Oak Tree Forest Limited

Ellern Mede Moorgate

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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

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

- The service did not have enough staff, who knew the children and young people well and received basic training and induction to keep people safe from avoidable harm. The hospital relied on agency staff but did not always ensure they were well trained. One agency member of staff had not received a proper induction and some did not have experience, or training, in working with patients with mental health problems and eating disorders. Some patients had to wait for assistance with personal care or for naso-gastric feeding because staff were too busy supporting other patients.
- Young people did not always get regular time with their named nurse.
- The service did not always have a qualified nurse on shift on both wards at all times.
- Not all clinic rooms were tidy. The clinic room on Aztec ward was cluttered with boxes of equipment on the examination couch. The clinical waste bin did not shut properly. These issues were similar to what we found at our last inspection.
- Care plans did not reflect children and young people's assessed needs, and were not always personalised, holistic and recovery oriented. 4 out of 5 care records we reviewed were not up to date.
- Managers did not make sure that they had staff with the range of skills needed to provide high quality care. They did not support staff with appraisals, supervision and the opportunity to learn via team meetings.
- The service did not plan and manage the discharge of children and young people well as there were no clear plans in place which showed when patients could be expected to be discharged.
- The service was not well-led. A number of issues raised at our last inspection had not been resolved including the clinic room on Aztec ward, agency staff training, and staffing levels.
- Governance processes were not effective, and audits did not always identify areas for improvement. The provider had not recognised several of the issues we found during the inspection.
- The provider had not ensured that staff had access to historical information on the new electronic care records system.
- Despite training being available, staff were not always knowledgeable about how the Mental Capacity Act applied to their work and they could not describe how they worked within the main principles of the Act. Managers did not audit compliance with the Mental Capacity Act.
- Patients did not have open access to outside space because this space was shared with adults which meant that supervision was required.
- Young people told us that although restraint was safe, not all staff carried it out consistently, because some agency staff were trained in different techniques.
- Staff morale was poor. Permanent staff felt over worked, unsupported and unable to take breaks. Some staff had been asked to act up into senior positions without the necessary training and induction. There was a high turnover of staff, and the hospital ward manager posts were vacant

However:

- The wards were safe and clean, well maintained and fit for purpose. Most patients and carers were happy about the quality of the facilities. The food on offer was high quality and varied enough to meet each patient's preferences.
- Medicines management had improved, and regular physical health monitoring was well embedded, especially for patients with complex needs. Staff followed good practice with respect to safeguarding.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents thoroughly and shared lessons learned with the whole team and the wider service.

Summary of findings

- The staff team included a full range of specialists including consultants, doctors, psychologists, an occupational therapist, a speech a language therapist, a dietitian, and a specialist learning disability nurse. The hospital had a lead for autism, senior support workers and activity co-ordinators to support patients in building their skills and confidence.
- Feedback from all the patients and carers we spoke with confirmed that permanent staff treated patients with compassion and kindness, respected their privacy and dignity, and understood their individual needs. They actively involved young people and their families in care decisions and kept them informed of significant events.
- Feedback from most of the patients we spoke with confirmed that patients were making good progress towards their recovery goals. The hospital had developed a step-down facility to support patients that were not ready to be discharged but did not require hospitalisation. This was not yet operational when we inspected the service. Staff made adjustments for young people with disabilities and other specific needs. All the patients who required it had a communication passport in place.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Requires Improvement 	• The service did not have enough staff, who knew the children and young people well and received basic training and induction to keep people safe from avoidable harm. The hospital relied on agency staff but did not always ensure they were well trained. One agency member of staff had not received a proper induction and some did not have experience, or training, in working with patients with mental health problems and eating disorders. Some patients had to wait for assistance with personal care or for naso-gastric feeding because staff were too busy supporting other patients. • Young people did not always get regular time with their named nurse. • The service did not always have a qualified nurse on shift on both wards at all times. • Not all clinic rooms were tidy. The clinic room on Aztec ward was cluttered with boxes of equipment on the examination couch. The clinical waste bin did not shut properly. These issues were similar to what we found at our last inspection. • Care plans did not reflect children and young people's assessed needs, and were not always personalised, holistic and recovery oriented. 4 out of 5 care records we reviewed were not up to date. • Managers did not make sure that they had staff with the range of skills needed to provide high quality care. They did not support staff with appraisals, supervision and the opportunity to learn via team meetings. • The service did not plan and manage the discharge of children and young people well as there were no clear plans in place which showed when patients could be expected to be discharged.

Summary of findings

The service was not well-led. A number of issues raised at our last inspection had not been resolved including the clinic room on Aztec ward, agency staff training, and staffing levels.

- Governance processes were not effective, and audits did not always identify areas for improvement. The provider had not recognised several of the issues we found during the inspection.
- The provider had not ensured that staff had access to historical information on the new electronic care records system.
- Despite training being available, staff were not always knowledgeable about how the Mental Capacity Act applied to their work and they could not describe how they worked within the main principles of the Act. Managers did not audit compliance with the Mental Capacity Act.
- Patients did not have open access to outside space because this space was shared with adults which meant that supervision was required.
- Young people told us that although restraint was safe, not all staff carried it out consistently, because some agency staff were trained in different techniques.
- Staff morale was poor. Permanent staff felt over worked, unsupported and unable to take breaks. Some staff had been asked to act up into senior positions without the necessary training and induction. There was a high turnover of staff, and the hospital ward manager posts were vacant

However:

- The wards were safe and clean, well maintained and fit for purpose. Most patients and carers were happy about the quality of the facilities. The food on offer was high quality and varied enough to meet each patient's preferences.
- Medicines management had improved, and regular physical health monitoring was well embedded, especially for patients with complex needs. Staff followed good practice with respect to safeguarding.

Summary of findings

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents thoroughly and shared lessons learned with the whole team and the wider service.
- The staff team included a full range of specialists including consultants, doctors, psychologists, an occupational therapist, a speech a language therapist, a dietitian, and a specialist learning disability nurse. The hospital had a lead for autism, senior support workers and activity co-ordinators to support patients in building their skills and confidence.
- Feedback from all the patients and carers we spoke with confirmed that permanent staff treated patients with compassion and kindness, respected their privacy and dignity, and understood their individual needs. They actively involved young people and their families in care decisions and kept them informed of significant events.
- Feedback from most of the patients we spoke with confirmed that patients were making good progress towards their recovery goals. The hospital had developed a step-down facility to support patients that were not ready to be discharged but did not require hospitalisation. This was not yet operational when we inspected the service. Staff made adjustments for young people with disabilities and other specific needs. All the patients who required it had a communication passport in place.

Summary of findings

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Summary of this inspection

Background to Ellern Mede Moorgate

Ellern Mede Moorgate is a hospital run by Oak Tree Forest Limited. It provides specialist eating disorder inpatient services for children and young adults.

The hospital was registered in September 2019 and provides treatment for up to 12 patients, both male and female. It has two six-bed wards. Inca ward is for young people aged 8 to 18 and Aztec Ward is for young adults aged 18 to 25. It offers treatment to patients with complex eating disorders and can support patients who require nasogastric feeding. The hospital has an on-site school to provide patients with an education during their admission.

The hospital had a registered manager and a nominated Controlled Drugs Accountable Officer (CDAO) in post at the time of our inspection. This was the same person.

The service is registered by the CQC to provide the following registered activities:

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

The service has been inspected twice previously since it opened. The last time was in September 2022 where we carried out a focused inspection as a result of concerns. We inspected the safe and well led domains and the provider was rated as requires improvement overall. We undertook this inspection of Ellern Mede Moorgate to find out if the provider had made improvements since the last inspection. We carried out an unannounced comprehensive inspection of all key questions. Although the provider had made improvements, there were still areas that required improvement.

What people who use the service say

We spoke with 5 patients and 4 carers of current patients. They told us that overall, the care at the hospital was good and patients felt safe. However, they said there was not always staff around when they needed them, especially on Aztec ward. They told us that there were many agency staff working on the ward and sometimes not enough familiar faces. Some people we spoke to felt some agency staff were not as caring as more permanent or regular agency staff.

Most patients and carers thought the hospital was clean and well maintained with good facilities, but one carer fed back that the visitor rooms were not homely or welcoming. Most of the patients we spoke with felt they had made good progress with their recovery, though one person with complex needs thought that staff could do a lot more to improve the quality of their care. We raised this with the provider following the inspection.

Patients gave excellent feedback about the quality of psychological therapy and also about the quality of the food. However, 2 carers fed back that they did not have access to family therapy when they thought this would have been useful.

Carers and patients thought that doctors, staff and managers were approachable and took any concerns seriously. They knew how to complain and were given opportunities to provide feedback about the service.

Summary of this inspection

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location. During the inspection visit, the inspection team:

- toured the building and looked at the quality of the environment,
- observed how staff were caring for children and young people
- spoke with 5 patients and 4 carers
- spoke with the registered manager for the service
- spoke with the consultant, the clinical services manager and the medical director
- spoke with 18 other staff members including doctors, nurses, support workers, allied health professionals, domestic and administrative staff
- attended and observed one morning communication meeting
- attended and observed the multidisciplinary meeting for 2 patients
- looked at 5 care records of patients
- Spoke with the independent mental health advocate for the service
- received feedback from one service commissioner
- reviewed the management of medicines, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

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 trust 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 provider must ensure that there are enough staff who are appropriately trained, supervised and supported to provide consistent care to patients. (Regulation 18)
- The provider must continue to ensure that staffing levels are reviewed so that patients are not left waiting for essential care. (Regulation 9)
- The provider must maintain and accurate, complete, and contemporaneous record to ensure care plan documents are up-to-date and reviewed in line with the provider's policy. The provider must also ensure staff can access historical data on the care records system. (Regulation 17)
- The provider must ensure staff understand how the Mental Capacity Act and its code of practice applies to their work. The provider must audit compliance with the Mental Capacity Act and the Code of Practice. (Regulation 17).
- The provider must ensure that each young person has a clear discharge plan which is monitored and reviewed to ensure the length of stay is appropriate for each patient. (Regulation 9)
- The provider must ensure that there is a qualified nurse on each ward, on all shifts. (Regulation 18)The service must ensure leaders have oversight of processes to improve staff morale and staff support. This includes ensuring there are adequate systems for team meetings, enabling staff to have regular breaks and appropriate support for staff acting up into senior roles. (Regulation 18).

Summary of this inspection

Action the service SHOULD take to improve:

- The provider should ensure they continue to monitor the clinic room on Aztec ward to ensure it is clean and tidy, with no apparent safety hazards.
- The provider should ensure that staff always have access to on-call assistance at the time they need it.
- The provider should ensure that all staff working in the service are aware of all ligature anchor points and are trained in safe environmental management
- The provider should ensure that there is a review of outside space to ensure all patients have free access.
- The provider should ensure that they review the suitability of visitors rooms and spaces.
- The provider should ensure that family therapy is available for patients and their families.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Specialist eating disorder services

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

Is the service safe?

Requires Improvement

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

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. The provider commissioned thorough health and safety reports, which we looked at as part of our inspection. There was also an on-site team responsible for maintenance and for carrying out any remedial works.

Staff could not observe children and young people in all parts of the wards. However, staff used regular observations in line with the individual risk assessments of patients. Mirrors had been placed throughout the wards to help staff observe patients and closed-circuit television was available in communal areas such as the corridors and lounges.

The ward complied with guidance on mixed sex accommodation. The accommodation was mixed sex, but 10 of the 12 bedrooms were ensuite. There were 2 female- only bedrooms that shared a bathroom. Staff explained how adjustments were made to the wards to ensure that single gender spaces could be provided on both wards as and when required.

Some staff did not know about all potential ligature anchor points, but the provider mitigated the risks to keep children and young people safe.The wards had anti-ligature fixtures and fittings that reduced the risk of fixed ligatures within the hospital. They had not had any ligature incidents from a fixed point in the previous 12 months. The provider had an up-to-date ligature risk audit, and most of the staff were aware of it. However, we spoke with one new agency nurse on the day shift that was not aware of what the ligature risks were on Aztec ward. The manager explained that this nurse would not have any unsupervised contact with any patients until she had been through an induction. She was there to help put patient feeds together and administer medicines but was supported by the registered manager and the clinical services manager throughout the shift.

Staff had easy access to alarms and children and young people had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well- furnished and fit for purpose. We toured the wards and spoke with patients to confirm our findings. The provider had an on-site maintenance team that responded quickly when needed. In one patient bedroom, the air conditioning had not been working since November 2022. We raised a concern about this because the patient involved spent all their time in their room. Following the inspection, the provider confirmed that it had been repaired and a mobile air conditioning unit had been installed in the intervening period.

Staff made sure cleaning records were up-to-date and the premises were clean. We spoke with cleaning staff and looked at cleaning records to confirm this. Patients and staff told us the hospital was always very clean.

Staff followed infection control policy, including handwashing. The provider had a named infection control lead who carried out monthly audits.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The resuscitation equipment was suitable for use with young people, but was in Aztec ward's clinic room, on the ground floor. Staff carried out regular drills to ensure the equipment could be transported to Inca ward in a timely manner. The provider also planned to install additional resuscitation equipment on Inca ward, following an incident where a patient required oxygen.

Staff checked, maintained, and cleaned equipment. However, on Aztec ward, the clinic room was still cluttered with boxes of equipment on the examination couch and an unused piece of medical equipment had been discarded on the floor. The clinical yellow waste bin did not shut properly. . Staff confirmed that equipment would be taken to the patient's room if they required examination, or they could use the couch on the other ward.

Following our inspection, the provider confirmed they had addressed the issues we found in the clinic room on Aztec ward, and the leadership team were carrying out weekly quality walk-rounds to ensure tidiness was maintained.

Safe staffing

The service did not have enough nursing staff to keep patients safe. The service relied on agency staff, who did not always know the patients well. The service did have enough medical staff who knew the patients well.

Nursing staff

The service did not have enough nursing and support staff to keep children and young people safe. The service relied on agency staff, who did not always have the right experience necessary to care for patients with mental health issues, including eating disorders. This was a concern at our last inspection. Permanent staff felt this put them under more pressure particularly when patient acuity was high, as they were most familiar with the patients and their needs.

In the period 1 December 2022 to 31 May 2023, there were 17 shifts, where there was only one qualified nurse to cover both wards. Thirteen of these shifts, (8-day shifts and 5-night shifts), were covered by a nurse that was not a registered mental health nurse, but for 7 out of the 8-day shifts, the registered manager, a qualified mental health and learning

disability nurse was counted into the numbers. On the night shifts, non-mental health trained nursing staff had access to an on-call manager, who was a mental health qualified nurse. However, there was one incident where a nurse had not been able to contact the on-call nurse because they did not answer their phone. There was no harm caused to the patient.

The service had high vacancy rates. The provider had 21 vacancies for health support workers and 5.5 vacancies for nurses. The provider had appointed a specific worker to help them recruit more staff and they had started to use a small pool of bank staff to cover nursing and support worker shifts. In the meantime, the clinical services manager had stepped in to support the nursing and senior health support workers to manage the wards. However, there was no identified cover when they were not available. Following the inspection, the provider told us they had recruited a nurse manager for each ward and the post on Inca ward had been filled. The position on Aztec ward was being advertised.

The service had high rates of agency nurses and support staff. Average agency use over the previous 3 months was just under 70% for nurses and 68% for health support workers. This was similar to what we found at our last inspection in September 2022.

Managers tried to limit their use of bank and agency staff and requested staff familiar with the service. The hospital manager had worked with agencies to try to ensure only staff that had worked at the hospital previously were offered shifts and many of the agency staff on the ward had worked there a number of years. However, there was still a shortage of regular agency nurses, which meant additional pressure on senior support workers running the shift, in the absence of ward managers.

Managers made sure most bank and agency staff had a full induction and understood the service before starting their shift. We spoke with staff to confirm this. Non-regular agency staff had an induction booklet and were shown around the hospital. However, we spoke with one new agency nurse that had not had a proper induction and was not familiar in working with patients with mental health issues or eating disorders.

The service had high turnover rates. In the previous 12 months the turnover rate was 53%, which meant a high proportion of staff had left the service. There were numerous reasons for this including career progression, and the role not suiting the staff who had left. The manager held recruitment days to try and give potential recruits a better insight into the role and improve retention rates.

Managers supported staff who needed time off for ill health. Staff had access to health and well-being support through an external company and an on-line app they could access.

Levels of sickness were slightly higher than for the provider's 3 other locations. The sickness absence rate for this location was 7%. This comprised mainly of short-term absences and a number of staff had suffered injuries from being assaulted by patients.

Managers had not accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Managers had recently carried out a review of core establishment staffing levels. On the day shift, minimum staffing levels were 1 nurse and 3 health support workers per ward and on the night shift, there was 1 nurse and 2 health support workers. Additional staff were brought in to support patients who needed on-going enhanced observations. However, staff and patients generally did not think there was enough staff to assist with feeding and helping patients with personal care. One patient told us they often had to wait to use the bathroom because there were not enough female staff to respond at the time, they needed it. The same patient also had to wait sometimes to see their key workers for planned sessions because they were involved in assisting with other patients on the ward.

The nursing management team could adjust staffing levels according to the needs of the children and young people. Additional staff were brought in to cover enhanced patient observations but all the staff we spoke with told us they were stretched and found it difficult to get breaks. The provider had agreed to pay staff in lieu of breaks, and they provided free snacks for staff. We checked staff rotas for the previous 3 months, and found they exceeded minimum safer staffing levels as long as nurse managers were counted into the numbers. Staffing shortages were most acute on Aztec ward, which was the ward providing care for adults with complex needs.

Following our inspection, the provider told us they had booked an additional nurse and additional health support workers on the day shift on Aztec ward to ensure staff could rotate regularly and take their breaks.

Children and young people did not always have regular one to one sessions with their named nurse. Patients told us they had regular time with their named support worker but there was a lack of permanent nurses. The clinical services manager acted as the named nurse for a patient with complex needs because of the shortage of permanent nursing staff, but there was no-one identified to cover this if this manager was absent.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed. Patients and staff confirmed that activities usually went ahead despite any staff shortages. On weekday shifts during the day, each ward had an additional staff member to assist with patient activities, therapeutic support and escorting patients out of the hospital grounds. There was also a therapeutic support worker, across the hospital, dedicated to supporting patients with autism.

The service had enough staff on each shift to carry out any physical interventions safely, but not all staff on shift had received training in restraint. We looked at records and spoke with staff to confirm that most staff received their restraint training before being counted into the numbers on a shift but on Aztec ward, we saw 1 non-regular agency nurse that had not had restraint training. They confirmed they would not be involved in restraining patients until they had received this training. The staff we spoke with felt more confident to use the restraint techniques than they did at our last inspection. The restraint techniques practised by provider and agency staff were accredited by the British Institute for Learning disabilities.

Staff shared key information to keep children and young people safe when handing over their care to others. Staff participated in a handover at the start of every shift. Managers had made improvements to the handover process to ensure the documentation clearly outlined the key risks and observation levels for each patient. In addition, we observed a second morning meeting that took place on weekdays, where managers and the multidisciplinary team shared information arising from the handovers on both wards. On Monday mornings, there was an extended meeting to review handover information from the weekend.

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 employed 2 full-time doctors who participated in an out of hours on-call rota. The on-call rota was shared between staff at the provider's other hospital in the region. Staff reported they could always access a consultant when they needed to.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift. We confirmed this when we spoke with a locum doctor who had been working in the service for around 2 years.

Requires Improvement

Specialist eating disorder services

Mandatory training

Staff had completed and kept up to date with their mandatory training. The staff we spoke with confirmed this and the completion rate for mandatory training was 91.9%. Most of the learning was e-learning but some courses like restraint training were face-to-face.

The mandatory training programme was comprehensive, but did not always meet the needs of patients. Non-regular agency staff were not routinely provided with training in eating disorders, or how to observe patients safely. Only 56% of agency staff had received this training but the provider was engaged in a rolling programme of activity to ensure that all regular agency staff were trained in observations and working with patients with eating disorders.

Managers monitored mandatory training and alerted staff when they needed to update their training. We confirmed this when we spoke with staff.

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, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed a sample of patient records to confirm this.

Management of patient risk

Staff knew about any risks to each child and young person and acted to prevent or reduce risks. Managers had made changes to the handover and observation processes to ensure that each patient's risks and observation levels were clearly visible to staff on the observation paperwork.

Staff identified and responded to any changes in risks to, or posed by, children and young people. As a minimum, each patient's risks were reviewed weekly by the multidisciplinary team, but risks could be identified, and observation levels changed following the morning handover meetings.

Staff followed procedures to minimise risks where they could not easily observe children and young people. Staff used regular observations in line with patients' risk assessments to reduce risks. All patients were on a general observation level, so staff knew where patients were on the ward, but some patients were on enhanced observation levels in line with their risks.

Staff did not always follow hospital policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. The provider made us aware of an incident where staff had not followed the search policy allowing a patient to secrete a ligature to attempt to harm themselves. The provider had investigated the incident and reminded staff about following the policy. The manager told us they had arranged for further training for staff, but we could not see any reference to this in the action plan following the incident review.

Requires Improvement

Specialist eating disorder services

Use of restrictive interventions

Levels of restrictive interventions were high. The provider used high levels of restrictive interventions which reflected the number of planned nasogastric feeds. There was also a patient that required a lot of restraint due to their levels of self-harming behaviour. In the 3 months before our inspection, there was an average of 38 restraints lasting longer than 10 minutes on Inca ward and, on Aztec ward, there were 89. Since our last inspection in September 2022, and the arrival of the new registered manager, there had been zero prone restraints across the hospital, which was an improvement on previous practice.

Staff did not participate in the provider's restrictive interventions reduction programme. The provider had a policy on restrictive practice and the use of force. The staff we spoke with were unaware of any specific programme to reduce restrictive practice, and were not involved in any meetings. However, some staff were working closely with an external specialist practitioner to reduce the levels of restrictive interventions with one particular patient.

Staff made attempts 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. Patients completed a patient inclusion in least restrictive intervention management plan (PILRIMP) with staff. This allowed patients to discuss their preferred de-escalation methods and what strategies might be used in the event of a crisis. The strategies identified within the PILRIMP were personalised and specific to the individual patient. We reviewed a sample of these when we looked at patient records. Patients gave us mixed feedback about staff skills in verbal de-escalation. Two patients said that some staff were more skilled and more patient than others and would try harder to use verbal de-escalation instead of putting hands on. Permanent staff and regular agency staff completed the provider's own restraint training, which was accredited by the British Institute for Learning Disabilities, (BILD). Non-regular agency staff completed accredited restraint training before starting shift and we confirmed this when we looked at agency staff training records and spoke with staff.

Staff understood the Mental Capacity Act definition of restraint and worked within it. They understood the principles of using restraint that was proportionate to the risk. Patients gave us mixed feedback and said some staff were more skilled than others at using restraint techniques, but none reported any injuries sustained as a result of being restrained.

Staff followed NICE guidance when using rapid tranquilisation but staff on site could not find rapid tranquilisation records for patients and the provider did not routinely audit whether physical observations had been carried out following its use. Following the inspection, the provider sent us an example of observations that had been carried out following rapid tranquilisation administration for one patient in May 2023. In May 2023, this procedure had been used 4 times on Aztec ward and 4 times on Inca. Following our inspection, the provider confirmed they would establish a routine audit to assure themselves that staff followed the appropriate guidance after administering rapid tranquilisation on every occasion.

When a child or young person was placed in seclusion, staff kept clear records and followed best practice guidelines. The hospital did not have a dedicated seclusion room, but there was a patient that was secluded in their room due to their own self-harming behaviour. Staff carried out regular nursing and medical reviews with this patient and there had recently been several independent reviews of their care.

Safeguarding

Requires Improvement

Specialist eating disorder services

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. They received training in both adult and child safeguarding.

Staff kept up to date with their safeguarding training.

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. We interviewed staff at all levels to confirm this and staff received mandatory training in equality and diversity.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The provider had a dedicated patient safety lead who was a qualified social worker and one of a number of safeguarding leads at location and provider level. The patient safety lead met regularly with the hospital social worker and, together, they were in the process of re-establishing regular meetings with the local authority safeguarding team.

Staff followed clear procedures to keep children visiting the ward safe. Patient's visitors were not allowed on the ward but there were several rooms patients could use to see visitors.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital employed a qualified social worker who provided support and guidance to staff about safeguarding concerns.

Staff access to essential information

Staff did not always have easy access to clinical information, and it was not always easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, but not all staff could access them easily. Permanent staff and regular agency staff had their own log-in to the system but some of the staff we spoke with did not always know where historical documents were stored. For example, staff could not locate one patient's previous capacity assessment or a health action plan for another patient. The provider had recently changed their electronic patient recording system and staff were not always clear about how to access historical information. The new system, however, was easier and clearer for staff to use than the previous system and generally patient notes were comprehensive.

Records were stored securely. There was a security protected system in place and staff had individual passwords to log-on.

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.

Requires Improvement

Specialist eating disorder services

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The provider had made significant improvements since our last inspection in September 2022. They had installed an electronic medicines administration system, which had reduced errors significantly, but we found one out of date medicine on Inca ward, which had not been removed.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and carers about their medicines. We checked patient records and found that hospital doctors and an external pharmacy reviewed patients' medicines regularly. Information leaflets were given to patients when they started on new medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. The hospital had a controlled drugs accountable officer registered with the Care Quality Commission.

Staff followed current national practice to check patients had the correct medicines. Staff had access to the current version of the British National Formulary, including the children's edition on Inca ward.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. Managers and pharmacy staff cascaded information to staff as necessary.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. None of the patients were prescribed high dose antipsychotic drugs. Patient and families were encouraged to attend the multi-disciplinary meetings and could challenge decisions about prescribing. We confirmed this when we spoke with staff and carers.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance. We looked at a sample of physical health monitoring records and saw that staff took physical health observations and responded appropriately when indicated.

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.

Staff knew what incidents to report and how to report them. We spoke with staff who told us they knew how to report incidents and gave us examples of where they had done so.

Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff reported serious incidents clearly and in line with the providers policy.

The service had no never events on any wards.

Requires Improvement

Specialist eating disorder services

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong. We looked at a sample of serious incidents and to a duty of candour letter to confirm this.

Managers debriefed staff after serious incidents, but staff told us they did not feel supported day-to-day with the emotional demands of the work, particularly with patients that required prolonged holds. Therapy staff did offer support and debrief which staff utilised, however staff did not feel this was enough especially in the light of the vacancies for the ward managers. Following our inspection, the provider confirmed that they would be strengthening supervision and support structures following an internal review of the culture of the wards.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. The provider had a patient safety lead that supported hospital managers to investigate serious incidents. We looked at a sample of serious incident reports to confirm that improvements had been made in this area and there was no longer a backlog of incidents awaiting review.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw examples of bulletins that managers circulated to staff with clear evidence of lessons learned. Staff could tell us about what had changed as a result of recent incidents.

Staff met to discuss the feedback and look at improvements to patient care. The hospital manager delivered workshops with staff where themes from incidents were discussed .

There was evidence that changes had been made as a result of feedback. Managers had made improvements to the handover and observations processes following an incident where a young person attempted to harm themselves while being closely observed.

Is the service effective?

Requires Improvement

Our rating of effective went down. We rated it as 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, but these were not reviewed or updated as regularly as they should have been. Care plans did not always reflect children and young people's assessed needs. They were not always personalised, holistic or recovery oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after. We looked at a sample of care records to confirm this.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. There was evidence in the care records we looked at that frequent physical observations were taken and recorded as requested by the medical team. Patients that needed them had health action plans and one patient told us that staff had been instrumental in identifying a serious underlying health condition.

Staff did not always develop a comprehensive care plan for each child or young person that met their mental and physical health needs. They did not always review and update care plans when children and young people's needs changed. We looked at a sample of 5 care records of current patients. Four out of the 5 care plans we looked at did not contain evidence that they had been reviewed in line with the provider's policy, which was monthly or as clinical need required. In one patient's care record, the care plan stated that the patient was receiving 4 naso-gastric feeds per day, but this was incorrect, and the patient's feeds had been reduced to 2. In the same patient's record, we could not find evidence of a care plan for the patient's use of glasses.

Care plans were not always personalised, holistic or recovery orientated. Some of them contained standard statements, which were not specific or measurable. However, most of the patients we spoke with reported they did feel there was a collaborative approach to their care, and some had made good progress with their recovery. The care planning documentation did not always reflect this.

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. The provider had recently recruited to a number of previously vacant posts including a psychologist and an occupational therapist. The service also had an autism lead who was in the process of being trained to provide additional support to autistic patients.

Staff delivered care in line with best practice and national guidance. The provider had a medical director and a lead psychologist to ensure treatments were delivered in line with relevant bodies including the National Institute for Health & Care Excellence.

Staff identified children and young people's physical health needs and recorded them in their care plans. Some patients had specific health action plans if they needed more support with physical healthcare.

Staff made sure children and young people had access to physical health care, including specialists as required. We saw in care records that dentists, opticians and other healthcare professionals visited the wards to see patients. Several patients had been referred to external specialists for other health concerns.

Staff met children and young people's dietary needs, and assessed those needing specialist care for nutrition and hydration. The service had a dietician and a speech and language therapist working across both wards. Just over half of the patients were being fed by naso-gastric tube and the chef worked jointly with the multi-disciplinary team to ensure other patients' nutritional requirements were being met.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. We confirmed this when we spoke with patients and staff. Staff organised group activities both on and off the wards.

Requires Improvement

Specialist eating disorder services

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. For example, the hospital used the Health of the Nation Outcome Scales (HoNOS) Children's Global Assessment Scale (CGAS) regularly to monitor patient's progress, symptoms and wellbeing. Staff regularly monitored patients' reported improvements in anxiety, depression and symptoms of anorexia.

Staff used technology to support children and young people. Patients had access to a tablet computer and a projector had been purchased to enable one patient to play movies in their room. Patients that wanted them had access to noise cancelling earphones. One patient who was noise sensitive told us the headphones were not effective, but staff were trialling different models to identify the most effective ones.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The provider had a comprehensive annual audit schedule showing which audits had been completed and which were due.

Managers used the results from audits to make improvements, but some audits did not always identify that improvements were required. For example, we saw that regular care plan audits were taking place, but they did not identify that some plans had not been reviewed or that they were not always reflective of all the patients' needs.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of children and young people on the wards. Managers did not always make sure agency staff had staff with the range of skills needed to provide high quality care. They did not support staff with appraisals, supervision, but they had opportunities to update and further develop their skills. Managers did not always provide an induction for new or newly promoted staff.

The service had (access to) a full range of specialists to meet the needs of the children and young people on the ward. In addition to the medical team, the provider employed psychological therapists, a speech and language therapist, a dietician, social workers, and a learning disability nurse and therapeutic support workers with access to enhanced training. An occupational therapist was due to start in June 2023. There was limited access to family therapy within the hospital, but some families had received this.

Managers did not always ensure staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff. Staff told us they sometimes struggled with having enough female members of staff on the shift, so one patient sometimes had to wait to have their personal care needs met. Only 65% of agency staff had received training in working with patients with eating disorders and some agency staff did not have any mental health experience. The provider was working to ensure that all regular agency staff had access to the same training as permanent staff but sometimes the provider had to use non-regular agency staff to help cover shifts. The provider had only 4 nurses trained to insert naso-gastric feeding tubes, which meant that sometimes there was delay in patients receiving their feeds. One patient told us to us that their feeds were sometimes delayed, and, on the day of our inspection, we saw that one of their feeds had been delayed by 10 minutes. The provider told us a further 3 nurses were booked to attend the training in June 2023. Permanent health support workers were appropriately trained, and many had completed the care certificate, which aims to equip health and social care support workers with the knowledge and skills needed to provide safe and compassionate care.

Managers did not always give every new member of staff a full induction to the service before they started work. We spoke with several senior support workers who had not had a specific induction to enable them to act up from a

support worker position. We saw 1 agency nurse that had not received an induction before working on Aztec ward. The provider could only evidence that 56% of agency staff had signed to say they had received an induction before starting their shifts. Following the inspection, the provider told us they were strengthening their induction procedures and auditing whether all staff had signed to say they had received one.

Managers did not always support non-medical staff through regular, constructive appraisals of their work. Nurses and support workers told us they did not receive regular supervision and did not feel supported with the emotional demands of their work. Due to staffing issues, the provider had only established a supervision process in January 2023. Since then, compliance with supervision amongst the nursing and healthcare support had been less than 50%. Managers had established a supervision matrix and intended to carry on making improvements in this area. Following the inspection, the provider told us they had appointed additional supervisors to ensure improvements.

Managers supported medical staff through regular, constructive clinical supervision of their work. A medical director and a lead therapist at provider level supervised and supported the multidisciplinary team. In the previous three months prior to our inspection, compliance rates were 100%.

Managers did not support permanent non-medical staff to develop through yearly, constructive appraisals of their work. We did not see evidence that adequate appraisal processes had been established at the hospital. Medical and multidisciplinary staff had access to processes to support their continuous professional development.

Managers did not make sure staff attended regular team meetings or gave information from those they could not attend. Following the inspection we requested copies of team meeting minutes for the previous 12 months, but we were provided with only 1 nurse team meeting record which occurred in April 2023. Staff on the wards told us they did not attend team meetings because they were too busy delivering patient care.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The provider did not carry out any routine training needs analysis, but they did ensure staff had protected time to carry out any mandatory and role specific training. Managers usually identified training needs through analysis of incidents that had occurred on the ward.

Managers made sure permanent staff received any specialist training for their role, but not all agency staff received training in working with people with an eating disorder. Following the inspection, the provider told us that going forward, they would ensure that eating disorder awareness training would be mandatory, not just desirable, before agency staff started on shift. Regular agency staff already had access to all the training that permanent staff had, including autism and eating disorders, meal support and re-feeding syndrome.

Managers recognised poor performance, could identify the reasons and dealt with these. Although the provider had challenges with staff, patients and carers confirmed that poor performance was addressed and where agency staff were involved, they would not work on the wards subsequently. Hospital managers had access to human resource support at provider level to support them to deal with staff performance issues.

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(s) 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 one of these meetings and saw that members of the multidisciplinary team worked effectively together to ensure patients' needs were met.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. Managers had made improvements to the way staff documented and shared information about patient care following an incident involving a patient attempting to self-harm.

Ward teams had effective working relationships with external teams and organisations. For example, staff invited community teams and commissioning bodies to Care Programme Approach, (CPA), meetings. The Independent Mental Health Advocate attended multidisciplinary meetings where patients wanted that.

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. Current compliance figures were at 89%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The hospital had 2 Mental Health Act administrators that worked across 2 hospitals and covered for each other when needed.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

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.

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. We confirmed this when we spoke with the advocate who visited the service regularly and had a detailed knowledge of hospital processes and the patients that wished to engage with advocacy, which was most of them.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time. We checked a sample of Mental Health Act records to confirm this.

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 and/or with the Ministry of Justice.

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

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed.

Requires Improvement

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. At the time of our inspection, all the patients were detained.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. However, managers had made improvements to the system following an incident where a patient's section had lapsed. We checked that robust measures had been put in place to prevent repeat occurrences.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They did not understand the provider's policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17, but they did understand the principles of Gillick competence as they applied to children under 16. Staff did not assess or recorded consent and capacity or competence clearly for children and young people.

Staff received and kept up to date with training in the Mental Capacity Act, but they did not have had a good understanding of the five principles, or how the Act applied to their work. We interviewed a large number of support workers and members of the multidisciplinary team, but found they often confused consent to treatment under the Mental Health Act with capacity to make specific decisions about treatment and care which were not covered by the Mental Health Act.

There was a policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff knew how to access. Staff had devised specific forms to record capacity to consent to treatment and care, but medical staff used these to record consent to treatment under the Mental Health Act.

Staff did not know where to get accurate advice on the Mental Capacity Act and left decisions to senior medical staff.

Staff gave children and young people all possible support to make specific decisions for themselves, but they carried out unnecessary capacity assessments with patients that clearly had capacity and could give valid consent for family involvement.

Staff did not assess and recorded capacity to consent clearly each time a child or young person needed to make an important decision. Staff working on the wards did not know where consent and capacity assessments were stored on the electronic patient record, and they did not know whether any best interest decisions had been made in respect of each patient.

The service did not monitor how well it followed the Mental Capacity Act, but following our inspection, they told us they would establish an audit process and provide more robust training for staff.

Staff did understand how to support children under 16 wishing to make their own decisions under Gillick competency regulations.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Requires Improvement

Specialist eating disorder services

Kindness, privacy, dignity, respect, compassion and support

Permanent 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 5 patients and 4 carers who confirmed that most staff were caring and compassionate. However, patients reported that some non-regular agency staff were not as caring as the regular staff.

Staff gave children and young people help, emotional support and advice, but often they had to wait because they were busy with other patients, especially on Aztec ward. Following our inspection, the provider told us they would increase the number of health support workers on Aztec ward so that patients did not have to wait too long for support.

Children and young people said most staff treated them well and behaved kindly. We spent time on the wards observing how staff interacted with patients. We saw highly positive interactions between staff and patients, particularly on Inca ward.

Staff supported children and young people to understand and manage their own care treatment or condition. We saw examples of how patients were involved in co-producing intervention plans so staff would know what specific support to provide if they were in distress.

Staff directed children and young people to other services and supported them to access those services if they needed help.

Staff understood and respected the individual needs of each child or young person. Permanent staff were extremely knowledgeable about each patient's specific needs and preferences. We spoke with patients and carers to confirm this and spent time on the ward observing how staff interacted with patients.

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. For example, we saw how staff sought permission from patients before speaking with their relatives.

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. We spoke with one family who told us they had a very thorough induction to the hospital and their loved one was shown round the ward when they were admitted. Other patients and families we spoke with also confirmed this.

Staff involved children and young people and gave them access to their care planning and risk assessments. Although care planning documentation was poor, all the patients we spoke with told us they felt very involved in their care. Many did not want copies of their care plans, but they had been offered them. Some patients told us they appreciated staff setting small short-term goals with them as it was less frightening. Patients did have copies of their risk and behaviour support type plans which they were involved in producing.

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). We saw many examples where staff found different ways to communicate with patients. For example, we saw one patient had a tablet computer to facilitate communication. All the patients with a diagnosis of autism had a communication passport in place.

Staff involved children and young people in decisions about the service, when appropriate. Managers were developing ways in which patients could be involved in recruiting staff but there was more work to be done in this area.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. The hospital had activity co-ordinators that facilitated regular patient community meetings. The hospital had a 'you said, we did' board to show how staff had responded to suggestions from patients. All patients were invited to provide feedback at their multidisciplinary meetings by using a form which staff helped them to complete beforehand.

Staff made sure children and young people could access advocacy services. The provider commissioned an independent advocacy service to visit the ward weekly. All the patients in the hospital had been offered support from the service and there were posters and leaflets around the hospital. Most of the patients at the hospital had seen the advocate at some point.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with 4 carers who confirmed that staff kept them informed, but sometimes there could be delays. We saw one comment in the provider's carer survey that suggested a parent had not been informed of a significant event concerning their loved one until they had read it in multidisciplinary meeting notes.

Two carers commented that they did not have access to family therapy when they thought this could have been beneficial. Managers were aware that one therapist was trying to cover a number of different locations, but they were hoping to improve this by recruiting more staff.

Staff helped families to give feedback on the service. The provider carried out parent/carer satisfaction surveys and we looked at the latest one from December 2022. Families were asked about a range of issues and managers produced a detailed analysis of themes and trends. Overall, carers were happy with the treatment their loved ones received but they were dissatisfied with family therapy and parents groups. The families we spoke with provided similar responses.

Requires Improvement

Specialist eating disorder services

Is the service responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Staff did not always plan the discharge of children and young people well. However, 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.

The hospital provided beds on a spot purchase bases, this meant they received new referrals for patients from a range of geographical locations. The service had set admission criteria. It provided a service for young people and adults who were aged between 16 and 24 years and had a diagnosis of an eating disorder with or without co-morbidities.

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. They monitored data detailing lengths of stay for each month. For example, the average length of stay in March 2023 was 569.

Managers and staff worked to make sure they did not discharge children and young people before they were ready. The provider had a new step-down facility attached to the hospital so that young people that did not need to be hospitalised but were not ready to be discharged completely could be supported. This was not operational at the time of our inspection.

Bed occupancy was high, but, when children and young people went on leave there was always a bed available when they returned. During the period February 2022 to March 2023, the provider reported bed occupancy was 100%. All admissions were planned admissions. Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of children and young people whose discharge was delayed. From the period February 2022 to March 2023, the provider reported no delayed discharges. However, there were 2 patients in the hospital that were waiting for alternative placements because the hospital was not the right environment for them.

Staff planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. However, we received feedback from a service commissioner who thought the provider could be more pro-active with discharge planning. The provider did not have specific discharge plans for patients, but discussed discharge with patients in multidisciplinary meetings. Relevant professionals were invited to these meetings, but we could not see where each patient was along their projected discharge pathway.

Staff supported children and young people when they were referred or transferred between services. Staff supported patients to attend other services, sometimes by escorting them to the place. Depending on progress and risk, young people were escorted by staff to visit home and eventually given over-night leave to attend home by themselves.

Requires Improvement

Specialist eating disorder services

Facilities that promote comfort, dignity and privacy

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 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 could make hot drinks and snacks at any time.

Each or young person had their own bedroom, which they could personalise. We spoke with four patients to confirm that they could chose colours for their room and have pictures on the wall if they chose. All rooms were en-suite except 2 bedrooms which shared 1 bathroom.

Children and young people had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. Each ward had an activities room, a lounge and communal dining room. With support, patients could use the kitchen, for cooking sessions. Off the main wards there was some outside space and two classrooms.

The service had quiet areas and a room where children and young people could meet with visitors in private. However, some young people told us they could be disturbed by noise from other patients that might be distressed. Staff provided young people with noise cancelling earphones to reduce the impact of disturbances from other patients.

Children and young people could make phone calls in private. Patients had appropriate risk assessments in place, and most could use their own mobile phones at set times, for example, outside school activities. The hospital had put safeguards on the WiFi to ensure patients were unable to access online content which could affect their recovery.

The service had an outside space that children and young people could access easily. Dependent on risk, patients could meet visitors outside the hospital grounds. Both wards shared the garden space, but staff ensured this was used under supervision, especially if both children and adults were in the garden at the same time.

The service offered a variety of good quality food. All the patients we spoke with, that were not on naso-gastric feeds, told us the food was very good and appetising. The staff were provided with food when they were on shift and they also told us the food was extremely high quality, and delicious.

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. The hospital had an on-site school which was registered and inspected by the office for standards in education, (Ofsted). We spoke with a carer who told us the provider had done everything in their power to ensure their loved one had access to the right education for them.

Staff helped children and young people to stay in contact with families and carers. Most of the young people in the hospital were in touch with their families and, all the carers we spoke with confirmed that staff encouraged their loved ones to maintain contact with them. Carers were encouraged to visit their loved ones in the hospital as much as they wanted, though they were not allowed on the wards.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. We confirmed this when we spoke with patients and carers, all of whom gave positive feedback in this area.

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 hospital had one accessible bedroom which had wider doors and an accessible shower. Some individual patient rooms had lights that could be dimmed or changed colour if that was helpful to them. Staff allowed one patient to keep their pet in their room because it was important to them. All the patients with autism had a communication passport in place.

Staff made sure children and young people could access age-appropriate information on treatment, local service, their rights and how to complain. We saw leaflets and induction booklets for patients, which contained information about their rights and how to complain. We spoke with the advocate who visited the hospital weekly to confirm that patients had easy access to this kind of information.

We spoke with the hospital manager to confirm the service could access as needed, information leaflets available in languages spoken by children, young people and the local community.

Managers made sure staff, children and young people could get help from interpreters or signers when needed. The manager confirmed that staff and patients had access to telephone and face to face services to help facilitate communication.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. All the patients and staff we spoke with said the chef was amazing and would always prepare food in line with patient's preferences and dietary needs.

Children and young people had access to spiritual, religious and cultural support. We saw how one patient was being supported by staff to access on-line spiritual 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.

Children, young people, relatives and carers knew how to complain or raise concerns. All the patients and carers we spoke with confirmed they knew how to raise concerns and make complaints. Patients had access to weekly facilitated meetings and could raise concerns there. We saw a 'you said, we did' board at the entrance to the adults ward.

The service clearly displayed information about how to raise a concern in patient areas and patients had access to an induction booklet with details about how to complain. There were posters in patient areas about how to contact the Care Quality Commission, (CQC) and reference to CQC's role in the complaints policy.

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

Requires Improvement

Specialist eating disorder services

Managers investigated complaints and identified themes. In 2022, the provider had received 3 formal complaints, a decrease compared to 7 complaints in 2021. All 3 complaints were partially upheld, and managers had identified actions, such as further training, following analysis of them.

Staff protected children and young people who raised concerns or complaints from discrimination and harassment. Staff encouraged patients to complain where they were not satisfied. They had private time with the independent advocate if they had any concerns about discrimination.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. All the carers we spoke with thought that staff and managers were very responsive to receiving feedback and complaints. They thought that any complaints would be taken seriously and investigated thoroughly.

We could not see evidence that managers shared feedback from complaints with staff, but we did see that learning was used to improve the service. The hospital did not receive many formal complaints, but managers had improved training for staff in observing patients following a complaint from a carer.

The service used compliments to learn, celebrate success and improve the quality of care. The provider kept a log of compliments and there were numerous thank-you cards in evidence on the wards.

Is the service well-led?

Requires Improvement

Our rating of well-led stayed the same We rated it as requires improvement.

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. –

The registered manager had been in post since August 2022, and had a good understanding of the service because they had worked as a manager in the hospital previously. They were also a qualified learning disability nurse and experienced in working with patients with an eating disorder. Key senior staff members such as the medical director and clinical operations director had been in their roles for a number of years and also had a lot of experience in working with people with mental health issues and eating disorders.

All carers we spoke with, thought the senior leadership team, including the registered manager were highly approachable and responsive in helping to resolve any concerns. The staff, however, thought senior managers did not always understand the day-to-day staffing pressures on the wards. We did see evidence that the hospital manager attended multidisciplinary team meetings as well as handover meetings to support staff. Senior managers visited the hospital frequently and we saw them on the wards engaging with staff.

Vision and strategy

Requires Improvement

Specialist eating disorder services

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team. The provider did not ensure that all staff working at the service always acted within their vision and values when providing care.

The provider had a strong set of values and staff could clearly explain how they were working holistically with patients to support their physical and mental recovery. The provider had a staff charter, and staff could be disciplined for not abiding by it.

All the staff we spoke with were committed to providing high quality care and supported each other to keep patients safe and meet their needs. However, patients told us that some agency staff were not as caring as permanent staff, and some had fallen asleep whilst on their observations. Carers and patients told us that managers dealt with these incidents quickly.

Culture

Staff did not always feel respected, supported or valued. However, they said managers promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff did not always feel supported by managers with staffing issues, particularly on Aztec ward. They did not always get chance to take breaks when they should have, and they did not receive regular supervision. Following the inspection, the provider told us that on Aztec ward, they were appointing additional staff to ensure staff could take regular breaks.

The latest staff survey showed that the overall satisfaction of staff with the hospital was only 61%.

The provider had a skills development pathway in place for both registered and non-registered staff. This meant staff could be funded to for additional qualifications including nursing and nurse associate roles. We saw 2 preceptorship nurses on the wards during our inspection and both had been funded through the hospital's skills development programme. We also spoke with the hospital's autism support lead, who was a health support worker undertaking further specialist training. Other health support workers were supported to develop skills to assist allied health professionals including psychologists and occupational therapists.

The provider carried out regular staff satisfaction surveys and included appropriate questions on how managers supported staff with equality and diversity issues and anti-discriminatory practice.

The provider's patient safety lead had carried out a thorough review of the culture of the hospital to identify any emerging concerns around closed cultures. A closed culture is where there is a poor culture that can lead to human rights breaches and or abuse. The provider concluded that, although there was not a closed culture at the hospital, there were a number of recommendations for further action, such as improved staff supervision and training. The review highlighted that staff felt confident to speak up and raise concerns without fear of reprisals.

Governance

Our findings from the other key questions did not always demonstrate that governance processes operated effectively at team level and that performance and risk were managed well.

Requires Improvement

Specialist eating disorder services

Although managers had made improvements to staffing, staff training and medicines management, there were still areas from our previous inspection that had not improved. Not all agency staff were aware of the ligature risks in the hospital and not all of them had been trained to support patients with mental health issues, and eating disorders. Some agency staff worked on the ward without restraint training.

The provider had installed a new electronic records system, but staff could not find some historical information including capacity assessments and rapid tranquilisation records.

Although staff had received training in the Mental Capacity Act, they did not demonstrate a good understanding of how this applied to their day-to day-work.

When we checked care plans, we found most of them required updating and they were not always reflective of the holistic care being delivered.

Staff were not receiving regular supervision or appraisal, and could not always get breaks from the ward when they needed them. Staff that were promoted did not always have a proper induction and the provider had a number of key posts vacant including the ward managers. Some patients could not always get the support when they needed it due to staff being busy with other patients.

Audits did not always identify deficiencies and incident reviews did not always highlight actions aimed at improving practice.

However, the hospital was clean and well maintained and there was enough staff to keep patients safe. The service had enough medical cover and the provider had recently recruited to several vacant posts including a psychologist and occupational therapist. Managers had reduced some restrictive practices, and were working with a specialist external team to reduce the levels of restriction with one patient in particular.

Safeguarding processes were well embedded in the hospital and the provider had carried out a review of the culture on the wards. Managers had reviewed the backlog of outstanding incidents that we found following our last inspection, and had made improvements to the incident review process.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care, but did not always use that information to good effect.

The management team met for regular governance meetings and had access to detailed information about the performance of the hospital including incident data, staff training, admissions and discharges, outcomes and audits. We looked at the governance meeting minutes from January 2023 to May 2023 but found that minutes were not always detailed and did not always identify which members of staff were responsible for follow-up actions. There was no meeting recorded in April 2023 but nothing to identify the reason why the meeting did not happen or what took place instead. However, the hospital had an improvement plan in place and managers had made a number of improvements following our last focussed inspection in September 2022.

The hospital had a comprehensive risk register which managers reviewed regularly. The register contained appropriate control measures and was reflective of the key risks that staff were concerned about.

The service had a business continuity plan and had put this into practice when there was a failure of their electronic records system.

Information management

Staff engaged actively in local and national quality improvement activities, but health support workers were not included in these activities.

Leaders and medical staff, including allied health professionals, met to discuss improvements to care and outcome monitoring. For example, there had been improvements in access to psychological therapy for patients and a decrease in restrictive practice including prone restraints. Psychometric testing including diagnostic assessments and routine outcome measures had been reviewed to ensure the team were using the most appropriate and up-to-date measures for children and young people.

The provider had partnered with a recognised training provider to develop a bespoke training package that included specialist training for delivering naso-gastric feeding interventions under restraint. Managers at the hospital offered the training to regular agency staff and staff confidence in using the techniques had improved since our last inspection in September 2022.

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 were part of the South Yorkshire & Bassetlaw (SYB) Provider Collaborative who had quality oversight for both the children's and adults wards. They met regularly with service commissioners and engaged with other specialist eating disorder and child and adolescent mental health services in the local area.

Managers also engaged regularly with Rotherham local authority and discussed safeguarding concerns with their local designated officer, (LADO). They had a working arrangement with the local hospital who provided support and consultation on medical matters.

Learning, continuous improvement and innovation

Staff engaged effectively in quality and service improvement activities.

The hospital participated in the Quality Network for in-patient child and adolescent mental health services, (QNIC). This demonstrated an on-going commitment by the team to improve the quality of their services. Managers told us they were also planning to participate in the quality network for eating disorders.

The leadership team had regular away days to focus on quality improvement and the multidisciplinary team had been involved in reviewing the hospital's neuropsychological assessment tools and routine outcome measures to ensure they were fit for use with children and adults.

Requires Improvement

Specialist eating disorder services

However, only those support workers with the specific role of therapeutic support worker were involved in quality improvement activities. Other health support workers were not engaged in opportunities for quality improvement, which meant that managers may have missed out on their ideas.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not maintain and accurate, complete, and contemporaneous record to ensure care plan documents were up-to-date. The provider did not ensure staff could access historical data on the care records system. • The provider did not ensure staff understood how the Mental Capacity Act and its code of practice applies to their work. The provider did not audit compliance with the Mental Capacity Act and the Code of Practice.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider did not ensure that there are enough staff who were appropriately trained, supervised and supported to provide consistent care to patients. • The provider did not ensure there was a qualified nurse on each ward, on all shifts. • The service did not ensure leaders had oversight of processes to improve staff morale and staff support.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The provider did not ensure that staffing levels were reviewed so that patients were not left waiting for essential care.

This section is primarily information for the provider

Requirement notices

- The provider did not ensure that each young person had a clear discharge plan.