Newbridge Care Systems Limited

Schoen Clinic York

Inspection report

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

Ratings

Overall rating for this location	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 improved. We rated it as good because:

- The service provided safe care, the ward environments were safe and clean, the wards had enough nurses and doctors and staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well-led and the governance processes ensured that ward procedures ran smoothly.

However:

- Staff, below medical level, could not always describe their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005
- There were challenges with the current premises in terms of space to support treatment and care.
- Patients fed back and quality audits showed that there were issues with the choice and quality of food provided.
- There was evidence that a decision made in a multidisciplinary meeting was not followed through and notes did not fully reflect the decision-making process.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Good 	Our rating of this service improved. We rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Schoen Clinic York

Schoen Clinic York is a specialist eating disorder hospital for up to 15 male and female adults with eating disorders. The registered provider is Newbridge Care Systems Limited.

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

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

The hospital had one registered manager and an accountable controlled drugs officer.

We have inspected Schoen Clinic York three times since it registered with us on 9 January 2019. Prior to this, the hospital was run by another provider. Our last inspection took place in January 2022 and our report was published in April 2022. At that inspection, we placed the service in special measures and issued 21 requirement notices in relation to the following breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 person centred care
- Regulation 10 dignity and respect
- Regulation 12 safe care and treatment
- Regulation 13 safeguarding service users from abuse and improper treatment
- Regulation 15 premises
- Regulation 17 good governance
- Regulation 18 staffing.

What people who use the service say

We spoke with five patients who told us that all staff were kind, considerate, respectful and approachable.

They told us they were fully involved in their care planning, risk assessments and ongoing treatment through attendance at meetings about their care. Patients reported positive experiences of multidisciplinary meetings to review their care. Patients told us that their care was individualised, they had regular 1-1 sessions with nurses and occupational therapy.

Patients who had been in the service longer told us about the gap in psychological therapies however the feedback regarding the current therapy sessions was positive. Patients told us that they were addressing issues that hadn't been previously addressed.

Patients told us they were involved in the service, could give regular feedback and felt listened to by managers.

However, three patients told us that there were issues with the choice and quality of the food provided. One of the three patients told us that they felt the service were listening to patient issues and this was the only downside to the service.

Summary of this inspection

How we carried out this inspection

During our inspection, we:

- Observed the care environment and how staff were caring for patients
- Spoke with five patients who were using the service
- Spoke with four family members of patients using the service
- Received feedback from four external providers / services
- Interviewed 13 staff including the hospital director, two consultant psychiatrists, two senior health care assistants and a health care assistant, two occupational therapists, dietician, nurse therapist, nurse, clinical lead and assistant psychologist.
- Attended and observed five multi-disciplinary team meetings, one lunch time and post meal support group and one patient meeting.
- Looked at six patients' care and treatment records on site.
- Carried out a specific check of the clinic and treatment room and medication management including six medication charts.

The inspection was carried out by two CQC inspectors and a specialist professional advisor and overseen by Sarah Dronsfield, head of hospital inspection.

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

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure that staff have a good understanding in relation to the roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 and that competencies are checked.
- The service should ensure they continue to gain patient feedback and improve the choice and quality of the food provided.
- The service should ensure it develops and delivers on short- and longer-term plans to improve the suitability of the premises.
- The service should ensure that multidisciplinary meetings notes fully reflect the decision-making process and are communicated clearly to all staff.
- The service should ensure that minutes of meetings are sent to relatives or carers when requested and in a timely manner.
- The service should consider reviewing the allocation of patients to a named nurse so that the named nurse is able to attend relevant meetings.

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, well furnished, well maintained and fit for purpose.

Safety of the ward layout

The provider completed a thorough annual risk assessment of all the ward areas and since the last inspection they had introduced a monthly ligature risk audit tool and individual environmental risk assessment for patients' bedrooms. The hospital had three out of 15 patient bedrooms fitted with anti-ligature fixtures and fittings so patients with identified or emerging risks could be placed in these rooms. One of the three bedrooms with reduced ligature anchor points was in use at the time of inspection.

All other areas of the hospital environment contained standard fixtures and fittings which could be used as fixed ligature anchor points for the purpose of hanging or strangulation. Staff knew about potential ligature anchor points and the ligature risk assessment stated that the management of ligature risks was through patient risk assessment and observation. The policy on observation had been updated to include different levels of observations for patients. All patients were observed every hour as a minimum. The provider had also implemented spot checks twice a week to ensure the changes to the observation policy were embedded and staff were documenting observations correctly. This also formed part of the monthly risk audit tool.

Staff could not observe patients in all parts of the ward due to the ward layout however this was mitigated by the introduction of patient observation levels and presence of staff in the communal areas of the ward.

The ward complied with guidance on eliminating mixed sex accommodation. All patients staying at the service were female at the time of inspection. All bedrooms had an ensuite bathroom. The service had created a female only space for when a male patient was admitted to the service and planned to use the space as an additional quiet room when only female patients were admitted.

When we arrived on site, we were informed of fire safety procedures. Copies of the fire evacuation procedure were visible and fire drills undertaken. Personal emergency evacuation plans were developed for all patients giving a clear explanation of how they will evacuate safely.

Staff had easy access to alarms and patients had easy access to nurse call systems. Since the last inspection the service had made alterations to the panic alarm system to address the previous issues. At the time of inspection, the meeting rooms and staff offices on the nurse call system needed re categorising, this was included on the service risk register and there were plans for this to be completed. All patient bedrooms and communal rooms were correctly categorised on the system. The service had undertaken a scenario-based training session with staff and tested the panic alarm and nurse call system and staff responded to the correct room. The service had also introduced a daily check of the nurse call alarm system for bedrooms in use.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and well furnished. Staff made sure cleaning records were up-to-date and the premises were clean. Domestic staff completed regular cleaning as part of the service's contract with the premises' landlord and all staff and patients we spoke with were complimentary regarding the domestic staff stating they were efficient, friendly and polite. The ward environment was decorated well and had no visible signs of damage or wear.

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

Seclusion room

The hospital did not have a seclusion room.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The service had implemented and completed an emergency equipment bag checklist to ensure equipment was in place and in date. Following a scenario-based training session the service identified some improvements it could make. All items in the emergency equipment bag were labelled so that they were easily identifiable in an emergency and the ligature cutters (specially designed items that offer an effective and safe method of cutting a ligature) were kept in the same bag so if they were required in an emergency staff didn't have to know which type was required.

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

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe and the service was fully recruited for health care assistants.

The service had 1.7 whole time equivalent nurse vacancies but this had reduced since the last inspection. This meant that the service still required the use of agency nurses however this had reduced in September 2022 to 9% of shifts covered by agency staff. Managers limited their use of ad hoc agency staff, used an approved list of agencies and, where possible, requested staff familiar with the service.

The service also used bank staff consistently to cover shifts. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had reducing turnover rates and reported a turnover rate of 6.94% between 01 February and 31 October 2022 which equated to a total of 19 staff. Managers explained that the majority of this turnover was at the beginning of the year.

Levels of sickness were reducing. Between 01 February and 31 October 2022, the short-term sickness rate of registered nurses was 12.7% and health care assistants was 9.6%. In addition, the service also supported one health care assistant on long term sick during this period.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. The minimum staffing level during the day shift was one nurse and two health care assistants and during the night shift one nurse and one health care assistant due to the number of patients. However, the service had two health care assistants at night and often adjusted staffing levels according to the needs of the patients.

Patients told us they had regular one to one sessions with their named nurse. However, the process of allocation of patients to a named nurse meant that the named nurse could not always attend the multidisciplinary meetings relating to those patients allocated to them.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely. Staff had used restraint on 23 occasions between 01 February and 31 October relating to one patient and on 17 occasions this restraint was care planned in their best interest to support the patient to be nasogastric tube fed.

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

Medical staff

The service had enough daytime and night-time medical cover and a doctor was available to go to the ward quickly in an emergency. The hospital had one full time consultant psychiatrist with a specialism in eating disorders and a locum consultant psychiatrist 0.6 whole time equivalent. A medical on call was shared between the hospital and another local independent mental health hospital. In the previous 9 months since the last inspection there was one occasion where the on-call doctor was required to attend the hospital.

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

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

Good

Specialist eating disorder services

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The providers training target was 80%. The overall compliance of the team was 89% and although some training courses were currently below the providers target this was mainly due to four new starters whose average compliance with all mandatory training courses was 37% which impacted on the overall compliance. Managers told us that the provider gave new starters a two-month period to complete all training, the new starters were still within this period at the time of inspection and courses had been booked.

The mandatory training programme was comprehensive and met the needs of patients and staff. A face to face training course had been delivered for staff on learning disabilities and autism since the last inspection and online training was available.

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

Assessing and managing risk to patients and staff

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

Assessment of patient risk

Staff completed risk assessments for each patient on admission. We reviewed six patients' risk assessments and found they contained a risk management plan, they were also reviewed regularly, including after any incident. Patients were also individually risk assessed for access to bedrooms, outside space and these informed observation levels.

Staff used a recognised risk assessment tool.

Management of patient risk

On admission, staff completed assessments for specific risk issues relevant to the patient group. Staff knew about any risks to each patient and acted to prevent or reduce risks. Risk assessments included falls risk assessment, choking risks assessment, Waterlow pressure sore risk assessment, physical healthcare and a body map. Risks were discussed and reviewed in multidisciplinary meetings weekly.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff followed procedures to minimise risks where they could not easily observe patients. All patients were checked on hourly as a minimum in line with policy and national guidelines.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. We spoke with patients which confirmed staff were using the policy to search patients bedrooms appropriately to keep patients safe.

Use of restrictive interventions

Levels of restrictive interventions were low and / or reducing. Between 01 February and 31 October there had been 23 instances of restraint for one patient.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. There had been some positive changes to the service as a result of this group which was having a positive impact on patient experience. We received positive feedback from the local provider collaborative, who had attended a meeting, stating there was now a robust clinical governance structure and effective embedding of meetings and lessons learnt since the last inspection.

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

Between 01 February and 31 October had no instances of using rapid tranquilisation.

The hospital had a blanket restriction register that recorded restrictions on patients' freedoms. There were 15 items recorded on the register. Some of these restrictions were necessary in terms of the health and safety of patients and visitors and some restrictions supported recovery. Some restrictions would be automatically applied on admission but then individually risk assessed. We looked at six patient risk assessments and found these contained an assessment on access to risk items, leave, restricted access to bedrooms and access to a fob for independent access on and off the unit. All restrictions applied would also be reviewed in weekly multidisciplinary meetings.

Safeguarding

Staff understood how to protect patients 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.

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

Staff kept up-to-date with their safeguarding training and at 01 November 2022, compliance was 100%. The service had linked in with the health partnership network which offered peer support, opportunities for safeguarding specialist training and a quarterly safeguarding bulletin. Managers attended some sessions and shared this with the wider multi-disciplinary team.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The service had also embedded safeguarding into team meetings and added to all meeting agenda templates.

Staff followed clear procedures to keep children visiting the ward safe. Patients told us that children had visited them, the ward carried out appropriate assessment and supported the visit and relatives we spoke with confirmed this.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Between 01 February and 31 October 2022 the service had made eight safeguarding referrals.

We also received positive feedback from the designated nurse safeguarding adults from the integrated care board who supported the service to improve safeguarding in respect of policies and reviewing procedures and processes.

Good

Specialist eating disorder services

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.

Patient notes were comprehensive, and all staff told us they could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We spoke with five patients during inspection and all patients told us that medication was discussed weekly in the multidisciplinary team meeting, which they were able to attend.

We reviewed six prescription charts and found that staff completed medicines records accurately and kept them up-to-date.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

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

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Staff stored and managed all medicines and prescribing documents safely. The service had a contract with a local pharmacy to undertake stock checks and an independent contractor to check and calibrate equipment annually. Internal audits of medicines, prescribing documents and medicines storage were in place.

Staff learned from safety alerts and incidents to improve practice, for example labelling of each item and package of emergency medicines and equipment.

Track record on safety

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

Reporting incidents and learning from when things go wrong

Good

Specialist eating disorder services

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 patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Between 01 February and 31 October 2022, the service had recorded 369 incidents. Since the last inspection the service had started to record when patients declined therapeutic intervention, and this accounted for 18% of the incidents recorded. This enabled the service to have a recorded oversight of this, review as a multidisciplinary team and adapt individual plans.

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

Staff reported serious incidents clearly and in line with provider policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. Staff attended several meetings. A number of staff we spoke with told us that, because the allied health professionals shared an office space, this gave them the opportunity to discuss patient care in a confidential space on a daily basis.

There was evidence that changes had been made as a result of feedback. For example, in September 2022 it was identified that observation sheets had pre-recorded times on them. This was changed with immediate effect to ensure the exact time of the observation was recorded in the event an incident occurred.

Are Specialist eating disorder services effective?

Good

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

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient on admission.

Good

Specialist eating disorder services

Patients had their physical health assessed on admission or soon after and regularly reviewed during their time on the ward. The new consultant to the team required some additional physical health training as part of their induction. All patients had national early warning scores taken several times daily which are used to identify acute deterioration, including sepsis and specific observations taken in relation to their eating disorder. The service also had GP provision and at the time of inspection were in the process of renewing the contract to provide additional support for physical health needs and annual health assessments.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We spoke with five patients who told us they were fully involved in the care planning process, copies were printed to enable them to make comments, these were then reviewed, and amendments made.

Staff regularly reviewed and updated care plans when patients' needs changed. Weekly multi-disciplinary meetings and regular 1-1 sessions with patients informed changes.

Care plans were personalised, holistic and recovery-orientated. In the six patient records that we viewed we saw evidence of areas covered such as housing, relationships and protective factors. Patients we spoke with were very positive about the occupational health provision to support with social needs and patients told us that the service made appropriate adjustments to support individual needs.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. The service employed occupational therapists, dieticians, a nurse therapist, assistant psychologist, consultant psychiatrists and nursing and healthcare staff. The service currently had vacancies for a social worker and psychologist, which was included on the service risk register.

Staff delivered care in line with best practice and national guidance. The service offered a range of psychological therapies and groups such as Maudsley Model of Anorexia Nervosa Treatment for Adults which is a National Institute for Health and Care Excellence recommended treatment, eye movement desensitization and reprocessing psychotherapy and enhanced cognitive behaviour therapy. The new assistant psychologist was also setting up to run several groups such as cognitive behaviour therapy, psychoeducation, dialectical behaviour therapy skills and a body image course. The occupational therapy team undertook several assessments including functional assessment, model of human occupation screening tool and adapted eating meal preparation skills assessment.

In the six patient records that we viewed we saw evidence that staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration such as nasogastric tube feeding. Patients we spoke with told us that the service made every effort to provide supplements that they preferred.

Good

Specialist eating disorder services

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The occupational therapy team prescribed an eight-week programme on meaningful life skills. The team also introduced a clinical educational skills group in September 2022 which covered topics such as safeguarding, mental health act, advocacy and relapse and re-feeding and relaxation. This was a rolling programme but also tailored to the needs of individuals.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Outcome measures were collated on admission and discharge in relation to the patient health questionnaire, generalised anxiety disorder questionnaire, eating disorder examination questionnaire and clinical impairment assessment.

Staff used technology to support patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements. The service had an audit schedule which included 26 audits undertaken at different frequencies and managers produced action plans as a result of the audits to make improvements.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. The service had one vacancy for a social worker 0.4 whole time equivalent, one vacancy for a psychologist and one vacancy for a consultant psychiatrist 0.5 whole time equivalent which was covered by a locum. The service had a nurse therapist and an assistant psychologist in post. The ward was being supported by the psychology team at another of the providers services. The assistant psychologist told us they had spent a week with this team as part of their induction which they found beneficial.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The staff completed a range of training, including those specific to their roles and the service type, for example, portion control training.

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

Managers supported staff through regular, constructive appraisals of their work. 100% of staff had an appraisal of their performance in the previous 12 months.

Staff received clinical and managerial supervision regularly. Data showed that an average of 89% of staff had received regular supervision in the previous four months.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Since the last inspection registered nurses were undertaking training in nasogastric tube feeding, medical monitoring in eating disorders, eating disorders in the perinatal period, pregnancy and early motherhood.

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

Multi-disciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary meetings took place weekly attended by relevant staff and patients. We attended five meetings during our inspection and found that these were collaborative, patient-centred and non-hierarchical. Patients reported that these were inclusive and that they felt able to raise any concerns they had.

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

Ward teams had effective working relationships with other teams in the organisation. Staff were working alongside counterparts from the other provider's services to support the team and provide support for patients.

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

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

We found that doctors understood their roles and responsibilities under the Mental Health Act 1983 but some staff we spoke with could not describe this well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. 100% of staff had completed this training. However, some staff we spoke with during inspection could not always describe the practical application of the Mental Health Act or describe the Code of Practice guiding principles.

The service did not have a Mental Health Act administrator, but an operations manager was due to undergo some training to lead in this area. Staff had access to the Mental Health Act administrator at another of the providers service for support and advice on implementing the Mental Health Act and its Code of Practice.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

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

Staff explained to each patient their rights regularly under the Mental Health Act in a way that they could understand. One patient told us that they couldn't recall the last time their rights had been read. The service clearly recorded the reading of rights on a patients' rights monitoring form which showed it had been completed in line with policy. The service would repeat as necessary and responded in relation to the patient we spoke with.

Staff made sure patients 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 patients' detention papers and associated records correctly and staff could access them when needed.

A sign was displayed to inform informal patients that they had a right to leave the ward. However, the service completed a risk assessment to allow access to a fob for independent access on and off the unit.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

The clinical audit schedule contained weekly Mental Health Act related audits such as section 132 patient rights and consent to treatment documentation. The service also carried out monthly audits of section 17 leave forms.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves and we saw clear evidence that the service assessed and recorded capacity clearly for patients. However, staff, below medical level, could not always describe their roles and responsibilities under the Mental Capacity Act 2005.

Staff received and kept up to date with training in the Mental Capacity Act and the Mental Health Act Code of Practice. 87% of staff were up to date with training in the Mental Capacity Act 2005. We saw evidence of multi-disciplinary discussions regarding capacity to consent to treatment and the best interest decision making process. However, some staff we spoke with on an individual basis did not have a good practical understanding.

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

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff knew how to access.

Staff knew where to get advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We reviewed six patients' care and treatment records and found evidence of assessment of mental capacity.

Good

Specialist eating disorder services

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service had a consent to treatment audit and audits of the patient record system to monitor how well it followed the Mental Capacity Act.

Are Specialist eating disorder services caring?

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

On inspection we observed interactions between staff and patients that were kind, respectful, and responsive when caring for patients. All five patients we spoke with told us that staff were very respectful, polite and caring.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. Most patients told us that staff were compassionate and understanding particularly in situations that can be difficult and distressing for patients.

Staff understood and respected the individual needs of each patient. We spoke with five patients who told us that the service tried to meet their needs. Patients gave examples such as adjusting visiting times for families, catering for allergies, physical health needs, medication and adapting care delivery. Patients told us that the service would always consider requests and gave a good explanation if it was not possible.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Two patients we spoke with gave an example of a time a staff member made an insensitive comment however we saw evidence that such incidents were dealt with by management and appropriate action taken.

Staff followed policy to keep patient information confidential. The service had introduced white noise boxes for outside of meeting rooms to help to reduce noise and ensure privacy. Staff offices have also been allocated away from patient areas to protect patient confidentiality

Involvement in care

Good

Specialist eating disorder services

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

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

Staff involved patients and gave them access to their care planning and risk assessments. All five patients we spoke with told us they were involved in completing and reviewing their care plans and risk assessments.

Staff made sure patients understood their care and treatment. None of the patients we spoke with had any communication difficulties however patients told us that all staff were approachable, information was explained clearly, and treatment was individualised.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. The service held weekly patient meetings, which we observed during inspection and had established a you said we did board. We also observed five patients' multi-disciplinary meetings where patients could raise any concerns and give feedback. The leadership team also undertook a monthly patient quality walk around which included first impressions, staff, nutrition, patient involvement, 1-1 sessions, consent and safeguarding and, except for food, the feedback was very positive.

Staff supported patients to make decisions on their care. All patients we spoke with were invited to attend all meetings about their care and relatives we spoke with told us that they were invited to meetings or received the minutes from them.

Staff made sure patients could access advocacy services. The service had some issues with advocacy provision earlier in the year however they were proactive in making changes and a new advocate started monthly drop ins at the service from August 2022. Patients we spoke with had accessed the service and gave positive feedback. We also sought feedback from the advocate who told us the service had given them a warm welcome and provided an induction. The advocate found the manager professional and responsive with any issues and told us patients are actively encouraged to use the support offered. A room was always made available to ensure meetings could be held in private.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. When patients went on community leave the service requested feedback from families or carers so that any problems could be identified and whether families needed any further support from the service. Specific therapeutic work was undertaken regarding family dynamics and relapse prevention work included the family so that they understood how to help and support their loved ones.

Staff helped families to give feedback on the service. We spoke with four relatives who said they could give feedback on the service and raise any concerns. One relative told us that they sometimes had to chase the minutes of meetings, or several came through at once.

Good

Specialist eating disorder services

Staff gave carers information on how to find the carer's assessment. Relatives told us they would be given relevant information or signposted to where they could find information.

Are Specialist eating disorder services responsive?

Good

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

Access and discharge

Patients' discharge was planned and managed well. Staff liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway.

Since the last inspection the bed occupancy did not go above 85%. However, the number of patients that could be admitted to the service was capped and therefore there was only 11 admissions since the last inspection and the average bed occupancy was 32%. At the time of our inspection, the service could admit up to nine patients and the bed occupancy rate was 67%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The new model of care implemented prior to the last inspection set out two pathways. The assessment and treatment programme was up to 12 weeks and the recovery programme was up to six months. However, patients could move from one pathway to another and length of stay was determined by individual need. The longest length of stay of existing patients was six months.

The service had three out-of-area placements at the time of inspection. Five out of the 15 beds provided at the service were commissioned by the local area commissioners. The remaining 10 beds were marketed nationally.

Managers and staff tried to make sure they did not discharge patients before they were ready and distance from home was considered when reviewing referrals. There was evidence of discharge meetings involving services that would provide aftercare. The service also offered outpatient therapy for one hour a week up to four weeks remotely to patients in the local area.

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

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

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

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

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed but had no delayed discharges.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We received feedback from a referring team who told us that the service was flexible to patient needs. They also told us that the consultant psychiatrist offered specialist assessments to individuals to help guide the community team in next steps for these individuals when inpatient admission was not appropriate.

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

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Patients had access to drinks and snacks in line with care plans, however, the food choice and quality did not always meet patients' expectations.

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

Most patients had a secure place in their bedrooms to store personal possessions. One patient did not have this in their room, but staff had offered to bring in a lockable set of drawers, which the patient had declined. There was also a storage cupboard with individual boxes for each patient that contained risk items.

Staff used the full range of rooms and equipment available to them and since the last inspection the hospital had made some changes to the environment to help support treatment and care. This was possible due to the number of current patients accessing the service as unused bedrooms could be utilised for additional space. Although some patients we spoke with told us that there was a lack of room and space, especially if bedroom access was restricted as part of their care plan.

The provider had longer term plans to move the hospital to another location but at the time of inspection no suitable land or alternative premises had been identified. During inspection managers told us that as a short-term plan they would be reducing the number of patients admitted to the service from 15 to a maximum of 13 patients. This would enable the service to create additional quiet areas or therapy rooms as a permanent fixture until alternative premises had been identified.

Patients could make phone calls in private.

Access to outdoor space was appropriately restricted and permitted by staff due to the type of service. Staff permitted access to the garden in line with the level of physical activity stated in patients' care plans. Informal patients, who were risk assessed, could have access to a fob to enable them to independently leave the hospital.

Some patients could make their own drinks and snacks and other patients required staff supervision for drinks and meals. The service had appropriate care plans in place which identified the level of supervision needed for each individual patient.

The service offered a variety of food choices to patients including options to meet various dietary requirements. However, feedback from three patients was that there was not a good choice and two of those three patients said the food was not of good quality. One patient told us the food was the only downside to the service and although they felt listened to there were still issues with the food. Due to the current location of the service another provider supplied all

meals and self-catering supplies under a contract. Since our last inspection the dietician undertook a daily food quality assurance audit which included missing items, poor quality items and issues regarding special dietary requirements. Between 01 July to 01 October 2022 81 issues were recorded for lunch and dinner, mainly regarding incorrect or missing items or quality of the food. The audit captured that 67% of issues were either rectified at the time or escalated. The service also completed a monthly patient quality walk around which included feedback on food. We looked at three completed checklists July – September 2022 and negative feedback was given on each one in relation to food choice and quality. Management met regularly with the provider to feedback concerns and made efforts to improve the food provided.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. For example, a patient wanted to finish their exams so the service developed a plan where they could engage in the programme while also having time to study. Most patients had a form of employment or education which had been put on hold whilst patients focused on their care and treatment. Most patients had goals to resume their studies or return to work in the future when they were able to.

Patients had access to their own phones to stay in contact with families and carers. One patient told us that they also used the patient laptop daily. The service welcomed visitors and both patients and relatives fed back that the service was supportive and accommodating, ensured that parking was available and always offered a hot drink and a snack.

Staff encouraged patients to develop and maintain relationships in the wider community. Staff told us that patients undertook community activities such as social eating and one patient told us their family member spent time on the ward and they cooked a meal for them.

Meeting the needs of all people who use the service

The service had the facilities to meet the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The service supported a recent assessment for a patient with autism and we received feedback from external agencies that the service was very accommodating when developing the treatment plan.

The service had recently developed individual patient portfolios which were kept on the shared drive and in a file in the staff office to ensure these were accessible to all. The portfolio's included what patients found helpful in certain situations. The templates were given to patients during a therapy session, completed and typed up and a copy given to the patient.

The ward had the facilities to support disabled patients. Staff had received training in moving and handling people and compliance at the time of inspection was 100%. The service had a wheelchair.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Information on complaints was displayed in the service and patients told us this also formed part of the welcome pack.

Good

Specialist eating disorder services

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

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

The service could provide a variety of food to meet the dietary and cultural needs of individual patients. One patient told us that the hospital had gone completely nut free as a result of their allergy.

Patients had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. In the previous nine months, six complaints had been made, one of these complaints was upheld and two partly upheld. No complaints were escalated to the ombudsman.

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

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

Managers investigated complaints and provided an outcome and an apology to patients.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff received learning from complaints quarterly in a newsletter.

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 improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles.

They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

During inspection we spoke with 13 members of staff who all told us the leaders of the service encouraged an open, supportive and honest culture. The leaders had an effective leadership style and it was evident that since the last inspection the service had developed an ethos which had a focus on patients experience and outcomes.

Good

Specialist eating disorder services

The hospital director told us that they had spent the day as a health care assistant recently which the staff and patients viewed positively, and this also led to some changes and improvements in the service.

Vision and strategy

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

The service had a clear vision and set of values that have been developed in consultation with relevant stakeholders with quality and safety as top priority.

Staff we spoke with felt they had the opportunity to contribute to discussions about the service and felt they had input and involvement in decisions and changes.

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

Culture

Staff felt respected, supported and valued.

Staff spoke positively about communication within the service and described a supportive environment. Staff we spoke with were positive about the provider.

Staff felt invested in. The provider had a staff reward scheme and recognised a member of staff within the service on a monthly basis. The service had also recently introduced a food bank for staff to support them with the rising cost of living and facilities were available for staff personal care.

Staff reported that the service promoted equality and diversity in daily work and provided opportunities for development and career progression.

They could raise any concerns without fear of retribution and were confident managers would deal with any difficulties appropriately as they arose, however no staff we spoke with raised any concerns within the workplace.

Since the last inspection the provider had commissioned an independent external review of culture and safety of the service. Managers also undertook staff surveys and an annual colleague survey had recently been launched.

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 systems policies, procedures and protocols had been reviewed since the last inspection and improved to reflect best practice. Staff at the service attended a range of meetings to enable information from local level and from provider level to be disseminated effectively. The multidisciplinary team worked well together to meet individual patient

needs and the meetings were collaborative and patient centred. However, there was evidence of a decision made in a patient's multidisciplinary meeting that was not followed through and notes did not fully reflect the decision-making process. The process of allocation of patients to a named nurse (who has the responsibility to ensure the actual delivery of safe and effective care during a patient's inpatient stay) meant they were not present during the meetings.

Local governance arrangements supported the delivery of good quality care. The service had systems and processes in place to monitor and manage their objectives and not only meet the required standards but to make improvements to ensure the best outcome for users of the service.

Although managers were aware of the importance of staff understanding their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 and all staff completed training in these areas, we found not all staff understood the practical application of these responsibilities.

The services safeguarding procedures had improved and the service was making appropriate notifications to safeguarding team and the care quality commission.

The service had multiple key performance indicators to gauge the performance of the team. Managers completed a quarterly performance monitoring report for commissioners, reviewed this information and set clear actions and targets for the service to improve performance.

Due to the current location of the service another provider supplied all meals and self-catering supplies under a contract. Feedback from some patients was that there was not a good choice and the food was not of good quality. The provider was gaining feedback about food quality daily and rectifying issues as much as possible and escalating these concerns to the food providers.

The provider was aware of the challenges and suitability of the premises for the service being provided and included premises on their risk register. The provider had a short-term plan to reduce occupancy to enable further space to be created for delivering care and treatment and a longer-term plan to move to another location.

Management of risk, issues and performance

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

Staff had easy access to patient information, we reviewed six patient records during inspection and found staff were maintaining good records. All patients had an individualised assessment and were reviewed and updated as patient needs changed.

The service had a schedule of audits and assessments in place which were completed by competent persons and were up to date. Learning from these audits was shared and used to improve service provision, performance and service user outcomes.

The service had a risk register in place which identified multiple risks. Six of these current service risks were categorised as a high risk, such as COVID-19, recruitment, admissions and nasogastric tube feeding and were reviewed regularly by the management team.

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

Good

Specialist eating disorder services

Information management

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

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

There was sufficient access to information technology hardware on the ward.

Information governance systems included confidentiality of patient records.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care and we observed that this information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff submitted data and notifications to external bodies as needed such as the local safeguarding team and Care Quality Commission.

The service had developed information-sharing processes, robust pathways and joint-working arrangements with other local services.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

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

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

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

Learning, continuous improvement and innovation

Managers told us that the services accreditation by the Quality Network for Eating Disorders had been suspended as a result of the rating from the last inspection and this would be revisited.

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

The nurse therapist attended a range of different working groups and the assistant psychologist informed us that they attended research meetings and worked with a professor external to the provider to aid learning and continuous improvement.