Newbridge Care Systems Limited

Schoen Clinic York

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

We are placing Schoen Clinic York in special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Our rating of this location went down. We rated it as inadequate because:

- We have taken urgent enforcement action against the registered provider following our inspection.
- The service provided care that put patients at the risk of physical and psychological harm because their needs, including dietary needs, were not always met, patients' risks and environmental risks from ligature anchor points were not assessed properly and not managed or mitigated sufficiently.
- The service had warning signs of a closed culture. Staff did not always provide holistic and person centred care that met patients' needs and staff did not always treat patients with compassion and respect. Some staff reported a culture where they could not raise concerns without fear of retribution and bullying and harassment from managers. Staff did not always report incidents and safeguarding issues that occurred appropriately internally and externally.
- The premises were not fit for purpose because there was not enough space for patient care and staff to work at the service to support patients. Two sheds had been erected in the garden and there was no space for a female only lounge to be compliant with eliminating mixed sex accommodation.
- The provider had not implemented the new model of care effectively and staff did not have the skills or tools to deliver the new model of care in practice.
- There were issues in relation to emergency equipment, safe medicines management, the nurse call alarm system and staff training was not all up to date. There was no training in learning disabilities or autism. There were also issues with a patients' rights being regularly explained under the Mental Health Act and the language in one risk assessment that was too medicalised.
- Governance systems and processes were not effective in identifying issues with quality and safety and this meant that there was insufficient oversight of what was happening in the service.

However:

- The service had recruited to almost all the vacancies in the service.
- There was a clear framework of meetings from ward to the provider's board.
- Some patients told us that some staff treated them with kindness and compassion.
- Assessments on admission to the service were comprehensive.
- Following our urgent enforcement action, the registered provider has taken action and started to make improvements to safety and quality in the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Inadequate 	Our rating of this service went down. We rated it as inadequate . See the summary above for details.

Summary of findings

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Summary of this inspection

Background to Schoen Clinic York

Schoen Clinic York is a specialist eating disorder hospital for up to 15 adults with eating disorders. The provider informed us the hospital could admit a maximum of one male patient at any time. The registered provider is Newbridge Care Systems Limited.

Schoen Clinic York is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

The hospital had two registered managers and an accountable controlled drugs officer.

We have inspected Schoen Clinic York twice since it registered with us on 9 January 2019. Prior to this, the hospital was run by another provider. Our last inspection took place in November 2019 and our report was published in March 2020. At that inspection, we issued four requirement notices in relation to the following breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 10 dignity and respect
- Regulation 13 safeguarding service users from abuse and improper treatment
- Regulation 17 good governance
- Regulation 18 staffing.

What people who use the service say

Patients provided mostly negative feedback about the service.

Patients told us that the food was poor quality and did not meet patients' individual needs. They told us that the self-catering for relevant patients had been stopped for four months and there had been disruption and a gap in psychological therapies due to turnover in the therapy team.

Patients reported that there had been a high turnover of staff, they had negative experiences of multidisciplinary meetings to review their care, felt not listened to by managers, did not have sufficient communication during a recent COVID-19 service lockdown and told us some staff were being treated unfairly by managers.

Four patients gave examples of poor staff attitudes and insensitive comments made towards them. One patient felt their physical health concerns had not been listened to or acted upon by staff.

Patients told us there was no dedicated space to meet visitors and child visits had to be held outside in the garden. They told us chairs in the group room were uncomfortable.

Patients were concerned that items were thrown down from windows above the service and that service users and staff from another service could be heard on the ward.

Summary of this inspection

Patients told us there were restrictions that meant that informal patients did not feel free to leave the service, patients could only complete laundry with staff supervision and two patients did not have access to their bedroom. Four patients told us they were concerned about ligature risks in their bedrooms.

However, patients told us that some nurses and health care assistants supported them well and treated them with respect and kindness. Patients could personalise their bedrooms.

How we carried out this inspection

During our inspection, we:

- Toured the care environments and observed how staff were caring for patients
- Spoke with six patients who were using the service
- Spoke with seven family members of patients using the service
- Received feedback via three comment cards
- Interviewed 16 staff including health care assistants, registered nurses, a clinical administrator, a dietician, a dietetic assistant, an occupational therapist, a consultant psychiatrist, a specialist therapist, a clinical manager, a lead nurse and the hospital director.
- Attended and observed one multi-disciplinary team meeting, one lunch time and one post meal support group.
- Looked at five patients' care and treatment records on site and all patients risk assessments and care plans remotely.
- Carried out a specific check of the clinic room and medication management including five medication charts.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that the environmental risks to the health and safety of patients are assessed, managed and mitigated. This must include the removal of potential ligature anchor points that can be reasonably and practicably removed. (Regulation 12)
- The service must ensure that measures put in place to manage and mitigate environmental risks are robust and adhered to in practice. (Regulation 12)
- The service must ensure that the nurse call alarm system is up to date and reflects the use of the ward environment. (Regulation 12)
- The service must ensure that emergency equipment is checked regularly to ensure that it is safe and ready to use if needed. (Regulation 12)
- The service must ensure that staff receive appropriate training for their roles. (Regulation 18)
- The service must ensure that staff complete comprehensive assessments of patient risks and develop risk management plans to manage and mitigate risks. (Regulation 12)
- The service must ensure that restrictions applied to patients are based on individual risk assessments. (Regulation 13)

Summary of this inspection

- The service must ensure that an observation policy is in operation that ensures that staff check the safety and wellbeing of patients regularly. (Regulation 12)
- The service must ensure that all safeguarding concerns are identified and reported appropriately to the local authority safeguarding team. (Regulation 13)
- The service must ensure that there is a clear model of care with training and tools for staff to implement in practice. (Regulation 17)
- The provider must ensure the safe and proper management of medicines. (Regulation 12)
- The provider must ensure that patients receive care that meets their needs. (Regulation 9)
- The provider must ensure that all incidents are reported appropriately, and appropriate action is taken following incidents to manage and mitigate risks. (Regulation 12)
- The provider must ensure that patient risk assessments are updated following incidents. (Regulation 12)
- The provider must ensure that patients' care plans are holistic, and recovery orientated. (Regulation 9)
- The provider must ensure that there is enough suitable and good quality food available to meet all patients' individual needs. (Regulation 9)
- The provider must ensure that governance systems and processes are effective in assessing and improving the quality and safety of the service and managing risks. (Regulation 17)
- The provider must ensure that all staff treat patients with dignity and respect. (Regulation 10)
- The provider must ensure that the premises are suitable for the purpose that they are being used. (Regulation 15)
- The provider must improve the culture of the service so that it is open and transparent and safe for people to raise concerns (Regulation 17).
- The provider must notify the CQC of occurrences in line with the regulations. (Regulation 18).

Action the service SHOULD take to improve:

- The provider should ensure that the ward has the facilities to be compliant with the guidance on eliminating mixed sex accommodation. (Regulation 12)
- The provider should consider monitoring data on sessions of activities and therapies offered and taken.
- The provider should ensure that patient records contain language and information that is easy to understand for staff and patients (Regulation 9).
- The provider should ensure that patients are informed of their rights under the Mental Health Act regularly (Regulation 11).
- The provider should increase patients' connections with the wider community (Regulation 9).
- The provider should ensure that the service participates on a reduction in restrictive interventions programme. (Regulation 13)
- The provider should audit adherence to the Mental Capacity Act. (Regulation 11)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Inadequate

Specialist eating disorder services

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Are Specialist eating disorder services safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

We have taken enforcement action against the registered provider and this limits our rating of this key question to inadequate.

Safe and clean care environments

The ward was not safe or fit for purpose because the provider had not taken reasonable and practicable steps to remove and reduce ligature risks in the care environment. There was also inadequate management of ligature risks to keep patients safe. The nurse call alarm system was not up to date which meant an emergency response may not go to the right place. However, the ward was clean, well equipped, well furnished and well maintained.

Safety of the ward layout

The provider had not taken action to reduce and remove ligature risks it had identified that would have been reasonable or practicable to do so. Staff completed an annual thorough risk assessment of the ward's areas. The hospital had three out of 15 patient bedrooms fitted with anti-ligature fixtures and fittings. None of the ten patients that were staying at the service were staying in the three bedrooms with reduced ligature anchor points. All other areas of the hospital environment contained standard fixtures and fittings which could be used as fixed ligature anchor points for the purpose of hanging or strangulation. The provider had no actions identified in the hospital's ligature risk assessment to reduce or remove the environmental ligature risks.

Although staff knew about potential ligature anchor points, there was inadequate mitigation of these risks to keep patients safe. The ligature risk assessment stated that the management of ligature risks was through patient risk assessment and observation. The policy on observation did not ensure staff checked that patients were safe and well regularly in line with national guidelines. The lowest level of observation only required staff to check patients were safe and well once during the day and night shifts. This meant that staff did not check patients were safe and well for hours. Patient risk assessments contained limited to no information on patient risks. This meant that staff may not be aware about the risks towards and from patients. Four out of six patients that we spoke with specifically told us they were

concerned about ligature risks in their bedrooms. We raised concerns with the provider in our inspection feedback about ligature risks in the care environment. A response from the provider confirmed the existing measures and therefore did not provide enough assurance that measures had been put in place to mitigate and manage the ligature risks in the hospital.

Staff could not observe patients in all parts of the ward due to the ward layout. There was no system or process to ensure staff were always present in communal areas of the ward.

At the time of our inspection, the ward complied with guidance on eliminating mixed sex accommodation. All patients staying at the service were female. All bedrooms had an ensuite bathroom. However, if a male patient was admitted to the service, there was no facility for a female only lounge. This meant that there was a risk that in the future the ward may not be compliant with eliminating mixed sex accommodation requirements.

Staff had easy access to alarms and patients had easy access to nurse call systems. However, the nurse call alarm system had been implemented when the service first opened in 2021 and some of the rooms had since changed use. This meant that when the nurse call points were used, that the location where the response was required was sometimes incorrect. In an emergency, this could mean a delayed response to the right place. However, all the patient bedrooms were correct on the system.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Domestic staff completed regular cleaning as part of the service's contract with the premises' landlord. The ward environment was decorated well and had no visible signs of damage or wear.

Staff followed infection control policy, including handwashing. Staff wore appropriate personal protective equipment (PPE) and the ward was equipped with hand sanitiser stations.

Seclusion room

The hospital did not have a seclusion room.

Clinic room and equipment

Resuscitation equipment was not always quickly accessible and emergency equipment and drugs were not checked regularly to ensure they were in date. However, the clinic room was fully equipped.

When we checked the emergency equipment bag with staff, it took them minutes to remove the tamper seals. In a medical emergency, this would result in a delay in providing appropriate life support. The defibrillator pads and lubricant jelly had passed their expiration dates and the resuscitation mask packaging was unsealed. A check in place incorrectly recorded that the epinephrine injection, used to treat severe allergic reactions, was due to expire in October 2022. This item was due to expire in January 2022. We raised these issues with emergency equipment during our inspection, the provider decided to stop the use of tamper seals immediately, disposed of the expired lubricant jelly, replaced the epinephrine injection and followed up the order of defibrillator pads with the supplier. A new checklist was implemented to try to reduce the risk of these issues recurring.

Staff checked, maintained, and cleaned equipment. Clinic room and fridge temperatures were monitored and recorded within the recommended ranges.

Safe staffing

The service relied on bank and agency staff and some shifts had not been filled. Activities and therapies had been disrupted at times due to staff shortages and service development. Staff may not have the skills and knowledge to meet people's needs and keep them safe from harm because they were not all up to date with the training required. The provider did not provide training on learning disabilities or autism. However, the service had enough medical staff.

Nursing staff

The service used bank and agency staff regularly and some shifts were not filled which meant there was not always enough nursing and support staff to keep people safe.

The service had vacancies for registered nurses but was over recruited for health care assistants. The service had vacancy rate of 21% for registered nurses which equated to 2.5 whole time equivalent positions. One of these positions was vacant due to a registered nurse being appointed to the clinical manager. The service had over recruited by 1.3 whole time equivalent health care assistants to ensure there was cover for staff absences and leave.

The service used agency staff consistently. Between 01 January and 31 December 2021, the average percentage of shifts covered by agency staff was 17%.

The service used bank staff consistently. Between 01 January and 31 December 2021, the average percentage of shifts covered by bank staff was 9%.

Between 01 April and 31 December 2021, the number of shifts not filled by bank and agency staff was 21. This represented 10 shifts that required a registered nurse and 11 shifts that required a health care assistant.

Managers limited their use of ad hoc agency staff and requested staff familiar with the service. Between 01 January and 31 December 2021, the average percentage of shifts filled by ad hoc agency staff was 2%.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service reported a turnover rate of 8%. This represented 49 staff leavers. There were 24 staff leavers in February 2021 due to the reconfiguring and re-location of the service.

Managers supported staff who needed time off for ill health.

Levels of sickness were low for registered nurses and average for health care assistants. Between 01 January and 31 December 2021, the average sickness rate of registered nurses was 3% and health care assistants was 11%. Between January and March 2021, the sickness rate for health care assistants was high at 29%, however this rate reduced significantly in the following months.

Inadequate

Specialist eating disorder services

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. The minimum staffing level during the day shift was two registered nurses and three health care assistants and one registered nurse and two health care assistants workers at night.

Managers could adjust staffing levels according to the needs of the patients.

Patients had regular one- to-one sessions with their named nurse.

Activities and therapies including leave had been disrupted at times due to changes in the multi-disciplinary team and a new clinical model being implemented. There was no data available on the number of activities cancelled due to staff shortages. However, the provider told us that there had not been any times that that leave was cancelled due to staff shortages.

The service would not always have enough staff on each shift to carry out high level physical interventions safely. At night, the minimum staffing level was one registered nurse and two health care assistants. However, staff had only used low level restraint once in the previous 12 months.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor was available to go to the ward quickly in an emergency. The hospital had one consultant psychiatrist 0.4 whole time equivalent with a specialism in eating disorders and a locum consultant psychiatrist 0.6 whole time equivalent. A medical on call was shared between the hospital and another local independent mental health hospital. In the previous 12 months, there were no occasions where the on-call doctor was required to attend the hospital.

If additional medical cover was required, managers could review medical staff provision and had access to other doctors from across the provider's other services.

Managers made sure all locum staff had a full induction and understood the service before starting their shift. The locum consultant psychiatrist had worked at the service for over 12 months.

Mandatory training

Not all staff had completed and kept up to date with their mandatory training. The provider's training target was 80% for all courses except safeguarding and prevent training which was 90%, information governance which was 95% and anti-bribery which was 100%. Seven out of the 42 training courses did not meet the provider's target. These were: breakaway techniques at 44%, professional boundaries at 66%, medical gas safety for nurses 71%, food safety level 2 at 73%, management of actual and potential aggression (restraint) 73% and information governance at 88%. This meant that staff may not have all the skills and knowledge required to keep patients and themselves safe.

The mandatory training programme did not provide any training on learning disabilities or autism. This meant that staff may not have the skills and knowledge to meet the needs of people with learning disabilities and/or autistic people. At the time of our inspection, the service had one patient with autism.

Although there was a system to monitor mandatory training and managers reminded staff to update their training, this did not ensure that staff kept up to date with all the mandatory training required.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients well. They did not always achieve the right balance between maintaining safety and providing the least restrictive environment to facilitate patients' recovery. Patients were permitted ongoing access to items that they could use to hurt themselves despite incidents occurring but were restricted in other ways which were not in relation to their individual risks. This included informal patients not being able to leave at will. However, there was low use of restrictive interventions and staff only used restraint after attempts of de-escalation had failed.

Assessment of patient risk

Staff did not complete comprehensive patient risk assessments. We reviewed all ten patients' risk assessments. These contained limited to no information on patient risk. The risk ratings were mostly recorded as low or no apparent risks. Nine out of ten risk assessments had no further context or statements on risk to show the rationale for the level of risk recorded. The only further information in some records was a log of previous occurrences prior to and during admission. The information contained in two patients' risk assessments did not reflect the risks that patients told us during our inspection. One patient risk assessment contained medicalised language that may be difficult for non-clinically trained staff and the patient to understand.

Staff used a recognised risk assessment tool.

Management of patient risk

On admission, staff completed assessments for specific risk issues relevant to the patient group including falls and pressure ulcers.

Risk assessments did not contain clear risk management plans or plans for unplanned discharge from hospital. Due to the issues with risk assessments, staff may not know all the information about patient risk and may not be able to manage all risks.

Staff did not always act to prevent or reduce risks or respond to changes in risks to, or posed by, patients. Two patient risk assessments contained incidents of patients using risk items, including a scalpel, to self-harm resulting in injuries and staff had not taken any action to manage and mitigate these risks. During our inspection, we escalated a concern about the mental state of a patient because we had informed staff of a concern and we were not assured that they had acted on this. The provider submitted information following our inspection about action they had taken in response to this concern.

Staff could not observe patients in all areas of the ward and did not follow good procedures to minimise risk where they could not easily observe patients. The provider's observation policy set out four levels of observation, the lowest level of observation only required staff to be aware of the general presence of patients during the day and night. This meant that patients may not have been seen for hours. This was significantly longer than the standard set out in national guidelines that states that staff should check patients' welfare at least every 30 to 60 minutes. In July 2021, staff reported an incident where a patient had not taken their own medication. Staff believed that the patient had been out on unit

leave that day. This meant that staff did not know their whereabouts during this time or whether they were safe and well. There was evidence that during this time the patient would have required support from staff. Patients also had access to ward areas that contained potential ligature anchor points. Since our inspection, the provider has changed the observation policy to meet national guidelines.

Although there was a policy in place to search patients' bedrooms, there was no evidence that this was used appropriately to keep patients safe. Patients had access to risk items and there was evidence from previous incidents occurring that these were not removed when it would have been appropriate to keep patients' safe.

The hospital had a blanket restriction register that recorded restrictions on patients' freedoms. The log recorded access to risk items was restricted and could only be provided to patients following individual risk assessment. The log did not specify what types of items were deemed to be risk items. A separate personal searches policy submitted at the factual accuracy stage, this stated that some items may be kept by staff and managed by the risk assessment and management process. None of the patient risk assessments contained an assessment on access to risk items. One patient risk assessment contained a statement that a patient could have access to risk items with no evidence of assessment or rationale and another patient risk assessment recorded the patient told staff they would keep their risk items. This patient had incidents of self-harm using risk items including a scalpel whilst staying at the service.

The provider told us that the fob system to enable informal patients assessed to leave the ward was not in operation due to a COVID-19 lockdown in a service that had a shared entrance. The blanket restriction register stated that a risk assessment was required to allow access to a fob for independent access on and off the unit. None of the informal patients staying at the service had ever had an individual risk assessment in relation to being able to leave the ward at the time or prior to our inspection.

Use of restrictive interventions

Levels of restrictive interventions were low. In the previous 12 months, there had been one incident of restraint. There had not been any incidents of seclusion, long-term segregation, prone restraint or rapid tranquilisation.

Although the provider had a reducing restrictive practice strategy, staff were not aware of and did not participate in any restrictive interventions reduction programme.

The service submitted data on the use of restrictive interventions to the specialised services quality dashboard which enabled them to benchmark the use of restrictive interventions against similar services.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Safeguarding

Staff did not always carry out their responsibilities to report allegations of abuse to the local safeguarding team appropriately. However, staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it in theory. The service had not needed to work with other agencies in relation to safeguarding.

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff had made one safeguarding referral in the previous 12 months. We were informed of an allegation of an unapproved restraint on a patient. At the time, managers had asked the patient their views in relation to the incident, but they did not make a safeguarding referral to the local authority safeguarding team. The provider told us that this was because the patient did not want a safeguarding referral to be made. Managers only completed supervision with the staff member involved and there was no incident report completed. This also meant that CQC were not notified of this incident.

Staff kept up to date with their safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm.

The service had not needed to work with other agencies in relation to safeguarding.

Staff followed clear procedures to keep children visiting the ward safe. Children and young people were not permitted access to the ward and visits could be supervised in a room accessible from the side of the building or at an alternative location.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The lead nurse was the safeguarding lead. Recruitment was ongoing to fill the service's vacancy for a social worker.

There were no serious case reviews relevant to this service.

Staff access to essential information

Staff had easy access to clinical information. However, the electronic care record system required updating because care plans in use were designed for the previous model of care.

Staff could access patient records easily. The patient care record system required updating because the templates for patients' care plans were in a format designed to be used with the previous model of care. The leadership team meeting minutes for January 2022 stated that a big piece of work was required to change the layout of care plans in line with the new clinical model.

Records were stored securely.

Medicines management

The service did not always administer as and when required medication in line with prescribing instructions or use systems to safely record and store patients' own medicines. There were some medicines incidents reported but staff also told us that medicines errors were not reported as incidents. However, the service used systems and processes for regular medicines to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff mostly followed systems and processes to prescribe and administer medicines safely. However, staff did not always follow the prescribers' instructions for administering one medicine that was to be taken as and when required. There was also evidence that staff directed the patient to find alternative strategies to this medicine on their own and they did not provide proactive support with this.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all prescribed medicines and prescribing documents safely. However, some patients had brought medicines and supplements that they had purchased into the service. Those medicines were stored in the clinic room, but staff did not record what medicines were present or complete medication checks on these medicines. We raised this with the provider and, in agreement with the relevant patients, these medicines were disposed of appropriately as they were not required.

Staff told us that they had been told not to report issues with medicines including medicines errors as incidents by managers. Between July 2021 to January 2022, there had been 11 medication errors reported. There was a risk some but not all medicines issues were reported and this meant that there was issues with oversight of the medicines incidents occurring and opportunities would be missed to learn from incidents and to manage and mitigate risks.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety

The service did not report any serious incidents or never events.

Reporting incidents and learning from when things go wrong

Staff and managers did not always recognise incidents and report them appropriately. Some incidents had been inappropriately rejected by managers. This meant that there was insufficient oversight of incidents occurring in the service and opportunities could be missed to manage and mitigate risks. Although lessons learned were shared with the team, these did not relate to patient safety incidents and opportunities were missed to take action to reduce the risk of incidents recurring to prevent avoidable harm. However, staff had followed the duty of candour in one incident appropriately.

Staff and managers did not have a clear understanding of what occurrences should be reported as incidents. They told us behaviour that was part of a patient's 'usual presentation' would not be reported as an incident and would only be logged in the patient's record. That included incidents of self-harm. Four staff members that we spoke to provided us with examples of occurrences that had not been reported as incidents.

The service did not have oversight of incidents occurring in the service. In July 2021, the provider implemented a different electronic incident reporting system. We compared incidents reported to information contained in current patient risk assessments. There were discrepancies between occurrences documented in patients' risk assessments not being reported as incidents and incidents that had been reported that were not updated in patients' risk assessments.

Inadequate

Specialist eating disorder services

We could not fully assess the extent of the number of incidents that had both not been reported or recorded in patients' records. There were also examples of occurrences raised to use that had not been reported as incidents. Managers had rejected seven incidents that staff had submitted appropriately. The insufficient oversight of incidents meant that the risks to patients' safety and quality of care provided could not be fully identified or assessed. Opportunities could be missed to manage and mitigate risks towards patients.

The service did not always learn from when things went wrong. The incident report system showed multiple incidents patients self-harming using blades whilst in the service. These incidents showed that staff were not proactive and did not take practical steps to reduce the risks of these incidents recurring to prevent future avoidable harm to patients. Due to issues with under reporting of incidents, we could not fully assess the extent of this concern.

Although staff understood the duty of candour, there was a risk that this would not be carried out appropriately due to the issues with under reporting of incidents. Staff had carried out the duty of candour appropriately in relation to one issue involving food.

There were no serious incidents reported for this service.

The service had a quarterly newsletter that shared the learning from incidents. However, although it was positive that lessons learned from incidents were shared, these were focussed on health and safety, food and information governance and did not include patient safety incidents.

There were no examples of lessons learned from incidents that happened elsewhere.

The provider did not report all incidents appropriately to the CQC using statutory notifications. Incidents that had been reported from July 2021 to January 2022 showed that on seven occasions patients had required hospital treatment following incidents of self-harm and/or unexplained injuries. CQC had not been informed of any of these incidents.

Are Specialist eating disorder services effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

We have taken enforcement action against the registered provider and this limits our rating of this key question to inadequate.

Assessment of needs and planning of care

Care plans did not always reflect patients' assessed needs and were not always holistic and recovery oriented. However, care plans were personalised and reviewed regularly.

Staff assessed the physical and mental health of all patients on admission.

Inadequate

Specialist eating disorder services

Staff completed a comprehensive assessment of each patient either on admission or soon after. All the five patients' admission records reviewed contained an assessment that included their physical health and history including mental health, family and social history.

Staff developed care plans that were not always holistic, and recovery orientated. Four out of the ten patients' care plans reviewed did not contain enough information in relation to patients' mental health needs including, self-harm and for one patient stated once that the patient was autistic but no information about their associated needs or how staff should support them. Multidisciplinary team plans were separate to care plans. The format of care plans was based on the previous model of care where care was separated into different pathways and levels. It would be difficult for staff and patients to fully understand what these levels meant for patient care as limited information was recorded to explain what the level represented. However, care plans were personalised.

Staff regularly reviewed and updated care plans.

Best practice in treatment and care

The new clinical model of care had not been embedded into practice well and staff did not have the training, skills or tools to deliver it in practice. The clinical audit schedule was not comprehensive and there was no use of quality improvement initiatives. Further developments were required to ensure that recognised rating scales to assess and record severity and outcomes were used throughout treatment. However, although there had been recent inconsistency in provision, staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health. Data was also submitted as part of national benchmarking of service.

Staff provided a range of care and treatment suitable for the patients in the service. The interventions were those recommended by best practice guidance and included, food and nutrition, psychological therapies and medication. However, there had been changes in the multi-disciplinary team and clinical model of care that had disrupted patients care and treatment in the last six months meaning that this had recently been inconsistent. Patients and carers told us that there had been gaps in the therapies and activities available. One patient's care felt that they had not had a good experience for the first six weeks of their admission.

A new clinical model of care was implemented in October 2021. Staff had not received training in the new model of care and did not have the tools to implement this in practice. Although the vision for the model of care was in line with best practice and national guidance, the care that patients received was a hybrid of the previous and new model of care which was confusing for staff and patients.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required. However, staff did not always take patients' own concerns about their health seriously and directed patients to book their own appointments with the relevant medical professional.

Staff did not always meet patients' dietary needs due to issues with food quality and quantity at the service. However, staff assessed patients' nutrition and hydration needs and developed appropriate plans.

The service used an admission and discharge outcome measure. However, due to the changes in the clinical model and multi-disciplinary team, the service was in the process of identifying further relevant and effective outcome measures.

Although the service had a clinical audit strategy and schedule, this was not comprehensive as had limited scope and it did not identify and address the issues and concerns that we identified. However, staff took part in clinical audits.

The service submitted data to the specialised services quality dashboards which enabled benchmarking the service's performance against similar services.

The service did not use quality improvement initiatives.

Skilled staff to deliver care

The ward team now included and had access to the full range of specialists required to meet the needs of patients 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. However, two staff reported negative experiences of supervision.

The service had recently recruited multi-disciplinary staff to ensure there was a full range of specialists to meet the needs of the patients on the ward. In the previous 12 months, all but one multi-disciplinary staff had left the organisation. The service had recruited to all but one vacancy for a social worker 0.4 whole time equivalent and one vacancy for a consultant psychiatrist 0.5 whole time equivalent.

Although training was not provided on learning disabilities or autism, managers ensured staff had the right training, qualifications and experience to be able to meet the other needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. Eighty two percent of staff had an appraisal of their performance in the previous 12 months.

Staff received clinical and managerial supervision regularly. Data showed that an average of 79% of staff had received regular clinical supervision and 86% of staff had received regular managerial supervision in the previous 12 months. However, two staff reported negative experiences of supervision and described this as punitive rather than supportive.

Managers made sure staff attended regular team meetings and gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. They were in the process of identifying and delivering specialist training relevant to staff roles. Registered nurses had completed training in nasogastric tube feeding and were awaiting a competency assessment to be developed. There were also plans for training in rapid tranquilisation.

Managers recognised poor performance, could identify the reasons and dealt with these.

Inadequate

Specialist eating disorder services

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary meetings took place weekly attended by relevant staff and patients. However, patients reported negative experiences and told us if they disagreed with decisions made then staff implied they would be discharged from the service.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation. Staff were working alongside counterparts from another one of the provider's services.

Ward teams had effective working relationships with external teams and organisations. Staff engaged external teams in meetings to plan patients' discharge and confirm ongoing support arrangements.

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. However, staff did not regularly inform one patient of their rights under the Mental Health Act and adherence to the Mental Health Act was not assessed regularly through audit.

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. Eighty four percent of staff had completed this training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. The service had an operations and Mental Health Act manager who was the lead for Mental Health Act legislation.

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.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Staff displayed information on the local advocacy services on the ward.

Staff did not always explain to each patient their rights regularly under the Mental Health Act. There was one patient detained under the Mental Health Act and their rights had not been explained to them since September 2021. However, when they did explain patients' rights, they did this in a way that they could understand and recorded it clearly in the patient's notes.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Inadequate

Specialist eating disorder services

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

A sign was displayed to inform informal patients that they had a right to leave the ward. However, informal patients told us that they could not leave the ward and the blanket restriction register stated that a risk assessment was required to allow access to a fob for independent access on and off the unit. The provider told us that this was due to a COVID-19 lockdown in another service that had a shared entrance but there was no evidence any patients had ever had an assessment for independent access to a fob.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act. There was evidence of discharge planning meetings under section 117 for one patient.

The clinical audit schedule contained some Mental Health Act related audits. However, the frequency of these audits did not provide sufficient assurance on the adherence to the Mental Health Act due to the frequency of completion. For example, section 132 rights were to be audited once per year, section 17 leave forms and consent to treatment documentation were due to be audited twice per year.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005.

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. Eighty seven percent of staff were up to date with training in the Mental Capacity Act 2005.

There were no Deprivation of Liberty Safeguards applications made in the last 12 months.

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.

We reviewed five patients' care and treatment records and there were no concerns relating to capacity identified. Therefore, we were unable to review any mental capacity assessments or best interest decision making processes.

The service did not monitor how well it followed the Mental Capacity Act through audits.

Are Specialist eating disorder services caring?

Inadequate

Our rating of caring went down. We rated it as inadequate.

Inadequate

Specialist eating disorder services

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat patients with respect, compassion and kindness. They did not always provide help and emotional support when needed and did not always respect the needs of individual patients. However, some staff provided kind, appropriate and respectful support.

Although when we were present on site, we observed interactions between staff and patients that were kind, appropriate and respectful, four patients out of the six patients we spoke with and two carers gave us examples of poor staff attitudes and insensitive comments made towards them. This included comments that would not be conducive to recovery in this type of service. Other examples included statements that made patients feel that if they disagreed with staff they would be discharged from the service and calling patients the wrong names. However, patients also told us that some nurses and health care assistants supported them well and treated them with kindness and respect.

Staff did not always give patients help, emotional support and advice when they needed it. One patient who was prescribed as and when required medication for agitation was told by staff they needed to identify alternative coping strategies for taking this medication themselves rather than asking for this medication. This did not demonstrate compassionate care or support the patient to meet their needs. In addition, the same patient felt their physical health concerns had not been listened to or acted upon by staff. Their record showed that staff had not been very responsive to the concerns they raised and directed them to contact a GP themselves. This was another example where staff had not shown compassion towards a patient. However, other patients provided positive examples where staff had supported them well.

Staff did not always understand and respect the individual needs of each patient. Four patients raised concerns that staff did not always respect or meet their health, cultural or ethical dietary needs.

Not all staff felt that they could raise concerns.

Staff followed policy to keep patient information confidential.

Involvement in care

Patients were not involved actively or collaboratively in the planning of their care and treatment. Care planning and risk assessment processes were not person centred. Seven out of ten care plans and four out of ten risk assessments did not contain patient views. Staff informed patients what was in their care plans after they had been written. Patient feedback showed that the percentage of people who would recommend the service had reduced significantly and was low. However, patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. A comprehensive booklet was provided outlining what to expect on admission.

Seven out of ten care plans and four out of ten risk assessments did not record patients' views. Staff discussed care plans with patients after they had been written which was not person centred. Although patients were not involved in their care plans most patients had seen a copy of their care plan.

Inadequate

Specialist eating disorder services

Patients raised concerns about meetings to discuss their care and treatment where they felt that if they disagreed with staff, it was implied they could be discharged from the service. However, staff made sure patients understood their care and treatment. Patients attended their weekly multi-disciplinary reviews about their care and treatment where they could input and ask questions.

Staff involved patients in decisions about the service, when appropriate. The service had a monthly patient business meeting for patients to talk about any issues or concerns.

The patient friends and family test results showed a trend in reducing percentages of patients that would recommend the service across 2021. This reduced from 100% in January to June 2021, 40% for June to September 2021 and only 20% for October to December 2021. The annual patient survey was completed in August and September 2021, there was a low response rate of 23% which represented three responses. Feedback about patient experience of the service was mixed with some aspects of the service reported to be positive and other areas negative. Negative areas included noise and food quality and positive areas included how nurses and health care assistants cared about and supported patients.

Staff supported patients to make decisions on their care.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff mostly informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Five out of seven relatives told us that staff kept them updated and involved them in their relative's care and treatment. One relative had attended family therapy at the service.

Staff helped families to give feedback on the service. The service asked carers to complete an annual survey. There were only two responses to the carers survey and feedback was mixed with one positive response and one negative response about carer involvement.

Staff gave carers information on how to find the carer's assessment.

Are Specialist eating disorder services responsive?

Inadequate

Our rating of responsive went down. We rated it as inadequate.

Access and discharge

Inadequate

Specialist eating disorder services

Patients' discharge was mostly planned and managed discharge. Staff liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. The provider had implemented a new model of care that aimed to reduce lengths of stay and discharge was rarely delayed for other than a clinical reason.

Managers made sure bed occupancy did not go above 85%. The average bed occupancy over the last 12 months was 85%. At the time of our inspection, the bed occupancy rate was 67%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. At the time of our inspection, a new model of care had been implemented that set out two programmes. One was eight to 12 weeks for a period of assessment and treatment and the other was up to six months for the recovery programme. Some patients at the service had been admitted prior to this model of care being introduced and their length of stay was higher. The average length of stay at the end of December 2021 was 105 days for patients remaining on the ward and 106 days for discharged patients. The longest length of stay was 13 months.

The service had out-of-area placements. Five out of the 15 beds provided at the service were commissioned by the local area commissioners. The remaining 10 beds were marketed nationally. One patient's family was funding their care. However, staff told us that they considered the distance from home when reviewing referrals to ensure that this was suitable.

Managers and staff tried to make sure they did not discharge patients before they were ready. However, there was an example where one patient had only had very limited home leave. There was evidence of discharge meetings involving services that would provide aftercare.

When patients went on leave there was always a bed available when they returned.

The hospital had one ward, so patients were not moved during their stay.

Staff did not move or discharge patients at night or very early in the morning.

The hospital did not have facilities to provide psychiatric intensive care unit. If a patient required more intensive care, then this would need to be sought externally in consultation with commissioners.

Discharge and transfers of care

The service had one delayed discharge in the past year due to clinical reasons.

Managers monitored the number of delayed discharges.

The only reasons for delaying discharge from the service were clinical.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

Inadequate

Specialist eating disorder services

Facilities that promote comfort, dignity and privacy

The food provision was unsafe and an unacceptable quality that did not meet patients' needs and posed a serious risk to patients' physical and psychological health due to the complex needs of the patient group. The provider had stopped patients self-catering due to service change and not individual patients' needs. The hospital had limited space for activities, therapies, quiet areas and hosting visitors. However, each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe.

Each patient had their own bedroom, which they could personalise. All bedrooms had ensuite bathrooms with a shower, sink and toilet.

Patients had a secure place in their bedrooms to store personal possessions. There was a storage cupboard with individual boxes for each patient that contained risk items. However, the blanket restrictions log did not specify which items were considered risk items and none of the patient risk assessments contained an assessment on access to risk items.

The hospital had limited rooms to support treatment and care. Aside from patient bedrooms, the ward environment had the following rooms: a lounge, a conference room, a therapy kitchen/laundry room, a dining room, a group therapy room, a clinic room, a treatment room and a bathroom. To increase facilities, the provider had introduced two sheds in the hospital garden which they had named therapy pods. The provider had longer term plans to move the hospital to another location. This was in the early stages and no suitable land or alternative premises had been identified.

Due to limited space, the service did not have dedicated quiet areas and or a dedicated room where patients could meet with visitors in private. However, during our inspection the ward had a quiet atmosphere and staff told us that patients tended to go out with their visitors.

There was not enough space for all staff, including therapy staff, to work from service at all times due to there not being enough workstations. This meant that staff, including therapy staff, were required to work from home at times and they would not be present in the service to provide direct care and support to patients.

Patients could make phone calls in private.

Access to outdoor space was appropriately restricted and permitted by staff due to the type of service. Staff permitted access to garden in line with the level of physical activity stated in patients' care plans. Staff checked patients' body temperature was 36 degrees or above before permitting access outside.

The service had appropriate plans in place for patients that reflected patient needs for the level of supervision needed to make and consume drinks and snacks. Some patients were permitted to make their own drinks and snacks and other patients required staff supervision for drinks and meals.

The service provided an unsafe and unacceptable quality and quantity of food that did not meet patients' dietary needs. Patients admitted to specialist eating disorder hospitals have complex needs and require medical stabilisation that cannot be completed in an outpatient setting. The key aims of hospital admission are weight stabilisation, restoration and maintenance.

Another provider supplied all meals and self-catering supplies under a contract. As a result of previous food quality issues, the provider had supplied ready made meals to the caterers and had stopped freshly cooked meals for the evening meal. At the factual accuracy stage, the provider told us that a new chef had been recruited and was undergoing pre-employment checks. Since our last inspection In November 2019, we received seven complaints/negative feedback relating to the quality and quantity of food to meet patients' needs.

Three members of staff and five patients raised concerns to us about the quality and availability of food provided. They told us the service ran out of staple foods regularly, food was poor quality and there was often limited or no food option to meet patients' dietary requirements. This included patients that required vegan, dairy free, gluten free and Kosher diets. Staff and patients told us it was common for patients to have to wait to eat breakfast because the service had run out of milk and examples were provided where milk had gone out of date and bread was mouldy. A patient told us they had been served food that contained plastic. One staff member reported that they had purchased food with their own personal money because the hospital did not have enough suitable food to meet patients' needs.

Following Kosher meals being provided, there was a lack of variety reported due to the same meals and desserts being ordered for many weeks.

Some patients told us that when they had been served inappropriate food that staff had challenged this as a "eating disorder behaviour" and not respected their ethical and cultural dietary requirements.

Staff and patients told us that concerns had been escalated to managers, however, the issues continued. We raised concerns in our inspection feedback about the quality of food provided, although the provider responded to our feedback, they failed to take any action in relation to food quality.

The provider had suspended patients self-catering in September 2021 because it was implementing a new clinical model of care at the service. Patients and staff told us that self-catering did not restart for any patients until January 2022 and they felt this impacted on patients' recovery. For one patient, this meant that they had stopped self-catering and would not resume this prior to their discharge where they would be living independently. The provider told us at the factual accuracy stage, that under the previous model of care self-catering would have continued for that patient and it was now following best practice guidance. However, the eligibility criteria for the self-catering pathway was vague and did not include this information.

Patients' engagement with the wider community

Staff did not routinely support patients with engaging in the wider community and activities outside the service. However, there were examples where family therapy had been provided to support family relationships and staff supported patients to go out into the community to complete activities such as shopping and walks.

Most patients had a form of employment or education which had been put on hold whilst patients focused on their care and treatment. Patients had goals to resume their studies and/or return to work in the future when they were able to.

Patients had access to their own phones to stay in contact with families and carers.

Inadequate

Specialist eating disorder services

Although patients went out into the community with staff for walks, to complete personal shopping and activities, there were no examples where staff supported patients to develop and maintain relationships in the wider community. Staff also told us that community activities such as social eating had stopped, and they were not aware of plans for this to restart.

Meeting the needs of all people who use the service

The service had the facilities to meet the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. However, there were issues with patients receiving foods suitable to meet their dietary needs.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

The ward had the facilities to support disabled patients. Staff had received training in moving and handling people and the service had a wheelchair.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Information on complaints was displayed in the service.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service could provide a variety of food to meet the dietary and cultural needs of individual patients. However, we identified issues with patients receiving suitable foods to meet their dietary needs.

Patients had access to spiritual, religious and cultural support.

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.

Patients, relatives and carers knew how to complain or raise concerns. In the previous 12 months, 11 complaints had been made. Four of these complaints were upheld, 5 were partially upheld, no complaints were not upheld, and no complaints were referred to the parliamentary health service ombudsman.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and provided an outcome and an apology to patients. Staff received learning from complaints quarterly in a newsletter.

Inadequate

Specialist eating disorder services

Patients reported that when they raised concerns, they felt staff implied they could be discharged from the service which meant that there was a risk that patients may not complain about their experience.

Staff knew how to acknowledge complaints.

None of the patients that we spoke with told us that they had raised a formal complaint, so we were unable to check if they had received feedback.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Are Specialist eating disorder services well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Some staff and patients told us that leaders were not approachable. Leaders did not always have a good understanding of all areas of the service. However, leaders were visible in the service and had the skills, knowledge and experience to perform their roles.

Leaders were established in their roles at the service and spent dedicated time at the service.

Leaders did not understand all the issues in relation to safety and governance identified during our inspection. This included issues relating to patient safety.

Leadership opportunities were available. An example of this was that a senior nurse had recently been appointed to the clinical manager role. However, one staff member told us they did not think there were equal opportunities for all staff for leadership development.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team. However, although there were meetings about the new clinical model, staff felt they did not have the opportunity to be meaningfully involved in discussions about the new model of care that was being implemented at the service.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.

Although the service held sessions to discuss the new clinical model, staff did not feel that they had the opportunity to contribute to discussions about the strategy for the service, especially when the service was changing. The clinical model for the service had changed in October 2021 and staff who were working at the service at the time told us that they felt the new clinical model had been introduced and imposed without meaningful input and full involvement.

Leaders could explain how they aimed to deliver high quality care within the available budgets.

Culture

This service had warning signs of a closed culture. Cultural issues were reported by most staff and managers. Some staff told us that they did not feel respected, supported and valued. Some staff told us that they could not raise concerns without fear of retribution and opportunities for development and career progression were unfair. Cases of bullying and harassment were reported to us. However, the provider had commissioned an independent external review of culture and safety of the service.

Patients and carers reported that staff did not always respect or treat patients with kindness or compassion. Patients' needs were not always met by staff. There were issues with openness and transparent because incidents were not always reported appropriately internally and externally.

Some staff told us that they did not feel respected, supported and valued by managers. These staff told us that they did not feel listened to and communication from managers was poor. Following raising concerns, one staff member reported that the response provided by a manager was insincere and felt their concern had not been taken seriously. We also observed a comment made by the hospital director to staff that was not conducive to an open culture where staff could raise concerns openly.

Some staff told us that they did not feel able to raise concerns without fear of retribution from managers. In the previous 12 months, five staff had raised concerns to the freedom to speak up guardian and all staff were aware of the provider's whistleblowing policy. We received three staff whistle blowings following our inspection raising concerns about the culture in the management of the service.

Some staff told us that they had experienced bullying or harassment at work or had witnessed other staff experiencing bullying and harassment. Two members of staff told us that supervision was punitive.

Recruitment and appointment of staff did not always follow the provider's policy. In one recruitment file that we reviewed, there was only one interview record when there should be an interview record completed per panel member and only one reference was received. The recruitment file did not contain an application form but did contain a curriculum vitae. However, the provider told us that they considered this process acceptable in terms of safe recruitment requirements.

The provider dealt with poor performance when needed. The provider reported that in the previous 12 months that there had been one formal grievance raised and six disciplinary investigations that related to two grievances, one external complaint and three informal complaints raised. All these cases were investigated by the provider.

Although cultural issues were reported, all staff felt positive and proud about their work and the support that they provided to patients and the team reported that staff worked well together.

Leaders told us that there had been challenges in the culture of the service and they believed that this was as a result of an unwillingness to accept the changes that were required in the service. The provider had directed managers to support staff and encourage change positively.

We raised concerns with the provider about the culture of the service and in response the provider commissioned an independent external review of the culture and safety of the service.

In the previous 12 months, the staff sickness rate was low for health care assistants and average registered nurses.

The provider had an employee assistant programme for occupational health and wellbeing.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and risks were not managed well. The new clinical model of care was not embedded in the service and tools were not in place to enable staff to deliver this in practice.

Governance systems and processes were not effective because they did not identify, assess and address all areas of quality and safety in the service. We identified issues with the management of risks and quality of care that either not been identified at all or the full extent had not been identified by the provider. Therefore, none or insufficient action had been taken to address these concerns.

There was a clear framework of what must be discussed at each level of the governance structure from the ward upwards to the provider's board. However, the effectiveness of governance relied on information reported and we identified that issues were not always reported appropriately.

The clinical audit programme was not comprehensive, so it did not provide assurance that staff were adhering to procedures and legislation.

The provider had implemented a new clinical model of care in October 2021. This model of care was not embedded into practice. There was no clear implementation plan or training for staff in the new model of care. The appropriate tools to enable staff to implement the clinical model of care were not in place. This meant that staff used a combination of tools from the previous model of care's pathway levels and care plans with some elements of the new model of care. Further work was required to ensure that staff and patients understood the model of care and that staff had the tools to be able to implement the model of care effectively.

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. However, systems to manage risk, issues and performance could not be effective if issues were not appropriately identified and reported.

Staff had access to the hospitals risk register. A quarterly newsletter provided staff with information on areas on the risk register.

The risk register contained five items including COVID-19 pandemic, the on call doctor rota relating to a doctor that was not at consultant level being part of the rota, some mandatory training courses not being up to date, not enough information technology equipment for staff and issues with the nurse call alarm system due to the display not matching the hospital floor plan. The issues in relation to information technology related to insufficient workstations at the service due to limited space meaning hot desks were required. At times some staff, including therapy staff, were required to work from home. As a consequence, when home working those staff would not be present in the service to provide patients with direct care and support.

There had been ongoing concerns relating to another service that shared the same building involving waste and noise. Although the provider was aware of the concerns, insufficient action had been taken to address these concerns and the issues remained ongoing.

The premises were not suitable for the service being provided. The provider had only moved into these premises in 2021 and had plans to move to another location. However, there was no plan for this to happen in the near future and no premises had been identified.

The service had business continuity plans for events that may stop the service operating as usual.

There were no cost improvements reported.

Information management

Information management systems were in place to enable managers to have access to information about the service's performance.

The service used systems to collect data from the service that was not over-burdensome for staff. All actions were centralised into one quality improvement plan which enabled clearer oversight of identified actions from meetings and audits.

Access to information technology hardware was sufficient on the ward. However, additional laptops had been implemented due to the COVID-19 pandemic and there was also not enough space at the hospital for all staff to work at the service at the same time.

Information governance systems included confidentiality of patient records.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Engagement

Managers engaged actively with 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.

Staff and patients received information about the work of the provider through meetings and bulletins.

Patients and carers had opportunities to give feedback on the service they received through surveys, the friends and family test and meetings to review care and treatment.

Patients and carers were not routinely involved in decision-making about changes to the service. However, they were informed of changes made that would affect their care.

Leaders engaged with external stakeholders such as, commissioners and other health and social care providers that formed the local provider collaborative. They made changes to the service to meet the needs of the local population.

Inadequate

Specialist eating disorder services

Learning, continuous improvement and innovation

The service was accredited by the Quality Network for Eating Disorders in May 2020 for the period up to May 2022.

The provider has a psychiatric research and ethics committee for the group that met monthly.

The provider had completed some research into whether a therapy group on over exercise was effective. This was a small scale research study and the outcome was that a further group would be run at Schoen Clinic York to evaluate the advantages and disadvantages further.

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 Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation: Patients' care plans were not always holistic or recovery orientated. Patients did not always receive care that met their needs.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: The premises did not have enough space to support patient care and staff could not all work in the service to be available to deliver patient care when needed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Medicines and emergency equipment were not always managed safely and properly. The nurse call alarm system was not up to date with the current use of the environment.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The service did not have a clear model of care with the tools and training for staff to deliver in practice. Systems and processes were not effective in assessing and improving the quality and safety of the service. There were warning signs of a closed culture and staff could not raise concerns openly.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Staff did not always refer safeguarding concerns appropriately to the local authority safeguarding team. Restrictions were not always applied in relation to individual patient risks.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff were not up to date with mandatory training. Staff did not received training in learning disabilities.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

Staff did not always treat patients with dignity and respect.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Not all reasonable and practicable steps had been taken to reduce and remove ligature risks in the care environment. The provider's policy on observation did not ensure that staff checked patients regularly to ensure that they were safe and well. Patient risk assessments were not comprehensive and did not have risk management plans. There were issues with the reporting of incidents and reported incidents being rejected inappropriately.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Patients did not have access to appropriate and sufficient food to meet their dietary needs consistently.