Oak Tree Forest Limited

Ellern Mede Derby

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We rated it as good because:

- The service provided safe care. The service had enough nursing and medical staff, but not enough permanent healthcare assistants to meet the needs of young people. The ward environments were safe and clean. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Most 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 and best practice. The service provided young people with opportunities for regular exercise and activities. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to a range of specialists required to meet the needs of young people on the ward. Managers ensured that most staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. Young people attended multidisciplinary meetings and had a voice in their care.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. The service 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.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly. The service had developed leaflets and communications aimed at young people and parents and carers.

However:

- The hospital had high healthcare assistant vacancy rates and a reliance on temporary agency staff.
- Not all staff were up to date with mandatory training topics. Three of the mandatory training topics fell below the service target rate of 90%: Immediate life support and fire compliance both 82% and manual handling 89%.
- One care plan for managing restrictive interventions during mealtimes and refeeding did not include young peoples' wishes.
- Not all staff had received regular supervision with a 77% compliance, the service target rate was 90%.
- Some front-line staff told us they felt levels of distress when restraining young people during mealtimes/ refeeding which impacted their wellbeing and staff morale.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Good 	• The service provided safe care. The service had enough nursing and medical staff, but not enough permanent healthcare assistants to meet the needs of young people. The ward environments were safe and clean. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding. • Most 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 and best practice. The service provided young people with opportunities for regular exercise and activities. Staff engaged in clinical audit to evaluate the quality of care they provided. • The ward teams included or had access to a range of specialists required to meet the needs of young people on the ward. Managers ensured that most staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. Young people attended multidisciplinary meetings and had a voice in their care. • Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. The service 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.

Summary of findings

- The service was well led, and the governance processes ensured that ward procedures ran smoothly. The service had developed leaflets and communications aimed at young people and parents and carers.

However:

- The hospital had high healthcare assistant vacancy rates and a reliance on temporary agency staff.
- Not all staff were up to date with mandatory training topics. Three of the mandatory training topics fell below the service target rate of 90%: Immediate life support and fire compliance both 82% and manual handling 89%.
- One care plan for managing restrictive interventions during mealtimes and refeeding did not include young peoples' wishes.
- Not all staff had received regular supervision with a 77% compliance, the service target rate were 90%.
- Some front-line staff told us they felt levels of distress when restraining young people during mealtimes/ refeeding which impacted their wellbeing and staff morale.

Summary of findings

Contents

Summary of this inspection

Background to Ellern Mede Derby

The hospital opened in July 2022. We undertook this unannounced comprehensive inspection as part of our ongoing monitoring and inspection of registered services.

Ellern Mede Derby is a hospital run by Oak Tree Forest Limited. The service provides eating disorder inpatient services for children and young people aged 8– 25 years. This hospital is for children and young people of all genders. The hospital offers 17 inpatient beds across two units Derwent ward and Trent ward. Derwent ward on the ground floor for young people aged 8 to 18 years. Trent ward is currently closed, on the first floor and is for 18 to 25-year olds.

At the time of inspection, there were five young people aged between 14 and 17 years admitted to Derwent ward. The hospital has an on-site school to provide children and young people with an education during their admission.

The hospital had a manager registered with the CQC in post at the time of the inspection. The hospital is registered by the CQC 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.

The service was registered in July 2022, this is the first comprehensive inspection. The main service provided by this hospital is a specialist eating disorder service for children and adolescent mental health services.

What people who use the service say

We spoke with five young people. They told us there were too many agency staff and did not feel comfortable and could not relate to them. Young people felt respected and supported by permanent staff. They said the advocate helped them and enjoyed sessions with the activity coordinator. They told us they liked baking, board games, artwork and dancing to music on YouTube. One person liked crocheting for a short period. Another person said they felt safe on the ward, but not in their head. One young person said everyone gets on, I am making progress here. I wish they would take community meetings more seriously.

One young person said they were restrained regularly, understood why and felt it was always done properly but still did not like it. Another person said too many staff were in the room at refeed times and restraint sometimes hurt and felt this could be improved.

How we carried out this inspection

The team that inspected this service consisted of one CQC inspector, a CQC inspection manager, a specialist advisor nurse practitioner and expert by experience who had experience working within children and adolescent eating disorder services.

This was a comprehensive inspection; we inspected against elements of the following Key Lines of Enquiry:

- Is it safe?

Summary of this inspection

- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

During the inspection visit, the inspection team:

- inspected Derwent ward, looked at the quality of the premises environment and observed how staff were caring for young people
- reviewed four young people's care plans
- reviewed four young people's risk assessments
- reviewed five prescription charts
- spoke with five young people who were using the service
- spoke with four young people's families and carers
- spoke with 20 staff including, registered manager, ward managers, consultant psychiatrist, junior doctor, nurses, senior healthcare assistant, healthcare assistant's, activity coordinator, dietician, social worker, psychologist, assistant psychologist, head teacher, teacher, chef, cleaners and administrators
- interviewed remotely independent mental health advocate
- reviewed staff rosters
- observed morning meeting, staff multidisciplinary team meetings, children in need meeting, staff training session
- looked at a range of policies, procedures and other documents relating to the running of the service.

Areas for improvement

The provider must ensure care plans are fully complete and include young people's wishes around restraint during mealtimes / refeeding.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Good	Requires Improvement	Good	Good	Good	Good
Overall	Good	Requires Improvement	Good	Good	Good	Good

Specialist eating disorder services

Good

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

Is the service safe?

Good

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could not observe children and young people in all parts of the wards due to the layout of the buildings. However, young people were supported with daily enhanced observations. Closed-circuit television camera monitoring was present with an overview of the communal and corridor areas. The service had curved mirrors placed around the ward to assist staff with young people's observations. Some young people required high level observations to help keep them safe. Staff completed young people's observations which were later reviewed and signed off by managers.

The ward complied with guidance and there was no mixed sex accommodation. At the time of the inspection young people admitted to the service were female. The service accepted young people who were male, and they would be accommodated. A bathroom closest to their bedroom would become a male only bathroom if a male young person was admitted.

There were no potential ligature anchor points in the service. Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. The ward had an ligature audit with identified ligature risks and mitigation for the risks. The service ligature risk audit were reviewed in June 2022 with a further review scheduled 21 to 22 February 2023. The ligature risk audit included a risk score coupled with a RAG (green, amber and red) rating risk score and description of the actions taken as mitigation. Staff reported individual risk assessments were carried out for young people in these rooms and action taken to mitigate risks, such as, implementing more frequent observations.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. Staff and young people had easy access to nurse call systems. Staff carried bleepers to respond to any emergencies.

Maintenance, cleanliness and infection control

Derwent ward areas were cleaned to a high standard, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. We reviewed and found they were up-to-date and the premises were clean. We saw housekeeping staff cleaning throughout the day during the inspection.

Staff followed infection control policy, including appropriate handwashing techniques, use of personal protective equipment and hand sanitiser was readily available. We saw posters around the ward promoting effective hand washing. One staff member was the infection control champion. Managers carried out monthly hand washing audits.

Clinic room and equipment

Clinic rooms were clean and tidy, fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Resuscitation equipment was checked regularly by ward staff. This included checking the oxygen tank, emergency drugs and the defibrillator. Staff carried out daily checks to ensure equipment were safe. The pharmacist visited weekly and checked medicine management and emergency medicines in the emergency grab bag.

There were seven sets of ligature cutters stored safely across the wards, and staff knew where they were located, these were checked regularly as part of clinical checks.

Staff checked, maintained, and cleaned equipment. Staff had access to equipment for monitoring physical observations, such as a thermometer and blood pressure machine. We saw evidence these were regularly cleaned and maintained.

Staff recorded daily fridge temperatures and knew the actions to take if these were out of range. We saw two missed entries in January, the registered manager took immediate action to follow this up.

Safe staffing

The service had enough nursing and medical staff, but not enough permanent healthcare assistants to meet the needs of the young people. Staff received basic training to keep people safe from avoidable harm.

Nursing staff

Many permanent staff we spoke with were new and had started work within the last six months.

The service had enough qualified nursing staff but not enough permanent healthcare assistants to meet the needs of the young people. The service had six whole time equivalent nurses. The service required 12 full time nurses, six nurses for each ward. There were no current vacancies for Derwent ward.

The service had 16 permanent whole time equivalent healthcare assistants with six new staff to commence work soon. The service still had 33 healthcare assistant vacancies. Managers were actively recruiting with 19 healthcare assistant's applications received. Each week one full day's interviews were set aside at the service for healthcare assistant

interviews, with a view to increase this to two days. Managers had advertised for two senior health care assistants to work opposite shifts alongside regular and agency staff to ensure consistent practice and meet the needs of young people. The full establishment levels for both wards including Trent ward (once open) would be 53 whole time equivalent healthcare assistants.

Managers requested agency healthcare assistants familiar with the young people and service. Managers tried to book regular agency staff who had completed five shifts or more. Managers had a plan in place with preferred supplier agencies to ensure regular staff. Some temporary staff had worked at the service for months.

Young people, families and carers told us they felt there were too many temporary staff and did not feel able to relate to them. Qualified staff told us they frequently worked 12 hour shifts without a break as they spent considerable time directing and supporting agency healthcare assistants.

The service had reduced nurse vacancy rates, but high healthcare assistant's vacancy rates remained. From July 2022 to January 2023 the number of shifts filled by bank and agency's staff were 30%, with a total of four qualified nurses shifts and 44 healthcare assistants shifts.

We sampled the staff roster from 1 to 31 January 2023. We saw on shifts there would be two nurses and five to six healthcare assistants. We saw a constant high use of agency staff throughout January 2023. For each day in January between two and five agency staff worked on shift. The exception was 2 and 3 January 2023 with no agency staff worked. On day shift 226 staff worked with 61 (27%) were agency staff. For the night shift 157 staff worked with 117 (74%) were agency staff. Qualified staff on day shift 52 staff worked of which 2 (8%) were agency staff. For qualified staff on night shift 31 staff worked of which 15 (49%) were agency staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Staff provided new agency staff a full-day shadow shift which included learning around young people's specialist care, health and safety, enhanced observations and the nurse call systems. This was coupled with an induction check list and induction booklet.

Managers had a recruitment plan in place and appointed a talent coordinator specifically for the hospital who ensured continuous advertising of vacancies, reviewing applications and arranging interviews promptly. The on boarding process had improved to ensure new staff were not delayed commencing work. The service were looking to attend an upcoming recruitment fayre. Trent ward was closed and will open once enough staffing are in place.

The service did not have a staff turnover compliance rate, but staff turnover rates were reducing. In a six-month period, August 2022 to January 2023 staff turn 36% (15 staff). August were highest with 13% (5 staff) and January 2023 lowest with 7% (3 staff) turnover.

Levels of sickness were reducing. Staffing data from 1 to 31 December 2022 showed staff levels of sick leave at 14%. The current staff sickness rate were 8% with a target rate of 5%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Some staff told us at times there were not enough staff to cover particularly during refeeding where mealtimes could run on. Staff told us that two non-clinical staff regularly covered staff who were attended to

young people's clinical needs. We immediately told managers who took action. The registered manager interviewed staff concerned and confirmed that is was not appropriate under any circumstances for non-clinical staff to supervise young people alone. Communications were followed up with the wider team with advice to call the nurse on call or manager in emergencies.

Managers could adjust staffing levels according to the needs of the children and young people. Additional staffing could be booked if a young person required a higher level of observation or there were pre-booked activities, which affected staffing, such as longer escorted day leave. Due to the levels of observation and young person risk the service worked with a high number of nurses and healthcare assistants on each shift. Agency health care assistants were routinely needed to cover enhanced observations. Staffing levels were discussed each weekday morning handover and by the multidisciplinary team.

There were sufficient staff available to enable young people regular one to one session with their named nurse.

Children and young people occasionally had their escorted leave, or activities cancelled, even when the service was short staffed. We spoke with five young people and one young person told us they had their escorted leave cancelled due to staff being moved to support another young person.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep children and young people safe when handing over their care to others. We saw this at staff handovers which all staff attended.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The service had a consultant psychiatrist and a medical director.

The doctor, medical director registered manager worked a rota to provide cover out of hours. All medical staff were permanent members of staff.

Mandatory training

Most staff had completed and kept up-to-date with their mandatory training. Staff training data for 1 and 5 February 2023 and showed mandatory training compliance rate of 96% with a service target rate of 90%. However, three of the mandatory training topics fell below this target of compliance such as: Immediate life support 82%, fire compliance 82% and manual handling 89%.

The mandatory training also included: Safeguarding, health and safety, and care notes and met the needs of young people and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

All frontline staff attended restrictive intervention support training for 2.5 days. Ninety-six per cent of staff had completed this training. A training company delivered restrictive intervention support training for the hospital team every 2 months for refreshers and new starters. At the time of the inspection one staff member has been trained as a

restrictive intervention support instructor and can now deliver training and support on site. The restrictive intervention support training included physical and theoretical safe administration of nasogastric feeds; and preventing responding and managing behaviours that challenge (violence and aggression). Nasogastric feeding is when a tube is placed through the persons nose and oesophagus and allows for fluids and nutrition to be passed directly into their stomach.

Staff were provided with training which included managing boundaries between young people with 100% compliance rate. Regular agency staff were offered a full day training including specialist eating disorders, meal support, privacy and restrictions, and nasogastric feeding interventions and professional boundaries.

The service provided comprehensive additional training for different staff groups face to face and on the electronic training system. Training included: patient use of mobile phones cameras and intranet devices, medication awareness, suicide prevention strategy, supporting LGBTQ and clients, sepsis awareness, outbreak management, cyber security awareness, and feeding pump training.

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children, young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

We reviewed four risk assessments and they included risk to self, including self-harm, suicide, self-neglect, risk to own health and degree of vulnerability to exploitation or victimisation. Risk assessments were up to date and comprehensive. Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate young people's recovery.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Staff assessed risks during the daily morning meetings. We observed a flash morning meeting where a staff from the ward and members of the multidisciplinary team attended to discuss the night before, and the day ahead. Young people were discussed, and any associated risks were reviewed, and action agreed to support the young people. Arrangements for section 17 leave were discussed, and any requests from young people. We saw staff discuss young people's observation levels and whether these needed to be escalated or reduced.

Staff identified and responded to any changes in risks to, or posed by, children and young people. In addition to the flash meetings staff reviewed and re assessed individual risks in weekly ward rounds, monthly governance meetings and nurse meetings.

Staff told us about frozen disposable gloves were offered to young people after a refeed as part of de-escalation and self-soothing. They would safely break the ice glove and enjoyed the activity. As the young people found the process of refeeding difficult staff would support the patient to use coping skills after the refeeding had taken place to manage a potential increase of risk for the patient.

Staff followed service policies and procedures when they needed to search young people or their bedrooms to keep them safe from harm. The service provided lists of prohibited items to prospective young people, their families and carers when they entered the service.

Staff followed procedures to minimise risks where they could not easily observe children and young people. Staff set the observation levels for young people according to the risk they presented. Some young people were on intermittent observations, which involved staff checking where the young person was four times per hour. Other young people were on continuous observations which involved a member of staff being allocated to be with the young person at all times, for their safety or the safety of others. Young people's observations were reviewed daily at the morning meetings, as well as at weekly multidisciplinary meetings.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. This programme supported the staff to reduce the number of incidents when restraint was required to keep the young person safe.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained children and young people only when these failed and when necessary to keep the child, young person or others safe. Staff used specialist restrictive physical intervention (physical holding restraint) when involved in and supporting young people with nasogastric feeding; or to prevent a them harming themselves or others. Information leaflets were available to young people, families and carers explaining physical holding restraint.

Monitoring data showed from July 2022 to February 2023 the service had 517 incidents of restraint with 425 were around nasogastric feeding. There were 82 incidents to prevent a young person causing serious intentional harm to themselves; 4 to prevent a young person causing serious physical harm to themselves by accident; 2 to prevent the patients absconding from lawful custody; 3 to prevent the young person's exhibit extreme and prolonged over activity.

Staff said some patients had high intensity restraint during nasogastric feeding. Qualified and unqualified staff told us they found this difficult particularly when it was prolonged, or with new or temporary agency staff. Managers told us staff were provided debrief after an incident support from the psychology with reflective practice sessions, check in with the multidisciplinary team, ward manager and registered manager.

Staff received regular specialist training to restrain safely with training accredited through the restraint reduction network national standards. Staff also received prevention and management of violence and aggression training at 90%.

One young person told the inspection team they had been restrained and felt frightened and staff did not appear confident with carrying out restraint and had been hurt. The registered manager took immediate action to review the incident on close circuit television, met with the young person, reviewed the young person care plans, discussed the incident with the medical staff and arranged a reflective session for staff.

Monitoring data showed from July 2022 to February 2023 there were two incidents of prone restraint. These prone restraints were undertaken for the minimal time possible to manoeuvre the young person into supine as safely and effectively as possible. The service had no incidents of using rapid tranquilisation.

The hospital had restrictions around safe mobile phone use. When young people entered the service agreed to individual plans for restrictions around use of their mobile phones for example mobile phones were not allowed during school time. Young people would hand over their phones to staff for charging before going to bed. Use of mobiles phones were closely monitored and discussed regularly with multidisciplinary teams and care planned for each young person. The hospital had restrictions around bedtimes and access to communal areas outside these times. Restrictions were explained to young people upon admissions and were reviewed regularly with the young person and the multidisciplinary team

Systems were in place to monitor the use of restrictive practices at morning meetings, monthly lessons learnt meetings, clinical governance meetings, reducing restrictive practice audits and feedback from advocacy.

Staff understood the Mental Capacity Act definition of restraint and worked within it. We looked at some medication charts records of the young people involved in the restraint and saw that staff followed National Institute of Health and Clinical Excellence guidance. Staff understood the Mental Capacity Act definition of restraint and worked within it.

Safeguarding

Staff understood how to protect children and 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 nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role and they knew how to apply it. Staff we spoke with understood safeguarding arrangements in the service and could give examples of safeguarding concerns they had identified and raised. Staff felt confident that if they did raise concerns they would be listened to and action taken.

The service opened July 2022 there had been a total of 24 individual safeguarding internal safeguarding concerns raised. Of these 24 cases, two were formally referred to the local authority designated officer, with the outcome substantiated in both cases; four are currently live, five kept open for ongoing monitoring (so a total of 9 open cases).

At the time of the inspection 100% of staff were up to date with their child safeguarding training. Safeguarding vulnerable adults training compliance rate were 91%.

The service had a safeguarding lead. All potential safeguarding concerns identified by staff were sent to the safeguarding lead and social worker who reviewed the concern and referred on to the local authority safeguarding team if appropriate. The social worker were new in post but told us they received safeguarding supervision. They also attended a meeting with social workers from the provider's other services and shared learning. The social worker knew where to seek advice in respect of safeguarding concerns.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Good

Specialist eating disorder services

Staff followed clear procedures to keep children visiting the ward safe. There was a dedicated room for visitors. The service were able to safely facilitate child visits whenever appropriate, coordinated by the social worker team and supported by the multidisciplinary team.

Managers took part in serious case reviews and made changes based on the outcomes. Safeguarding information were shared at meetings with external providers, schools, police and local children and young people's mental health safeguarding teams. Staff carried out quarterly and annual safeguarding assurance audits.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. Regular bank and agency staff could not access electronic records, but plans were in place to address this. Managers monitored young people's care records to ensure they were up detailed and up to date.

Staff used a combination of electronic and paper records, staff made sure they were up-to-date and complete

Records were stored securely. We saw areas where records were held were kept locked.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff followed systems and processes to prescribe and administer medicines safely. Young people own medicines were labelled correctly. We saw staff discussions at the weekly ward round with the multidisciplinary team the ward doctors to ensure that all mental health professionals were aware of the young people's medicines and any changes made.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We observed discussions during a ward round with one patient about the patient's medicines, side effects and review of dosage.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely. An external pharmacist visited weekly and audited medicine management.

Staff followed current national practice to check patients had the correct medicines when they were admitted, and ongoing.

Good

Specialist eating disorder services

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. The multidisciplinary team discussed safety alerts at ward rounds and clinical governance meetings.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Systems were in place to monitor the use of medicines from feedback from young people's community meetings, morning meetings, ward rounds, multidisciplinary meetings, serious incidents and learning from medicine management audits.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance. Medical staff involved young people when making decisions about their health, care and treatment. We observed at ward meetings young people could join in the ward round and discuss their medication and physical health.

Young people's mental and physical health checks were carried out regularly and recorded, to ensure the medicines were safe and effective for them to take. The service doctor were responsible for young people's physical health, together with the multidisciplinary team.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. 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 children and young people honest information and suitable support.

The service managed safety incidents well. Staff knew what incidents to report and how to report them using the electronic incident reporting system. Staff told us that they would report any incident of harm, potential harm and risks to safety.

Staff raised concerns and reported incidents and near misses in line with the service policy. There had not been any incidents which had met the threshold of a serious incident.

Staff reported serious incidents clearly and in line with service policy. Incidents were discussed in daily handover, multidisciplinary team meetings, in reflective practice, supervision and staff meetings

Staff received e-learning training for duty of candour with compliance at 97%. Staff understood the duty of candour. They were open and transparent, and would provide children, young people and families a full explanation if and when things went wrong. However there had been no incidents where staff had followed through the duty of candour policies and procedures. Staff could explain the duty of candour process.

Managers debriefed and supported staff after any serious incident. Staff we spoke with confirmed debriefs were held for both staff and young people after incidents. Many staff spoke about challenges when responding to restrictive

interventions with young people particularly during mealtimes and refeeding. Some staff talked about feeling distressed and did not feel well supported after mealtime incidents. The service had a wellbeing champion. Staff were offered reflective practice group were available to staff. Stress management e-learning were available to staff with a 95% compliance rate.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. The head of patient safety and safeguarding lead investigated incidents. Incident reviews were detailed with follow up actions and a named person who was to follow up on these actions.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared learning with their staff about never events that happened elsewhere. Staff told us how they received updates of incidents from across the providers other hospitals and aware of themes and trends.

Staff met to discuss the feedback and look at improvements to patient care. Managers shared information regarding incidents and safeguarding concerns in the daily morning meetings, nurses and healthcare assistants' meetings.

There was evidence that changes had been made as a result of feedback. Monthly lessons learnt bulletins were available for staff via email along with e-learning information. The bulletins highlighted themes and provided helpful tips and strategies. The service had picked up incidents that staff had fallen asleep on duty. For December 2022 the learning theme was -Staying awake on duty. Strategies and information were provided on how to ensures staff didn't sleep on duty.

The service carried out monthly audits looking into themes from incidents. All incidents were analysed, and any themes and trends discussed with the staff team.

Is the service effective?

Requires Improvement

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Most care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after. We reviewed the care and treatment records of four young people. All records had a detailed comprehensive mental health assessment on admission. Care plans included a school and therapeutic timetable for each young person. Not all young people regularly attended school provision. The teachers and multidisciplinary teams had plans in place to address this.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward which included a full physical health check of vital signs, electro-cardiogram and blood tests. All young people had a formal assessment of their nutritional status carried out by a dietitian on admission.

Good

Specialist eating disorder services

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs. We saw evidence of physical health care plans, self-harm reduction, risk care plans, dietary needs and meal plans, and nasogastric feeding plans. We saw weight restoration plans with young people weighed and measured regularly.

Staff regularly reviewed and updated care plans when children and young people's needs changed. These plans were reviewed weekly with the young people at multidisciplinary meetings, care programme approach meetings and updated when the young person's needs changed.

All but one care plan were personalised, holistic and recovery orientated Each patient had a- patient inclusion in least restrictive management plans (PILRIMPs) which were developed with young people and included their wishes and preferences around restrictive interventions; in particular, during refeeding. We looked at four patient inclusion in least restrictive management plans. One young person required daily physical support during refeeding; their plan did not reflect their specific and sensitive needs. The young person said they had been hurt when restrained during refeeds and wanted to see improvements around restraint.

Staff told us they asked young people how they would like to be supported after restraint and during refeeding and were aware of young people wishes. Some young people wanted to listen to music. This was an area many staff told us they found challenging.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the children and young people in the service and consistent with national guidance on best practice. Young people had weekly access to one to one therapy, coping skills group, body image groups with the psychologist or in a group.

The activity co-ordinator developed a personalised pictorial activity programme in consultation with the young person and multidisciplinary team. They provided activities which supported the young people with eating disorders, for example, baking group sessions, henna beauty care, trips to the animal farm, local café and charity shop.

Staff identified children and young people's physical health needs and recorded them in their care plans. Physical health records showed staff carried out vital signs monitoring as prescribed for each young person. These included blood pressure, temperature and oxygen saturation levels. The service had a physical examination suite available on site.

The service had policies and procedures on how to manage nasogastric feeding. This policy followed the National Patient Safety Agency guidance to safely insert nasogastric tubes. The policy was detailed and had a clear focus on least restrictive interventions, with an emphasis on how to avoid the need for nasogastric feeding. The service required staff to have a yearly nasogastric feeding competency test, which assessed staff's administration techniques. This competency test was also carried out following any concerns raised, such as after an incident.

Staff made sure children and young people had access to physical health care, including specialists as required. The service had links with paediatric consultants at a local paediatric hospital. We also saw evidence of young people being supported to attend hospital appointments when needed.

Staff met children and young people's dietary needs and assessed those needing specialist care for nutrition and hydration. We saw young people's personalised mealtime plans. Some young people were eating regular oral meals, others had nasogastric feeding. All the young people were at the point of making their own food and had access to a therapy kitchen. Nutritional snacks were available at set times throughout the day.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. We saw at ward round the multidisciplinary team provided information and supported to young people around taking regular walks, use of the garden area and healthy bedtime routines. The activity coordinator provided weekly yoga sessions. The dietitian were setting up healthy eating groups for the young people.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. Staff completed Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS) regularly to monitor young people's progress, symptoms and wellbeing. Outcome measures were also used within individual meetings with young people to review care and treatment plans.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The registered manager undertook regular environmental and faculties audits which included: Care notes, school provision, maintenance team, domestic team, community meetings, medicine management, emergency medical resuscitation, induction and handover, mobile phone contacts, and dieticians. Managers used results from audits to make improvements. We saw action points in the audits to make changes in the service.

Skilled staff to deliver care

The ward team included or had access to a range of specialists required to meet the needs of children and young people on the ward. Managers made sure they had staff with the range of skills 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.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including agency staff.

The service had to a range of specialists to meet the needs of the children and young people on the ward. Most staff had the skills and knowledge to meet the needs of people with an eating disorder. The service opened in June 2022 with new staffing joining the service. Not all staff had extensive experience working in the eating disorders field. All nursing staff were specially trained to safely carry out nasogastric tube insertion and enteral feeding. Some healthcare assistants were trained to undertake electrocardiograms and bloods.

Whilst the service had a range of professionals as part of the multidisciplinary team some key posts had just been recruited to and due to commence work in the next few months. This included an occupational therapist, art therapist and family therapist.

The psychology team were present on the ward to support young people so they could talk through their thoughts and feelings. The psychology team provide young people a range of therapy for example one to one, group work, self-image groups. An art therapist had been appointed and due to start work in April 2023.

Managers gave each new member of staff a full induction to the service before they started work. Staff we spoke with confirmed they had undertaken a comprehensive induction programme. The service had a buddy system, where a new starter would work closely with another member of staff to support them in their learning and development.

Managers supported most staff through regular, constructive appraisals of their work. All staff said they received monthly supervision and yearly appraisals. However, staff data showed only 77% of staff had received monthly supervision against a service target of 90%. Some multidisciplinary staff received external professional supervision.

One hundred percent of staff had completed an appraisal in the last 12 months. The service target was 100%.

All staff described good opportunities to develop their professional skills. They were able to access further training courses.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff attended governance meetings, nurses meeting, healthcare assistant meetings and staff were encouraged to attend. A range of topics were discussed, such as, incidents, safeguarding, training, new referrals and any updated to the environment. All staff were able to add topics to the agenda. Minutes were kept from these meetings and available for staff to review.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The provider had developed an online learning platform that made it easier for staff to access and engage with training and development sessions. The platform was flexible and particularly helpful for staff, who might otherwise find learning opportunities more limited. One staff member said the online training were interactive and relevant to their role and responsibilities.

Managers made sure staff received any specialist training for their role. All staff received eating disorder training. Some staff attended accredited courses outside the service.

Managers recognised poor performance, could identify the reasons and dealt with these, with support from the service human resource team.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit children and young people. They supported each other to make sure children and young people had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. We observed a child in need multidisciplinary meeting where staff demonstrated strong links with local authority and community services to meet young people's health and education needs. The young person's parents were invited; the young person attended and were involved in decisions about their care and treatment.

Staff supported young people and their families to participate in six weekly care and treatment reviews.

Ward teams had effective working relationships with other teams both inside and external to the organisation, these included advocacy, acute and mental health services, education and community groups.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. We saw a variety of leaflets which were available to young people and their families about the ward, the staff, care and treatment and safety on the ward

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain children and young people's rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Where young people were subject to the Mental Health Act 1983, their rights were protected.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice from the Mental Health Act administrators based at the service. Ninety-two per cent of staff received training in the role of the Mental Health Act administration. At the time of inspection 97% of staff had completed training in the Mental Health Act. Staff had received additional Mental Health Act training- Detained patients' rights 92% and Locked doors 97% compliance rate.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Access to policies and procedures were available on the ward at the nurses' stations.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. The Independent Mental Health Advocate visited the service weekly and supported young people during ward rounds, mental health tribunals and hearings. They supported both informal and young people detained under the Mental Health Act.

Staff explained young person their rights under the Mental Health Act in a way that they could understand. They repeated this as necessary and recorded it clearly in the young person's notes each time.

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. We saw evidence of young people section 17 leave discussed at morning meetings and at ward rounds.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw the SOAD had spoken to young people and provided their opinion.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed. All section papers were scanned onto the electronic record system and hard copies kept by the Mental Health Act administrator.

Good

Specialist eating disorder services

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed posters to tell them this. We saw leaflets aimed at young people and parents and carers about young people's rights when admitted informally on the ward.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act administrator completed audits to ensure staff were applying the Mental Health Act appropriately. This included a check of the Mental Health Act paperwork, that young people were informed of their rights regularly and that treatment authorisations had been completed appropriately.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of inspection, 92% of staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so. Staff understood how to support children under 16 wishing to make their own decisions under Gillick competency regulations.The Mental Capacity Act applies to people over the age of 16. For decisions about care and treatment in those under 16, staff referred to guidance on Gillick competence. This is a test established by case law to assist clinicians to determine whether a child of 16 years or under is competent to consent to medical examination or treatment. If a child is Gillick competent, they can give informed consent to an informal admission and treatment. Gillick competence training was part of staff induction with a 100% compliance rate. We saw in handover notes and at the nurse meetings they discussed appropriate consent Gillick competency.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision. If the service had concerns about the competence or capacity of a young person to make a decision, staff requested an assessment under the Mental Health Act. All patients who were fed via a nasogastric tube were detained under the Mental Health Act.

Is the service caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Good

Specialist eating disorder services

Staff treated children and young people with compassion and kindness. They respected children and young people's privacy and dignity. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for children and young people.

We spoke with five young people who told us they felt well supported, and staff were kind caring, and respectful. We observed and heard many positive interactions between young people and staff. Staff understood and respected the individual needs of young people.

Staff gave children and young people help, emotional support and advice when they needed it. We saw many examples of staff active listening and provided verbal reassurance to young people.

Staff supported children and young people to understand and manage their own care treatment or condition. We saw staff explaining to young people why daily of tasks should be completed. The advocate said the hospital staff were person centred and “scheduled in time” to explain to young people the rational why clinical decisions had been made.

Staff directed children and young people to other services and supported them to access those services if they needed help. We saw in the child in need meeting staff discussed and supported young people to their local high school and community services.

All the young people said permanent staff treated them well and behaved kindly. However, they all said they did not feel comfortable with agency staff and had difficulty relating to them.

Staff understood and respected the individual needs of each child or young person. Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved children, young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that children and young people had easy access to independent advocates and to child helplines.

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission. The young people and families and carers told said they visited the service at the beginning of the admission process and were provided with written information about the service.

Staff involved children and young people and gave them access to their care planning and risk assessments. Young people told us they could access their care plan, if they wished to.

Staff made sure children and young people understood their care and treatment (and found ways to communicate with children and young people who had communication difficulties). One young person's care plan included information using plain English, short sentences to communicate with the young person.

Staff involved children and young people in decisions about the service, when appropriate. Young people attended weekly community meetings and discussed the importance of their physical and psychological safety and who they could approach to support discuss this further. Staff directed young people to the therapy and nursing team. One young person said messages from community meetings were not always relayed to the multidisciplinary team.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. The young people gave feedback at the community meetings for ward improvements. For example, young people had asked to refresh the mural in the sensory room with one of their own designs as it was not autistic friendly. To replace the décor on one wall in the dining room and investigate the smell in one of the toilet drains. Staff had followed up these points.

Staff supported children and young people to make decisions on their care. Not all young people wanted to attend the weekly multidisciplinary meetings, but each you person had a preferred way to be involved in decisions around their care. Some young people sent their own questions to the activity coordinator to ask questions on their behalf.

Staff made sure children and young people could access advocacy services. The advocates attended the hospital weekly. Their contact details were displayed in communal areas of the ward. The advocate said the multidisciplinary team were responsive to young people's feedback and any concerns raised were discussed in multidisciplinary meetings, or feedback from the lead nurse or activity coordinator. The main theme feedback from young people was they did not feel comfortable with agency staff.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We saw families and carers attended a virtual parents group meeting in February 2023. Managers were setting up regular families and carers network.

Families and carers were invited and involved the multidisciplinary meetings, children in need meetings, and care programme approach meetings. Some families and carers provided written questions to be asked at meetings when not attending.

Young people could also provide feedback via the feedback forms in reception and community meetings. Young people were consulted on matters such as redecoration, furniture choices and menu plans in the weekly community meetings. The multidisciplinary team worked closely with young people and staff in an open and approachable manner.

Families and carers were able to provide feedback at any time by calling the ward as well as during the weekly multidisciplinary team meetings

Good

Specialist eating disorder services

Staff helped families to give feedback on the service. We spoke with four families and carers and many commented that communication had improved with the service. They now receive a weekly multidisciplinary team meeting report where their relatives care and treatment were discussed. One comment received it was difficult to get hold of staff for feedback during the weekends as there were no reception staff to take calls. The telephone would ring unanswered for a long time.

Staff gave carers information on how to find the carer's assessment. Young people, families and carers were allocated a social worker who would work with the families and the multidisciplinary team to assess families and carers needs throughout admission. If considered beneficial the social worker would request a for assessment from the local authority

Is the service responsive?

Good

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. As a result, children and young people did not have to stay in hospital when they were well enough to leave.

Derwent ward was a small unit the desired occupancy level was 100%, which had been risk assessed as safe. However, one child and adolescent mental health service bed were not in use which made the occupancy levels 78% (717 of 918 available days).

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. This was a new service, staff had not discharged any young people. The current length of stay were 144 days.

The service had out four out of-area placements.

Managers and staff worked to make sure they did not discharge children and young people before they were ready. Staff were preparing to discharge one young person. We saw in the young person's care records plans around connecting with their local high school and community dietician.

Discharge and transfers of care

Children and young people did not have to stay in hospital when they were well enough to leave. The service had not discharged or transferred any young people since the hospital opened in June 2022.

Staff carefully planned children and young people's discharge and would work with care managers and coordinators, schools, local authorities, and commissioners. Young people may transition back home, short term foster care or to supported housing. The service would follow national standards for transfer.

Facilities that promote comfort, dignity and privacy

Good

Specialist eating disorder services

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. Each child and young person had their own bedroom, most with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and children and young people.

Each or young person had their own bedroom, which they could personalise. We saw bedrooms had young people's personal belongings including soft furnishings and pictures.

Children and young people had a secure place to store personal possessions. In young people's bedrooms we saw a cupboard under the bed which could be locked, and additional storage available on the hospital site.

Staff used a full range of rooms and equipment to support treatment and care. The service had a hub lounge a multi-use area for activities with young people. There was a spacious dining area and therapy kitchen room known as the Bistro where young people accessed therapeutic activities. However, the Bistro was used as an additional staff kitchen area and break room. The service had a feeding room in a quieter part of the hospital.

Managers were planning to convert one room to a "wobble room" a special quiet room where staff could visit if they felt overwhelmed and needed some peace and quiet.

The service had quiet areas and a room where children and young people could meet with visitors in private. A family room was available for families and carers with a separate toilet area which included baby changing facilities.

Children and young people could make phone calls in private. Upon admission young people agreed to individual contacts around use of mobile phones. Mobile phones was closely monitored and discussed with multidisciplinary teams and care planned for each young person. The hospital had a ward phone young people could access.

The service had an outside space that children and young people could access easily. We saw garden areas at the rear of the hospital with a soft surface area and garden furniture.

Children and young people could make their own hot drinks and snacks and were not dependent on staff. Young people could access snacks at set times during the day. Young people's drinks and snacks intake were monitored by staff in line with their individual meal plans.

The service offered a variety of good quality food. The chef prepared daily fresh meals on site. Young people had individual meal plans agreed under the direction of dietitian and multidisciplinary team.

Children and young people's engagement with the wider community

Staff supported children and young people with activities outside the service and made sure children and young people had access to high quality education throughout their time on the ward.

Staff made sure children and young people had access to opportunities for education and work and supported them. Young people had access to school provision, but some young people were not attending regularly. Teachers and the multidisciplinary team had plans in place to address this. The school provision were based in a room that had been converted from a young person's bedroom. The service had plans for a standalone outer school building. The school provision were awaiting their first Ofsted inspection

Staff helped children and young people to stay in contact with families and carers. Young people told us they spoke regularly to families and carers by phone or virtually. Family and carers visits were arranged by appointment.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. Young people said they went to the local shops in the community and to town. One young person attended a live concert with staff.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The hospitals had adapted bedrooms, bathrooms and lifts. We saw posters on wards reflected young people's backgrounds and protected characteristics with words of encouragement around their care and treatment.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain. We saw a range of written information that children and young people could access, with appropriate symbols and pictures. A leaflet was available that explained the role of each staff member in the multidisciplinary team.

The service had information leaflets available in languages spoken by children, young people and the local community. Managers told us if they needed any information translated this would be arranged centrally by the provider.

Managers made sure staff, children and young people could get help from interpreters or signers when needed. Managers said if they needed any information translated this would be arranged centrally by the provider. We saw in Derwent ward written information included access to interpreters.

Children and young people had access to spiritual, religious and cultural support. The hospital had a multi faith room. They had a range of holy books, prayer mat compass and other faith materials. If a young person wanted a visit from a faith leader staff could arrange this.

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 wider service.

Children, young people, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern. In ward areas there were complaints and feedback forms and suggestion boxes. Staff understood the policy on complaints and knew how to handle them. Written information provided to young people, families and carers outlined how the complaints process worked.

Managers investigated complaints and identified themes. Staff protected children and young people who raised concerns or complaints from discrimination and harassment. Data showed since opening the service in August 2022 there had been four concerns received by managers. This included three whistleblowing concerns. Themes were around clinical care, workforce issues, vacancy rates, staff sleeping on observations. One whistleblowing concerns were not upheld and two were partially upheld.

Good

Specialist eating disorder services

One informal complaint was from a neighbour about lighting, parking and noise levels. This was partially upheld with actions taken.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. One family member said they received timely feedback after raising a concern.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared learning from complaints at governance meetings, nurses and heath assistants' meetings and multidisciplinary team meetings. This was followed up with monthly bulletins with monthly topics and themes taken from lessons learnt.

The service used compliments to learn, celebrate success and improve the quality of care. Staff could be nominated by young people, and staff could nominate another colleague for a monthly award.

Is the service well-led?

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children, young people, families and staff.

Managers had the right skills, knowledge and experience to perform their roles. Managers had a good understanding of the services they managed. Staff told us that the registered manager were visible and approachable, and open to change. Managers and staff confirmed development opportunities for career progression were available and were encouraged to take these up.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff we spoke with knew Ellen Mede Derby's vision and values: Kind and caring, honesty and integrity, respect and dignity, professionalism, team player and robust. We saw evidence of the provider's vision in numerous service meeting minutes and on notice boards. Staff were able to articulate the philosophy of the service.

Most staff felt listened to and able to influence service delivery. Many staff spoke positively about the service and were proud of their work and enjoyed their role.

Culture

Good

Specialist eating disorder services

Staff felt respected and supported however not all staff felt supported. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Some frontline staff spoke about the challenges of supporting patients at mealtimes /refeeding and using restraint clinical holding coupled with aggression. Support were available to staff which some staff accessed. Other staff said the ward were busy ward and there was not enough time to seek support. For example, when supporting temporary staff during refeeding the pressures increased for permanent staff. Some staff said this impacted their morale. Managers were aware of the issues and had plans in place to develop and support the new team.

Most staff spoke positively about the service and told us that the provider was a good employer to work for and were focused on providing high quality care. Staff were supportive of each other. We saw evidence of effective teamwork with staff volunteering to help cover shifts, so young people were supported by staff that knew them. We saw staff had good rapport with young people.

The service promoted equality and diversity in daily work. One staff member told us how satisfying to see so far "young people's journey." Watching them develop confidence, life skills and soon to exit the hospital and live in the community using the skills they had learnt.

Most staff reported they felt listened to and able to speak up if they had concerns. Staff knew about the Speak Up Champion and the whistleblowing process with posters around the service with contact details.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Managers operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Managers held regular clinical governance meetings, which enabled the escalation of information upwards and the cascading of information from the management team to frontline staff. Staff told us that governance issues were cascaded down and were routinely discussed at the different team meetings.

There was a consistent approach to monitoring and auditing the quality of the service or outcome measures for young people in order to improve the quality of the service delivered

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Most care plans were personalised, holistic and recovery orientated. All but one care plan did not include the young person wishes for managing restrictive interventions during refeeding. The young person told us they were restrained regularly and felt restrictive interventions during refeeding could be improved.

Good

Specialist eating disorder services

The hospital had high healthcare assistant vacancy rates and a reliance on temporary agency staff. However, staff recruitment plans had improved with a dedicated staff recruiter for the hospital and ongoing recruitment of healthcare assistants. The processing of applications and interviews were taking place weekly. The on boarding process had improved to ensure new staff were not delayed commencing work.

Not all staff had received regular supervision with a 77% compliance rate and the service target were 90%. The hospital were not able to provide data with a breakdown of staff supervision. However, we spoke with 20 staff, who told us they received monthly supervision, and unplanned supervision if they asked for it.

Not all staff were up to date with mandatory training topics. Three of the mandatory training topics fell below the service target rate of 90%: Immediate life support and fire compliance both 82% and manual handling 89%. However, staff were provided with a comprehensive online training and mandatory training programme to meet young people's needs.

Some front-line staff told us they felt levels of distress when using restrictive interventions with young people during mealtimes/ refeeding; which impacted staff morale and their wellbeing. The staff team were new, and managers were working to build up resilience in the team.

However, we saw effective multidisciplinary meetings across the service helped to reduce patient risks and keep patients and staff safe. Staff notified and shared information with external organisations. Managers were open and transparent and explained to young people when something went wrong.

Staff said the service provided information governance systems to measure key performance indicators and to gauge the performance of teams. Managers had information that supported them. The managers had access to the risk register, which were reviewed regularly.

Information management

Staff engaged actively in local and national quality improvement activities.

Managers and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Managers told us about regular review of the risk register. They had plans to cope with unexpected events.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers had frequent and regular engagement with the provider's partner hospitals in the Provider collaboratives.

Senior managers engaged with external stakeholders such as commissioners. The provider worked closely with public health including attendance at quality and governance meetings.

Learning, continuous improvement and innovation

Good

Specialist eating disorder services

The provider ensured staff from the hospital attended external conferences. Staff were involved in Patient Safety Incident Response Framework (PSIRF) launch for early intervention in eating disorders and staff attended lunch and learn sessions.

The hospital planned to continue the annual cycle membership from April 2023 with the Quality Network for Inpatients CAMHS (QNIC).

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure care plans are fully complete and include young people's wishes around restraint during mealtimes / refeeding.