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Tier 4
Child & Adolescent Mental Health Service Review Report

Provider: Huntercombe Cotswold Spa CAMHS

Date of Review: 14th June 2018

Review Undertaken By:
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Sophie Carter CAMHS Case Manager,
Theresa Mugwagwa, Supplier Manager
all from NHSE West Midlands.

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1. Introduction

The purpose of this report is to formally report back to providers about the recent service review which was undertaken by NHS England Midlands and East (INSERT HUB). The review considered how the provider's service(s) are performing against NHS England Contract quality requirements as described within the INSERT YEAR NHS Standard Contract for Specialised Mental Health Services.

In addition, the review seeks assurance that the service is meeting or has appropriate action plans in place to meet QNIC and CQC Standards, is working to the least restrictive model with robust care pathways to meet the needs of Young People and is able to demonstrate positive outcomes for this patient group within a safe and therapeutic environment.

2. Background

Huntercombe Cotswold Spa is an inpatient Eating Disorder service which has designated provision for both adolescents and young adults. The focus of the visit on the 14th June was on camhs provision. The site which is situated in Worcestershire takes patients referred from the West Midlands and also some out of area patients.
The service has CAMHS provision on a separate floor of the building to Adult provision.
This was a planned annual visit and not in the context of any concerns.

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3. Overview of Findings

Below is a summary overview of the findings of the service review. Details of the findings are provided on the following pages of this report and an Action Plan which identifies areas for improvement can be found at Appendix A

Overall Ratings per Service Area	RAG
Pre Admission Documentation	
Care Planning Process	
MDT Care Planning and CPA process	
Physical Health	
Eating Disorder (only relevant if unit accept eating disorder young people wither primary or secondary)	
Clinical MDT Entries	
Risk Assessment	
Legal Issues	
Education	
Enhanced observations; seclusion; segregation and restraint	
Serious Incidents	
Safeguarding	
Staffing	
QNIC Registration, Service Spec Compliance & CQC Findings	
Environment	
Advocacy	
Young person feedback / Staff feedback	
Transition	

Green **– Compliant** Amber **– Partly compliant** Red **– Not compliant**

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Audit Items	Service Expectations	RAG	Case Manager Comments	Providers Comment
Pre Admission Documentation	• Referral/admission process/is there a form 1 and 2 • Pre-admission assessment • Initial MDT treatment plan and risk assessment • Looked After Children nurses informed of all LAC admissions – all staff aware of process • Consent Forms / MHA Papers • Information pack sent out to young people / parent prior to admission and web link available		No concerns regarding the process. Referrer dialogue pre-admission is encouraged and service appears responsive to enquiries. The service has a clear entry criterion which focusses on patients with some level of motivation and insight into the nature of their difficulties. Therefore in usual circumstances, patients detained under the MHA or requiring NG feeding under restraint would not usually be considered.	
Care Planning Process	• Evidence of young people / carer involvement and agreeing to care plan		Care plans show good evidence of young peoples and	

	• Copy given to young person • HONOS-CA (for CAMHS) / SDQ/ CGAS • What care plans are available? • Do the care plans relate to the risk assessment • Evidence of liaison with locality teams (CPA invites /Tier 3 updates attendance recorded/ • Key worker / care coordinator allocated • Evidence of liaison with family/nearest relative/Next of Kin • Evidence of clinical outcomes and discharge planning • How much leave is the patient having and is it linked to a discharge plan • Evidence of individualised care plan • Evidence of review in line with changing need • Cultural / Religious needs have been identified		parent/carer involvement. There was good correlation between the assessed needs, risk assessments, care plans etc. Very good examples also seen of SMART objectives being set. Good documented and verbal evidence of parent/carer liaison. Patients have appropriate access to leave – team to ensure leave process is followed as per contract if this will exceed the 5 nights. All efforts made to meet individual, cultural and religious needs.	

Audit Items	Expectations	RAG	Case Manager Comments	Providers Comment

MDT Care Planning & CPA process	• What care plans are available • Needs and outcomes clearly identified • Evidence of young person / carer engagement • Evidence of team member input • Evidence of timely review by MDT, including ward round • Is there evidence that the young person is engaging in at least 25 hours of therapeutic activities per week? List details of interventions/activities • What plans are in place if the young person refuses to engage? • Evidence of young person /carer invite/attendance at clinical meetings i.e. ward round/CPA • CPA documentation – when was the last CPA/has there been a date set for the next CPA • Evidence of reports from all disciplines feeding into the CPA process		Good examples seen of full MDT involvement in the care planning process. Individual staff spoken with felt valued by the MDT and that there views and imput was taken on board. Good range of educational and vocational activities. One or two young people felt weekends and bank holidays there wasn't much to do.	
Physical	• Young person's physical health needs are under continual review		Physical health care plans clear	

Health	and addressed as part of a care plan • Access to a healthy /balanced diet and choice of meals • Access to GP • Support with weight management and managing activity levels – access to exercise groups / equipment • Access to chiropodist / hairdresser/dentist/optician as appropriate • Access to smoking cessation / diabetes/ alcohol & drug abuse services / clinics		and comprehensive. As an ED unit, there was reasonable choice. Yes. Yes – as required.	.
Eating Disorder	• Behaviours (ie exercise, vomiting,			

(only relevant if unit accept eating disorder young people wither primary or secondary)	meal supervision) • Addressing anorexic / bulimic cognitions i.e. do they run any groups on challenging anorexic thinking, motivational enhancement therapy (MET), psycho-education group? • Meal planning (involvement of dietician, management of re-feeding) • Do the nurses get involved in meal plan changes? • Do the young people with an ED eat separately? • Are young people encouraged to prepare food themselves as they progress through programme? • How is EBW (expected body weight) calculated? • Medical monitoring? Do they follow the Junior MARSIPAN? Does the unit have the resources to do bloods, ECG, blood glucose and BP monitoring? Outcomes- are they monitored and how? • Access to therapy – what is available to the young people/carer? What training do staff receive - do		There are a number of individual and group sessions to address these issues. Nurses felt they could be involved in this if appropriate. Young people can generally choose where they sit and more/less support can be given by staff as required. Centiles are used. Junior Marsipan is used. Family Therapy, Psychological interventions – individual and group programmes.	

	they tap into any of the specialist ED units • Use of their day programme for local people and its effectiveness. Is it ever used as a step up to avoid hospital or always as a step down transition? involvement - any specific ED liaison / input locally i.e. BEAT		Staff feel their training needs are well supported. Wider ED services across the Huntercombe Group. Links with wider network and local presence inc appearance on national Radio programme to raise ED awareness.	
Clinical MDT	• Entries should be reflective of			

Entries	young person pathway and relate to care plans • Entries should reflect young person's views of their care • Entries should have dates, times, signatures, designation of author and printed names for each entry • Entries by all disciplines in one contemporaneous record • Evidence of regular contact with named nurse/keyworker • Evidence of contact with all disciplines i.e how often is the patient seen by his/her doctor? • Reflect meaningful treatment and engagement in activities • What paperwork is used for staff handovers • How are changes from staff handovers and wards rounds cascaded to staff; patients/carers • How are concerns about changes in patients' presentations: - documented cascaded to staff/patient		Good link between clinical entries and assessed needs. Entries clear, contemporaneous and professional. All disciplines contribute to clinical entries. Young people felt that the team, including their named nurses were available, accessible and supportive. Young people who have had previous hospital admissions elsewhere commented that this Hospital "gets them" and feel individually understood and hence more optimistic about their prognosis and recovery. Handovers are comprehensive. Good examples seen of task allocations at handover. Written log of this makes it easy to audit.	
Risk assessment	• Evidenced based tools being			

	used • Risk areas identified clearly • Evidence of risk assessment and management strategies • Males and Females have separate access corridors?		There are not separate corridors due to the current patient mix and patient profile. Designated rooms can be for male patients and staff would be in that area when patients are present. All rooms are en-suite and single.	
Legal issues	• Prison/immigration transfers • Section papers • SOADS • Rights read • Access to external representation		No concerns	

Education	• OFSTED registration status • Evidence of communication with mainstream schools • SEN Statement of Education/EHCP		Access to regular education and good links maintained with home schools.	
Enhanced observations; seclusion; segregation and restraint	• How many young people are on enhanced observations? • Do they each have an associated care plan? • Evidence of meaningful comments on the observations sheet • Reviewed in line with the organisation's policy and reduced to the minimum at the earliest opportunity • How many incidents of seclusion in past 6 months? • Are the seclusion records/reviews accurate and recorded in the agreed format as per hospital policy? • Are there any patients currently in long term segregation or nursed separately from their peer group? Is there an associated care plan and policy being adhered to? • How many incidents of restraint		None currently on enhanced observations. Not seen at this visit. None – service does not utilise seclusion. None. No full restraint.	

	in the last 6 months? • Is there a detailed record including reasons for, length of, and method by which he/she was restrained?			
SUI's	• Overview of incidents at service, how many in previous 6 months/are there any themes? • Does the risk assessment and care plans reflect the SI? • Follow SIRI policy. Follow the SCG additional guidance on SIRI's. • Compliance against action plans • Evidence of lessons learned		SI's are very few/far between. Service demonstrates good understanding of what may constitute an SI and staff are encouraged to report anything of concern. Cotswold Spa receive lessons learned bulletins from wider across THG.	

Safeguarding	• Clear and accessible policies and procedures, flow chart visible on the unit. • Named safeguarding leads for local area • Evidence of safeguarding training • Discussion with staff about: their understanding of what constitutes a safeguarding concern Do staff know how/who to report to and how it is managed		Safeguarding leads identified. Not seen today but advised that all staff receive the appropriate level of training. Staff demonstrated good knowledge of who and how to report a concern.	
Staffing	• Skill mix. • The staff - patient ratios, • Is it clear who is undertaking each role on the ward e.g. security nurse, nurses allocated to enhanced observations etc.? • Is there a shift plan taking into account the patient's needs?		2 Nurses and 4 HCAs during day time reduces to 1 nurse and 3 HCA at night. No agency staff used currently. Low staff turnover. Shift plan/task allocator seen.	

	• Vacancies & how this is being managed • What is the current sickness level and how much of this is work related? • Annual appraisals have been carried out • Supervision, training, development - for permanent - and bank/agency staff • Base line matrix checked against the duty rota of any shift. • added to section on SIs • Staff aware how to raise concerns • Staff aware of how to manage concerns/complaints for patient/carer • Induction process for: - permanent staff - bank/agency staff • Approved for facilitating student placements • All staff have had DBS checks		A couple of vacancies are being filled and in recruitment process. The service also has student nurses and good links with the local University. Yes There is a wider THG CAMHS induction programme. No wider concerns regarding staffing. Staff we spoke with appeared happy, well-motivated and enjoyed working at Cotswold Spa with some travelling a considerable distance to work there. Good evidence of staff progression and a new Nurse Specialist post alongside the Ward Manager post.	

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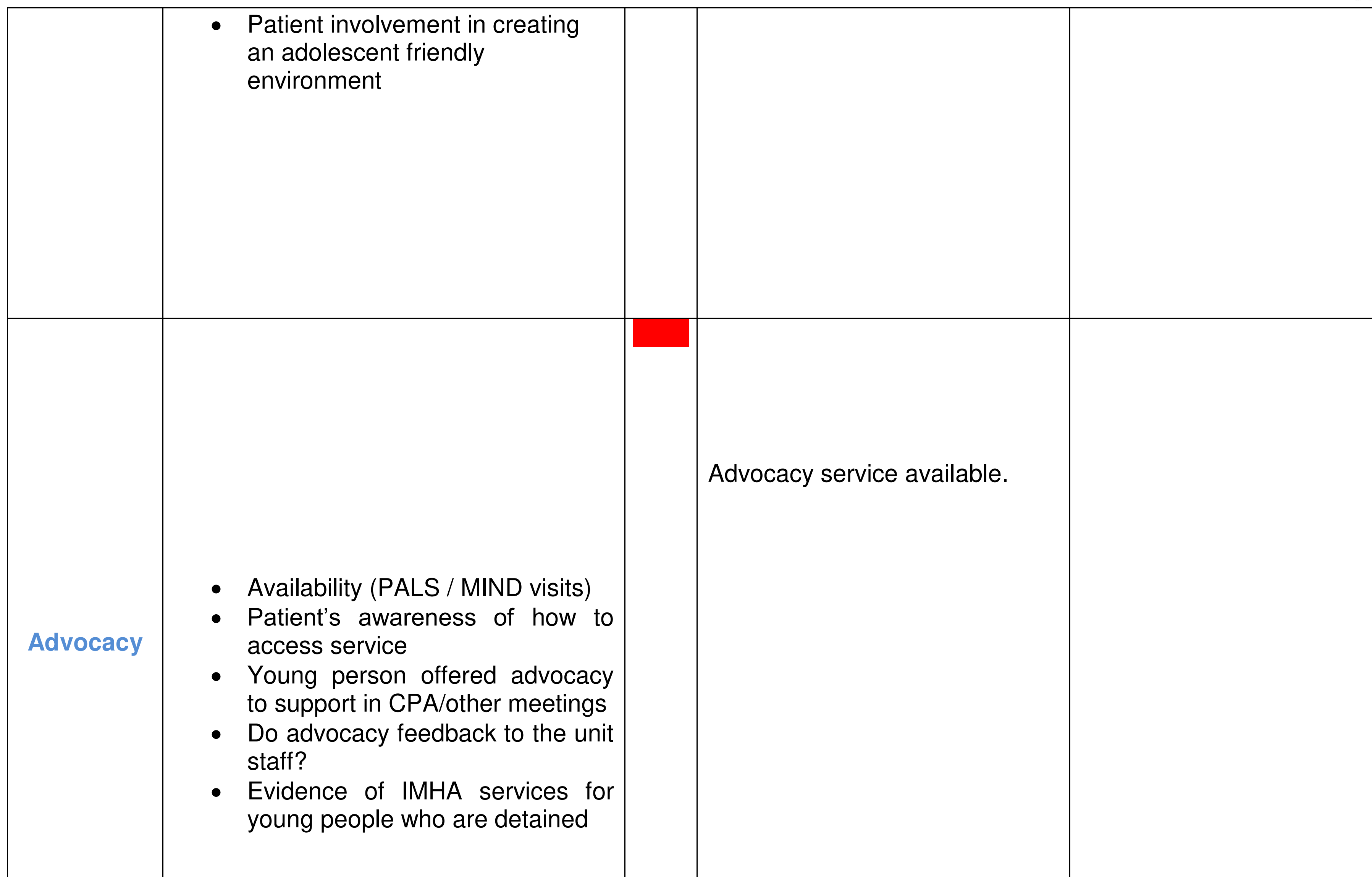
Audit Items Provider has	**Expectations**	**RAG**	**Case Manager Comments**	**Providers Comment**
QNIC registered and Service Specification Compliant.	• Registration with QNIC confirmed and any recent visits shared and reports/outcomes discussed. • Been assessed against various elements of the service specification and remains compliant. • Ligature compliance (if appropriate)		Risk assessed and it is possible there may be some risk points however patient profile is carefully assessed when referral is received and kept under review from point of admission. Cotswold Spa is not a service that would admit detained patients or patients with a high level of known deliberate self- harm.	

Environment	• Noise • Light • Heat • Furniture • Space • Staff's attitude on approach (welcoming, friendly, avoidant…) • Cleanliness • Potential impact on care pathway • Staff's attitude with patients/carers • Specific visiting areas • Storing of confidential information		The environment is clear, tidy and welcoming. Young people commented that on admission, they were pleasantly surprised to find it did not really resemble "a hospital". The dining area is bright and well designed (with involvement in young people). Staff from the reception area, the cleaning staff, admin staff and the clinical team were all polite, friendly and welcoming.	



	• Patient involvement in creating an adolescent friendly environment			
Advocacy	• Availability (PALS / MIND visits) • Patient's awareness of how to access service • Young person offered advocacy to support in CPA/other meetings • Do advocacy feedback to the unit staff? • Evidence of IMHA services for young people who are detained		Advocacy service available.	

Young person feedback *If the patients are in agreement to meet with the case manager; this should be facilitated.* *Ask if the patient is happy to speak to*	• Does the young person know why they are in hospital and are they happy with his/her current placement? • Does he/she have any issues of concern? • Does he/she feel safe on the ward? • Does he/she have regular access to advocacy? • Is he/she able to see family or friends on a regular basis? (If so, how is this facilitated?) • Is he/she clear about his/her care plans and do they have a copy? • What is his/her view of his/her care pathway? • Does he/she know who his/her named nurse is?		Young people spoke very positively of the service. They felt listened to as individuals and they felt well supported by the staff team. Young people felt safe and well cared for. Family contact is maintained. Distance is an issue for a few. Young people had access to care plans and felt involved in them. Young people spoken with felt they were making progress in	

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you and do they want an advocate or anyone with them?	• Does he/she know other members of the MDT and how often he/she sees them? • Does he/she attend the ward round? If so, is he/she able to access an advocate for support, if desired? • Does he/she have enough to do each day and does he/she have a planner? • Are the activities available interesting and relevant? • Any other issues the patient wishes to raise should be noted.		their treatment. Young people met with members of the MDT regularly. They attend weekly ward rounds also. Some young people wanted more activities evenings and weekends.	
Staff feedback	• How long has the member of staff known [select a patient] the patient? • Does the staff member have a clear understanding of the patients needs? • Are they aware of issues identified in the care plans? • Do they have an understanding of the patient's risks? • Can the member of staff describe the levels of observations available in the hospital and is he/she aware of the level of		Staff spoken with had a very good knowledge of the patients in their care.	

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	observation relating to the patient being reviewed? • How would he/she feed into the MDT/care plan any concerns he/she may have about a patient? • Is he/she aware of his/her responsibilities with regard to the care of patients? • With whom would he/she raise concerns about the quality of care on the ward? • How often does staffs receive supervision/opportunities for training/reflective practice? • Do staff feel safe on the ward?		Staff morale appeared good and there was a genuine sense that staff enjoy coming to work at Huntercombe Cotswold Spa.	

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Audit Items	Expectations	RAG	Case Manager Comments	Providers Comment
Additional Comments	• As part of the review further matters or concerns may have been observed and require further inspection and/or need to be passed onto line management/other agencies e.g. CQC. • Urgent actions noted in report highlighted/discussed		There were no significant concerns noted. There were several areas of very good practice including communication passports for all, shift handovers and task allocations. Care plans being SMART are also to be commended. Parents spoken to were very positive about their experience of the service. Communication and involvement were said to be excellent and many felt the service had been a "lifeline" both to them and their child.	
Transition	• Evidence of transition process being adhered to		Transition can occur within the Provider due to the nature of the service and the environmental layout (CAMHS and Adult on different floors with no planned unsupervised contact between the two provisions).	
Date completed:	Case Manager: Tina Ward 17/07/18	Case Manager Signature:		Provider Signature:

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Optional provider action plan can be added in response to this review