Huntercombe Hospital - Maidenhead

Quality Report

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Date of inspection visit: 11-13 June 2019
Date of publication: 12/08/2019

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	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

We rated Huntercombe Hospital Maidenhead as Good because:

- The wards had enough nurses and doctors. Staff assessed and managed risk well, followed good practice with respect to safeguarding, and had a dedicated social work team with a named social worker for each ward.
- The provider had made substantial progress in the reduction of restrictive practices and blanket restrictions across the hospital.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the young people and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of young people on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment.
- Staff treated young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of young people. They actively involved young people and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that could provide aftercare, and while delayed discharges did occur due to the lack of available specialist placements, the provider worked closely with commissioners and other providers to seek suitable alternatives.
- The service was well led and the governance processes ensured that ward procedures ran smoothly. The provider was engaged in a number of initiatives to improve staff wellbeing and morale, and invested well in training and career development.
- Young people and their carers gave mostly positive feedback about the relationships they had with staff and the impact of their treatment on their lives.

However:

- Physical health was inconsistently monitored using the paediatric early warning system (PEWS) which meant there was a risk that a young person's deteriorating health might not be identified early enough.
- The service was not applying a positive behaviour approach to the management of behaviour that challenged, as staff who had been previously trained had left the organisation. Staff training levels in positive behaviour support were below target at 57%.
- At the time of our inspection, only 67% of staff had received mandatory training in the Mental Health Act. This had increased to 73% for all staff within two weeks of the visit, which was still below the target of 75%.

Summary of findings

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Summary of this inspection

Background to Huntercombe Hospital - Maidenhead

Huntercombe Hospital - Maidenhead is a specialist child and adolescent mental health inpatient service (CAMHS). It is a 60 bed independent hospital. It provides specialist mental health services for adolescents and young people from 12 to 25 years of age and is registered to treat young people who are detained under the Mental Health Act 1983. It also treats young people who are admitted informally. Huntercombe delivers specialised clinical care for young people of all genders requiring CAMHS, including eating disorders. The hospital and its surrounding grounds are within a rural setting and are situated near a town with easy access to transport links and shops. In-house sports and social facilities include a gymnasium, an enclosed garden and a sports area. Young people are supported in their education via the hospital school. Where appropriate the young people have access to the hospital grounds and local community facilities.

The hospital consists of four wards.

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

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

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

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

All wards accepted young people of all genders, although during this inspection Tamar, Severn and Thames wards had both male and female young people, Kennet ward had all female young people:

The hospital was previously inspected in September 2017 as part of a well led review of the Huntercombe Group. The hospital was not rated as part of this review, and so held it's rating from February 2016 which was Good overall. Following the February 2016 inspection we rated the effective key question as requires improvement, all other key questions were rated as good.

Our inspection team

The team that inspected the service consisted of four Care Quality Commission inspectors, including a registered mental nurse (RMN). The team was supported on-site by three specialist advisors; a consultant psychiatrist who was a medical director, and two RMNs, all of whom were specialists in child and adolescent mental health.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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.

Summary of this inspection

During the inspection visit, the inspection team:

- visited all four wards and looked at the quality of the ward environment, including clinic rooms and two treatment rooms where nasal-gastric tube feeding was carried out
- reviewed clinical audit records for Tamar ward and 16 prescription cards from Thames, Tamar and Kennet wards
- interviewed 15 young people from across all four wards
- interviewed four parents of young people who were being treated at the hospital
- interviewed the following senior staff; acting medical director, hospital director, head of nursing and quality , senior quality partner, deputy quality manager, process improvement manager, social work lead and education manager (head teacher)
- interviewed the following ward based medical staff; three consultant psychiatrists, an associate specialist doctor and a junior doctor
- interviewed the following ward based clinical staff; all four ward managers, seven nurses, a night nurse, and a student nurse
- met with five members of the therapies team (the head of therapies, a systemic practitioner, therapist, an assistant occupational therapist and an assistant psychologist)
- interviewed two senior support workers and three support workers
- interviewed staff from the human resources department
- reviewed care records for 17 young people
- observed a multi-disciplinary team meeting in Thames Ward
- observed morning handover meetings on Severn ward and on Thames ward, and a ward round on Severn ward
- reviewed the management of three complaints in detail, from the point the complaints were raised to the conclusion of the investigation
- reviewed minutes of key meetings, including service user involvement meetings, restrictive practice review meetings, and two sets of clinical governance meetings
- reviewed other key documents, including staff training and development plans, estates plans.
- reviewed rotas, supervision, training and appraisal data for the four wards covering six months leading up to the inspection
- reviewed policies governing restrictive practices, medicines management, safeguarding and single sex accommodation.

What people who use the service say

The 15 young people we spoke with generally spoke highly of regular staff, saying they were “kind”, “supportive”, “easy to talk to” and “good”. Young people told us that staff were very good at explaining what medicines were for and helping them to understand how they worked for them. Young people said they generally felt safe and that there was enough staff around on the wards. However, young people also told us that when staff were very busy they did not always follow the detail of their care plans, for example, using a word around meal times that the young person had told them was unhelpful.

Some young people said that individual staff members were good at communicating with their parents, but most said that this was an area for improvement, for example, letting their parents know about key meetings or informing them about an incident they had been involved in. Some young people commented that some agency staff, especially night staff, were less supportive and rougher when using physical interventions. Young people complained that night staff sometimes fell asleep while carrying out their observations, a concern that the hospital had acknowledged and were addressing with individuals and the staff team as a whole. Young people said that when too many of their peers were on higher levels of observation this meant that staff had less time to engage with them and they could get bored. Young people said that the youth engagement practitioners helped them keep occupied and have fun.

Summary of this inspection

Parents consistently fed back that communication from the hospital could be poor on occasion, and this was a theme in complaints we received in the lead up to the inspection and during the inspection period. Some parents had noted recent improvement in communication and welcomed the introduction of family information days. Parents we interviewed also spoke very highly of the ward staff and of senior staff, describing individuals as “amazing” and expressing gratitude for the help their child had received. Some parents felt the wards could be short staffed and that ad-hoc agency staff were less skilled than permanent or regular workers.

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?

Good

We rated safe as good because:

- All wards were clean, well equipped, well furnished and well maintained. Challenges posed by the layouts, age and listed status of the wards were generally well managed through staff observations and adaptations, for example, perspex across windows and secure netting across the stairwell in the main building.
- The service had enough nursing and medical staff, who knew the young people and received basic and specialist training to keep young people safe from avoidable harm.
- Staff assessed and managed risks to young people and themselves well and followed good practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme, which had made significant progress since the last inspection.
- Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named safeguarding leads at ward level, in the social work department, and within the senior leadership team.
- Staff had easy access to clinical information via the electronic case management system and it was easy for them to maintain high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave young people honest information and suitable support.

However;

- The age and listed status of some areas of the building posed challenges to patient safety that could only be mitigated through increased staffing.

Summary of this inspection

- We observed examples of staff applying the medicines management policy inconsistently with regard to the recording of controlled drugs and the disposal of medicines.
- Not all mandatory training was at or above the required level of 75%. PREVENT (prevention of radicalisation) was at 66% and search at 54%.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- While all young people received a comprehensive physical health and medical assessment on admission, staff were inconsistent in their use of the Paediatric Early Waring Scale (PEWS).
- Positive behaviour support (PBS) had not been effectively embedded at the service, as staff members who had received advanced training the previous year had left the organisation. Only 57% of staff had completed the training. This was clearly detailed as a priority on improvement plans for the service.
- On one of the three wards, only 67% of staff had received supervision within the 42 day period specified in the provider's supervision policy.
- Data submitted by the hospital prior to the inspection shows that only 64% of staff had received training in the Mental Health Act. This had increased to 73% within two weeks of the inspection visit, but was still below the required level of 75%.

However, we found the following examples of good practice

- Staff assessed the physical and mental health of all young people on admission, and consistently completed admission checklists. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that young people had good access to physical healthcare.
- Staff participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward team included or had access to the full range of specialists required to meet the needs of young people on the ward. Managers made sure they had staff with a range of skills

Summary of this inspection

needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

- Staff from different disciplines worked together as a team to benefit young people. They supported each other to make sure young people had no gaps in their care. The ward team had effective working relationships with other relevant teams within the hospital and with relevant services outside the organisation.
- Staff supported young people to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to young people under 16. Staff assessed and recorded consent and capacity or competence clearly for young people who might have impaired mental capacity or competence.

Are services caring?

Good

We rated caring as good because:

- Staff treated young people with compassion and kindness. They respected young people's privacy and dignity. They understood the individual needs of young people and supported young people to understand and manage their care, treatment or condition.
- Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. The hospital actively considered requests from young people around the reduction of restrictive practices, and had recently enabled young people to safely have access to smart phones, internet and television streaming services on the wards. Monthly service user involvement meetings were an opportunity for young people to give feedback and make suggestions and requests.
- The hospital ensured that young people had easy access to independent advocates, who attended monthly clinical governance meetings to feed back themes to the senior leadership team.
- The service had endeavoured to make the hospital more young-person friendly, for example, through the appointment of youth engagement practitioners to organise fun activities, the introduction of canine-assisted therapy and through consulting young people on how the wards and main areas could be decorated.

Summary of this inspection

- Parents and young people told us that communication between ward staff and families could be poor. The provider had begun improving communication with families through family information days and personalised communication plans for each patient. These plans included a named point of contact for every young person, and details of how to reach them.

However:

- Some young people told us that ad hoc agency staff were less caring and approachable, and less considerate of their needs, for example, being noisy at night time and talking to each other in languages other than English, which young people found unsettling. The hospital management had acknowledged these concerns and were carrying out spot checks at night and issuing best practice bulletins to staff.

Are services responsive?

Good

We rated responsive as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. Where discharge was delayed due to the lack of suitable alternative provision, the hospital worked closely with commissioners to try to address this.
- Staff facilitated young people's access to high quality education throughout their time on the wards.
- Young people could make hot drinks and snacks at any time
- The wards met the needs of all young people who used the service, including those with a protected characteristic. Staff helped young people with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- The design and layout of the wards did not always support young peoples' privacy and dignity. On Severn ward, newly fitted doors had viewing panels that could not be controlled from inside the room by the patient, only by staff from the outside. Hospital managers told us that this had been an oversight and committed to have the panels adjusted straight away.

Summary of this inspection

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for young people and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- The service invested well in the learning and development of staff, providing enhanced training opportunities and opportunities for career progression.
- Senior leaders had engaged the service in new initiatives to improve the wellbeing and morale of staff, with a view to improving recruitment and retention.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities

However:

- Whilst all senior clinical leadership roles were covered, some were temporary staff while permanent appointments were made. All wards always had medical cover from a consultant, junior doctor, and/or associate specialist, however there was a potential risk that the number of temporary arrangements could create sudden change, for example, a locum doctor leaving at short notice.

Detailed findings from this inspection

Mental Health Act responsibilities

We carried out a detailed review of the use of the Mental Health Act on all four wards in November 2018. The service submitted an action plan to address 14 areas of concern that will be reviewed at a subsequent mental health act review visit.

In 2017, we served a requirement notice for a breach of Regulation 11, need for consent, of the Health and Social Care Act 2008 (Regulated Activities). We told the provider it must ensure that all staff understood the Mental Capacity Act and Gillick competence. This is when a patient under the legal age of consent is considered to be competent enough to consent to their own treatment rather than have their parents' consent. In addition the provider must ensure that Gillick competence is assessed for each patient less than 16 years of age and ensure that capacity is assessed for those over the age of 16. On this inspection we found that the provider had met this requirement notice; staff and managers we interviewed understood Gillick competence and assessed young people appropriately.

The young people we spoke with had been given information about their rights on transfer or admission to the ward and were aware of their rights and how they could exercise them. Some young people had obtained support from an advocate, who visited the wards regularly. Information about advocacy and how to access it was displayed on wards and in main areas and explained the difference in role between the general advocate and that of the Independent mental health advocate (IMHA). Young people detained under the Mental Health Act are legally entitled to help and support from an IMHA.

Staff we spoke with understood the rights of detained patients and informal patients, and ensured they had access to appropriate specialist advocacy, however data submitted by the hospital prior to the inspection shows that only 64% of staff had received mandatory training in the Mental Health Act. This had increased to 73% within two weeks of the inspection visit, but was still below the required level of 75%.

Mental Capacity Act and Deprivation of Liberty Safeguards

Assessments of whether or not a child or young person could consent to medical treatment took full account of the age of the patient. Staff documented competency assessments of young people under the age of 16 and capacity assessments of young people over the age of 16.

Staff we interviewed all understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to young people under 16.

Staff assessed and recorded consent and capacity or competence clearly for young people who might have impaired mental capacity or competence. Mental Capacity Act training was mandatory for all staff and 91% had received it within 12 months of our visit.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Safe and clean environment

- We found most ward areas to be clean, tidy and well kept, throughout the communal areas, patient bathrooms and bedrooms. Fixtures and fittings were well maintained. Staff carried out regular risk assessments of the ward environments, however the layout of some wards meant that blind spots existed and could only be mitigated by the presence of staff observing young people out on the wards. On Kennett ward, ward managers told us that the presence of convex mirrors to eliminate blind spots had been piloted, but had proved distressing for young people with eating disorders and been removed. Also on Kennet ward, leaves and debris had built up between window panes and Perspex safety covers. Staff told us that this was due to recent windy and wet conditions, and managers told us that an application was being made to English heritage to gain permission for the windows to be replaced.
- Each ward had a clinic room, which we found to be well ordered and clean. Staff kept appropriate records which showed regular checks took place to monitor the fridge temperatures for the safe storage of medicines. Emergency equipment and medicines were stored on the wards in the nurses' offices. On Severn ward, the resuscitation bag we checked contained items that were out of date, although records showed that they had been recently and regularly checked. The service audited all resuscitation bags on the site the same day as this was raised by the inspection team, and all out of date items were replaced.
- On all wards, nurses' stations had internal windows that were fully or partially obscured by perspex panels. Staff told us that this was to prevent young people from looking through and viewing other patient's confidential information, however it also prevented staff from easily seeing out and into the ward. Sufficient staff were present on the ward outside the office to ensure patient's safety, however we observed young people jumping up to look over the perspex and gain the attention of the staff. Managers agreed that it would be safer for staff to be able to see clearly out of the nursing stations and said the service was considering one way mirrored glass or adjusting the layout of the offices to prevent confidential information being viewed by young people via the windows.
- An automated external defibrillator and anaphylaxis pack was in place on each ward. The wards had access to an electrocardiogram (ECG) machine. An ECG is a test which measures the electrical activity of the heart to show whether it is working normally. The equipment was regularly checked to ensure it was in order. Staff told us that equipment such as weighing scales and the blood pressure machines were regularly calibrated and that the equipment was checked on a regular basis. None of the clinic rooms had an examination couch, if required doctors examined young people in their bedrooms.
- All wards had ligature "heat maps" that identified potential ligature anchor points around the wards. Ward managers again informed us that these risks were managed through one to one observations of young

people. A ligature anchor point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. All bathrooms and bedrooms were furnished with anti-ligature fittings, with the exception of Kennet ward where only three were completed and the rest were in progress. There had been incidents on Thames and Severn wards of young people tying ligatures without anchor points, using clothing or other material. This risk was managed through regular checks of higher risk areas like lounges, bathrooms and dining rooms, and through removing high risk items from bedrooms according to individual risk assessment. Staff had received training on managing ligature risks and staff were able to tell us where the high-risk ligature anchor points were and how these risks were mitigated and managed. The service had carried out ligature risk assessments using the provider's ligature audit tool on all wards within the preceding 12 months, with all wards assessed as posing a high risk of ligature due to poor lines of sight. Induction packs for new staff included clear guidance on how ligature risks were managed and how to report new risks. Staff had identified high-risk areas such as the bathrooms, lounge and dining rooms and ensured they regularly monitored these areas.

- All wards were registered to provide mixed sex accommodation, although Kennett ward was treating only female young people at the time of our inspection. Mixed sex accommodation protocols were in place to ensure that young people had appropriate access to bathroom, toilet and same sex communal areas. For example, on Severn ward, all young people were female at the time of our inspection, however staff would create single sex zones when male young people were admitted. The hospital policy on mixed sex accommodation included clear guidance for staff in supporting transgender young people. On Thames ward, concerns about gender segregation that we raised at our last inspection had been resolved through the use of single sex corridors and zoning of bedrooms when required.
- All staff carried personal alarms in order to summon help, and carried radios when leaving the wards, for example, to supervise young people in the outside areas of the hospital.
- CCTV was used across the site, and recorded for three months, to enable the investigation of incidents and allegations. The systems covering Kennet ward had recently been upgraded to a better system with high definition, and we saw on the estates improvement plan that this was due to be rolled out on the PICU wards next.
- Shortly prior to our visit, a patient detained on Severn ward had absconded from the hospital via a garden routinely used by young people from the PICU ward, while on one-to-one observations with a member of staff. The patient had been able to climb over a fence and leave the hospital grounds. This was the second incident of this type to have occurred within one month. Access to this garden had been immediately suspended, however young people could still get access to fresh air in other areas. A serious incident review meeting took place during the inspection, however a second review meeting and an external root cause analysis (RCA) was commissioned by the hospital in the weeks following the inspection. The outcome of this investigation was not available at the time of this report.

Safe staffing

- We reviewed staffing levels for all four wards for the six months leading up to the inspection, and found that staffing levels were consistently adequate to ensure safety of the wards. Ward managers told us that they were able to source staff from other wards to respond to urgent staffing needs, for example, short notice sickness or an increase in patient acuity that required enhanced staffing levels for individual young people.
- The service had a high number of vacancies for qualified staff across the site (26.25 whole time equivalent posts, and seven permanent appointments awaiting start dates), however only two qualified nurses had left their posts in the six months prior to the inspection, and only 11 staff in total had left their posts within six months of starting. The service had 26.6 whole time equivalent unqualified posts vacant, and had 22 new starters in the recruitment pipeline. Whilst agency use was high for qualified staff, ward managers and senior managers told us that the majority of agency staff were on long term contracts, with many having worked for the hospital for several years (up to 11 years, in one case.) These staff received the same induction and mandatory training as permanent employees, and we were told by young people, staff and managers that these staff performed at the same level as permanent staff. Long term contracted agency staff hours accounted for between 38% (on

Thames ward) and 53% (on Severn ward) of all nursing hours worked. Training data showed that compliance for mandatory training for long term agency staff was between 90% and 93% across the wards.

- The provider had taken steps to address the high nurse vacancy rate through targeted social media campaigns, recruitment bonuses, links to universities and an in-house training programme to support unqualified staff to undertake nursing training.
- The provider adhered to safer recruitment processes, and all newly recruited staff had enhanced disclosure and barring service (DBS checks). DBS checks were renewed every three years, and professional registrations for qualified staff members were checked monthly. We checked a sample of long term and ad hoc agency staff member files, and five permanent staff files. All contained references, evidence of identity and DBS checks. All contained evidence of mandatory training having been completed.
- Sickness rates varied across wards, but had mostly fallen over the six months prior to the inspection. On Tamar, sickness had dropped from 10% in December 2018 to 5% in May 2019. On Severn sickness had risen slightly from 7% to 9%, with an average of 6.5% through the period. On Thames sickness rates were consistently around 3%, and on Kennet had fallen from 8% to 6%.
- All staff told us there were sufficient staff to deliver care to a good standard and the staffing rotas indicated that there were always sufficient staff on duty. Staff and young people commented that when a high number of patients required enhanced observations, for example, two-to-one staffing, or a staff member within eyesight or arm's length, then staff had less time for other young people and this created staffing pressures. Ward managers told us that senior managers understood the needs of the wards and supported them to rota on additional staff members in advance of this occurring, and that staff were swapped across wards to meet the needs of young people.
- There was administrative support available in the hospital which included reception staff available during the day, ward clerks and medical secretaries. This meant clinical staff could spend more time in direct contact with young people.
- Staff were available to offer regular and frequent one-to-one support to young people. There were usually enough staff on each shift to facilitate young peoples' leave and for activities to be delivered. Staff and young people told us that activities were sometimes cancelled due to staffing issues, and understood this to be due to other young people needing enhanced observations rather than sickness or vacant posts. Young people told us they were offered and received a one-to-one session with a member of staff most days. Information from the young people's daily records showed that this was the case.
- The hospital had adequate medical cover over a 24 hour period, seven days a week. Out of office hours and at weekends, on-call doctors were available to respond to and attend the hospital in an emergency. Consultant psychiatrists were identified to provide cover during the regular consultant's leave or absence. Shortly after our visit a locum consultant left the hospital at short notice, and cover provided by another consultant whilst a replacement was found.
- Mandatory training was at 89%, with the majority of mandatory training levels at or above 88% (including child protection, safeguarding vulnerable adults levels two, three and , mental capacity act, deprivation of liberty safeguards, information governance, fire safety, equality and diversity, basic food hygiene, infection control, control of substances hazardous to health, medicines management, PRICE, serious incident san therapeutic observations). The exceptions were PREVENT (prevention of radicalisation)(66%) and search (54%). The provider had schedules in place to address these within the quarter.

Assessing and managing risk to young people and staff

- In six months prior to the inspection there had been 2,162 episodes of restraint, none in the prone position. Almost half of these were on the specialist eating disorder unit, Kennet ward, where every episode of nasogastric feeding was correctly recorded as an incident of restraint. The lowest number (87) occurred on Tamar ward. The hospital had committed to implementing a positive behaviour support approach to reducing incidents of restraint, which it found had risen significantly since the last inspection. Staff and managers were of the view that the increase reflected the increased complexity of the young people being admitted to the hospital.

Good

Child and adolescent mental health wards

- The hospital did not have a seclusion space, as a previous suite was decommissioned following a CQC visit. The hospital told us that staff used de-escalation, and when necessary would restrain young people in their bedrooms.
- Staff received training which included prevention and management of violence and aggression training, which included how to safely and appropriately use physical restraint. At the time of our inspection 84% of staff were trained in this approach, and staff who were yet to receive the training did not restrain young people. Staff practiced relational security to a high standard and staff actively promoted de-escalation techniques to avoid restraints where possible. Relational security is the way staff understand and use their positive relationships with young people to defuse, prevent and learn from conflict. We observed staff speaking gently and supportively to young people who were distressed and who needed to be restrained in order to receive nasogastric feeding.
- Risk assessments were completed for all young people on admission to hospital and followed the format in the electronic care record system. All 17 care records we reviewed contained up to date risk assessments with risks clearly identified and detailed risk management plans that included instructions for staff in how to prevent and respond to high risk incidents.
- The crisis and contingency section of the risk summary contained information that young people had contributed to and participated with the risk assessment and care planning process. We found that where possible these sections were written from the young person's perspective and in their own words, and young people we spoke with commented that permanent staff were good at remembering their individual ways of coping in and recovering from a crisis.
- Staff told us, where they identified particular risks, they safely managed these by putting in place relevant measures. On the PICU wards, it was frequently the case that young people were on one-to-one observations, and sometimes two to one or three to one if this was necessary. All newly admitted young people were nursed on a one to one basis with staff until risk assessed to reduce this level of observation.
- Since the last inspection, the service had undertaken considerable work to review and reduce restrictive practices, and blanket restrictions. This was monitored at senior level through a specific working group, and at ward level. The hospital had recently lifted a blanket restriction on young people having smartphones in the hospital, meaning that subject to individual risk assessments, young people could now access the internet and contact friends and relatives freely. The hospital required cameras within the phones to be disabled, to manage risks of sexual exploitation and to protect the privacy and dignity of other young people, and internet could only be accessed via the hospital network to prevent inappropriate material from being accessed. The hospital had held education sessions on cyber bullying and sexual safety, and managers told us that this work would be ongoing to support young people to stay safe online, in particular in relation to eating disorders. The usage of media and mobile phones was carefully managed via individual risk assessment and through the patient review meeting process, and reviewed on a daily basis on each ward via the morning multidisciplinary team meetings.
- The hospital had also lifted a restriction on young people viewing a popular tv streaming service on the hospital televisions, and were managing the young people's access to age appropriate content in line with individual risk assessments. The young people welcomed the lifting of these restrictions, although some fed back that they would like to have access to their cameras and to any films and television programmes they chose.
- Searches took place according to individual risk assessments only, usually on return from leave to ensure that high risk items were not brought onto the ward. All bedroom doors could be locked by young people from the inside, with override locks and anti-barricade fittings to ensure safety. All young people had access to a locker where they could keep personal items, and would have this restricted through individual risk assessment only. Blanket restrictions that remained in place had been well thought through and had a clear rationale. On Kennet, Severn and Thames wards, bathrooms were kept locked, which staff told us was due to the high risk of self harm. This policy was under review, in light of the new anti-ligature bathrooms providing a level of mitigation for this risk.
- All staff we spoke to understood that if young people were informal patients (i.e. not detained under the Mental Health Act) they were able to leave the wards. All informally admitted young people we spoke with

understood they could leave the wards should they wish to do so, provided they had parental consent or had been assessed as competent using the Gillick framework if they were aged under 16. There were notices by the ward entrance doors to confirm this, although young people did need to let a member of staff know that they were leaving.

- All of the staff we spoke with knew how to raise a safeguarding issue or concern. Staff said they completed an electronic incident form and they would inform the nurse in charge or the ward manager. All staff were aware of who the hospital safeguarding lead was and how to contact them. Ward managers were safeguarding leads at ward level, supported by a dedicated full time social work lead, and the head of nursing and quality. Safeguarding team contact details and flow charts of the safeguarding procedure were placed in all of the wards both in the nurses' office and also on the young people's notice boards. The social work lead had recently begun to hold safeguarding drop in clinics for staff on the wards to support their learning and understanding of safeguarding. Safeguarding children and adults training had been completed by 93% of staff.
- We reviewed 16 prescription charts, and found one error where medicine had been administered and not signed for. If young people had any allergies, these were listed on the front of the prescription chart. If any high dose antipsychotic medicine was prescribed, this was noted and physical health monitoring forms were included in the prescription charts. The medicines were stored securely in the clinic rooms. Daily checks were made of room and refrigerator temperatures to ensure that the medicines remained suitable for use. All medicines needed were available. The provider had a contract with a national pharmacy provider to manage medicines across the site, that included a pharmacist visiting each of the wards weekly and carrying out routine audits to ensure that staff were managing medicines safely.
- On Thames ward, we observed a member of staff disposing of non-controlled medicines that were no longer required without recording what had been disposed of. We spoke with the ward manager, reviewed the medication policy and the disposal records on the clinic room and were assured that this was likely an isolated incident. Also on Thames ward, we found that bins for the disposal of non-controlled medicine that was no longer required (through being out of date or no longer prescribed) had not been emptied for several months, despite a contract being in place with a national pharmacy to remove and dispose of these monthly. The new ward manager and the head of nursing and quality addressed this on the day that we raised it.
- Controlled drugs were stored and managed appropriately. On Tamar ward, we found that there was no index of controlled drugs included in the controlled drugs book, meaning although all controlled drugs and their administration were properly logged, there was no list readily to hand of all the controlled drugs being stored and administered on the ward.
- We looked at the ordering process and saw the process for giving young people their regular medicines. All medications checked were in date. There were good processes and procedures in place on the ward in relation to medication reconciliation. This is where the ward staff would contact general practitioners on admission, to confirm what medicines and dosages the patient was taking so that these medicines could continue while the patient was on the ward. This meant young people were provided with their prescribed medicines promptly.
- Care records showed and young people told us that staff gave young people good information about medicines. Staff discussed medicines in multidisciplinary care reviews. Prescription charts had patient consent forms and patient capacity and competence assessments readily available. All prescription charts included photographs of young people to ensure medication was administered to the right young person.
- Staff used clear protocols to support young people to see their family. Each request was risk assessed thoroughly to ensure a visit was in the young people's best interest.

Track record on safety

- The provider reported 12 serious incidents at the hospital between April 2018 and April 2019. The provider defined a serious incident as any event or occurrence that has led to moderate or severe harm or death, or harm for an extended period. Such incidents required investigation by the provider, who told us that the majority of these incidents related to absconscion whilst on escorted or unescorted leave, and self harm. The

provider told us that they had responded to incidents of young people absconding by improving physical security in the grounds of the hospital, improving risk assessment in advance of leave and improving communication with families to support safer management of leave. The provider told us that lessons learned from self harm incidents had resulted in personal searches being carried out after young people returned from leave, and reducing access to risk items on wards.

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew how to recognise and report incidents on the providers' electronic recording system. Incidents and lessons learnt from incidents were shared at the hospital's daily morning meeting which was attended by representatives from each ward and chaired by the head of nursing and quality. Ward managers would share lessons learned with ward based staff and the hospital also distributed "lessons learned" bulletins to all staff in the hospital. These bulletins were clearly displayed in nursing stations and we saw that they were discussed in handovers, however we were concerned that managers did not have a way of assuring themselves that all staff had reviewed and understood the lessons learned and could therefore apply them to their day to day practice.
- We reviewed two sets of minutes from monthly clinical governance meetings and found that they included discussions of incidents and any identified themes. The morning ward handover meetings and multi-disciplinary meeting we observed, also included discussion and debrief following incidents. The hospital had a dedicated member of staff who managed the electronic system for reporting and recording incidents, accidents and complaints.
- All staff we spoke with understood what kind of event should be treated as an incident or serious incident, and gave examples that included restraint, self-harm, verbal abuse and the use of rapid tranquilisation. Ward managers carried out regular drills for staff to practice responses to emergencies, including medical emergencies. All staff felt that teams were well supported with debriefs following incidents, and care records showed that young people were also debriefed and offered support.

Duty of candour

- The provided discharged their duty of candour, which and sets out specific requirements that providers must follow when things go wrong with young people's care and treatment. This included informing people about the incident, providing reasonable support, providing truthful information and an apology when things went wrong. We saw in incident records that all incidents had been discussed with young people and their parents.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- All care records we reviewed contained detailed and timely assessments for young people. Staff had assessed all young people for their current mental state and physical healthcare needs, and consistently used an admission checklist to ensure all assessment activity was carried out promptly. A routine blood test and electrocardiogram (ECG) were carried out for all new young people. An ECG is a test which measures the electrical activity of the heart to show whether or not it is working normally. The hospital had introduced the paediatric early warning system (PEWS) to assess young people' physical health, however on all four wards we found these were being used inconsistently, and not fully completed. This could place young people at risk of a physical health issue not being detected early and so not getting the appropriate treatment quickly.
- Care plans were holistic and included the views of young people, and we saw that they were regularly updated. The care plans were recovery focused. Young people told us that they were included in the planning of their care.
- All care plans were stored securely on the electronic recording system and were accessible.

Best practice in treatment and care

- Staff followed the National Institute for Health and Care Excellence (NICE) guidance, such as the guidance on 'depression in children and young people' and the

'identification and management, of young people when planning their treatment and care'. Medicines were prescribed in conjunction with psychological therapies such as individual therapy and family interventions. Young people being treated for anorexia nervosa received careful physical health monitoring and psycho-social interventions, in line with a specific "re-feeding" policy.

- Our observations of both ward rounds and multi-disciplinary team meetings showed the full range of professional disciplines had input into discussions around young people's care and treatment.
- Young people had access to a range of psychological therapies such as cognitive behaviour therapy, occupational therapy, drama and movement therapy, art therapy, canine-assisted therapy, eating disorder therapy, dialectical behavioural therapy, one to one sessions and group work. The therapies team were a strong presence on all wards, delivering between three and four hours of group work per week on each ward plus one-to-one psychosocial sessions. Groups included mindfulness and coping skills, and were carefully scheduled to fit around school time. Family therapy sessions were also offered, for example, to support parents to understand eating disorders and to support their child around meal times.
- The therapies team used a range of recognised outcome monitoring tools to measure young people's progress in treatments, namely EDE-Q, HoNOSCA and RCADS. The team were also undertaking a data mapping exercise to look at trends in frequency, timing and severity of incidents, and to look at how activity scheduling could reduce risk of incidents at key times of the wards.
- The hospital employed a physiotherapist, and was equipped with two gyms, both on the PICU wards and both unavailable at the time of the inspection as the equipment needed servicing. The hospital was considering the redevelopment of gym space in to a multi-purpose studio area.
- In the months leading up to the inspection, the provider had created four youth engagement worker posts, with a dedicated worker for each ward. The purpose of these posts was to provide age appropriate and recovery focussed activities for young people, with the overall aim of improving school attendance and recovery outcomes. The youth engagement workers organised activities including badminton, making bath bombs, and physical games for healthy exercise to replace daily walks around the hospital grounds.
- Staff assessed young people's nutrition and hydration needs, and developed care plans where necessary. All young people receiving nasogastric feeding had specific care plans to manage this, and we found food and fluid charts to be completed accurately.
- Staff were involved in local audits at ward level, for example, medicine and clinical equipment, as determined by the hospital's quality assurance framework. Ward managers, nurses and clinical team leads were involved in monthly clinical audits, which covered the key domains of the CQC regulations and fed into a quality improvement plan that was overseen by the monthly clinical governance meetings.
- Staff representatives from each ward, senior clinicians and managers attended the monthly clinical governance meeting and scrutinised clinical effectiveness. Areas looked at included models of care, quality of care records, physical health promotion, consent, audit and research.

Skilled staff to deliver care

- The staff across the wards came from various professional backgrounds, including medical, psychology, nursing, support work, occupational therapy, family therapy, eating disorder specialists, art therapy, dance and movement therapy, activity co-ordination, dietetics and education. A pharmacist visited the hospital weekly to audit medicine stock and processes.
- All staff received a thorough induction into the service, including temporary staff. The organisational induction included mandatory and specialist CAMHS modules. Ad hoc agency staff brought in at short notice were inducted to the ward by a senior member of staff according to a checklist, and were recruited from agencies with which the hospital had agreements in place to ensure a minimum level of training.
- The parent organisation had developed a CAMHS specific training pathway for qualified and unqualified staff, that included specialist training in working with young people with mental health problems. Senior managers had recently agreed a reciprocal partnership agreement with the local general hospital around joint clinical training, which would enable the hospital's

RMNs to receive training in physical health to the same standard as registered general nurses (RGNs). This was due to commence within three months of our inspection visit.

- Only 57% of staff has received training in positive behaviour support (PBS), as staff who had received as staff members who had received advanced training the previous year had left the organisation. This meant that positive behaviour support had not been effectively embedded at the hospital. This was clearly detailed as a priority on improvement plans for the service.
- Across the site, 79% of staff had received supervision within the required 42 days prior to the inspection. On Tamar ward, 90% of staff had received supervision within this time frame, with three overdue by less than 10 days. On Kennet, this figure was at 100%. On Thames ward, 61% of staff supervisions were in date, with 22 supervisions overdue. The longest a member of staff had been without supervision was 10 weeks, most were overdue by less than two weeks. On Severn, 64% of staff supervisions were in date, with 19 supervisions overdue, the longest by six weeks. Both Severn and Thames wards had recently had new ward managers start, who told us they were aware of the overdue supervisions and had plans in place to ensure staff were appropriately supervised. Managers provided us with up to date supervision data covering the month following our visit, which showed Severn Ward had increased to 67% and Thames to 89%, making 86.5% of staff supervision in date across the hospital. The hospital used an electronic tracking system to flag when supervisions were due or overdue.
- Staff we spoke with said they received individual and group supervision on a regular basis as well as an annual appraisal. Staff participated in regular reflective practice sessions where they were able to reflect on their practice and incidents that had occurred on the wards, and on ad hoc issues that affected the site either directly or indirectly, for example, to reflect on a high profile incident at another hospital of a young person taking their own life.
- Managers provided staff with annual appraisals, and the compliance rate was at 89% for all staff across the hospital. including non-ward staff. On Tamar and Kennet ward, compliance was at 100%had received an annual appraisal this was 100%. Appraisals included objectives that incorporated the providers' key values. The revalidation of all medical staff was up to date.
- Senior managers were well supported by the hospital human resources department and the wider organisation to implement disciplinary and capability procedures with individual staff when then need arose. Five members of staff were suspended and under investigation during the inspection period, and four were under enhanced supervision in response to allegations relating to safeguarding.

Multidisciplinary and inter-agency team work

- A fully integrated multidisciplinary team worked across the wards. We observed patient review meetings and staff handover meetings and found representatives from all disciplines to be active contributors.
- We observed interagency working taking place, with staff creating strong links with primary care and the local acute hospital being particularly positive examples.
- The service had a dedicated social work department that was responsible for liaising with local children's social care and teams from the young person's home area. The service accepted referrals nationally, which posed a challenge to building effective links with each individual area. However the social work department had developed systems to approach this most effectively, including building a directory of key contacts for each area they came into contact with.
- In response to the high volume of safeguarding referrals and concerns that the hospital managed, senior management had recently set up a local safeguarding board, chaired by the head of nursing. The safeguarding board had met twice and was attended by commissioners, the local authority designated officer (LADO) and the local general hospital. We reviewed minutes and terms of reference of this meeting and saw that it undertook to review all open cases for safeguarding that met local area thresholds, and included a professional forum to review and discuss strategies to keep young people safe. The meeting was also used for the LADO and other partners to ratify new policies and guidance for staff around safeguarding. The

hospital had identified high and increasing incidents of self harm among young people, and had asked the board to support a thematic review of self harm occurring whilst on enhanced observations by staff.

Adherence to the Mental Health Act and Code of Practice

- We carried out a detailed review of the use of the Mental Health Act on all four wards in November 2018. The provider was asked to provide an action statement in response to 14 areas of concern identified at that visit. Progress will be reviewed at our next mental health act review visit. Mental health act review visits are unannounced.
- In 2017, we served a requirement notice for a breach of Regulation 11, need for consent, of the Health and Social Care Act 2008 (Regulated Activities). We told the provider it must ensure that all staff understood the Mental Capacity Act and Gillick competence. This is when a patient under the legal age of consent is considered to be competent enough to consent to their own treatment rather than have their parents' consent. In addition the provider must ensure that Gillick competence is assessed for each patient less than 16 years of age and ensure that capacity is assessed for those over the age of 16. On this inspection we found that the provider had met this requirement notice; staff and managers we interviewed understood Gillick competence and assessed young people appropriately.
- At this inspection, the young people we asked had been given information about their rights on transfer/ admission to the ward and were aware of their rights and how they could exercise them. Some young people had obtained support from an advocate, who visited the wards regularly. Information about advocacy and how to access it was displayed on wards and in main areas and explained the difference in role between the general advocate and that of the independent mental health advocate (IMHA). Young people detained under the Mental Health Act are legally entitled to help and support from an IMHA.
- Staff had access to Mental Health Act administrative support and advice from specialist clinicians within the hospital.
- At the time of our inspection, 67% of staff had received mandatory training in the Mental Health Act. This had increased to 73% for all staff within two weeks of the visit. Managers told us that the low number was due to the previous module being a high level course delivered externally that did not meet the needs of the service. Shortly before our visit a new training module had been added to the online training programme with three levels that could be completed according to staff grades (basic, intermediate and advanced.) Managers told us that training compliance for the MHA would be at or above 90% within 6 to 8 weeks of the inspection.

Good practice in applying the Mental Capacity Act

- Assessments of whether or not a child or young person could consent to medical treatment took full account of the age of the patient. Staff documented competency assessments of young people under the age of 16 and capacity assessments of young people over the age of 16. Staff we interviewed all understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to young people under 16. Staff assessed and recorded consent and capacity or competence clearly for young people who might have impaired mental capacity or competence.

Are child and adolescent mental health wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- We observed positive interactions between staff and young people across all wards. We observed nursing and support staff spending most of their time out on the ward engaging young people and saw spontaneous activities taking place like painting and crafts.
- Young people mainly praised the attitude and behaviours of staff and managers, saying they were easy to talk to and understood them. Some young people complained that night staff could be noisy and inconsiderate and this prevented them from sleeping, and that some night staff were rougher when using restraints. The hospital had noted this feedback and we saw that it had been discussed at both the hospital safeguarding board meeting and clinical governance

meetings. To improve quality of care delivered by night staff there had been agreement to increase rotation of staff to ensure that night staff also worked with young people on day shifts, and staff bulletins about the risks of sleeping and the consequences of failing to safeguard young people was displayed on office notice boards. A cycle of out-of-hours spot checks by senior managers had been started. Senior management had also approached the issue of staff sleeping from a staff welfare perspective and agreed to provide welfare packs for night staff including snacks and hot drinks and reminded staff and managers of the importance of taking breaks, encouraging staff to be open and honest if they needed an additional break.

- Staff we interviewed spoke positively about the young people, using appropriate and non-stigmatising language, and showed compassion for their situation. Staff understood that behaviour that challenged or posed high levels of risk was generally a communication of unmet need, and was something that the staff should work supportively to address.
- On the PICU wards, staff were observed to be sat with young people on higher levels of observation without engaging them in activity or conversation. When we asked managers about this, they told us that this may be due a specific care plan for the young person (for example, to allow them space to calm down after an incident), or the preference of the young person. Staff also told us that school attendance was a high priority and so engaging and fun activities had to be carefully scheduled for young people aged 16 and under so as not to conflict with school time.

Involvement in care

- The hospital had worked hard in the period leading up to the inspection to improve parents' involvement in their children's treatment. Six-weekly family information days for each ward were facilitated by the therapies and social work teams, offering parents the opportunity to talk to staff from different disciplines and to ask questions about the service.
- Service user involvement meetings were held monthly, where young people could give feedback about the hospital and make requests, for example, changes to menus. Staff told us about specific activity that the therapies team supported, led by young people, to inform the management of meal support groups. Young people spent time teaching staff, through perspective taking exercises, what it felt like to have an eating disorder, and to understand the effect of staff words and actions around food.

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

Good

Access and discharge

- Staff planned and managed discharge well. Young people we spoke with knew what their discharge plans were and told us that delays were due to factors beyond the control of the hospital, for example, local care managers sourcing supported living placements in their home areas. Where discharge was delayed due to the lack of suitable alternative provision, the hospital worked closely with commissioners to try to address this. This was especially common on the PICU wards where some young people needed to move to a low secure hospital or a specialist service for young people with autistic spectrum disorder (ASD). We observed examples of the hospital working hard to support these young people and manage high levels of risk while a suitable placement was being sought, and the hospital worked closely with commissioners and other providers to minimise delays for young people. As a minimum, delayed transfers of care were reviewed weekly.
- The social work department liaised with the relevant children's social care teams from the young peoples' home areas to ensure appropriate information was shared at the start and end of treatment.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital had a variety of clinic rooms, therapy rooms, activity rooms and visitors rooms. Wards had an occupational therapy kitchen and both PICU wards had gyms, although these were out of use at the time of our inspection. There were lounges with sofas and televisions on each ward. The hospital had extensive grounds and ample outdoor space.

Good

Child and adolescent mental health wards

- The facilities on all wards could not always maximise privacy and dignity. On Kennet ward, five rooms were shared doubles, meaning that 10 young people shared a room with another patient. If one of the young people was on enhanced observations, this meant that both young people would have a member of staff in their bedroom for this period of time. Ward managers acknowledged that this was a concern, and said that in practice it was often possible to allocate the shared rooms according to young people's preferences, but not always.
- On Severn ward, newly fitted window viewing panels could not be controlled from the inside of young people' bedrooms. Ward managers told us this was an oversight and committed to have the adjustments made as soon as possible. Some PICU young people told us that there had been some occasions when all staff were supporting young people on high levels of observations, and they had to wait for someone to be available to unlock a bathroom for them to use the toilet. The locked PICU and eating disorder ward bathrooms was being reviewed by the restrictive practices oversight group.
- Staff facilitated young people's access to high quality education throughout their time on the wards. Ofsted had rated the hospital school as Good, and young people on the PICU wards could access education from dedicated rooms within the ward while they were too unwell to attend the main school. All teaching staff received specialist CAMHs training. Each pupil had a link teacher. Link teachers recorded the student's mental health functioning in education weekly using a recognised scoring system, which was shared with the multi-disciplinary team and discussed at patient review meetings. These scores were also transferred to young people's care programme approach (CPA) report along with the details of lessons they have attended and their learning outcomes. School staff told us that this system helped the MDT gain better insight to the young person was presenting in education which is often very different from how they present on the wards, for example, all staff we asked told us that incidents in the school were extremely rare. School staff worked hard to ensure that the hospital admission caused as little disruption as possible to young people's education, obtaining and transferring education records from other areas.
- Young people could make hot drinks and snacks at any time. Feedback about the food was mixed, and the hospital had committed to engage young people in the menu planning process.

Meeting the needs of all people who use the service

- The wards met the needs of all young people who used the service – including those with a protected characteristic. Staff helped young people with communication (for example, through British Sign Language), advocacy and cultural and spiritual support. The school had been accredited by Stonewall as a school's champion, for actively committing to target bullying of LGBTQ (lesbian, gay, bisexual, trans or questioning) young people, and celebrating diversity.

Listening to and learning from concerns and complaints

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service. We reviewed four complaints in detail and found the hospital had investigated thoroughly and been open and transparent where things had gone wrong. The hospital had employed a dedicated process improvement manager to lead on the management of complaints. In the reporting period leading to the inspection, the hospital had investigated 34 formal complaints, none of which had been referred to the health service ombudsman. Three had been fully upheld, 28 had been partially upheld. A further 15 were still under investigation.

Are child and adolescent mental health wards well-led?

Good

Leadership

- Several key senior clinical staff members had left the service in the months prior to the inspection, with cover provided by locums or permanent staff in acting up arrangements while permanent appointments were made. The number of temporary and locum arrangements posed a risk of key staff leaving at short notice and of a loss of continuity of leadership. The head

of nursing and quality had worked at the hospital for a number of years in a different senior role, and at the time of the inspection was on a temporary locum arrangement that had been planned to support the transition and induction of the new hospital director. Following a resignation, a new permanent medical director had been appointed from within the organisation and was due to start within three months, and an experienced consultant psychiatrist was providing acting up cover during the transition. Both qualified psychologists were locums on temporary contracts, one covering maternity and one providing cover until a permanent appointment started, also within weeks of the inspection. One PICU consultant finished their notice period shortly prior to the inspection, with cover provided by an associate specialist. The second PICU consultant was also a locum, who left at short notice in the days following our visit. We were assured, through discussion with senior managers and viewing staffing structures and rotas, that medical cover was at all times sufficient to ensure safe care, and ward staff we interviewed did not raise high staff turnover as a concern or something that impacted on their ability to care for young people

Vision and strategy

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for young people and staff. Ward staff told us they knew the senior leadership team and that they were a frequent presence on the wards, speaking with staff and young people and providing ad hoc advice and support around clinical issues.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff we spoke to understood the values of the organisation and the service, which were clearly displayed on service literature throughout the hospital. The organisational mission statement was "nurturing the world one at a time", and staff also cited "compassion in practice" and the "7 C's" (care, compassion, competence, communication, courage, commitment and culture).
- The hospital estate is a 13th century manor house, in some places listed by English Heritage, with no areas that were purpose built for a hospital. This posed challenges across all wards, including lines of sight and blind spots, which in some cases could only be mitigated through staffing supervision. The hospital had a three year environmental improvement work programme that detailed all the works required to improve and where possible modernise areas of the building, prioritised according to the impact on patient safety. The 2019 plan covered further improvements to bathrooms to make all Kennet ward bathrooms anti-ligature, dining room refurbishment which was in progress during our visit, and replacement of the ground floor PICU windows which were in poor condition. The plan also contained provision for smaller capital expenditure to cover furniture, soft furnishings and other operational needs. The plan was being overseen by the hospital director and a dedicated estates manager. Additional funding had been awarded by the parent organisation to improve the school. The service planned to develop projects with service users to decide how they would like the money to be spent on changing the school environment.

Culture

- The service invested well in the learning and development of staff, providing enhanced training opportunities and opportunities for career progression. The organisation had a dedicated CAMHS training and development pathway for both qualified and unqualified staff, and a preceptorship programme for newly qualified nurses. The pathways were new but well developed and included a structured induction, a workbook, blended face to face and e-learning, webinars and mentorship.
- We found good evidence of staff members being supported to progress their career within the organisation, including unqualified staff. Three members of the therapies team and a member of the quality and compliance teams that we interviewed had all begun as support workers and had been trained and developed within those roles before progressing. The hospital had one trainee nurse being supported through the "Growing our own" nursing programme, who was employed at the hospital whilst qualifying as a registered general nurse (RGN). The hospital had six of preceptor (newly qualified nurses) who were working through a six-month structured mentoring programme.

Governance

- Staff received their mandatory training to target (with the exception of three courses), supervision and appraisals. There were sufficient staff available on every shift in each ward to deliver good care to young people. The human resources systems allowed senior and ward managers to be alerted when supervisions or appraisals were overdue; where we found supervisions overdue there was generally a good reason and a clear plan to bring them up to date.
- Clinical audits were regularly carried out to ensure treatment and therapy was effective. Staff were confident that they learnt from incidents, complaints and patient suggestions and feedback.
- The hospital nasogastric feeding policy included essential guidance on refeeding syndrome, hypoglycaemia and electrolyte imbalance, all of which were important clinical risk considerations when treating young people with eating disorders. The hospital also had a policy to manage suicidality and extreme agitation. We would expect to see these policies in place, to guide staff on how to deal with medical and psychiatric emergencies that can occur in services providing treatment for young people with an eating disorder.
- Ward managers, senior clinicians and managers attended the monthly clinical governance meeting where they looked at patient safety, patient experience and staff management. We reviewed minutes that showed these meetings were well attended and that staff from across all disciplines contributed actively.
- A daily site operations meeting took place every day with representatives from each ward, management and support services. This meant all key staff were aware of the challenges, occurrences and developments facing the service on a day to day basis. This meeting was chaired by the head of nursing and quality, ensuring that the senior team were well connected to current risk issues facing staff on the wards.
- The hospital had begun improving its systems for engaging with parents, through family information days and beginning to develop an admission pack for parents. The service had not carried out a patient experience survey in the 12 months prior to the inspection, meaning they did not have a way of systematically collecting patient and carer feedback and analysing the results. The senior managers told us that this was due to the parent organisation renegotiating the process with the external company who carried out surveys on their behalf, and that they mitigated against this gap in their knowledge of patient experience through gathering and reviewing feedback through informal sources, including on-line reviews.
- The therapies team, social work team and senior members of the multidisciplinary team all told us that they had the autonomy to drive improvements within their own areas of work, and that they felt very well supported.
- We reviewed the strategic and operational risk register, and ward managers told us that they were able to submit items of risk for inclusion on the risk register. High risk entries on the risk register included recruitment and retention, ligature risks, young people absconding, self harm, and the increasing levels of acuity on the wards and the necessary increase of staffing levels that were needed in response.

Management of risk, issues and performance

- We reviewed clinical quality audits, human resource management data and data on incidents and complaints. The information was summarised and presented monthly in a key performance indicator dashboard, which allowed the management team to identify performance and quality issues and respond accordingly.
- The provider maintained a live risk register covering all types of risk, including risks to young people, which detailed control measures and assessed likelihood and severity. The parent organisation had a policy of connecting the group board to issues at ward level (known as ward to board assurance), through local clinical governance meetings feeding into a quality assurance group. This group also received information put from the organisational nurses forum, a long term segregation and seclusion committee and a health and safety committee. Information was gathered through a standardised quality audit framework based on regulations and best practice which is completed at local site level. The group used an early warning and escalation scorecard has been developed to give monthly feedback to senior leaders, which included quality and safety issues.
- The restrictive practices sub-forum was overseen by the clinical governance structure and focused on a site wide risk assessment that covered all known restrictions, ensuring that all restrictions were kept under continuous review at senior level

- Locally, hospital performance was monitored and managed using dashboards and reviewed at senior managers meetings attended by leaders from the wider organisation.

Information management

- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. The hospital used a number of dashboards to present real time and periodic performance reports.

Engagement

- Staff told us they felt respected, supported and valued by colleagues and managers. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- The hospital had recently developed a multi-faith room in a staff only area of the main building where staff could pray and meditate. In response to issues raised by staff about divisions within teams between staff from different cultural backgrounds, senior managers had commissioned an external organisation to explore and address this.
- In response to staff feedback, a staff welfare area had been created in a cabin-style building in the hospital grounds, in order to provide a space for staff to take breaks outside the ward environment. The senior leadership team had committed to adopt the Institute for Healthcare Excellence "Joy in Work" framework to prevent burnout in front line staff. This approach seeks to understand what motivates staff to do their jobs, identify barriers to delivering a good service, apply a systems approach and use quality improvement (QI) methodology to achieve positive change. The service had also begun a programme of training staff members as health and wellbeing coaches, including the opportunity to gain coaching qualifications, and training in mental health first aid, in order or promote health and wellbeing within the staff team. The hospital held weekly "wellbeing brunches" in the main dining room where staff were encouraged to meet and offer each-other informal collegiate support. Some staff told us that it was difficult to attend these sessions or make use of the welfare cabins, as the needs of the young people meant that they could not be released from the wards, however some used these initiatives as examples of how the organisation made them feel valued and supported.

Learning, continuous improvement and innovation

- Staff engaged actively in local and national activities to improve the quality of their services such being part of an accreditation scheme. Kennet ward carried out peer reviews as part of the Quality Network for Inpatient Child and Adolescent mental health services (QNIC) and was accredited. Severn and Thames ward had been assessed but reports were not yet published. All wards were registered with QNIC and followed the clinical audit cycle with self-review and peer review. QNIC was developed from the National Inpatient Child and Adolescent Psychiatry Study 2001.The network aims to demonstrate and improve the quality of inpatient child and adolescent psychiatric inpatient care through a system of review against the QNIC service standards.

Outstanding practice and areas for improvement

Outstanding practice

The provider had made substantial progress in the reduction of restrictive practices and blanket restrictions across the hospital. Young people were now able to have their smartphones and tablets during their stay, subject to individual risk assessment, and could access online movie streaming services. The restrictive practices sub-forum was overseen by the clinical governance structure and focused on a site wide risk assessment that covered all known restrictions, ensuring that all restrictions were kept under continuous review at senior level.

The provider had begun a number of initiatives to improve retention and morale of ward based staff, investing in welfare and career development. In response to staff feedback, a staff welfare area had been created in a cabin-style building in the hospital grounds, in order to provide a space for staff to take breaks outside the ward environment. The senior leadership team had committed to adopt the Institute for Healthcare Excellence "Joy in Work" framework to prevent burnout in front line staff. This approach seeks to understand what motivates staff to do their jobs, identify barriers to delivering a good service, apply a systems approach and use quality improvement (QI) methodology to achieve positive change. The service had also begun a programme of training staff members as health and wellbeing coaches, including the opportunity to gain coaching qualifications, and training in mental health first aid, in order or promote health and wellbeing within the staff team. The hospital held weekly "wellbeing brunches" in the main dining room where staff were encouraged to meet and offer each-other informal collegiate support.

The staff across the wards came from various professional backgrounds, including medical, psychology, nursing, support work, occupational therapy, canine assisted therapy, family therapy, eating disorder specialists, art therapy, dance and movement therapy, activity co-ordination, dietetics and education.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that training levels for all staff in the Mental Health Act exceeds 75%.
- The provider must ensure that the Paediatric Early Warning System (PEWS) is used correctly and consistently across the wards, to monitor changes to young people's physical health
- The provider must ensure that a positive behaviour support approach is embedded across the hospital, to enable an effective response to young people whose behaviour poses a challenge to the service.

Action the provider SHOULD take to improve

- The provider should ensure that staff can see through the internal windows of the nursing stations while maintaining confidentiality and ensuring good information governance practices.
- The provider should complete the work needed to ensure that all young people are able to control the vision panels in their bedroom windows, to enable them to protect their own privacy and dignity, and remove the loose stones in the outside area outside the ward to prevent them being used by unwell young people to harm themselves or others
- The provider should ensure that all staff are aware of the procedure for disposing of unused medicines.
- The provider should establish a system that ensures that managers are assured that lessons learned from incidents are read and understood by all staff.
- The provider should complete the work to ensure the fencing around the walled garden adjacent to the PICU basketball court is of appropriate height and design, to not allow young people to abscond from the hospital.
- The provider should continue the work to ensure that staff supervision takes place within the specified 42 day period consistently across all wards of the hospital.

Outstanding practice and areas for improvement

- The provider should actively review the use of shared bedrooms on Kennet ward, in light of the potential impact on patients' privacy, dignity and safety.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that training levels for all staff in the Mental Health Act exceeds 75%. The provider must ensure that the Paediatric Early Warning System (PEWS) is used correctly and consistently across the wards, to monitor changes to young people's physical health The provider must ensure that a positive behaviour support approach is embedded across the hospital, to enable an effective response to young people whose behaviour poses a challenge to the service.