Huntercombe Young People Ltd

Huntercombe Hospital Maidenhead

Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

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

Until 5 March 2021 the hospital was run by Huntercombe (No.12) Limited. It was rated inadequate and in special measures.

On 5 March 2021 Huntercombe Young People Ltd took over the running of the hospital. On 18 March 2021 we undertook an unannounced, focused inspection. This was the first inspection of the hospital under the new provider.

Following our inspection, our concerns about the quality of care remained. We therefore served the provider with a notice of decision under Section 31 of the Health and Social Care Act 2008, imposing a condition on their registration from 25 March 2021. The condition means that the provider must seek written permission from the Care Quality Commission before admitting or readmitting young people to Severn or Thames wards psychiatric intensive care wards (PICUs), and must not admit any more than 10 young people on each ward until further notice.

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

The provider did not have in place:

- robust governance and oversight of the review of care to ensure it was fit for purpose and any improvements to the quality of care for young people could be made;
- robust governance and oversight of the management of incidents, including safeguarding incidents;
- a holistic, proactive and preventative approach to care (such as positive behavioural support (PBS) in line with national best practice and guidelines);
- a least restrictive approach to care, in line with national best practice and guidelines;
- an approach to care on the PICUs that was in line with National Minimum Standards for PICUs.

The provider must become compliant with this regulation by 22 April 2021.

We did not rate the hospital following this inspection.

We found that Huntercombe Young People Ltd had made a number of improvements including, brightening up the environment on Severn ward, improving prescribing practices, reducing the use of intramuscular as required medication, carrying out appropriate capacity/competence assessments and regularly inviting parents/guardians to participate in patient review meetings.

Whilst clear progress had been made against some actions that we had identified previously and that were known to Huntercombe Young People Ltd, others had not been progressed.

Summary of findings

However, Huntercombe Young People Ltd recognised that significant improvements needed to be made and had put in place a new, strengthened, leadership team, some of whom had started on the day of the inspection. We found that they demonstrated a good understanding of the issues at the hospital and appeared to understand what they needed to do to address these in a timely manner.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Inspected but not rated	

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 18 years of age. The hospital delivers specialised clinical care for young people of all genders requiring inpatient CAMHS, including eating disorders.

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

The hospital consists of four wards:

• Kennet ward 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).

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

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

• diagnostic and screening procedures

• treatment of disease, disorder or injury.

Huntercombe Hospital Maidenhead had previously been inspected in November and December 2020 and was rated inadequate overall and placed into special measures.

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

What people who use the service say

We spoke with six young people and three relatives.

Five out of six young people we spoke with told us they felt they were now involved in their care. They were all aware of positive behavioural support plans but had mixed feelings regarding their usefulness and how staff utilised them. Young people we spoke with on Severn ward told us they appreciated having activities scheduled to occupy them.

Summary of this inspection

The relatives we spoke with gave mixed feedback about communication from the hospital. Some relatives told us that they had a really positive experience, that they felt totally involved in the care of their loved one and that they were kept updated about all aspects of care. Other relatives told us that they felt they had to fight for information all the time, particularly if there were any incidents. All of the relatives we spoke with told us that staff were kind, friendly and caring.

How we carried out this inspection

The team that inspected the hospital comprised the head of hospital inspection for the region, three inspectors, a Mental Health Act reviewer and two specialist advisors with experience of working in CAMHS.

As this was a focused inspection we did not rate the service as we only looked at some of the key lines of enquiry across the safe and well-led domains.

The inspection team carried out the following activities as part of the inspection process:

- Visited all four wards at the hospital to review the environment and observe how staff were caring for and interacting with young people
- Spoke with six young people
- Spoke with three relatives
- Spoke with the interim hospital director and the hospital director from another hospital provided by Huntercombe Young People Ltd who was supporting him
- Spoke with the head of nursing
- Spoke with 15 other staff including a team leader, support workers, senior support workers, a youth engagement practitioner, a doctor, a support worker manager and nurses
- Reviewed nine care records, 25 PBS plans and 17 medicines charts
- Reviewed consent to treatment paperwork for all 15 patients on the PICUs
- Observed an incident review meeting
- Reviewed Human Resource (HR) files for five permanent staff and 10 agency staff members

Looked at a range of policies, procedures and other documents relating to the running of the service.

Areas for improvement

Following this inspection, we served the provider with a notice of decision under Section 31 of the Health and Social Care Act 2008, imposing a condition on their registration. The condition requires that the provider must seek written permission from the Care Quality Commission before admitting or readmitting young people to Severn or Thames wards psychiatric intensive care wards (PICUs), and must not admit any more than 10 young people on each ward until further notice.

Preventing the admission or readmission of young people without written permission and limiting the number of young people that are able to be admitted to the Severn and Thames wards (until further notice) allows the provider an opportunity to review the care it delivers to young people and ensure it delivers care that takes a least restrictive, person centred, proactive and preventative approach that is in line with national best practice. It allows the provider to ensure there are enough staff deployed that are skilled and competent to deliver safe and effective care to young people. It allows the provider to ensure there is appropriate senior nursing leadership on the wards. Lower numbers allow the staff that are currently caring for the young people on the wards to focus on these young people's care without the added

Summary of this inspection

pressure of having to deal with new admissions or re-admissions. Care for an increased number of young people exposes them to a significantly increased risk of harm. In addition, it allows the provider the opportunity to consider its model of care on the wards and promote a positive culture whereby young people have active plans to prepare them to move to appropriate alternative care placements and mitigate the risk of young people being exposed to harm.

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

The provider did not have in place:

- robust governance and oversight of the review of care to ensure it was fit for purpose and any improvements to the quality of care for young people could be made;
- robust governance and oversight of the management of incidents, including safeguarding incidents;
- a holistic, proactive and preventative approach to care (such as positive behavioural support (PBS) in line with national best practice and guidelines);
- a least restrictive approach to care, in line with national best practice and guidelines;
- an approach to care on the PICUs that was in line with National Minimum Standards for PICUs.

We told the provider they must become compliant with this regulation by 22 April 2021.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Child and adolescent mental health wards

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Child and adolescent mental health wards safe?

Inspected but not rated

- On Thames and Tamar wards the floors and dining areas were very dirty and the paint was flaking on the walls. On Severn ward there was a section of the wall in the dining area that had been damaged, leaving the metal underneath exposed and the paint around it easy to pick off. This posed a risk to patients who may be looking for items to ingest. Staff were unable to tell us what had caused the damage. Managers assured us that this would be addressed. Some of the patients we spoke with also told us that hygiene and cleanliness on the wards needed to be improved.
- Staff did not always follow best practice with regards to safety in the clinic rooms. The expired medicines bin in the clinic room on Severn ward was full but not sealed, and the sharps bin in the clinic room on Tamar ward was full, which posed a risk of injury.
- Managers and staff told us that all young people at the service had what staff referred to as Positive Behaviour Support (PBS) plans in place. We reviewed 25 of these plans across all wards but found they were focused on managing specific aspects of risk behaviours rather than on describing a holistic, proactive and preventative person-centred approach that built on individual strengths and the development of new skills. This was not in line with nationally recognised best practice. Staff told us that PBS plans were regularly reviewed, however some of the plans we looked at had not been reviewed since they were initially written. In two instances staff were using plans which had been created in January 2021.
- Staff stored PBS plans for each patient in a file in the nursing office on each ward. Staff told us that they were required to sign that they had read the PBS plan for patients they were observing. However, the most recent signature on the signing sheet for some of the plans on Severn ward was dated two weeks prior to the inspection. Patients we spoke with told us they had been asked to contribute towards their PBS plans, and we saw evidence of this, but some patients told us staff did not read them.
- Staff were required to complete PBS e-learning training every three years. Training records showed that 91% of staff on Kennet ward, 86% of staff on Severn ward and 94% of staff on Thames and Tamar wards had completed this. However, staff we spoke with demonstrated a lack of understanding of PBS and how it can be used to enhance a patient's quality of life and support them to achieve their goals. Staff told us that the plans were useful for helping them to understand how to de-escalate challenging behaviour.
- Staff did not follow nationally recognised best practice to ensure that the least restrictive interventions were used. All 15 patients on the PICUs were on constant within eyesight or within arms' length observation from between one and four members of staff. Two patients were receiving hands on support from staff, where staff were holding their arms at all times. Despite this, between 5 and 16 March 2021, there were six incidents reported where young people on these wards had managed to self-harm or ingest foreign bodies.
- Staff assigned to carry out patient observations did not have the required knowledge or skills to do so. The provider's supportive engagement and observation policy states that all staff assigned to carry out patient observations should be assessed as competent to do so. However, records showed that only 45% of staff on Severn ward and 46% of staff on Thames ward had been assessed as competent. We reviewed observation records which showed that staff who had not completed their observation competencies had still been assigned to observe patients.

Inspected but not rated

Child and adolescent mental health wards

- There were two young people at the service who had been on a PICU for over a year with no clear plans for discharge. This was not in line with National Minimum Standards for Psychiatric Intensive Care Units for Young People (2015) which state that CAMHS PICUs are intended for short stays of up to six weeks. Therefore, young people were not receiving a proactive or strengths-based approach to their care and treatment and were at greater risk of restrictive interventions. Some of the parents we spoke with told us of the difficulties and frustrations they had experienced in trying to obtain updates about discharge plans.
- The approach to care was not continually reviewed to ensure that it was fit for purpose and improve the quality of care to meet all the needs of young people. Staff told us that observation rationales were reviewed daily, however as this was not recorded in care notes there was no evidence that these reviews were taking place.
- Staff did not keep up to date with mandatory training courses. For example, only 45% of staff on Severn ward, 70% on Tamar and Thames wards and 71% on Kennet ward were up to date with their managing medication training.
- We found three instances where treatment certification forms had been sent to the hospital from a second opinion appointed doctor (SOAD), but the form had not been passed to the relevant ward for inclusion in the relevant medication record.

However:

- Severn ward had recently been re-decorated and was observed to be bright and welcoming. Staff were in the process of setting up a sensory room on the ward.
- The service used systems and processes to safely prescribe, administer, record and store medicines. All of the medicines charts we reviewed showed that the appropriate legal authorisation was in place. We reviewed the medicines in the fridge and cupboard on Tamar ward; all were in date.
- The use of intramuscular as required medication had reduced.
- Staff we spoke with on Kennet ward were able to give examples of times when they had supported patients to take risks in order to achieve self-identified goals.
- Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence. We reviewed consent to treatment paperwork for all 15 patients on the PICUs and found that all patients had up to date capacity/competence assessments relevant to their age. However, on Thames ward documentation around why patients had been assessed as lacking capacity could have been clearer.
- Responsible clinicans clearly documented discussions with young people around their medication. Some of the relatives we spoke with also told us they were kept updated regarding any changes to medication, including minor changes.
- We reviewed HR files for five permanent staff members and 10 agency staff members and found that they all had a Disclosure and Barring Service (DBS) check in place.

Are Child and adolescent mental health wards well-led?

Inspected but not rated

- Governance processes did not operate effectively. Managers told us that meetings frequently took place to discuss and agree improvements, but this information did not filter down to the staff working on the wards who were unaware of these meetings and any required improvements as a result of the meetings.
- The provider had not implemented an effective approach to ensure the implementation of a PBS approach across the hospital. Staff had been supported to create what they thought were PBS plans but these focused on dealing with specific risks rather than describing a proactive and preventative approach to care.
- The service did not have effective processes in place to ensure that lessons learned from incidents were identified and shared with staff. We reviewed how incidents were reported and monitored and found that although incidents were

reported through an incident reporting system, the systems and processes for reviewing incidents lacked a robust structure. The new leadership team confirmed that the governance and oversight needed addressing. We observed an incident review meeting; the purpose of the meeting was to review incidents from the previous day and ensure appropriate action had been taken. Some attendees appeared to lack an understanding of the purpose of this meeting and did not present information succinctly. Although we were told that another meeting was held to review themes, trends and identify learning, the 15 staff we spoke with told us that they did not receive feedback after reporting an incident and lessons from incidents were not shared with staff at ward level and across the hospital. Some staff we spoke with lacked understanding of how lessons learned from incidents on other wards would be relevant to them.

- At the time of the inspection there were 24 open safeguarding incidents that had not been resolved. Prior to the inspection we spoke with safeguarding leads from NHSE/I and the local authority who expressed concern about how robustly safeguarding incidents were managed. Practice was not in line with the provider's own policy/national best practice. This meant that incidents, including safeguarding incidents, were not being monitored and managed adequately and there was a risk that the service did not have a robust system to identify and assess risks to the health, safety and/or welfare of the young people receiving care.

However:

- A new interim hospital director commenced in post on the day of the inspection. The interim hospital director was an experienced registered manager and was being supported by a hospital director from another CAMHS hospital owned by the provider. The directors demonstrated a clear understanding of the problems at the service and told us how they planned to address them. They planned to involve staff and young people in creating an action plan and driving forward the improvements needed. They recognised that a change in culture was needed to ensure that improvements made would be sustained.
- Leaders told us that they felt well supported by the executive team at Huntercombe Young People Limited and that they were committed to providing the resources needed to ensure improvements were made at the hospital.
- The head of nursing was very visible within the service and young people felt he was approachable. Staff we spoke with told us he attended the wards every day and offered them a lot of support.
- An experienced senior nurse had recently been appointed to improve nursing practice on the wards, focusing on the PICUs to begin with.
- Staff told us they generally felt supported by the leadership team and that they were a positive presence on the wards, including on weekends.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	S12 Notice of Decision to vary a condition of registration **The provider was failing to comply with Regulation 12, (1), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	S29 Warning Notice **The provider was failing to comply with Regulation 17, (1), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**