile phones, the internet, bedrooms, toilets, outside space, lockers and smoking. These applied to all young people irrespective of whether they were detained under the Mental Health Act or informal. On Wedgewood, staff displayed notices on the doors of toilets indicating what times they were locked and why but not when the doors would be unlocked (other than “as required”). We also found other doors to be locked (art room) without any notices or explanation. Young people told us that staff were inconsistent in their approach to locking doors despite the ward manager’s assurance that doors would be left open. Two young people felt frustrated by some of the restrictions on the ward as they felt they did not always seem to have a good rationale behind them. They said that the ward "felt like a prison" because of the number of locked doors and especially disliked having to be let into their bedrooms by staff. On Thorneycroft ward, we found a similar set of restrictions in place. Managers had recognised that the blanket restrictions were not justified and had a plan to reduce them. One objective for Thorneycroft was that staff would leave internal doors unlocked as default and only locked with clear signage stipulating reason, time and review. However, one staff member on the ward told us they did not feel comfortable leaving doors, including

toilets, unlocked on the ward. We heard from both staff and young people that managers had not yet achieved this objective and doors could still be found locked on occasion. Managers were monitoring the situation and had asked staff to report all incidents of a locked door. Managers had also planned to reduce restrictions on the use of mobile phones and access to the internet but their plans required confirmation of policies at Huntercombe Group corporate level. We reviewed a draft policy on personal searches that stated there should be an individualised rationale for a search in all cases and that this would be related to the person's risk assessment. We found that this individualised approach to personal searches had already been put into practice on the wards. Thorneycroft staff specifically discussed the risk assessment for and requirement to undertake searches post leave. However, the experience of young people was that staff did not always make clear the reason for conducting a personal search. All young people said that their belongings are searched on return to the unit but the staff always made sure they are there with them during the search and they don't mind this. Staff obtained consent for property searches and then carried them out in the presence of young people, to ensure that staff properly managed prohibited and restricted items.

- Young people were able to make themselves a hot or cold drink at any time of day on Thorneycroft ward.
- We found that information advising young people of their rights as an informal patient was available and that signs were clearly displayed on both wards and an information leaflet for young people.
- Ward staff used clinical observations as opportunities to engage with young people in activity and to offer support.
- The clinical policy on rapid tranquilisation was not in line with the latest national institute for health and care excellence guidance (violence and aggression: short-term management in mental health, health and community settings) that had been issued in April 2015. It continued to reference older guidance published in 2005 that had been superseded by the 2015 guidance. Managers had organised training in the use of rapid tranquilisation but it was not designed specifically for staff working with children and young people as recommended by the national institute for health and care excellence.
- There had been eight incidents of the use of rapid tranquilisation in the three month period between November 2016 and January 2017.
- Ninety four per cent of staff were up to date in training in safeguarding adults and children level three. In addition, a group of medical staff, clinical leads and hospital managers were trained to level four. Managers had promoted this group of staff as safeguarding leads in the hospital and additional safeguarding champions on the wards supported them. The lead social worker was responsible for the co-ordination of safeguarding within the hospital. She was working to develop a framework for the ongoing support of safeguarding leads and champions. We were assured that notifications were being made and the hospital social work team were in regular contact with the local authority designated officer for safeguarding children.
- Staff maintained good medication management practice with the support of an external pharmacist who visited the hospital weekly. The clinical pharmacist produced regular reports on compliance with regulations and any omissions or errors found in their scrutiny of prescriptions. The medication management committee reviewed these report and implemented actions to maintain medicines safety.

Track record on safety

- The hospital reported 29 serious incidents in the six months between August 2016 and the end of January 2017.
- Managers had reported all incidents that met the threshold for a statutory notification to the CQC in a timely manner. The CQC and NHS England were assured that lessons were being learnt and improvements made where appropriate through monthly meetings with managers during this period.
- Managers shared information about improvements to all staff through a simple summary report that staff discussed in supervision and ward meetings.

Reporting incidents and learning from when things go wrong

Requires improvement

Child and adolescent mental health wards

- All staff knew what required reporting as an incident and had access to the electronic incident reporting system.
- Staff had a good understanding of the need to be open and transparent and explain to young people if and when things go wrong. Managers had encouraged a culture of openness and transparency as part of the improvement programme following the imposition of special measures.
- There was a daily examination of incident reports by the senior management team at a morning meeting and feedback given to clinical staff on lessons learnt through completion of a simple action plan. We also saw evidence that when managers learnt lessons, they shared them within the Huntercombe Group as part of their renewed governance structures.
- When managers identified lessons to be learnt they monitored the implementation of change and effectiveness at the monthly governance meeting.
- Managers offered staff the opportunity to debrief following significant incidents. A record was made of the debriefing and managers reviewed the discussions to determine if they could learn any lessons.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We examined eight care and treatment records of young people on Wedgewood and five on Thorneycroft ward. All care records demonstrated a comprehensive assessment of the young person completed within 72 hours of their admission to the hospital by nursing and medical staff. Further assessments from occupational therapy, psychology and other clinical staff expanded on this initial assessment.
- Care records showed that a physical examination had been undertaken and that there was ongoing monitoring of physical health problems. Medical and nursing staff engaged positively with physical health issues.
- We found that care records were up to date and reflective of the young person's needs often expressing those needs in the young person's voice. Care plans were up to date but did not always reflect specific, measurable, achievable, realistic and time-limited (SMART) goals. Record keeping around care programme approach and multidisciplinary team meetings was of a high quality with the inputs from all disciplines, the young person and their family all clearly recorded.
- Staff stored care records securely on the computerised care notes system. They also had access to summary information on paper for staff who lacked access to the electronic records and as a back-up in case of system failure.

Best practice in treatment and care

- Aside from our concerns about the policy supporting the use of rapid tranquilisation, we found that other prescribing followed national institute for health and care excellence (NICE) guidance and took into consideration cautions around prescribing for young people and children and those young people being treated for an eating disorder.
- Hospital managers were not able to offer young people the full range of psychological therapies recommended by NICE as there were outstanding vacancies for two psychologists and a family therapist. The impact, was to reduce the effectiveness of treatment at the hospital and potentially delay recovery and discharge. The quality network for inpatient CAMHS (QNIC) service standards considers the provision of family and individual psychotherapy as essential. Managers were able to demonstrate that they had an active recruitment strategy in place and the posts had been filled temporarily, however, staff had chosen not to stay at the hospital. The lack of psychological therapy was also a concern of some young people and NHS England.
- Medical staff on site supported physical healthcare needs and when a specialist opinion was required they liaised with the local acute hospitals.
- On Wedgewood, staff regularly assessed and continually monitored the nutrition and hydration needs to ensure the physical well-being of the young people following national guidance on the treatment of eating disorders.

- Staff used recognised rating scales to assess and record severity of the problem of and outcomes for the young people in their care. The health of the nation outcome scales for children and adolescents (HoNOSCA) was used to record the severity of psychological, physical and social problems.
- Staff nurses on both wards were involved in an ongoing of clinical audits that included care and discharge plans, infection control, including mattress audits and medication managements. For example, two members of the senior nursing team carried out a regular infection control audit. They used this audit to inform an action plan that the hospital's governance committee monitored monthly.

Skilled staff to deliver care

- Although the hospital employed a range of therapy staff, we heard from our focus group with them that they lacked a clear management structure. They believed that this and the lack of a therapy strategy had contributed to this situation had contributed towards problems of recruitment and retention. We also heard that there had been no needs assessment to inform resource allocation of therapy staff which led to therapy staff overlapping in their interventions with young people. This had created confusion for some young people about which sessions should have priority in their recovery. The CQC and NHS England had raised similar concerns about the lack of co-ordination of therapeutic interventions at monthly engagement meetings. Managers had told us that the new governance and quality lead at the hospital, an occupational therapist, would be responsible for leading the therapy team in the future.
- Nurse managers had improved supervision rates steadily over the months since our last inspection. In local policy, nursing staff were required to receive supervision at least once every eight weeks. In the eight weeks before 30 January 2017; 92% of nursing staff on Wedgewood ward and 88% on Thorneycroft ward had participated in a supervision session. Staff employed as allied health professionals, activity workers and psychological therapists had no clear management structure in place. Only seven out of 15 of these workers (46%) were up to date with supervision.
- Managers had completed annual appraisals for 98 out of 160 (61%) eligible staff. Therapy staff had completed appraisals at a lower rate of only four out of tem (40%).
- Hospital managers had reviewed and expanded the induction programme for all staff to include a week of orientation and mandatory training and then further days differentiated for clinical and non-clinical staff.
- The percentage of non-medical staff that have had an appraisal in the last 12 months was 90%
- Managers had introduced staff training in positive behavioural support. It provided staff with a framework for developing an understanding of behaviour that challenges. Staff were trained to assess the broad social, physical and individual context in which the behaviour occurs, and use that information to develop a range of support strategies. The overall goal was to enhance the person's quality of life, thus reducing the likelihood of challenging behaviour occurring in the first place. Clinical staff we interviewed were all positive about the impact of this training on their practice and reported an increased confidence in managing behaviours that challenge.
- Previously we had found that qualified nurses responsible for administering naso-gastric feeds had not received specialist training or any ongoing programme of clinical updates. In response, managers established a competency framework for the administration of naso-gastric feeds and provided training to introduce qualified nurses to the new standard. On this inspection, 91% of eligible staff had received training in this critical clinical skill.
- Through our monthly engagement meetings, managers had demonstrated that they address any staff performance issues promptly and effectively.

Multidisciplinary and inter-agency team work

- We were able to observe multidisciplinary team meetings on both wards during our inspection. Both were well organised and made provision for the young person and were possible their families to participate. The hospital director led a hospital wide meeting to review staffing levels and incidents of the day before each weekday morning. This was a multidisciplinary meeting with representatives of both wards, medical, social work and therapy staff in attendance alongside

the quality and data management team. This senior management team meeting discussed potential safeguarding referrals and management plans to mitigate risks following any incidents. Teaching staff at the hospital were very positive about their integration into the care team and the quality of communication between the clinical team and education department at the hospital. Teachers had access to the care-notes and incident reporting systems and participated in the multidisciplinary team meetings.

- We found that there were systems in place to deliver a handover from a written report prepared by the shift before. This meant that other staff arriving after the main handover for nursing staff in the morning and at night could easily update themselves on any new risks and amendments to care plans since their last shift. These meetings also discussed the allocation of duties for the shift ahead so staff could agree the allocation of tasks and be aware of the content of their day in advance.
- Through the hospital social work team the ward staff had developed effective working relationship with the local authority and the home authority of children from out of area. There was regular contact with the local authority designated officer for safeguarding children.

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

- The responsible clinician undertook the medical scrutiny of the medical recommendations of detained young people on admission. They completed a form used to evidence the completeness of the recommendations, for all the detained young people this had been completed. Out of hours, qualified nursing staff undertook the receipt and scrutiny of documents.
- The hospital managers employed a full time Mental Health Act administrator based at the hospital. The role covered receipt and administrative scrutiny of documents, ensuring leave authorisation are current and completed properly, uploading documents on to care notes, systems in place to alert the Responsible Clinician (RC) of consent to treatment rules and expiry of sections and nursing staff of section 132 reading of rights to young people.
- The Mental Health Act administrator also arranged tribunals and managers panel hearings. Where a patient had not submitted an appeal the Mental Health Act administrator had a system in place to ensure a reminder was sent for an automatic referral to the tribunal service. Staff on the wards knew how to contact the Mental Health Act administrator for help and advice.
- Leave was authorised through a standardised system, staff recorded any specific conditions. At each multidisciplinary meeting leave was discussed and granted on the basis of a risk assessment.
- The ward staff completed a specific form for young people taking external leave; this recorded a description of the patient, their destination and a risk assessment. On return from leave, staff recorded how the patient's leave went.
- There was an inconsistent approach amongst nursing staff regarding leave on Wedgewood ward, where a patient required the use of restraint to administer treatment via a nasogastric tube. Some staff felt this should not prohibit a patient's leave and allowed young people to go out. Whereas others felt, leave could not take place.
- The Mental Health Act administrator provided a document to family and carers regarding leave, this included information about what leave is, the conditions and the importance of returning on time from leave. During our visit, there were no young people absent without leave or missing. In the previous twelve months until the end of January 2017 there had been one incident of a detained young person leaving the grounds without authorisation. They returned to the hospital within an hour of their leaving accompanied by staff.
- On our previous inspection, we found that only a limited number of staff had been trained in the Mental Health Act. Training had been limited amongst clinicians to medical and qualified nursing staff. Only 30% of that group were up to date in their training in May 2016.Training had been expanded to all clinical staff and we found on this inspection that 58% of eligible staff were now up to date with their Mental Health Act training. Managers informed us all staff would now receive mandatory training in the Act. However, the Huntercombe Group had not implemented policies relevant to restrictive and other clinical practices in line with the revised Code of Practice until the week of our

inspection. Managers had not planned the implementation of the revised policies and when staff training in the Mental Health Act would be updated to reflect these changes. The Mental Health Act administrator had a slot within the staff induction programme to ensure new staff understood their role and responsibilities in regard to the Act.

- Staff provided all treatment for detained young people under an appropriate legal authority. Where young people were being treated on statutory treatment forms known as T3, they were kept with the medication cards.
- Records showed that staff made both informal and detained young people aware of their rights. Where young people were detained under the powers of the Mental Health Act, they were informed of their rights on a monthly basis, this included a verbal explanation and written information. The Mental Health Act administrator sent a reminder to the ward staff regarding section 132 rights. This ensured young people received an explanation on a regular basis. Staff provided informal young people with an information leaflet detailing their rights.
- Detention paperwork was available for inspection; this included the Approved Mental Health Professional (AMHP) reports. It was in good order and easy to locate in all the files.
- The Mental Health Act co-ordinator completed regular audits on the accuracy and completeness of section 17 leave, section 132 (rights), capacity/competence forms, treatment and use of the independent Mental Health Act advocate. These audits were reviewed at the monthly integrated governance meetings.
- The wards had access to two advocacy services. One service provided advocacy support to all young people; however, where issues related to detention staff made referrals to an independent mental health advocate service. Staff had displayed posters for both services around the ward that included a photo of the advocates.
- Both advocacy services felt young people were aware of their legal status on the ward, whether this was informal of a section of the Mental Health Act. Where young people lacked the capacity to understand the role of the advocacy service, the multidisciplinary team would assess whether the patient would benefit from the support of an advocate and make a referral accordingly.

Good practice in applying the Mental Capacity Act

- There no applications made for authorisation of a Deprivation of Liberty Safeguards in the six months before 31 January 2017.
- Staff were trained in the Mental Capacity Act via an e learning module and 85% of staff were up to date with this training.
- There was a policy available to inform staff of the requirement s of the Mental Capacity Act including the provisions of the Deprivation of Liberty Safeguards (DoLS).
- The wards used the same consent to treatment forms for young people under the age of 16 and for those aged 16 and over. However, the form omitted the diagnostic test required by the Mental Capacity Act . The assessment of mental capacity is a two stage process, including the diagnostic test and functional test. Before you can assess whether a patient meets the functional test, the diagnostic test has to be completed. The lead consultant psychiatrist had raised this issue with the Huntercombe Group medical director. However, at the time of our inspection no action had been taken centrally to correct the form.
- Staff understood the principles of the Mental Capacity Act in supporting young people to make their own decisions. Given the age group of the young people at the hospital if they were unable to make a decision for themselves staff could, on some issues, consult their parents for an opinion and if appropriate consent.
- We found staff to have a good understanding of the Mental Capacity Act' definition of restraint covering the use or threat of the use of force to make someone do something they are resisting, or restrict a person's freedom of movement, whether they are resisting or not.
- At the time of the inspection, there was no regular review or audit of the use of the Mental Capacity Act in place at the hospital

Requires improvement

Child and adolescent mental health wards

- We found that staff were aware of the difference between Gillick competence (in the case of children under 16) and mental capacity (in the case of young people 16 and over). When staff admitted young people to the ward, they documented depending on their age their capacity or competence to consent to admission.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

- Our observations of care on the ward were that when staff interacted with young people they demonstrated care and respect. We observed staff attending promptly to any distress exhibited by young people in their care including a prompt response to any young person's request for support.
- Young people on the wards told us about their care. They felt that regular and nursing staff were very caring, listened to their concerns and involved them in care decisions. They were less positive about some agency staff who were not regular members of their care team.
- We heard that young people felt able to feedback their concerns about their care to staff via community meetings and written complaints but stated that they felt issues were not always resolved or resolved in a timely manner. Two of the young people felt that staff did not always speak to them in a way that reflected their age and maturity and on Wedgewood they did not feel that some staff had appropriate knowledge about eating disorders leading to inappropriate comments. However, these concerns were not reflected more generally in the monthly survey of young people's views about care at the hospital for January 2017. All of the 12 young people who completed the survey answered positively to questions about being treated with dignity and respect.
- In the interviews we conducted with staff we found that they had a good understanding of the individual needs of the young people they cared for. Both staff and young people felt that this personal knowledge improved the quality of care.

The involvement of people in the care they receive

- On admission, young people were given an induction to the wards and some information on ward routines and the clinical team. Staff had drafted this introductory pack in collaboration with young people at the hospital.
- We found evidence that young people on both wards had been involved in care planning and attended multidisciplinary team reviews to discuss their progress. On Wedgewood ward, we found that each patient was provided with their own file, this contained their care plans, leave authorisation forms, information about their named nurses and healthcare support workers, capacity (in the case of young people aged 16 and over) Gillick competence (in the case of children) and a hospital passport. Young people completed this passport, providing staff with key information about themselves, including for example their likes, dislikes, their current stress triggers, how to keep them safe, personal care needs and communication. On Thorneycroft, young people told us of regular discussions with their key nurse about their care plans and involvement in positive behavioural support meetings to reflect on the effectiveness of interventions to reduce their distress. We saw evidence that staff offered young people on Thorneycroft copies of their care plans but not all had agreed to take them.
- Young people on both wards were aware of the availability of advocacy services and were familiar with the local advocates who regularly visited the wards.
- Carers told us that staff regularly invited them to care discussions and staff on the wards informed them of any updates. For carers on Wedgewood, the lack of consistent consultant cover on the ward had caused frustration. However, other members of the clinical team had provided some continuity. Hospital managers were exploring information technology solutions to allow carers live involvement in care reviews remotely. Managers had also planned carer support meetings to provide carers with a forum to discuss any concerns and request information from staff. Respondents to the carer satisfaction survey in December 2016 all answered positively about staff giving them time to ask questions and being supported by staff members.
- Regular weekly community meetings on the wards allowed young people to discuss directly with staff their views about proposed changes and their own priorities for change. We observed one community meeting and

Requires improvement

Child and adolescent mental health wards

found staff to be attentive to the opinions of the young people attending and that their opinions informed change on the ward. A weekly newsletter for the young people, written in part by them, shared information and decisions from these meetings across the hospital. Managers also sought the views of young people and their families through regular monthly surveys. In January 2017, 60% of young people at the hospital and 55% of their parents had completed the survey.

- Young people had become routinely involved in interviews for staff wishing to work at the hospital.
- Some young people had made advance decisions to inform their care that staff had recorded in their notes for future reference.

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

Requires improvement

Access and discharge

- NHS England commissioned inpatient CAMHS beds at a national level. The West Midlands regional NHS England team worked closely with the hospital to secure a bed for young people close to home if required.
- Managers maintained ward occupancy below 100% and there were no reported cases of a young person not having access to a bed on their return from leave. NHS England had capped ward occupancy levels in June 2016 and the number of patients on each ward had increased as the hospital made improvements.
- There was no evidence that staff moved young people between wards in the last six months. The model of care at the hospital only supported such a move on clear clinical grounds justified by a change in clinical presentation.
- Staff planned discharges in advance, in discussion with families and the young person. Discharge took place, wherever possible, during the morning to allow an early return home. In the six months before the end of January 2017, there have been no delayed discharges from the service. Staff prepared detailed discharge care plans, which identified the aftercare arrangements for the ongoing mental health, and social care needs. In the case of young people previously detained under Section 3 of the Mental Health Act staff noted aftercare arrangements in line with Section 117 of the Act. The hospital social work team ensured that home local authorities were involved in discharge planning of young people and children in their care.
- Since the closure of Hartley ward, the only way to move a young person to a psychiatric intensive care unit if they required more intensive care had meant a transfer to another hospital. With a very limited number of CAMHS PICU beds nationally, this had meant patients transferred to a setting were removed from their home in the West Midlands. However, case managers at NHS England continued to liaise with Huntercombe Stafford and review the potential for re-admission as the young person's needs reduced if that was a suitable step down and brought the young person closer to home before discharge.

The facilities promote recovery, comfort and dignity and confidentiality

- Both wards had clinic rooms where medical staff could examine young people. Rooms were also available for education and activity on both wards. However, access to activity and education rooms was restricted and the main social areas of the wards had a limited range of activities available.
- We found that on Thorneycroft bedrooms lacked curtains and there was no access to light switches within the rooms. This left young people in potentially vulnerable position, although the site is isolated and not overlooked. With no internal control over light their comfort and dignity was also negatively impacted.
- We found that a visiting area was available on Wedgewood ward but not Thorneycroft ward. There was limited space on site to make further change and no facilities to support younger siblings visiting the hospital. Managers recognised this as requiring further attention as the reopening of the psychiatric intensive care unit would put further pressure on the visiting areas and two meeting rooms it shared with Thorneycroft ward.
- Young people told us of difficulty in making calls in private. Due to the limitations placed on a young person accessing their bedrooms without staff on Wedgewood ward, finding a private space was challenging. Staff told

us they tried to accommodate private phone calls by allowing access to the meeting rooms and other private space on the ward. However, young people felt this was an added degree of restriction as they had to explain why they required such privacy.

- One young person who had received naso-gastric feeds under restraint was upset that staff sometimes used rooms other than the clinic room. They felt that they could cope better with the feeds in the clinic room because saw the treatment as medication. If they happened elsewhere they though that everyone on the ward knew and their dignity was compromised.
- Both wards had only limited access to outside space. Thorneycroft was based on the first floor and access to the garden and activity area was via a locked staircase. Young people could only have access in the company of staff who unlocked intervening doors. The young people on the psychiatric intensive care unit, when it re-opened, would also share this area and previously this had meant each ward only having part time access to the outdoors. Managers had not addressed this issue during the closure of the psychiatric intensive care unit. Following our last inspection report managers had developed the outdoor space outside Wedgewood ward with some new landscaping, planting and a screen to protect the privacy of young people using the area. Young people had given their views about what should go into this new recreational area. All were looking forward to the arrival of the rabbits the ward were purchasing following their suggestion to have pets to care.
- Young people on both wards reported that they felt the food tasted "all right" but would prefer to have more choice and the opportunity to cook their own food.
- There were limitations on the access to snacks and drinks on Wedgewood ward that were justified by the treatment needs of the individual young people on the ward. Staff took care to monitor the nutritional input and hydration of the young people to ensure their physical well-being was improving. Only in the week previous to our inspection had managers allowed free access to drinks on Thorneycroft ward as part of their programme to eliminate blanket restrictions at the hospital.
- Young people felt able to personalise their bedrooms with pictures and some personal items. On Wedgewood ward, young people did their own laundry. On both wards where staff had restricted personal items because of an identified risk, belongings were held securely and could be accessed by request.
- Each ward had activity workers, who organised activities for groups and individual young people. They ensured activities were available seven days a week but only for a limited period during the day. Some young people reported that they would prefer more activities in the evenings after school and therapy sessions had ended. As well as concerns about activities being cancelled young people on Thorneycroft had raised a concern that if an outing was organised there was not an alternative ward based activity for those without leave from the hospital.

Meeting the needs of all people who use the service

- There were limited adjustments made to the ward environments to support people requiring disabled access. A lift provided access to Thorneycroft ward which was on the first floor whereas the accessible toilet was located on the ground floor. Stairs provided the only access to bedrooms on the first floor of Wedgewood ward. There was no level access to the ground floor facilities on Wedgewood ward or to the garden space. Site managers had not allocated disabled visitors to the hospital a dedicated parking space to ease their access into the two main buildings.
- Most information was immediately available in English only but staff could source materials in other languages on rights under the Mental Health Act and other subjects as required. Ward managers had provided young people with a wide range of information about local services, ward routines and their rights. Staff displayed some of this information on themed notice boards on the wards, including daily updates on staffing and activities and kept copies in leaflet form to distribute to individual young people on their request.
- When required ward staff could arrange for interpreters and/or signers to attend the hospital to support a young person's communications needs as required.
- There was a choice of food available to young people on both wards. Catering staff tried to accommodate personal choice, religious requirements or ethnic

preferences for food. On Wedgewood ward, the dietician supported young people in making food choices that would meet their preferences and support their recovery.

- There was no dedicated space for young people to worship within the hospital. Meeting rooms in both buildings were used to support prayer and reflection. However, they were not always available to young people when they requested their use. One young person also told us of delays in sourcing a prayer mat and copy of the Quran for their use on the ward.

Listening to and learning from concerns and complaints

- A total of 59 complaints had been received in 2016 with 19 upheld. No referrals had been made to the ombudsman.
- We saw information displayed within the patient areas regarding complaints. Young people knew how to make a complaint and two young people on Thorneycroft ward told us that they had complained about staff cancelling planned activities. Both had received acknowledgement of their complaints and had the opportunity to discuss their concerns with a manager.
- Staff understood the complaint management system and to make an initial attempt to manage any complaints informally. In the three months between October and December 2016, managers had closed all complaints within 25 days meeting the local standard for a response. This was a significant improvement on our findings in May 2016 were there was a backlog of complaints to be examined the majority relating to staff behaviour. The overall trend was a reduction in the amount of complaints received from a peak in February 2016.
- Managers had brought lessons learnt to the attention of staff through an email based lessons learnt bulletin and direct to staff meetings.

Are child and adolescent mental health wards well-led?

Requires improvement

Vision and values

- Staff knew the Huntercombe Group's key values of prioritising individualised quality innovative care Manager's promoted the group's aspiration of 'nurturing the world one person at a time' in information for staff and patients.
- Managers were developing models of care for each ward at the hospital that would reflect the organisation's values and objectives.
- The hospital director and quality manager were known to all staff and regularly visited the wards. Senior executive from the Huntercombe Group had also been regular visitors to the two wards and staff knew them well.

Good governance

- Managers had prioritised mandatory training in the skills needed to provide safe care as a first priority following the initial feedback from our inspection in May 2016. Staff were trained in safeguarding and life support skills with managers monitoring the levels of training on each shift and provided assurance to the CQC and NHS England that an agreed minimum level of skilled staff were always deployed on the wards.
- There was an improvement in the rate of appraisals and supervision since our last inspection. However, overall levels of appraisal remained low and therapy staff as a group had the lowest rates of appraisal and supervision. This reflected their concerns about not being involved in the general improvement plan for the hospital.
- At the time of the inspection, there were 18 posts vacant out of 33 (55%). Managers had attempted to mitigate this gap and provide consistency of care through block booking agency nurses on contracts of six months duration. However, managers had recognised this as a medium term solution and were still addressing the longer term problems of recruitment and retention of qualified nursing staff.
- Increased staffing levels had meant more time for nurses to spend on direct care activities and this was staff evidenced this in the number of one to one sessions with young people they recorded.
- Staff participated in clinical audits and report incidents, receiving feedback from managers on both. The daily hospital senior management team meeting reviewed incidents promptly and targeted feedback and any lessons learnt to staff.

- Managers discussed information from the reporting systems and audits at a monthly governance meeting. These meetings involved a wide range of clinicians from the wards of all professions, senior clinical and administration managers. Local hospital managers shared decisions and lessons learnt with the national Huntercombe Group quality assurance team and regular specialist CAMHS service meetings.
- The senior management team managed the hospital risk register and they reviewed it at the monthly governance meeting. The latest version of the risk register we reviewed during our inspection included the risks identified above around recruitment of nursing and therapy staff and continuity of leadership at the hospital. Staff could, through incident reporting, add concerns for inclusion in the risk register.

Leadership, morale and staff engagement

- There were no cases reported of staff reporting bullying or harassment.
- Staff on both wards were aware of the whistle-blowing process and that they could approach the CQC with any concerns.
- There was a split in the confidence of staff that management would listen to concerns without any risk of victimisation. Nursing staff on the wards were secure in the belief that their managers would listen to concerns and act upon them. Members of the therapy team believed that managers had not listened to their concerns and that this was reflected in the absence of a therapy strategy as part of the hospital's improvement plan.
- Staff from all disciplines told us that their morale and job satisfaction had increased in the six months prior to our inspection. All staff told us that they now felt that the hospital was a safe place to work. We heard concerns from some staff that they worried that managers would reduce staffing levels again in the future if the hospital came out of special measures. However, they were confident that they felt empowered to speak out about the state of care to managers and would not let the hospital return to the position it had been in.
- Qualified nursing staff had the opportunity to participate in a local university's leadership development course. Two nursing staff had recently enrolled on this course.
- Staff reported positive experience of team working on Thorneycroft ward and that the ward manager had provided strong leadership to guide the team through multiple changes. Two staff on the ward expressed concerns about the potential negative effect of splitting the team to allow some staff to move to the psychiatric intensive care unit. Overall, the cohesion of the different clinical teams was positive within themselves but uncertain about the future because of problems of recruitment, leadership and the challenge of re-opening the psychiatric intensive care unit.
- On this inspection, we found staff to be more open in interviews about their doubts and concerns. This reflected a positive change in the culture of the hospital in regard to transparency and learning lessons from incidents. Staff told us that extended to increased duty of candour with young people when something went wrong.
- Managers offered staff the opportunity to feedback on their experiences of the events leading to the hospital going into special measures at a series of away days in late 2016. Externally facilitated to promote openness amongst staff, local managers and directors from the Huntercombe Group nationally attended to hear from staff first hand. Follow up sessions were being organised to develop some of the themes highlighted by staff into action plans to inform future service development.
- Both the hospital director and quality lead, that had led the improvement programme since July 2016, were leaving the hospital in the month following our inspection. This change in leadership threatened the stability of the gains they had made. We discussed these challenges with commercial director of the Huntercombe Group who provided assurances that the group were already seeking a suitably experienced hospital director to come into post. A new and permanent quality and governance lead had already taken up their post in January 2017 and was shadowing their predecessor before they left the hospital. The hospital director had also appointed the new quality and governance lead to manage therapy staff inside the hospital. However, senior managers acknowledged the

challenges for a new leadership team to become familiar with the hospital and embed the improvements already made. As the outgoing managers had not secured permanent nursing leadership at a ward level continuity of leadership was a general concern within the hospital. The nurse manager on Thorneycroft was to take a new position covering both Thorneycroft and the reopened psychiatric intensive care unit and the clinical nurse leader on Wedgewood was on a temporary contract. Managers had been consistently trying to recruit to the three ward manager posts but had not successfully appointed into post at the time of our inspection.

Commitment to quality improvement and innovation

- The hospital was part of the quality network for inpatient CAMHS (QNIC). The service was not currently accredited by the scheme but had started the process with Wedgewood ward the subject a peer review exercise in January 2017. Managers had incorporated early feedback from that visit into the hospital improvement plan.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that they remove any blanket restrictions and that any ongoing restrictions are based on individualised risk assessments of young people.
- The provider must ensure that policies and training on rapid tranquilisation are up to date with NICE guidance.
- The provider must provide sufficient, appropriate and co-ordinated therapeutic activities and access to psychological therapies must be available on all wards.
- The provider must introduce a management structure to encompass therapy staff and provide ongoing support through supervision and appraisal.
- The provider must ensure that all eligible clinical staff are trained in the Mental Health Act and the revised code of practice.
- The provider must ensure all assessments of mental capacity are complete, and refer to both diagnostic and functional tests, and a young person's right to refuse treatment is included in the description of Gillick competency. The provider must introduce an audit of their compliance with the Mental Capacity Act and the application of Gillick competency.

Action the provider SHOULD take to improve

- The provider should ensure that provision is made to allow young people to summon help in an emergency if they are unable to call out to staff.
- The provider should ensure that staff recruitment initiatives are increased to secure a permanent staff base to enable safe, effective and high quality care.
- The provider should ensure that mandatory training levels continue to increase across all areas to the local target.
- The provider should ensure that they develop a training and implementation plan to inform staff of the policy changes made in line with the revised Mental Health Act code of practice ratified in February 2017.
- The provider should ensure that psychological interventions, occupational therapy and activities are co-ordinated in individualised therapy programmes for young people.
- The provider should improve visiting facilities to allow more flexibility for visitors to see the young people in private and include the option of visits onto the wards.
- The provider should monitor and review the number of activities offered, taken up or cancelled.
- The provider should ensure that a dedicated parking space is available to patients and visitors to the hospital with mobility needs to allow easy access to the main hospital buildings.

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
Accommodation for persons who require nursing or personal care 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 Clinical policies were out of date and not in line with NICE guidance. Training to support good clinical practice in rapid tranquilisation did not address the needs of children and young people. There was a lack of psychological therapies available to young people and other therapy staff lacked leadership, which affected their effectiveness.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 We found that blanket restrictions were in place that were not necessary or proportionate as a response to the risk of harm posed to the service user or another individual this is a **breach** of regulation 13 (1) (4) (b) (c) and (5) . There was no evidence of any individual risk assessments to justify their application.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	There was no ongoing monitoring of the use of the Mental Capacity Act and application of Gillick competency in those under 16 to guide practice development.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Therapy staff were not receiving regular supervision and lacked a management structure to appraise and support their professional development