Oak Tree Forest Limited

Ellern Mede Ridgeway

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- 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.
- 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 service had named safeguarding committee for safeguarding concerns.
- Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery-oriented.
- Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the service they managed and were visible in the service and approachable for children, young people, families and staff.
- Staff felt respected, supported and valued. They could raise any concerns without fear.
- The service managed 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 understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Staff explained children and young people's rights to them.
- The majority of 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.

However:

- The provider did not have a comprehensive documented risk assessment of night time staffing levels across the two wards and the cottages outlining how risks were managed and mitigated to ensure that young people remained safe at all times.
- Although some recent appointments had been made, there were vacancies in some key multidisciplinary roles, such as an occupational therapist and a senior social worker. This limited the professional expertise available to the service and the young people. Turnover of staff was high within this hospital, especially for non-registered nurses
- Young people did not always feel they were involved in decisions about the service. Young people did not always get regular updates and timely information on the progression of the issues they had raised, such as information on timescales for the completion of repairs, from senior managers.
- Reflective practice groups were not regularly taking place on all wards. When they did occur no more than two or three staff were able to attend the group because the wards were unable to release staff.

Summary of findings

- Staff were not recording clearly on the medicine administration records which route the medicine has been administered by, for example orally or by nasogastric tube. Staff did not always label opened liquid medicines with the date opened and new expiry date. The service did not always report incidents of omitted doses of medication. Incidents involving medicines were not always thoroughly investigated, there was therefore a risk that learning was not identified and shared with staff.
- Whilst wards were safe, clean, well equipped and fit for purpose, furnishings were not always well maintained.
- There was nothing on display in the wards that indicated the wards were inclusive environments looking to meet the needs of those young people with protected characteristics.
- Young people were not told routinely about the closed circuit television (CCTV) cameras throughout the hospital on admission.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Good 	• The rating for this hospital remained the same. We rated this service as good.

Summary of findings

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Summary of this inspection

Background to Ellern Mede Ridgeway

We undertook this short notice announced comprehensive inspection of Ellern Mede Ridgeway as part of our ongoing monitoring and inspection of registered services.

Ellern Mede Ridgeway is a hospital run by Oak Tree Forest Limited. It provides eating disorder inpatient services for children and young people aged 8– 18 years. This hospital is for children and young people of all genders. However, at the time of our inspection the young people were all female.

The hospital has two wards and two cottages, each of these areas provides a different treatment programme.

- Lask Ward has 10 beds and offers high dependency intensive treatment for children and young people with highly complex eating disorders. This ward can support children and young people with nasogastric feeding.
- Nunn Ward has 12 beds and is a general eating disorder ward. It provides a recovery focused programme for children and young people who are stabilised and require ongoing support.
- Cottages are pre-discharge areas. Each of the two cottages have space for three children and young people who have been assessed as low risk of harm to self or others and are physically stable.

At the time of inspection, there were 25 young people aged between 12 and 18 admitted to the service.

The hospital has an on-site school to provide children and young people with an education during their admission. Ofsted were carrying out an inspection of this school at the time of our visit. The school was previously rated as outstanding in all areas in 2018.

The service has a registered manager in post and is registered by the CQC to provide assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

We last inspected this service in January 2020. The service was rated as good overall, with the safe domain being rated as requires improvement. We issued two requirement notices to the service following this inspection stating actions the service must take:

- The provider must ensure that staff complete the required physical health observations on young people following administration of rapid tranquilisation or record reasons why this was not done in accordance with best practice and the service guidelines.
- The provider must ensure that medication for young people is administered as prescribed and that adequate precautions are taken to ensure medication does not go out of stock.

What people who use the service say

Young people reported the majority of staff were kind, thoughtful and supportive. Young people commented their recovery was due to the permanent staff members. One young person commented when they were upset staff were able to comfort them and help them feel safe.

However, young people reported some agency staff were not empathetic and felt they needed more training in meal support techniques. All young people reported there were not enough staff, especially at nights and weekends.

Summary of this inspection

The majority of carers spoke with very high praise for the staff and the care that had been offered at this hospital. One carer said the service went above and beyond, and another said they looked at their child as a whole person, supporting their individual needs.

The service had received 19 compliments within the last six months. These included compliments from young people who have left the service and were thanking the service for the support in their recovery.

How we carried out this inspection

The team that inspected this service consisted of two CQC inspectors, a CQC inspection manager, a CQC pharmacist specialist, an expert by experience and a specialist advisor who had experience working within children and young people's eating disorder services.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

We used CQC's interim methodology for monitoring services during the COVID-19 pandemic including on site and remote interactions.

During the inspection visit, the inspection team:

- visited the service, observing the environment and how staff were caring for young people
- spoke with four young people who were using the service and reviewed feedback from the hospital's patient satisfaction survey.
- spoke with nine carers of those using the service
- spoke with 29 members of staff including, the clinical operations director, the hospital manager, ward managers, nurses, healthcare assistants, and a range of staff working within the multidisciplinary team such as a family therapist, headteacher, consultant psychiatrist and the human resources director.
- attended a 'morning meeting' and a multidisciplinary team meeting
- reviewed four young people's care and treatment records including specific documentation related to the Mental Health Act.
- reviewed how medication was managed and stored, including a review of medicine administration records
- reviewed three staff recruitment records
- reviewed information and documents relating to the operation and management of the service.

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Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- All young people completed a Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP) with staff. This was a set of questions which allowed young people to discuss any possible future restraints and their preferred management of these incidents. This allowed staff to support young people to develop their own personalised support plans, including triggers and preferred interventions. These plans were handwritten by the young people, in their own words.
- The hospital had developed the role of an Autistic Spectrum Disorder (ASD) lead nurse in response to the increase of referrals for young people with ASD or ASD traits, as well as an eating disorder. This role provided individual assessments and care planning for young people as well as support and guidance for staff. The service planned to increase the capacity of the ASD lead nurse by training non-registered nurses to be ASD champions.

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 SHOULD take to improve:

- The provider should ensure a comprehensive risk assessment of the staffing establishment and skill mix at night is carried out and recorded.
- The provider should continue to recruit into key multidisciplinary roles and focus on staff retention and creating career progression opportunities to reduce turnover.
- The provider should ensure that all liquid medication is labelled with the date opened and new expiry date and that medicine administration records accurately record the route of medicine administration.
- The provider should ensure that communal areas are refreshed and worn furniture replaced.
- The provider should ensure reflective practice for staff occurs, and that staff are supported to attend the sessions.
- The provider should ensure young people feel involved in decisions about the service and their own care, and receive timely and regular updates on concerns they have raised
- The hospital should ensure there is sufficient information available to young people with protected characteristics which makes it clear staff are approachable and welcoming.
- The provider should ensure staff fully inform all young people about the CCTV in operation throughout the hospital on admission

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Specialist eating disorder services

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

Are Specialist eating disorder services safe?

Good

Our rating of safe improved. We rated it as good.

Safe and clean care environments

All wards were safe, clean, well equipped and fit for purpose. However, furnishings were not always well maintained.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff could not observe young people in all parts of the wards. This risk was mitigated through regular observations and mirrors throughout the unit. Where individual young people were identified as being at risk, increased observations, including one-to-one, were used.

Staff were aware of personal items that could create potential ligatures. Staff understood the wards' ligature response protocols and knew the location of the wards' ligature cutters. Each ward had a heat map which identified high risk ligature areas in the environment. A ligature risk assessment had been carried out on 5 October 2021 for the main hospital site and 4 October 2021 for the cottages.

The ward had an action plan addressing identified ligature risks. For example, the windows in the young peoples bedrooms needed replacing to ensure they were anti ligature. Staff reported individual risk assessments were carried out for young people in these rooms and action taken to mitigate risks, such as, implementing more frequent observations.

The service had closed-circuit television (CCTV) in all communal area and corridor areas. CCTV was recorded and was used to review incidents on the wards. A risk assessment was completed when deciding where to place these cameras. There were no cameras facing young people's bedrooms or toilet areas. The wards had posters explaining there was CCTV in operation and how the young people could go about requesting more information on this. However, young people were not routinely told about the CCTV cameras on admission. Managers informed us there were ongoing discussions about including this information in the admissions handbook.

The service complied with guidance on eliminating mixed-sex accommodation. Most young people referred and admitted to the service were female. The service accepted young people who were male, and they would be accommodated on Lask Ward or in the cottages where they had single rooms. A bathroom closest to their bedroom would become a male only bathroom if a male young person was admitted.

Staff and young people had easy access to nurse call systems. Staff did not carry individual alarms. When staff needed support from colleagues, they would press the wall mounted alarms, this was the process of escalation for all wards including the cottages.

Fire safety arrangements were in place. All drills, testing and servicing was recorded in a fire folder, which was up to date with current information. The latest fire risk assessment was completed on 4 March 2021. There was evidence of regular fire alarm tests and servicing of equipment. The most recent fire drill was carried out on 7 January 2022, although there was no documented learning identified following this drill. Although the current young people did not require personal emergency evacuation plans, staff were alert to the need to develop these for young people who may require assistance to leave the building in an emergency. Staff completed fire safety training as part of their role. At the time of the inspection 80% of staff had completed fire prevention and awareness, and 78% had completed service specific fire procedure training.

Maintenance, cleanliness and infection control

Ward areas were clean, safe and fit for purpose. However, some furnishings were not well maintained and there were signs of wear and tear. For example, the paint on the walls was peeling in bedrooms and communal areas and the sofa in the lounge on the ground floor was torn. The hospital had a maintenance action plan which highlighted actions to be completed and estimated completion dates. The action plan had tasks such as re-painting bedrooms, however, this plan did not include actions to re-paint other communal areas of the ward such as the quiet room, or update worn furniture.

Staff made sure cleaning records were up-to-date and the premises were clean. We saw housekeeping staff cleaning high touch areas throughout the day.

Staff followed infection control principles including appropriate handwashing techniques, use of personal protective equipment and hand sanitiser was readily available. We observed all staff wearing face coverings in all parts of the service.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Resuscitation equipment was checked every day by ward staff. This included checking the oxygen tank, emergency drugs and the defibrillator. The hospital carried out an audit to ensure these daily checks were being completed. The records we reviewed confirmed these checks happened every day.

Ligature cutters were stored safely on each ward and staff knew where they were located, these were checked each day as per the daily clinical checks.

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

Staff recorded daily room temperatures and fridge temperatures and generally knew the actions to take if these were out of range.

Safe staffing

With the use of agency and bank staff, the service had enough nursing and medical staff who knew the children and young people and received training to keep people safe from avoidable harm.

Staffing

With the use of bank and agency staff, the service had enough nursing and support staff to keep children and young people safe.

At the time of the inspection the hospital had vacancies for 6 registered nurses, and 38 vacancies for non-registered nurses. These both had a vacancy factor of 36%. Vacancies had risen following an increase in working establishment levels for non-registered nurses. The service attempted to recruit into these positions all year round. Five non-registered nurses had been recruited and were in the process of pre-employment checks, prior to starting their roles in April 2022.

The service used agency staff and their own bank staff to cover vacant regular shifts and when additional staff were needed. When the service used agency staff, managers requested staff familiar with the service. Managers were able to book agency staff in advance in block bookings. Managers made sure all agency staff had a full induction and understood the service before starting their shift. The service had an induction checklist for agency staff which included information on topics such as fire procedures, location of emergency equipment and ensuring they were aware of the safeguarding procedures. The agency staff we spoke with confirmed they attended an induction and had access to the training offered by the provider.

Safe staffing levels were achieved on most shifts. From September 2021 to February 2022 99% of shifts for registered nurses were filled and 97% of non-registered nurse shifts.

The service had calculated the number of registered nurses and non-registered nurses required for each shift based on Royal College of Psychiatrists' Quality Network for Inpatient CAMHS (QNIC) standards. Managers adjusted staffing levels according to the needs of the young people. Additional staffing could be booked if a young person required a higher level of observation or there were pre-booked activities, which affected staffing, such as longer escorted day leave.

Due to the levels of observation and young person risk the hospital worked with a high number of registered nurses and non-registered nurses on each shift. Staffing levels were discussed each weekday morning by senior managers.

On the day of our inspection Lask Ward had two registered nurses and 15 non-registered nurses. On the night shift they had one nurse and 13 non-registered nurses. Nunn Ward had two registered nurses and 10 non-registered nurses on the day shift. At night they had one registered nurse and nine non-registered nurses. The cottages were separate to the main unit but located close by. The cottages were staffed by one registered nurse and four non-registered nurses on the day shift. At night the cottages had four senior non-registered nurses. The cottages had no allocated registered nurse on the night shift, the nurse from Lask Ward would cover the cottages when needed, for example, for medication and responding to any incidents. The hospital reported only senior non-registered nurses would be rostered to work within the cottages when a registered nurse was not present.

As there was one registered nurse allocated to Lask Ward and Nunn Ward on a night shift, there were times when the wards would be without a registered nurse, for example, when the registered nurse was on their break and when the Lask Ward nurse needed to attend the cottages. The registered manager reported that when a registered nurse had their break or left the ward they informed the registered nurse on the other ward. They reported it was unlikely the nurse would leave the hospital grounds on a night shift and would be contactable in an emergency if needed. The ward staff also had access to out of hours support from a range of colleagues such as a senior nurse a specialty doctor, a consultant, a manager, a member of the senior management team and a maintenance team member. Only very low risk young people who were nearly ready for discharge were placed in the cottages. No naso-gastric feeding, requiring a registered nurse took place at night. No incidents had occurred at night involving patients in the cottages. However, the provider could not provide us with a documented comprehensive risk assessment of night time staffing levels and skill mix across the two wards and the cottages, outlining how risks were managed and mitigated to ensure that young people remained safe at all times.

There were sufficient staff available to enable regular one to one sessions with young people took place. Young people rarely had their escorted leave or activities cancelled. The service had enough staff on each shift to carry out any physical interventions safely.

The service had day and night medical cover and a doctor was available to go to the ward quickly in an emergency.

The hospital had two consultant psychiatrists, plus a medical director who was based at the service. The hospital had three junior doctors. The doctors worked a rota to provide cover out of hours. All medical staff were permanent members of staff.

Staff turnover in the service over the last six months was 18%. For non-registered nurses the turnover figure was 28%. Some young people found working with new staff difficult. We heard concerns around young people feeling they needed to retell their stories and be supported on one to one by people who did not know them and their distraction techniques. One parent commented their child had had four different consultant psychiatrists during their admission. Two parents said each of these doctors had a different approach which they needed to get used to and readjust to their ways of working with them.

Staff reported they felt the service could do more to retain staff and described a lack of opportunities for career progression as an issue affecting retention. Staff expressed an interest in starting more apprenticeships in the service. There was currently an apprentice social worker who had just started and had previously been a support worker at the service. Senior managers were aware of the need to improve staff retention and were looking to establish more apprenticeships and career development opportunities. There was also an increased focus on staff well-being.

Over the past six months the sickness rate for the hospital had been 6%, including COVID-19 related illness. The hospital had a target of under 4% for sickness.

Mandatory training

The majority of staff had completed and kept up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of young people and staff. All staff we spoke with including agency staff reported that they had undertaken specialist eating disorders training. Agency and bank staff had access to the providers mandatory training programme.

Basic life support training was mandatory for all non-registered nurses. At the time of inspection 82% of staff had completed this training. Intermediate life support was mandatory for all registered nurses and doctors. At the time of inspection 96% of staff had completed this training

At the time of the inspection 61% of staff required to complete mandatory training on preventing and managing violence and aggression had done so. The service reported this was due to the changeover of training providers and the cancelling of face to face training during a recent COVID-19 outbreak. Senior managers reported planned training for staff in March 2022 and April 2022 which would improve their compliance figure in this area. The provider later informed us that this training had been completed resulting in a compliance figure of 93%.

The hospital had a training target of 90%. Some of the mandatory training topics fell below this target of compliance, such as, fire procedure training was 77%, health and safety awareness 78%, meal support 78% and moving and handling 59%. Since inspection the hospital reported some of these figures had been improved, for example, fire procedure training was 86% and meal support was 90%. Overall, staff in this service had undertaken 92.5% of the various elements of training that the service had set as mandatory.

Managers monitored mandatory training and alerted staff in supervision when they needed to update their training.

Assessing and managing risk to children and young people and staff

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

Assessment and management of patient risk

During the inspection, we reviewed the risk assessments of four young people. Staff completed risk assessments for each of these young people on admission. They updated and reviewed risk regularly, including after any incident.

The risk assessments included risks specific for this cohort of young people, for example, water loading and excessive exercising.

Staff knew about the risks to each young person and acted to prevent or reduce risks. Young people's risk was discussed in handover meetings which were attended by all staff on shift. These risks were also discussed at the morning meeting and the weekly multidisciplinary team (MDT) meetings. Meetings included discussions on young people's progress and changes to individual risk following incidents.

Risk management plans were discussed and updated regularly in MDT meetings. We saw evidence of risk being taken into consideration when creating care plans, such as, care plans around observation levels.

We observed a morning meeting during our inspection. Senior members of staff attended these meetings every morning and discussed observation levels, staffing and any incidents that occurred in the last 24 hours.

The service set the observation levels for young people according to the risk they presented. Some young people were on intermittent observations, which involved staff checking where the young person was four times per hour. Other

young people were on continuous observations which involved a member of staff being allocated to be with the young person at all times, for their safety or the safety of others. One young person had two staff members with them at all times due to enhanced risk. Young people's observations were reviewed daily at the morning meetings, as well as at weekly MDT meetings.

Staff followed policies and procedures when they needed to search young people or their bedrooms to keep them safe from harm. Staff were aware of these procedures.

Use of restrictive interventions

Staff had a good understanding of the provider's restrictive interventions programme. Staff made attempts to avoid using restraint by using de-escalation techniques. Staff restrained young people only when these failed and when necessary to keep the young person or others safe. There were no reported incidents of seclusion or long-term segregation.

The hospital had a policy on the prevention and management of violence and aggression. This policy made clear it was focused on how to avoid a restraint, focusing on least restrictive practice and ensuring the dignity and safety of the young people was protected. This policy was due to be updated in March 2021, however a review had not been carried out.

Between December 2021 and January 2022, the service reported 907 incidents of restraint.

Of those incidents, 873 were planned restraint intervention to support nasogastric feeds. We saw evidence of individual care plans in place for those young people who received nasogastric feeds under restraint.

We reviewed three restraint incident records. These records included information such as, the staff involved, how long the restraint lasted, the types of holds used and a record of the young person's post incident vital signs. All young people were checked post restraint for any injuries. The hospital manager reviewed all restraint incidents. These incidents were also discussed at daily handover, at the weekly ward round and at the quarterly clinical governance meetings.

Staff received a bespoke evidence-based training programme looking at restrictive interventions for its young people called Ellern Mede Restrictive Interventions Support Training (EMRIST). This training comprised of workshops, presentations and workbooks to consolidate the learning. Ellern Mede enhanced this training by adding a focus on improving the experience of nasogastric feeding for children and young people. At the time of inspection 61% of staff had completed this training.

All young people were offered the opportunity to complete a Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP) with staff. This was a set of questions which allowed young people to discuss any possible future restraints and their preferred management of these incidents. This allowed staff to support young people to develop their own personalised support plans, including triggers and preferred interventions. Some young people refused to complete this with staff, however all records we reviewed showed evidence of completed PILRIMPs handwritten by the young people.

There had been no use of intramuscular rapid tranquilisation in the last six months. The service had seen a rise in self harming and agitated behaviours over the last six months. However, staff had increased their usage of de-escalation

techniques to manage these behaviours, reducing the need for rapid tranquilisation. The hospital had a rapid tranquilisation policy which included information on what should occur after an incident of rapid tranquilisation had occurred, such as, a debrief with the young person, an MDT review and it had time scales for when physical health observations should be carried out in line with National Institute for Health and Care Excellence (NICE) guidance.

Staff applied blanket restrictions on young peoples freedom only when justified. Blanket restrictions were proportionate to the needs of maintaining safety as well as a supportive environment for an eating disorder service. For example, the service did not permit young people to bring sharp objects onto the premises and toilets remained locked after mealtimes.

The service only placed enhanced restrictions on young people if there was a specific need to do so, such as removing specific items if there was a risk of harm to self or others or restricting the amount of exercise a young person could do if this impacted on their recovery.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The service had named safeguarding committee for safeguarding concerns.

Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. All staff said they had training on how to recognise and report abuse, and they knew how to apply it. Staff we spoke with understood safeguarding arrangements in the service and could give examples of safeguarding concerns they had identified and raised. Staff felt confident that if they did raise concerns they would be listened to and action taken.

At the time of the inspection 83% of staff were up to date with their child safeguarding training.

The service had a safeguarding committee, consisting of the registered manager, social worker, lead nurse and a consultant psychiatrist. All potential safeguarding concerns identified by staff were sent to the safeguarding committee who reviewed the concern and referred on to the local authority safeguarding team if appropriate.

If an urgent concern arose at the weekend, when members of the safeguarding committee were not available, the duty doctor was expected to make the alert to the local authority.

The service took action in response to safeguarding concerns to ensure young people remained safe. The outcomes of safeguarding investigations were recorded.

The service had raised approximately 50 safeguarding concerns in the last 12 months. The most common safeguarding concerns related to disclosures of historic abuse and allegations of breaches of professional standards.

Lessons learned from safeguarding concerns were shared with all staff via email and at monthly team meetings.

The social worker received regular safeguarding supervision. They also attended a meeting with social workers from the provider's other services once a week and shared learning. The social worker knew where to get advice in respect of safeguarding concerns.

Two young people using the service had turned 18 years old and were classified as adults. They were both waiting for a place in another service. While they remained at Ellern Mede Ridgeway they were monitored by staff on a one to one basis.

Young people could receive visits from other young people such as siblings or friends. Visits were supervised by an adult and took place in a room away from the wards.

Staff access to essential information

Staff had easy access to clinical information and maintained high quality clinical records.

Young people's notes were comprehensive and all staff could access them easily.

Staff used a combination of electronic and paper files to store and record young peoples care and treatment records. These were stored securely in the nursing offices of each ward. Physical health observations were recorded on paper and stored securely in the clinic rooms. Physical health observations including weights were reported in weekly MDT meetings which were recorded electronically.

Medicines management

The service had systems and processes to prescribe, administer, record and store medicines, however staff did not always do this safely. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff administered medicines to young people in a personalised way. There were varying degrees of support depending on what each person needed.

The provider had a detailed competency workbook and assessment for medicines which all staff responsible for administering medicine had completed.

The relevant Mental Health Act forms were in place to allow for administration in the person's best interest. However, where there were multiple routes prescribed for a medication, staff were not recording clearly on the records which route the medicine has been administered by, for example orally or by nasogastric tube.

Staff reviewed young people's medicines regularly and provided specific advice to people and carers about their medicines. We saw documentation of regular multidisciplinary meetings where medicines were reviewed. Staff engaged with young people to ensure they were involved in their treatment plans. Staff provided support to young people about their medicines including family members when young people were able to go for home leave.

A pharmacist reviewed medicines each week and provided advice on administration and monitoring. There was a process for the pharmacist to raise interventions which required actioning by the clinical team. Advice from pharmacy was available remotely outside of the weekly visit and staff knew how to access this support.

Medicines were in stock, stored appropriately and did not exceed expiry date in most cases. However, we saw evidence of opened liquid medicines in the fridge that were not labelled with the date opened and new expiry date. We observed staff following processes when transferring medication between internal wards as well as on receipt of medicines from external deliveries.

The service had systems to ensure staff knew about safety alerts and incidents, so people received their medicines safely. The pharmacist produced a report to the governance committee each month demonstrating incidents and trends in incidents. This report also included issues with supply of medication. However, we also saw omitted doses in the prescription chart audit which had not been reported. Incidents involving medicines were not always thoroughly investigated, there was therefore a risk that learning was not identified and shared with staff.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Relevant Mental Health Act forms were completed and reviewed regularly. There had been no use of rapid tranquilisation in the last six months. The service had a focus on least restrictive interventions, supported by the PILRIMP. Staff we spoke with were aware of these least restrictive principals and the need for de-escalation as a first step.

We saw evidence of de-prescribing and tapering doses where young people were taking medicines for anxiety. The young person was involved in these discussions.

Staff reviewed the effects of each child or young person's medication on their physical health according to the manufacturer's instructions. A young person was recently started on a medicine which required physical health monitoring prior to starting and regularly throughout treatment. We saw evidence that the initial health checks were completed.

Track record on safety

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well.Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

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

Managers investigated incidents thoroughly. Incident reviews had detailed follow up actions and a named person who was to follow up on these actions.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us incidents were discussed in daily handover, multidisciplinary team meetings, in reflective practice, supervision and staff meetings. Monthly lessons learnt bulletins were available for staff, along with e-learning information. All incidents were analysed and any themes and trends discussed with the staff team. The service carried out monthly audits looking into themes from incidents.

Managers debriefed and supported staff after any serious incident. All staff we spoke with confirmed debriefs were held for both staff and young people.

Staff met to discuss the feedback and look at improvements to young people's care. Senior staff shared information regarding incidents and safeguarding concerns in the daily morning meeting.

Good

Specialist eating disorder services

There was evidence that changes had been made as a result of feedback. For example, following a thematic review of medicine errors, the service had made changes to the way medicines were managed. This had led to a decrease in the number of medicine errors and plans for the service to have electronic prescribing.

The service had no never events on any of their wards.

Staff understood the duty of candour. They were open and transparent and gave young people and families a full explanation if and when things went wrong. For example, the service had apologised to a young person following concerns regarding consent.

Are Specialist eating disorder services effective?

Good

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

Assessment of needs and planning of care

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

We reviewed the care and treatment records of four young people. All records had a detailed comprehensive mental health assessment on admission. Young people had their physical health needs assessed on admission, which included a full physical health check of vital signs, electro-cardiogram (ECG) and blood tests.

All young people had a formal assessment of their nutritional status carried out by a qualified dietitian on admission, in line with the Quality network for inpatient CAMHS (QNIC) Eating Disorder guidance. QNIC is a network of similar services who use a review and accreditation scheme to promote good practice.

Staff developed a comprehensive care plan for each young person that met their mental and physical health needs. We saw evidence of physical health care plans, risk care plans, dietary needs plans, and nasogastric feeding plans. These plans were reviewed weekly with the young people in MDT meetings, and updated when the young person's needs changed.

Care plans were personalised, holistic and recovery orientated. This was clearly demonstrated in the Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP) for all young people.

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.

Good

Specialist eating disorder services

Staff provided a range of care and treatment suitable for the young people in the service and consistent with national guidance on best practice.

Young people had access to psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE) including cognitive behaviour therapy, art therapy and family therapy. However, this work was for individual young people, we did not see any therapeutic groups offered as described in the QNIC eating disorder standards, due to a lack of clinical psychologists within the hospital.

Activity co-ordinators worked with the young people to design the activity programme. They provided activities which supported the young people with eating disorders, for example, they held a breakfast club once a week and also took young people out for activities, such as a social snack or a visit to a local café.

All families were offered evidence-based family interventions that addressed eating disorders and the majority of families took part.

The hospital had developed the role of an Autistic Spectrum Disorder (ASD) lead nurse in response to the increase of referrals for young people with ASD or ASD traits. This role provided assessments and care planning for young people as well as support sessions and guidance for staff on some of the links between autism and eating disorders. For example, when a young person expressed a dislike for certain foods, this may not be an eating disorder 'fear food', but an autism preference based on texture. This role was created to support young people feel heard and understood. This nurse had been able to also support families, offering sessions with carers as well as signposting them to local support services. Trend analysis had also been completed for young people with ASD, and they were able to note a trend where a young person would change their clothes before an incident, this supported staff in being able to recognise potential distress and intervene earlier to deescalate the situation.

Staff ensured young people had access to physical healthcare. The hospital had strong links with a paediatric consultant at a local paediatric hospital. They also liaised with their local hospital A&E departments to discuss the arrangements in place when one of their young people needed to visit A&E. This was to ensure a better joint working model and a better experience for all young people and staff. We also saw evidence of young people being supported to attend hospital appointments when needed.

Physical health records showed staff carried out vital signs monitoring as prescribed for each young person. These included blood pressure, temperature and oxygen saturation levels.

The service had a clear protocol on how to manage nasogastric feeding. This policy followed the National Patient Safety Agency guidance to safely insert nasogastric tubes. The policy was detailed and had a clear focus on least restrictive interventions, with an emphasis on how to avoid the need for nasogastric feeding. At the time of inspection 100% of the staff required to carry out nasogastric training had done so. The hospital also required staff to have a yearly nasogastric feeding competency test, which assessed staff's administration techniques. This competency test was also carried out following any concerns raised, such as after an incident.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. Staff completed Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS) regularly to monitor young people's progress, symptoms and wellbeing. These outcomes were recorded on a central database by the psychology team, who would review general themes and trends. Outcome measures were also used within individual meetings with young people to review care and treatment plans.

The service monitored the effectiveness of care and treatment and used the findings to improve them. The service completed clinical audits in areas such as safeguarding, consent and capacity and ligature risks. The service often used results from audits to make improvements. For example, following their most recent restrictive practices audit the hospital planned to develop their PILRIMP training to include more emphasis on positive behaviour support plans to help understand and support the young people's individual needs.

Skilled staff to deliver care

The ward teams had access to a range of specialists required to meet the needs of children and young people on the ward, although there were vacancies in some key disciplines. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills.

Staff had the skills and knowledge to meet the needs of people with an eating disorder. Many staff had extensive experience working in the eating disorders field. All nursing staff were specially trained to safely carry out nasogastric tube insertion and enteral feeding. Healthcare assistants were trained to undertake electrocardiograms (ECG) and bloods.

Managers gave each new member of staff a full induction to the service before they started work. Staff we spoke with confirmed they had undertaken a comprehensive induction programme. A booklet had been introduced to support healthcare assistants adjust to the new role. They had also recently introduced a buddy system, where a new starter would work closely with another member of staff to support them in their learning and development.

Whilst the service had a range of professionals as part of the multidisciplinary team there were some vacancies for key posts including an occupational therapist, senior social worker and clinical psychologist. This limited the professional expertise available to the service and the young people. The service tried to mitigate this by supporting other, often less experienced, staff to cover these areas of work. Occupational therapy was currently provided by activity co-ordinators and therapeutic support workers, whilst the occupational therapist position was being advertised.

Whist the clinical psychology post was vacant, the service had a family therapist, a counselling psychologist and an art therapist. Since the inspection the service had appointed someone into the role of clinical psychologist, who started in March 2022. They had also appointed a social worker due to start their role in May 2022.

All staff said they received regular supervision and appraisals. Eighty-five per cent of staff had received supervision in line with the hospital's policy, and 92% of staff had completed an appraisal in the last 12 months. Several multidisciplinary staff received external professional supervision.

All staff described good opportunities to develop their professional skills. They were able to access further training courses. For example, one staff member was due to start a one-week specialist yoga course related to working with autistic young people.

The provider had developed an online learning platform that made it easier for staff to access and engage with training and development sessions. The platform was flexible and particularly helpful for night staff, who might otherwise find learning opportunities more limited.

Team meetings occurred once a month and staff were encouraged to attend. A range of topics were discussed, such as, incidents, safeguarding, training, new referrals and any updated to the environment. All staff were able to add topics to the agenda. Minutes were kept from these meetings and available for staff to review in the nursing office.

A family therapist facilitated a reflective practice group for staff on each ward. On Nunn Ward they had been taking place every two weeks but no more than two or three staff were able to attend the group because the ward was unable to release staff. Reflective practice groups had not been taking place on Lask Ward recently as the family therapist facilitating the group had been on sick leave. The hospital manager had been offering ad hoc groups for supervision as they recognised it was difficult for ward staff to be released from their duties. The clinical operations director and hospital manager had begun offering informal 'tea and chat' sessions for staff to have a space to reflect and discuss any concerns.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers understood the processes for managing poor performance and gave clear examples of the process they would follow to manage this. This included coaching on appropriate behaviours, providing additional training and support, and disciplinary action via their human resources team when necessary.

Multi-disciplinary and interagency team work

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 teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff from different disciplines worked together as a team to benefit young people's care. They described close and supportive working relationships with other professionals. Staff focused on providing the best care and treatment for the young people in their care.

Staff held regular MDT meetings to discuss young people and improve their care. We observed a weekly MDT review meeting. This meeting allowed staff to share clear updates on each young person and reviewed their care, treatment and risk management plans. We saw different members of the MDT were listened to by colleagues and their input was valued.

We attended the hospital daily situation meeting. This involved a review of each ward, staffing status and any emerging risks for the individual young people.

Education staff at the onsite school were fully integrated into the multi-disciplinary team. They attended weekly multidisciplinary team meetings where the needs and progress of the young people were discussed. Feedback from the MDT was shared with teachers to enable consistent support to the young people when they were in school.

The hospital had effective working relationships with external teams and organisations. For example, the service had close links with the local authority safeguarding team, as well as young people's local community care teams.

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. Staff explained children and young people's rights to them.

Where young people were subject to the Mental Health Act 1983, their rights were protected. Staff complied with implementing the Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. At the time of inspection 91% of staff had completed training in the Mental Health Act.

Young people had easy access to information about mental health advocacy. The Independent Mental Health Advocate (IMHA) visited the service and supported young people during ward rounds, mental health tribunals and hearings. They supported both informal and young people detained under the Mental Health Act. The IMHA's contact details were displayed in communal areas of the ward and they visited the ward in person at least once per week. The advocate reported the hospital was very responsive to young people's feedback and any concerns raised were discussed in MDT meetings.

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

Staff made sure young people could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician.

Staff requested an opinion from a second opinion appointed doctor (SOAD) when they needed to.

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

The Mental Health Act administrator completed audits to ensure staff were applying the Mental Health Act appropriately. This included a check of the Mental Health Act paperwork, that young people were informed of their rights regularly and that treatment authorisations had been completed appropriately.

Good practice in applying the Mental Capacity Act

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

Staff had a good understanding of the Mental Capacity Act and the five statutory principles. At the time of inspection, 84% of staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

The Mental Capacity Act applies to people over the age of 16. For decisions about care and treatment in those under 16, staff referred to guidance on Gillick competence. This is a test established by case law to assist clinicians' to determine whether a child of 16 years or under is competent to consent to medical examination or treatment. If a child is Gillick competent, they can give informed consent to an informal admission and treatment.

Staff assessed and recorded competence and capacity each time a young person needed to make an important decision. When reviewing treatment records, we saw evidence of competence and capacity being assessed once per week by a doctor. These assessments included the material decision to be made, the discussion that had taken place with the patient and evidence supporting the clinician's judgement about whether the patient had the requisite competence or mental capacity to make this decision. These assessments were reviewed in weekly MDT meetings.

Good

Specialist eating disorder services

Staff supported young people to be involved and make decisions on their care for themselves. They also involved families in the decision-making process. When staff assessed a young person as not having competence or capacity, they made decisions in the best interest of the child or young person with their family and considered the young person's wishes, feelings and history.

If the hospital had concerns about the competence or capacity of a young person to make a decision, staff requested an assessment under the Mental Health Act. All patients who were fed via a nasogastric tube were detained under the Mental Health Act.

Are Specialist eating disorder services caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

The majority of 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.

We observed staff treating young people with compassion and kindness. Staff spoke with understanding, compassion and empathy when talking about young people they were caring for. Staff were passionate about their work.

Young people reported the majority of staff were kind, thoughtful and supportive. Young people commented their recovery was due to the permanent staff members.

Staff gave children and young people help, emotional support and advice when they needed it. One young person commented when they were upset staff were able to comfort them and help them feel safe.

However, some young people reported some agency staff were not empathetic and felt they needed more training in meal support techniques. All young people reported there were not enough staff, especially at nights and weekends. Young people commented there were not enough staff to carry out activities on weekends or open the toilet doors at night. They reported this led to less activities on these shifts and one young person said it was difficult to find free members of staff on the night shift when needing support.

Staff understood and respected the individual needs of each child or young person. This was seen in the Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP) where young people were able to write in their own words the interventions that work well for them.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards young people. Staff we spoke to felt confident in raising issues with managers. Staff had received additional training on boundaries within therapeutic relationships. At the time of inspection 92% of staff had completed boundaries for staff training.

Staff followed policy to keep young people's information confidential. Information was kept in nursing offices. Meetings to discuss a young person's care were held in offices and meeting rooms to ensure conversations could not be overheard.

The service had received 19 compliments within the last six months. These included compliments from young people who had left the service and were thanking the service for the support in their recovery.

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

The young people reported they were introduced to the ward and the service as part of their admission.

Young people reported they were involved in their care planning, although not all of them had copies of their care plans. The majority of young people felt treatment plans were explained to them, although others felt this was not always done clearly. The most recent annual patient survey found 60% of young people did not feel they were involved in their treatment decisions. The hospital were in the process of reviewing and developing an action plan for the concern raised and were planning to further discuss the feedback they received in the ward's community meetings.

We saw clear evidence of young people's involvement in the PILRIMP care plan. These plans were handwritten by the young people, in their own words. These plans included information around distraction techniques, how they liked to be communicated with and how they would prefer any potential physical intervention to be carried out. The service also collected feedback from young people and carers on how well the plan was working and made adjustments as needed.

Young people completed an activities checklist on admission to help identify their hobbies and interests. Activities staff tailored activities according to the young person's expressed interests and could easily obtain appropriate craft materials or other equipment to support the young person to engage.

Young people were invited to the MDT meeting where the team discussed their progress. They were also invited to give feedback to the meeting in writing. Staff told young people about the outcome of the meeting if they chose not to attend in person. MDT discussions were person-centred and looked at the holistic needs of each young person.

Staff made sure young people could access advocacy services. All young people knew how to contact the advocate if needed.

However, when young people were asked in their annual survey if they felt able to contribute to decisions about the service 50% disagreed, 20% strongly disagreed and 30% neither agreed or disagreed. Young people were therefore not feeling involved in decisions about the service, when appropriate. The hospital had identified this was a concern from the survey and were in the process of developing an action plan.

All young people knew how to provide feedback about their experience. The service had feedback forms in communal areas. The service also collected feedback via an annual patient survey. The activities staff facilitated a community group meeting once a week where young people could raise concerns about the environment or other issues affecting

their stay. Some ward staff or managers attended the community meeting, but staff reported that attendance was inconsistent. Young people did not always get regular updates and timely information on the progression of the issues they had raised, such as information on timescales for the completion of repairs, from senior managers. It was not always clear who the owners of particular actions or concerns were, which meant it was difficult for young people to follow up with the right person. Young people reported this made them less likely to want to participate in these meetings, and we saw evidence of no comments from young people when reviewing the community meeting minutes.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

The majority of carers we spoke with gave very high praise for the staff and the care that had been offered at the hospital. One carer said the service went above and beyond, and another said staff looked at their child as a whole person, supporting their individual needs.

Carers were very happy with the level of communication from the service. Carers were updated weekly via emails following MDT meetings, as well as updated as needed throughout the week. Carers reported staff were always available to talk to when needed, and they received timely responses to emails.

Carers also raised some areas of improvement, such as, more training for agency staff on eating disorders, more activities should be planned for the weekend, the admission booklet should be updated and the system to book a room to visit their child could be updated as it was sometimes difficult to book.

Some carers spoke also about the difficulty not being able to visit when there was an outbreak of COVID-19 on the ward, but they understood the rationale behind this.

Other carers spoke about inconsistencies with medical staff and how to contact them, for example, some doctors were happy for carers to email them directly, whereas others were not.

The family therapist facilitated a parents' group every month. Parents provided support for each other. The group invited outside speakers on relevant topics. The autistic spectrum disorder lead nurse had spoken to the group and upcoming topics for discussion included self-harm and the Mental Health Act.

Are Specialist eating disorder services responsive?

Good

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

Access and discharge

Staff planned and managed the majority of discharges of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. As a result, children and young people usually did not have to stay in hospital when they were well enough to leave or reached the age of 18.

Good

Specialist eating disorder services

The hospital worked closely with the North Central East London (NCEL) provider collaborative for admissions and continued to provide services to commissioning teams across the country, with a new contractual agreement with the East of England.

At the time of our inspection 17 young people were from London boroughs. Eight young people were out of area placements, 32% of the young people. The registered manager commented they ensured all carers were kept up to date with the care and treatment of their child to support them to feel involved, and this was confirmed by the feedback we received from carers.

From August 2021 to February 2022 bed occupancy ranged from 82% to 93%. At the time of inspection, the hospital had 25 young people, a bed occupancy of 89%.

The service had admission criteria, that is, children and young people who were aged between eight and 17 years and had a diagnosis of an eating disorder with or without co-morbidities. Young people could be informal or detained under the Mental Health Act. Most admissions to the service were planned transfers from other mental health services although on occasion emergency admissions were accepted.

From December 2021 to February 2022 the service received 104 referrals. A referrals manager coordinated regular referrals meetings with the management team**.** The medical director and clinical operations director reviewed all referrals. An assessment was then carried out, either in person or via video call. As the length of stay for these young people could be long, the service had an agreement with commissioners to keep up to five young people on their wait list at one time.

When we inspected the service, they had four young people on their wait list due to a recent discharge. Those who were on paediatric wards, or those previously known to the service were given priority due to the level of risk. Those who had not been accepted onto the wait list would be signposted to other services via their referring team.

Managers and staff worked to make sure they did not discharge young people before they were ready. Between April 2021 and December 2021, the service had an average length of stay of 275 days. The social worker worked closely with young people as they prepared for discharge and they ensured the community care teams were involved in all planning. The service had two cottages which they used as step down units to support young people when they were approaching discharge.

When young people went on leave their bed was always available when they returned. Young people moved between wards only when there were clear clinical reasons, or it was in the best interest of the young person. Staff did not move or discharge young people at night or very early in the morning.

Discharge and transfers of care

Young people did not have to stay in hospital when they were well enough to leave. Between April 2021 and December 2021 there were 13 discharges from the hospital.

Staff carefully planned young people's discharge and worked with care managers and community care coordinators to make sure this went well. Of the four care records we reviewed two young people had discharge discussions documented. The other two young people were on the high dependency unit and were too unwell to engage with discharge discussions.

Discharges followed a gradual approach made with the young person, their carers and the community teams. Young people would initially have escorted and unescorted leave. If this went well this would extend to having time at home, followed by overnight leave. This plan would continue until the young person and staff felt confident the young person was ready to be discharged from the service.

Managers monitored the number of young people whose discharge was delayed and took action to reduce them. Three young people had their discharge delayed over the past six months. These were all young people who had turned 18 whilst on the unit. The ward informed us discharge planning began when young people turned 17.5 years old. These young people had been referred to adult units, however due to the increase in risk or change in presentation those placements were no longer appropriate. The service continued to work with commissioners, external services and community teams to manage safe discharges. Two 18-year olds were admitted to the service at the time of the inspection.

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. Bed areas were shared by two young people. There were quiet areas for privacy. The food was of good quality but young people wanted more variety.

Bedrooms were shared, with two young people in each room. Each of the cottages had one single room, as well as one room on Lask Ward. Should the hospital have a male young person admitted, they would use a single room.

The service reported they risk assessed children and young people when they assessed who shared rooms. This was not only done by ensuring young people were of a similar age, but also a similar stage in their recovery. The young people we spoke to said they preferred to share their room and were asked if they wanted to have a single room. Bedrooms were small but could be personalised.

Young people did not always have a secure place to store personal possessions. Young people reported the safes in their bedrooms were not used as staff did know how to operate them. There was also only one safe per bedroom, despite two young people sharing a room. This was raised with senior managers who reported instructions would be given to staff on how to use the safes and a review of furniture would take place to ensure equal access to storage for each young person.

The hospital was a small site, but young people had access to a range of rooms and equipment to support treatment and care. For example, a quiet room on Lask Ward, TV room and activities room. The activities room contained a large range of materials, games and musical instruments that the young people could use.

There were rooms off the unit where young people could meet with visitors. Young people who were well enough and either informal or had been granted leave, could meet their families and visitors outside of the premises if they preferred to do so.

Young people were able to make telephone calls in private. Young people had access to their own mobile phones. The service had put safeguards on the WiFi to ensure young people were unable to access online content which could affect their recovery.

The hospital had a large outside garden. The young people could access this garden and staff often accompanied young people to this area.

Whilst there was a programme of activities for the weekend, and a therapeutic support worker was allocated to work these shifts, young people felt there were not enough activities at the weekend.

The hospital had access to a van and a driver for excursions, although the use of this had been impacted by COVID-19 restrictions.

Children and young people's engagement with the wider community

The young people were able to attend the on-site school. The on-site school was registered with Ofsted. Ofsted rated the school as 'outstanding' at their last inspection in January 2018. The Ofsted report described how the school ensured 'that teaching staff and health professionals work together exceptionally well to improve pupils' life chances.' Hospital staff encouraged the young people to attend school. When young people were not well enough to attend school, education staff went to the wards to see them and provide suitable educational activities. The service had supported young people to achieve positive results academically both GCSEs and A levels. The school was able to source the specialist teachers necessary to teach a wide range of subjects. Teachers kept in regular contact with the young person's home school and helped facilitate their return to education on discharge.

Staff helped young people to stay in contact with families and carers. Young people were able to access computers and their own personal phones to enable video calls when there was an outbreak of COVID-19 and visiting was suspended

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 was accessible to young people with disabilities. There was a lift available and mobility hoists were available for use throughout the hospital.

The service had access to interpreters when required. Written information could also be translated if a young person's first language was not English, but this was not required for the current inpatient group.

Staff supported young people to take part in a range of activities when they were not in school or taking part in therapies. The activities coordinators supported young people back into education, helped them be together socially and remain occupied. The activities and equipment provided were based on the interests and preferences of the young people, for example currently knitting and crochet. Activities staff had a budget to obtain equipment and materials and could do so easily and promptly. They also offered activity groups such as yoga twice a week and a daily community walk for those who were able to take part. At the weekend therapeutic support workers supported the young people with activities. Activities coordinators worked until 7.30pm two evenings a week to support the young people with activities.

Young people on bed rest were provided with activity packs including board games, cards, sketch books and journals.

A range of food options were available for young people which met dietary and cultural needs. Young people reported the food was okay but would like to have more variety for sandwich fillings.

Staff ensured young people had access to appropriate spiritual support. The service had a multi-faith room where copies of religious texts were kept. The service had in the past supported young people to attend places of worship should they want this.

Good

Specialist eating disorder services

Staff received training in equalities and diversity, at the time of inspection 98% of staff had completed this.

Following the last inspection, the service introduced mandatory training in supporting LGBTQ+ clients and this had been completed by 86% of staff. Young people were able to address specific needs in their Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP). However, there was nothing specific on display in the wards that indicated the wards were inclusive environments looking to meet the needs of those young people with protected characteristics.

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.

Over the last 12 months the hospital received 20 complaints. Two were formal complaints, three were whistleblowing complaints and 15 were informal concerns. These complaints were mostly from young people and carers.

Children, young people, relatives and carers knew how to complain or raise concerns. There were leaflets displayed in communal areas as well as the waiting room with information on how to complain or provide feedback.

Staff understood the policy on complaints and knew how to handle them. The hospital policy stated the service had 25 days to formally respond to a complaint. The service kept a log of all complaints with their outcomes, this supported them in monitoring their adherence to the time scales. Managers investigated these complaints and identified themes. The themes were logged through their complaints analysis reports.

Of the 20 formal complaints, all but three were responded to within the appropriate time frames. Where these time frames were exceeded, complainants were sent a letter with an apology and an explanation for the delay.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback was discussed in clinical governance meetings. This was then spread to the wider team by managers in team meetings, and emails with lessons learnt bulletins. For example, all staff were reminded of the least restrictive principles following an incident where a young person was given water through their nasogastric tube, despite this not being care planed.

The service kept a log of the compliments they received. The service used compliments to learn, celebrate success and improve the quality of care.

Are Specialist eating disorder services well-led?

Good

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

Leadership

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

Good

Specialist eating disorder services

Leaders had experience to manage the service safely. Key senior staff members such as the medical director and clinical operations director had been in their roles for a number of years.

Leaders had a good understanding of the service they managed. They could explain clearly how the teams were working to provide high quality care and they knew the individual young people well.

Staff described the registered manager as visible and approachable, and said they could get support from them when they needed it.

The senior management team who had oversight of all the provider's services, although physically based at Ellern Mede Ridgeway, were seen by some staff as somewhat remote. This led to a feeling of staff not always being appreciated or valued.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. The provider had a philosophy of care which centred around supporting young people to be able to take control of their eating disorder, with the support of the hospital and their families. Their goal was to help the young person develop trust in the team and use the hospital as a resource to gain the strength and confidence to challenge the illness.

A number of staff spoke about a 'never give up' attitude when it came to young people's recovery and treatment plans.

Senior staff had successfully communicated the provider's vision and values to the frontline staff. They ensured values were discussed in team meetings and individual supervision.

We saw staff acting in line with these values and young people and carers described the majority of staff as kind, respectful and compassionate.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt positive and proud about working for this service and the positive outcomes they had seen for the young people they cared for.

Staff described good morale and were positive about their colleagues. Staff spoke highly of the management team and the culture within the organisation.

Staff had not reported any cases of staff bullying or harassment. All staff described the registered manager as very approachable and supportive and felt valued by peers and other disciplines. However, not all staff felt valued by the senior leadership team.

Development opportunities were available to staff, but due to the small size of the service opportunities were limited. We saw evidence of staff who began as healthcare assistants and staff nurses had been supported into ward manager and senior nursing positions. The hospital was also in the process of beginning more apprenticeship schemes for staff; they currently had an apprentice social worker. However, some staff described a lack of opportunities for career progression.

The service had a whistleblowing policy and had a Freedom to Speak Up Guardian. Regular reminders of this policy were sent to staff via email. Staff said they were able to speak up about any concerns they had and felt they would be listened to.

Managers dealt with poor staff performance when needed. Managers gave clear examples of the process they would follow to manage poor performance. This included coaching on appropriate behaviours, providing additional training and support, and disciplinary action when necessary.

Staff appraisals included conversations about career development and how they could be supported. The service offered an education fund available for all permanent staff, who have been employed for over one year, to support continuing professional development.

Staff had access to support for their own physical and emotional health needs through an occupational health service. This was available to staff via an application on their mobiles, the application had a range of support and guidance, including being able to book individual counselling sessions. The service had also recently recruited a wellbeing and inclusion manager who would start in the coming months. This manager would also focus on developing equality, diversity and inclusion within the service.

The provider recognised staff success within the service, for example, through the monthly staff 'extra mile' awards. Young people, carers and staff could nominate a member of staff for exceptional care and support.

Governance

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

Governance arrangements were in place that supported the delivery of the service.

There was a clear framework of what must be discussed at a ward or management level in meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

The service held quality safety and strategy meetings every three months. These meetings were attended by senior staff members across all of the provider's locations and had a structured agenda. The meetings had updates from subcommittees, such as the audit committee and governance committee and also reviewed risks, safeguarding and incidents that had occurred and affected the provider as a whole.

The hospital also had monthly quality meetings where they discussed performance, risks and updates specifically related to the Ellern Mede Ridgeway hospital site. These local monthly meetings would discuss the local concerns that needed to be raised with the provider as a whole at their larger quarterly quality safety and strategy meetings. Senior members from the Ellern Mede Ridgeway team attended these meetings and there was a structured agenda. The service provided a range of updates based on the CQC's key lines of enquiry. The meeting minutes showed good oversight of service delivery and quality, they discussed and provided links to recent audits, recent risks and any recent

feedback. The service had action plans documented for each point discussed. However, not all agenda points were discussed at each meeting. For example, February 2022 minutes did not document discussions on agency usage, mandatory training compliance and updates from team meetings. January 2022 minutes did not document discussion on the risk register, young people's physical health or updates from team meetings. It was therefore unclear if concerns raised by staff at ward team meetings were being discussed and considered by senior staff.

The hospital held morning meetings each weekday where senior members of staff gathered to discuss young people's observation levels, staffing and any incidents that occurred in the last 24 hours.

The service had robust recruitment and employment processes in place. We reviewed three staff human resources files whilst on site. These files were well-organised and contained appropriate information regarding the recruitment process, references, disclosure and barring service checks and where appropriate confirmation of professional registration.

Staff participated in local audits. From January 2021 to December 2021 the service carried out audits in 17 areas. Examples of audits included infection prevention and control audits, prescription chart audits and environmental audits. Outcomes of these audits were discussed in the monthly quality meetings. The prescription chart audit found examples of medication errors. In response to this the service worked closely with their pharmacist to introduce an e-prescribing platform, which included more safeguards in ensuring prescriptions were entered correctly.

The service had external auditors assess their health and safety and conduct a fire risk assessment. Following these reviews, the hospital compiled a list of the actions required, who was responsible for the action, and any updates. Some of these actions had been completed, such as, developing home working guidance and moving combustible materials to safe spaces. Other work was ongoing, such as, ensuring the automatic smoke ventilation system was regularly serviced and ensuring risk assessments for employees were up to date.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at the service level. For example, ensuring all staff complete training in professional boundaries following safeguarding concerns.

Staff understood the arrangements for working as a team and linking with external organisations. For example, staff engaged with the young people's schools, local community team, social workers and their funding organisations.

Management of risk, issues and performance

The service had effective risk management systems in place.

Staff maintained and had access to the risk register at ward and provider level. The register was updated at the governance meetings and staff at all levels could escalate concerns when required. Staff concerns matched those on the risk register, for example, staff retention and use of agency staff.

The service had plans for emergencies, for example, a power cut. The service had a business continuity plan which covered a range of possible incidents and recovery plans. Plans included emergency contact details and a list of action staff should take in the event of an emergency.

Information management

The service had systems and the technology in place to carry out their roles effectively.

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. Data was collected and used to produce regular reports for the senior management team which provided oversight of the service.

Information governance systems included confidentiality of young people's records. Training in data protection regulations was included in the hospital's mandatory training. At the time of inspection 91% of staff had completed this training.

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

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff had access to an application on their phone where they could access health and wellbeing advice, as well as their upcoming shifts.

Staff made notifications to external bodies as needed, including the Care Quality Commission. The service made safeguarding referrals to the local authority safeguarding team when they were concerned about possible abuse of young people.

Engagement

Patient, carers and staff were able to provide feedback to the service. Managers used this feedback to make improvements.

Staff and young people had access to up-to-date information about the work of the provider and the services they used. Staff were kept up to date thorough team meeting and emails. Young people were kept up to date through community meetings. Due to the small size of the hospital managers were able to meet with staff and young people regularly.

Young people and carers had opportunities to give feedback on the service they received. Young people completed a yearly survey on topics related to their experience of care at the hospital. The hospital was in the process of developing an action plan following the most recent survey results. Young people could also provide feedback via the feedback forms in reception and community meetings. Carers were able to provide feedback at any time by calling the ward as well as during their monthly carer meetings. Young people were consulted on matters such as redecoration, furniture choices and menu plans in the weekly community meetings.

Managers and staff had access to the feedback from young people, carers and staff and often used it to make improvements. For example, MDT members such as therapists and the pharmacist attended community meetings following young people reporting feeling they needed more information on these topics. However, whilst there were opportunities for young people to provide feedback at community meetings, they did not feel these concerns were being adequately addressed. Young people did not always receive updates or feedback on the matters they discussed. Young people reported this made them less likely to want to raise feedback at this meeting.

Young people and staff could meet with members of the hospital's senior leadership team to give feedback. The management team worked closely with young people and staff in an open and approachable manner.

Directorate leaders engaged with external stakeholders such as commissioners. For example, senior staff members were actively engaged in the eating disorder network for the local provider collaborative.

Good

Specialist eating disorder services

Learning, continuous improvement and innovation

Staff engaged effectively in quality and service improvement activities.

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. The provider had recently developed an Autistic Spectrum Disorder lead nurse role to improve the service by offering young people with ASD traits timely access to professional assessments and their care planned in line with their needs. A staff member from another Ellern Mede hospital recognised the need for this role and proposed the idea to management. This role provided assessments and care planning for young people as well as supervision support and guidance for staff in the best practice techniques for caring for those with ASD. The service planned to increase the capacity of the ASD lead nurse by training healthcare assistants to be ASD champions for each hospital site.

Innovations were taking place in the service. The service created the Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP) to support young people be involved in their care and treatment. This framework specifically looked at ensuring least restrictive practice was used for all young people. The service had also created EMRIST, a bespoke training package for restraining young people, with specific emphasis on safe practice when planning nasogastric feeding. This training comprised of workshops, presentations and workbooks to consolidate the learning.

The provider ensured staff from the hospital were involved in external conferences. Staff had recently presented their values and ethos on nasogastric feeding at an eating disorders conference in London.

The hospital was part of the NCEL provider collaborative. NCEL is a group of health providers who have agreed to work together to improve the care pathway for their local population. Hospital seniors attended quarterly meetings to discuss their quality reviews, service development and improvement planning. Through NCEL the service took part in a monthly clinical and quality group, complex case review group and were part of the eating disorders workstream. This workstream involved working on a project with the network to pilot an intensive short-term inpatient pathway. The hospital also participated in clinical and quality meetings for other provider collaboratives, such as North West London and Surrey Heartlands.

The hospital was involved in a subgroup committee specifically looking into children who use head banging as a coping or self-harm mechanism, led by the National Mental Health & Learning Disability Nurse Directors Forum.

The hospital had been participating in regular QNIC reviews. This was a quality standard programme of peer reviewers measuring the service against the standards. However, the hospital had not signed up for accreditation through this network.