Invited Review Service Report

27th February 2026

of

Skye House
Within NHS Greater Glasgow and Clyde

Date site visits carried out:

Wednesday 22nd & Thursday 23rd October 2025

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | IRS INVITED REVIEW SERVICE

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1. Executive summary

Greater Glasgow and Clyde commissioned the Royal College of Psychiatrists to undertake a review of its inpatient child and adolescent unit, Skye House, following the broadcast of a documentary on the BBC in February 2025 which made allegations of cruelty. In the documentary, young people and their families raised concerns regarding lack of involvement in treatment decisions, overuse of restrictive interventions, lack of access to therapies, variable access to activities, inadequate staffing numbers and poor staff attitudes.

The full terms of reference can be found in Appendix 1- page 55.

The review was undertaken by five specialist reviewers who had expertise in child and adolescent psychiatry, patient safety, governance and expert lived experience and was supported by a review team manager and the wider Invited Review Service (IRS) team.

The review team considered the standard of care provided to young people admitted to Skye House and the extent to which it aligned with Scottish national good practice and guidelines. It was undertaken in two phases, with phase one focusing on governance systems and phase two on clinical models and experience of young people and families. A large number of documents were reviewed and interviews conducted with young people, including current and past inpatients, families, multidisciplinary clinical staff and Skye House leadership staff.

The review team found that whilst many young people had good experiences at Skye House and received good clinical care, there were inconsistencies in key areas of service planning, delivery, involvement of young people and their families in treatment and decision-making, clinical models, staffing and skill-mix, and in the planning, delivery and governance of restrictive interventions. The team found that certain cultural norms have developed in Skye House over time, which normalise the above practices in the context of increasing acuity of clinical presentations, inadequate staffing and skill-mix, unsuitable physical environment and inadequate information flow.

This report therefore describes the above issues, and focuses in particular on the planning, delivery and governance of treatment and care to young people with eating disorders, who comprise a substantial proportion of inpatients admitted to Skye House. A systems lens is used throughout to present cross-cutting themes.

The review team has made specific recommendations regarding enabling the involvement of young people and families in their treatment and care, developing a specific clinical model for eating disorders and young people with complex comorbid conditions, improving staffing numbers and skill-mix to deliver the clinical model, and focusing on development of the right attributes in staff, as well as improving governance and oversight of restrictive interventions, child protection and whistleblowing.

2. Introduction

2.1 Reasons for this review

A BBC documentary was broadcast in February 2025, which outlined allegations of cruelty within Skye House. The documentary drew upon interviews with 28 former patients, several of whom described severe distress during their time in the unit. These accounts highlighted the vulnerability of the young people admitted to Skye House, many of whom are detained under the Mental Health Act (MHA) and therefore unable to leave until deemed clinically fit for discharge.

These disclosures prompted significant public concern and led the Minister for Mental Wellbeing to state in Scottish Parliament that the issues raised were being treated with "the utmost seriousness."

In response, government ministers arranged meetings with NHS Greater Glasgow and Clyde (NHSGGC), NHS Lothian and NHS Tayside to consider the implications of these concerns. NHSGGC, the Health Board that provides Skye House, initiated a full internal review of the quality of care provided at the service. In view of the potential systemic failings in safeguarding, culture, and clinical care that emerged during the BBC programme, NHSGGC confirmed that, in addition to its internal review, it had commissioned an invited review by the Royal College of Psychiatrists to ensure external scrutiny, specialist oversight, and impartial assessment of the concerns raised.

2.2 Approach to the review

The preparatory phase involved agreeing the review's terms of reference and appointing a review team, with particular emphasis on ensuring an appropriate balance of Child and Adolescent Mental Health Services (CAMHS) expertise and patient safety knowledge. The team also included a Lay Reviewer who has extensive experience in invited reviews.

Once the review team was established, they met with Skye House staff in July 2025 to outline the scope of the review and to provide an opportunity for staff to ask questions regarding the invited review process.

Phase one focused on a review of a range of documents. The review team looked at staff organograms, governance and management structure documents, Mental Welfare Scotland reports and reports by the Quality Network for Inpatient CAMHS (QNIC), Internal investigation reports, data regarding lengths of stay, referrals and complaints data, staff handbooks and policies and procedures.

In September 2025, the review team sought further documentation to gain a more detailed understanding of how real-time information flows through the unit. The intention was to assess how incidents, DATIX notifications, and other key data are disseminated to clinical staff and senior management, and to better understand the reporting structures and communication pathways that shape day-to-day practice.

The additional request included up-to-date staffing structures, information on access to general and physical healthcare support, demand and capacity data, community demand data, referral data from the previous 12 months, and documentation describing pathways between inpatient services, any outreach provision, and community services.

Documents received during September and October 2025 included minutes of the Operational Management Group meetings, the admission and discharge pathway policy, updated organograms, the nasogastric (NG) feeding policy, the physical healthcare policy, the 2025 unit status update, and the West of Scotland Tier 4 CAMHS Network Inpatient Data Report.

The review team also considered Scotland specific legislation and guidance and received advice on where this may differ from legislation/guidance in England. These are listed in the “references” section of this report, and guidance is quoted as appropriate in relation to specific recommendations.

2.3 Acknowledgement

We want to express our sincere thanks to the young people, families and staff who contributed to this review. Your openness, candour and honesty — often in the context of difficult, painful and sometimes traumatic experiences — have been invaluable. We recognise the emotional labour involved in revisiting these experiences, and we are deeply grateful for the trust you placed in sharing them.

Our intention throughout this review has been to understand the systems, processes and culture that shaped care, including the circumstances in which care did not meet the standards that young people, families and staff should be able to expect. The insights you provided have helped us see the pressures, constraints and unmet needs that affected everyone involved.

We hope that all who contributed, and the wider service, can see that the purpose of this work is to support meaningful improvement: creating the conditions in which staff are equipped, supported and able to work collaboratively with young people and families to provide a safe, therapeutic and nurturing environment where everyone can thrive and continuous improvement be made.

3. Methodology

This review used a systems lens – Systems Engineering Initiative for Patient Safety (SEIPS). The SEIPS approach was used to examine the service as an interconnected system rather than a collection of individual tasks or staff behaviours. Using the SEIPS model, allowed the review team to move away from an inspection of individual practices to considering and understanding how the work system – people, tools, environment, organisational processes, and culture – shapes the outcomes experienced by young people, families, and staff, rather than attributing problems to individuals.

This methodology explores how workflows, communication pathways, staffing patterns, physical layout, policies, and cultural norms interact to produce both the intended outcomes (such as safe, therapeutic care) and unintended ones (such as delays, safety risks, or inconsistent practice). By analysing the whole system in this structured way, SEIPS helps identify where the design of the work environment supports or hinders safe, effective CAMHS care, and highlights opportunities for sustainable improvement that go beyond fixing isolated processes.

3.1 Limitations of this review

As with any review of this nature, there are a number of limitations, which are outlined below.

The review team was able to meet with many staff members, as well as current and former patients; however, it was not possible to interview all individuals who may have wished to contribute. Every effort was made to include as many young people, families, and staff as possible to ensure that a broad range of perspectives informed the findings of this report.

All young people who were inpatients at Skye House at the time of the review were invited to participate. Some were, however, too unwell to engage in an interview. As a result, a self-selected group of young people took part.

Those who participated were offered the choice of speaking individually or as part of a group, with support from independent advocacy.

The review team requested documentation relating to governance, procedures, and incident recording. While a range of relevant documents was provided, more detailed information regarding data recording and the review of individual incidents was not available, and the material received was largely in collated form.

In line with the agreed terms of reference, the review team examined twelve sets of clinical notes randomly selected by Skye House. These included records for current inpatients as well as those for young people who had been discharged in 2024.

3.2 Description of the service – Skye House

Skye House is a unit that provides specialist inpatient mental health care for young people aged between 12 and 17 years from the West of Scotland health board areas. The West of Scotland region includes Dumfries and Galloway, Ayrshire and Arran, Lanarkshire, Greater Glasgow and Clyde, and Forth Valley health boards, and the service also accepts referrals from parts of NHS Highland (Argyll and Bute) and NHS Western Isles in recognition of easier geographies for families. It is a 24-bedded unit, comprising three eight-bedded wards, Harris, Lewis and Mull.

It provides inpatient treatment for young people with conditions like severe depression, eating disorders, psychosis, obsessive-compulsive disorders and those with a history of trauma, significant emotional liability, suicidal thoughts and actions. Due to the continuing lack of in-patient provision for young people with a diagnosis of learning disability in Scotland and a lack of access to intensive psychiatric provision also for young people nationally, at times Skye House may be asked to care for young people whose needs are not those for whom it was primarily designed.

All bedrooms are en-suite, and there is a purpose-built gymnasium, fully equipped classrooms, landscaped gardens and overnight accommodation for visiting families.

While young people are admitted to Skye House, they attend the unit school, therapy groups, family sessions and individual sessions.

Skye House has a large multidisciplinary team based on site who are available to support the needs of the young people staying there; the team consists of psychiatrists, nursing staff, occupational therapy staff, speech and language therapy staff, pharmacy staff, physiotherapy staff, an activity coordinator, specialist dietetics staff, systemic therapy, psychology, art therapy, spiritual care and business support and facilities staff.

4. Key findings and Recommendations

Our over-arching observation and key findings are described below. These are based on our review of over 150 documents, our visit to the unit in October 2025 where we were able to meet with staff, young people and their families, and our observations of clinical and other meetings. We carried out in-person interviews/conversations with staff (support workers through to managers) and video interview/conversations with young people, supported by independent advocacy, families of current and past inpatients, and staff members.

The review team found staff at Skye House to be welcoming and open. Many expressed cautious optimism about the future and contributed constructive ideas for improvement. A proportion of staff elected not to participate, noting that they had been involved in numerous previous reviews. Several staff members reflected that the recent BBC documentary felt unbalanced and that the unit had not been afforded an opportunity to respond.

Overall, staff acknowledged that there was learning for the unit and described changes already underway. They emphasised that the most significant area of improvement related to how young people and their families were engaged in their care, including improvements in the mechanisms for seeking and responding to feedback.

At the same time, staff recognised that the BBC documentary had left a legacy of complex emotional responses within the workforce. Many described uncertainty about how to interact with young people in its aftermath and reflected a sense of disempowerment.

Below we set out a number of key observations and findings, along with the review team's aligned recommendations. A collated version of the recommendations can be found in Appendix 4-Recomendations.

Key finding 4.1 - Involvement of Young People and Families in Care and Treatment

The review team found some evidence of strong practice in involving young people and their families in their care and treatment. A recent development was the introduction of a carers' meeting, led by the service manager and senior occupational therapist with the purpose of providing support to families, which had been well-received. Skye House community meetings, which are patient meetings, facilitated by the senior occupational therapist, were also viewed as beneficial. A member of the review team had an opportunity to attend one of these meetings and noted they provided opportunities not only for young people to share their views but also for peer support and constructive challenge where ideas might not be appropriate or feasible. This approach was encouraged and appeared to work well.

The team noted that, while these forums were functioning effectively, their impact could be further strengthened through more consistent attendance and participation from the nursing team/wider multi-disciplinary team (MDT), and with a clear process for taking feedback and learning to other forums for service planning and delivery as well as resolution of concerns.

Following the visit, the team also had an opportunity to review some clinical notes – within which were some excellent examples of work with young people to explore their own presentation and what they felt would support them with their own recovery goals. These included:

- "Exploring our senses with explanations and strategies"
- Self-evaluation pie chart
- "Things I worry about"

One young person told us: "My support plan after leaving hospital was really nice and based on keeping your body healthy and safe."

However, the care plan template used in the electronic record did not evidence collaborative person-centred plans. Its structure was rather separate and ordered around work routines, i.e., individual tasks, rather than individual needs.

Although the care plans stated they were collaborative, the format did not evidence this; the young person's voice was not clearly visible, and the excellent work described above did not appear to feature as part of the care plan.

Letters to parents were addressed to "parent/carer" rather than by name/s of the recipients which felt very impersonal particularly when we could see that parents had attended meetings on the unit in-person with staff. We felt these letters should be more personalised.

We saw an example of a family who required an interpreter and this was clearly facilitated for meetings; however, we couldn't see a communication plan in the records and the letters to parents were written in English.

Some parents reported offering feedback only when concerns become unavoidable. One parent described "picking my battles" and raising only the most significant issues to avoid "too much conflict". This suggests that families may feel unable to share emerging concerns early, potentially due to perceived power imbalances, fear of negative consequences, or a lack of confidence that feedback will lead to change. Other parents described raising an issue with staff and being told they should put in a complaint, when instead the parent had hoped to have a discussion with staff about their child's needs. The service should explore how to create conditions where parents and young people feel able to raise thoughts/concerns proactively, without fear of conflict.

Young people similarly reported mixed experiences regarding involvement in their care. They feel able to speak up but often believe their views do not influence decisions. Some described raising concerns but "nothing ever happens", which can erode trust and reduce future disclosure.

The team found that whilst there was evidence of opportunities for feedback this still remains inconsistent. There was evidence that both parents and young people did not feel able to raise concerns.

These practices are inconsistent with the relational, rights-based expectations of Getting it right for every child (GIRFEC) and The Promise, which emphasise listening, partnership, and psychological safety.

Some young people also spoke about how 'one size doesn't fit all'; they explained their care didn't feel personalised and that they were being 'squashed' into pre-defined model. This will be explored further on page 26 under the "Key Finding 4.3- "Clinical model of care" section.

We heard that limited access to psychological therapies leaves some young people feeling that physical recovery is prioritised over mental recovery.

We also heard that many young people did not feel adequately prepared for admission to Skye House and experienced the process, and their sudden separation from their families, as traumatic. Parents similarly told us that they did not know what to expect.

We heard that although there is advocacy provision, it is able to achieve only small-scale changes rather than system-wide modifications.

Overall, the above findings suggest a gap between procedural involvement ("you are allowed to speak") and meaningful involvement ("your voice shapes what happens next"). The team noted that closing this gap requires intentional work with young people, ensuring their contributions are heard, valued, and acted upon.

We found that there was not a service-wide approach to involvement of young people and their families in shaping the service.

Recommendations arising from key finding 4.1.

The review team are aware of the principles of the MHA Scotland and that services must have the welfare of the child at the heart of all they do. The care provided must be in accordance with the United Nations Convention on the Rights of the Child (UNCRC), which is now embedded in Scottish Law.

We make the six following recommendations in this regard. Many of these themes are cross-cutting, in keeping with the systems lens used in this review.

4.1 Recommendation one: The service should explore ways of providing more information about Skye House before the young person is admitted (where this is possible). This should include photographs and videos of the unit, and cover orientation to the unit by staff, exploring young people's and their families' hopes/fears/goals for the admission, an explanation of the purpose of different meetings and how decisions are made regarding care planning and passes/discharge etc, and a guide to raising concerns. A useful resource may be to consider inviting views from young people who have previously been admitted to Skye House, and their families. We recognise that this will not be possible for all admissions, such as for young people admitted in crises and out of hours; however, in such cases, the service should provide such information to the young person and crucially, to their families, as soon as possible after the admission. There should be a discussion with the young person, their family and the locality CAMHS team, regarding their goals and expectations of the admission. These should be agreed with all parties at an early care planning meeting which should be convened promptly after admission. The arrangements necessary for discharge should also be agreed and planned from this meeting. The current reduction in the number of beds presents an opportunity for Skye House to consider making this improvement.

4.1 Recommendation two : The service should strengthen its approach to gathering and responding to feedback from parents and carers, recognising that some families may currently feel unable to raise concerns until issues become unavoidable. This suggests a lack of psychological safety and relational trust, which is inconsistent with the

expectations of GIRFEC, UNCRC incorporation, and The Promise. The service should develop proactive, relational, and low-barrier mechanisms for families to share thoughts/concerns early, and ensure that raising feedback is experienced as safe, welcomed, and influential.

This will enable:

- Earlier identification of emerging issues
- Stronger partnership with families for a truly collaborative approach
- Improved alignment with rights-based and relational practice
- Reduction in escalation-driven complaints
- Qualitative feedback from families on psychological safety

4.1 Recommendation three: The above should involve opportunities for the wider multi-disciplinary team to hear first-hand from young people and families.

4.1 Recommendation four: We saw some excellent examples of feedback to young people from issues raised in care review meetings. And we recommend that these are extended to other meetings where treatment and care decisions are made.

4.1 Recommendation five: The current care-planning template within the electronic patient record requires review, as the voice of the child and young person is not clearly reflected. In line with GIRFEC, UNCRC incorporation, and the commitments of The Promise, the service should explore ways to ensure that care plans meaningfully capture what matters to the young person, their views, preferences, and aspirations. This includes using rights-based and recovery-focused language that positions the young person as an active partner in their own care. The service may wish to consider using goal based outcomes to capture the aims of treatment from the young person's perspective.

4.1 Recommendation six: There should be a “communication with carers/families” care plan agreed at the point of admission for every young person, to include title and name of the parent/carer and how they wish to be addressed, the method and frequency and mode of contact, and any other reasonable adjustments that need to be met.

Key finding 4.2- Staffing Numbers, Attributes, Skill-Mix and Well-being

In keeping with the systems lens we have used, we focused on the inter-play of multi-disciplinary staffing numbers, skill-mix, well-being and attributes on the delivery of safe and therapeutic care to young people.

4.2.1 Staffing Numbers & Attributes

We found evidence of significant efforts to strengthen staffing numbers in the last year. We noted that, previously, staffing numbers were not always adequate to deliver safe and good quality care for young people. Difficulties in staffing previously, particularly in qualified nurse and healthcare assistant numbers, meant that prior to early 2025, the unit was reliant on agency and bank staff to fill shifts. We were told that at that time, non-substantive staff were therefore asked to undertake tasks such as completing observations and mealtime support which young people found uncomfortable as they did not know these staff members. Some young people told us that these tasks were not completed as skilfully as regular staff members would have done them, and sometimes without awareness of the agreed care plan. We are aware that Skye House has used only substantive staff since early 2025 to complete bank shifts. We are advised that substantive staff are engaged on a recurring multi-shift basis, which ensures that all staff are known to young people.

The significant staffing pressures have at times led to variability in the interactions of staff with young people. Whilst we saw and were told about instances of very compassionate and supportive care from staff, we were also told about insensitive or inappropriate interactions. We were told that dedicated staff, stretched by high workloads, could at times become disengaged and focused on completing tasks, for example during mealtime support. We heard from families that high staffing pressures meant that staff were often unable to make time to meet with them, listen to their concerns, or provide feedback to them regarding the progress made by their child.

However, we also heard from young people and families about staff going the extra mile to meet their needs and to comfort them when they were in distress, despite being under such pressure.

When considering the many pressures on staff, a clinician reflected that there was a culture of “we’re too busy for our patients.”

Young people told us that sometimes, even with adequate staffing, they observed nursing staff sitting in the office rather than interacting with them.

Staff told us that they had raised concerns about staffing levels, being overworked, and the impact this had on patient interactions and safety. They recognised that they were unable to deliver care to a standard that they wanted, and many staff therefore described experiencing stress relating to their to professional role and possible moral injury. Although they recognised that senior ward staff were overwhelmed too, some described being “unclear” about the management structure and perceived management as remote and unresponsive.

We heard from young people that there has been an unpredictability in the approach of staff so that young peoples’ feelings of emotional safety on a particular shift depended on which staff were on duty. We also heard that lack of staffing meant that there were insufficient activities for young people on weekends. and that young people may not have the opportunity for time in the outdoor space or activity space. Some young people said that the staff did not always know what had been agreed at meetings about their care plan, so did not know if they were allowed to exercise or not- they gave examples of when they had not been allowed to exercise at the weekend when they felt this had been previously agreed.

We are mindful that some young people may have wished to engage in physical exercise and physical activity, but this may have been precluded by their clinical presentation and physical health. One young person said, “The activities on the ward are really good. I go to lots of different things. I really enjoy the creative sessions and walks. … at weekends the ward feels silent, it's really difficult.” Other young people described enjoying creative activities, walks, and special events such as the Christmas fair, which boosted confidence and connection.

A young person said she felt that the Skye House wards were “extremely understaffed” and said they had observed “one person doing the job of three people— for example, measuring weights, supervising meals, and doing observations, all at once. “I empathise with the nurses. How are they expected to spread their time with patients and do all the other jobs? They do their best to make time."

A parent said, “They did their best. I have no issue with what staff tried to do. They were working in exceptionally difficult circumstances. I know the staff were raising concerns with the Board about not having enough resource. But what were the Board doing?”

We heard several instances of young people feeling that staff had used inappropriate, humiliating or insensitive language.

This was a particular challenge for neurodiverse young people, although several young people reported a similar experience at one time or another.

The following concerns were raised with us.

“Some nurses use really insensitive humour, and I don’t understand that because I’m autistic.”

“Staff were so busy. They took their frustration out on us. They’d get angry with us if we did something they didn’t like. I get that they were so busy and there weren’t enough of them, but still.”

Another young person said, “10% of staff were nice all the time. They were the ones we looked for. 70% were nice if they were doing okay. But they weren’t nice if they were struggling. The rest, 20%, they were pretty horrible. They shouldn’t have been allowed to be there.”

One young person described significant discomfort with a male nurse observing her whilst she was using the toilet during one to one observations.

However, we also heard very positive feedback.

“Nurse XX was always kind, always had a nice thing to say.”

A parent told us, “It feels like things are improving but very slowly. I wish I had had the opportunity to meet other parents.”

“XX the family therapist was fantastic. He always made time for us as the parents, not just to do therapy but to answer our questions and just generally make us feel heard. We just needed someone to tell us we weren’t bad parents.”

“Dr XX was superb. He was not very talkative but knew what he was doing.”

Several young people also described feeling that staff ultimately had their best interests at heart. A young person said they felt safe raising any concerns with staff.

They understood that, even though they might not agree about their treatment, because they wanted to lose weight due to their anorexia, they knew that "the staff were on my side, and they had my best interests at heart." They said, "I will always remember the good care that's helped me."

We saw excellent examples of young people being given increasing amounts of responsibility for activities such as design and budgeting as their confidence and ability improved.

During our visit, we heard that the number of beds was being reduced by a third to enable the service to support the current staff to continue with the agreed training and to induct a new cohort of staff.

The review team concluded that young people recognised that staff behaviours change towards them when staff were under pressure and were able to understand why this happened. However, from a safeguarding and child protection perspective, these inconsistent interactions between staff and patients left young people feeling fearful. They experienced an unpredictable environment where they could not reliably anticipate how they would be treated.

4. 2.2 Skill-mix

We found that the skill mix of the multidisciplinary team has not always been aligned with clinical need, particularly with the increasing complexity of presentation of young people. For instance, we observed and were told by staff and young people that the unit has not always been able to meet the needs of neurodiverse young people, including those with autism and young people with intellectual disability. Staff told us that there had been a marked increase in the prevalence of neurodiversity amongst young people admitted to the unit over recent years.

Staff told us they did not feel adequately trained or resourced to meet the needs and risks of young people with this complexity. Young people and families described experiences that reflected these concerns .

We heard that although training had been provided, this was not accompanied by protected time to attend training, and the necessary

change in infrastructure or the support for staff to put their training into action.

We also noted that despite improvement in some areas, there remain some key gaps in the skill mix of the service, particularly for experienced qualified nurses, dietitians, activity coordinators and clinical psychologists which leads to considerable delays in young people accessing these crucial specialist supports. We were told by a specialist clinician - "I also need to provide specific training and input to catering and supporting families... I want to be able to do and provide proper service improvements, but I can't do anything other than the immediate response role and firefighting. The service is very over-stretched. I have been sending regular emails to management. I don't have any time to eat or drink when I'm on shift - I'm just firefighting".

Senior clinical staff told us that they felt that their training and expertise were sometimes underutilised, with the service bringing in external trainers. This was linked with frustration at not having time to train and supervise staff and be supported in having a role in improving practice and standards. Some staff had much experience, for instance in restraint supervision and governance improvement. Several staff told us that they could deliver in-house training. However, they could not do this due to staffing constraints.

In relation to eating disorders, please see Key Finding 4.3- Clinical model of care page 26.

5. Staff Wellbeing

A number of staff presented as exhausted and struggling to stay positive despite their clear commitment to the young people. Several nurses commented on the 'low morale' on the unit. We were told – "I'm just absolutely exhausted.... I love my job at Skye House. I'm really passionate about the young people in Skye House, but I just can't sustain this....".

Another nurse however, told us that Skye House was a great place to work and had recommended it to others as an excellent place to gain experience and training. A manager said they believed that "Most problems with culture at the moment come from burnout and exhaustion."

Some nurses felt that the wider multi-disciplinary team does not fully appreciate the stresses for nursing staff, and managers likewise do not understand the full pressures, with nurses experiencing constant scrutiny and complaints.

Due to lack of time, some staff supervision and training opportunities have been missed.

We were told about exceptionally challenging situations staff had to manage, including serious self-harm and difficult interpersonal interactions, with multiple stressful incidents occurring on the unit at times when staffing levels were insufficient to respond safely.

Several of the nurses described having no protected time or opportunity to reflect on these events, which they felt were ignored and often normalised by the wider staff group and management.

A band 5 nurse, a band 6 nurse, and a support worker all reported inadequate staffing and a lack of trained staff on some shifts, especially at night. This would result in staff being expected to do work outside their role and greatly affected their ability to provide safe and compassionate care. Several members of staff felt a reliance on agency staff led to disrupted patient care and increased their workload due to the need to supervise unknown staff. They were therefore relieved that since early 2025, no agency staff have been used, that substantive staff are engaged on a multi-shift basis, and that bank staff with experience and skill in working in Skye House have now been recruited to permanent posts.

Some staff described feeling very unsupported by 'management' when raising workload issues, and on return from sick or maternity leave - they strongly felt this contributed to burnout and a sense that they are not valued or supported in their role. These comments related to management at ward, service and Board level. They described their own strong personal commitment to the young people in the unit as their motivation for continuing to work in an organisation they otherwise found disempowering and, at times, undermining.

Overall analysis of key finding 4.2

The feedback paints a picture of a unit with pockets of excellent and compassionate care, but also significant inconsistency in staff behaviour, communication, and therapeutic engagement. Young people's experiences are heavily influenced by:

- who is on shift
- the environment at the time
- the level of structure and activity available
- the degree to which their voice is heard and their wishes enacted
- whether nursing staff had time or psychological availability to listen and chat with young people

The most concerning themes relate to dignity, insensitive language, and inconsistent safeguarding of emotional safety, which carry clinical, safeguarding and reputational risks. There is a significant risk that insensitive or inappropriate interactions with young people may undermine their sense of safety, trust, and dignity within the service.

While some behaviours may stem from staff fatigue, workload pressures, or burnout, other instances reflect conduct that falls below expected professional standards. We are advised by NHSGGC Board that they addressed these concerns when they were identified. Without clear differentiation and timely intervention, these behaviours can contribute to a culture where young people feel dismissed or devalued, potentially exacerbating distress, disengagement from care, and poorer clinical outcomes. This is inconsistent with trauma-informed, rights-based practice and the expectations set out in GIRFEC, UNCRC incorporation, and The Promise. Addressing these issues requires both adequate staffing levels, supportive measures for staff wellbeing, space and time for staff to reflect on their practice, and firm assurance that all interactions uphold the values and standards expected in children's mental health care.

At the same time, the positive feedback demonstrates that the unit has the foundations of a strong therapeutic culture – when staff were attuned, trained, and supported, young people felt cared for, safe, and able to progress. It was striking that many of the staff interviewed were aware of the shortcomings in care provided, and the impact this has had on young people and staff.

Despite having experienced extremely difficult conditions on the unit, and sometimes in their employment, many of the staff described a strong personal commitment to the young people and to improving care. They had valuable insights, based on their experience at Skye House and other services, into how the care provided could be improved. They were very keen to be fully involved in the improvement process.

Recommendations arising from key finding 4.2.

Note: Section 4.3 (Clinical Model) describes the systemic impact of gaps in staffing numbers, attributes, and skill-mix on the unit's ability to treat young people with eating disorders and disordered eating.

We make the following eight recommendations:

4.2 Recommendation one: The service should undertake an urgent review of staff whose interactions with young people have involved insensitive or inappropriate language or 'humour'. This review should be supported through close supervision and management oversight to understand the underlying factors contributing to these behaviours — including the impact of workload, stress, or burnout — and to distinguish these from conduct that falls below expected professional standards. Clear actions should then be taken to ensure that all staff interactions align with trauma-informed, rights-based practice and uphold the dignity and wellbeing of young people.

4.2 Recommendation two: The service should be enabled to continue with a reduced bed base and use the opportunity to review the model of care together with the environment improvements needed.

4.2 Recommendation three: This should include a review of the multi-disciplinary establishment to align staffing numbers and skill with the high complexity and acuity of patients. Management must ensure there are adequate staffing levels to allow for protected time for mandatory and specialist training for all staff.

4.2 Recommendation four: Some gaps in skill-mix need urgent attention, such as dietetics, activities coordinator for school holidays and weekends, and psychological therapies provision.

4.2 Recommendation five: The unit should review and adapt both its clinical model and its therapeutic environment to ensure they are responsive to the needs of neurodiverse young people. This includes embedding neuro-affirming principles into assessment, formulation, communication strategies and intervention; ensuring sensory-friendly and predictable environments; and strengthening staff capability to recognise and respond to neurodiversity within mental health presentations.

4.2 Recommendation six: The service should urgently review and address the causes of ongoing staff loss across disciplines, including psychiatry, and put in place a clear retention plan that responds to longstanding concerns about understaffing and its impact on safe practice.

4.2 Recommendation seven: The service should explore incorporating value-based and safety based recruitment in order to develop a culture that empowers all staff to speak out about unsafe, concerning or disrespectful practices.

4.2 Recommendation eight: The Health Board's communications team should develop a communications plan to share improvement progress and strengthen public and stakeholder confidence.

Key Finding 4.3- Clinical model of care.

We note that Skye House is a mixed unit. It admits young people with eating disorders and other serious mental illness, very significant levels of emotional dysregulation, self-harm and suicidality, learning disability and neurodiversity. There are often additional complex factors relating to trauma, family circumstances and care with most of the young people having complex formulations and care and treatment needs. The differences in provision provided by the various referring health boards, social care and education all influence the expectations of admission, and patient flow into, and out of, the unit.

One of the experienced senior doctors described their approach to inpatient care as being one of intensive and detailed assessment in the early stages of admission which would inform a biopsychosocial formulation, which would in turn inform the treatment provided, the care plan, and goals of admission. The doctor was not sure this was the approach to inpatient care provided for all patients. They noted that it was often difficult to get psychology involvement in the early assessment and formulation, as shortages in psychology provision meant an internal waiting list for this input for individual young people.

4.3.1 Eating Disorders and Disordered Eating

We found clear evidence that the complexity and acuity of young people admitted to Skye House has increased over time. At least half the young people admitted have an eating disorder or disordered eating, often alongside co-occurring conditions such as neurodivergence, and a proportion of young people also present with other mental illnesses such as psychotic disorders. This means the inpatient multi-disciplinary team is required to meet the needs and manage the risks of young people with multiple, intersecting conditions rather than a single primary diagnosis.

Governance reports reviewed prior to the visit indicated that the unit had been experiencing significantly increased acuity for several years.

These reports, however, did not explicitly acknowledge that this pattern likely represented a sustained and permanent shift in the profile of young people referred to Skye House.

Earlier recognition of this trend may have enabled the service to consider its overarching clinical model of care at an earlier stage.

Staff described the challenges of supporting neurodiverse young people who also present with eating disorders or disordered eating, and the increasing pressure to admit children and young people with complex care needs who may not have a primary mental illness. We found that some young people admitted to Skye House now present with combinations of eating disorders, autism, psychosis, depression, and other co-occurring neurodevelopmental conditions. This means the service needs to make consistent reasonable adjustments, in line with Scotland's rights-based duties under GIRFEC, UNCRC incorporation, and The Promise, to ensure that care is accessible, appropriate, and responsive to individual needs.

At present, the unit does not have an overarching model of care that transcends diagnostic boundaries and provides a shared framework for the whole multi-disciplinary team. A unifying model — for example, one grounded in neuroaffirmative, attachment-informed and trauma-informed practice — would support consistency, uphold rights-based principles, and ensure that all young people receive care that is developmentally attuned and aligned with national expectations.

We heard that young people with eating disorders and disordered eating made up about 50% of the inpatients, but there was no clearly articulated model of care for this cohort. Staff talked about the challenge for both young people and their families of adjusting to an inpatient episode of care and treatment that the young people struggled to accept, very often in the context of detention under the MHA. Young people told us that the focus appeared to be on weight restoration above all else.

"I do try to tell people things, but it's really hard because of my own anxiety.... I feel my physical recovery is better than my mental recovery. I have only seen psychology and art therapy once or twice, as the focus is so much on physical health."

The lack of a model of care for young people with eating disorders and disordered eating is a key area for the unit to develop and therefore a SEIPS analysis was undertaken specifically in this area. We understand that subsequent to the site visit and review of documents, NHSGGC have been developing Eating Disorders practice guidance.

This review highlights the system-wide factors influencing the delivery of care for young people with eating disorders or disordered eating within Skye House. The analysis identifies pressures across the work system, the resulting impact on processes, and the outcomes experienced by patients, families, and staff.

4.3.2 Person Factors

Young people often present with complex eating disorders that shape their perception of treatment, including resistance, fear, or mistrust. Many have multiple diagnoses, adding further complexity to assessment, engagement, and care planning.

Patients reported that there is a 'one size fits all' approach which can make them feel they are being shaped to fit the system rather than the system being designed to support them to work to and achieve their goals. As the ultimate goal, after medical stabilisation and inpatient therapy, will be to enable the young person to eat in their home environment, the development of shared goals with the young person and their family is key, including involving the family in meal time support interventions.

Families frequently experience distress at the point of admission, particularly when community treatment has not been successful. This can create a sense of loss of control, a feeling of failure and heightened emotional responses.

Staff are also affected. Anxiety related to scrutiny of their care and their actions, complaints, and the high-risk nature of eating disorders and disordered eating care influences confidence, decision-making, and psychological safety. The emotional load is significant for all involved. This can result in staff feeling that they have no choice but to use restrictive interventions to maintain safety, instead of being able to take an individualised approach.

Staff shortages mean care cannot always be delivered as planned, especially with providing support to young people after Nasogastric(NG) tube feeding. The constantly low staffing numbers can result in it becoming normal for staff to not provide such support even when staffing would allow it, and this has left some young people feeling that staff did not care about them.

We heard about instances of good practice, such as an eating disorders nurse with specific physical health training.

4.3.3 Task Factors

Key clinical interventions for this cohort – particularly NG feeding – are high-risk, technically demanding, and may often require physical restraint. This increases cognitive load and emotional strain for staff, which in turn increases the potential for harm. The sequencing and coordination of tasks can be challenging and requires specialist training and a standardised model of care (see environment).

4.3.4 Tools and Technology

There is no recognised or accredited training pathway for staff working with eating disorders or disordered eating on the unit. This creates variability in competence, confidence, and formulation skills. Staff are actively working to improve formulation, but the absence of structured training remains a barrier.

4.3.5 Physical Environment

The current ward environment does not support specialist eating disorders treatment. Treatment rooms used for NG tube feeds are not optimally located and are too hot. The dining room is described as stark, chaotic, noisy, and unsuitable for all young people, causing particular difficulties for neurodiverse young people. The loud acoustics in the whole ward environment means that young people are greatly impacted by the sound of other young people's distress. One young person described this as a significant trigger to traumatic thoughts related to the restraint and NG feeds. Environmental stressors contribute to distress for young people and increase the difficulty of delivering therapeutic mealtime support.

4.3.5 Organisation of Work

Cultural factors – including fear of criticism, scrutiny, and organisational oversight – shape how care is delivered and how it is received.

Staffing, workload, and resource constraints further influence the system. Policies, procedures, and training gaps contribute to inconsistent practice.

There is a high level of emotion and anxiety associated with managing eating disorders presentations. Without an evidence-based model or specialist training, individualised care becomes difficult to deliver consistently.

4.3.6 External Influences

External scrutiny and review processes place additional pressure on the service.

Food availability is variable, limiting choice and flexibility. The non-availability of certain 'snacks' caused difficulty between staff and young people, with the latter feel that they were being held to strict regimens without staff providing a full range of choice.

Skye House does not have a systematic process for working closely with all community eating disorders teams, which can result in it feeling like two separate and disjointed episodes of care. A standardised approach is in place for NHSGGC which is the originating area for half the young people placed at Skye House. A systematic approach in this area for all community eating disorders teams will enable admission goals to be agreed at the outset, jointly agreed with the young person and their family, with the aim of discharging the young person home in due course, and will enable the community eating disorders service to work with families to provide support, education and information, particularly on how they can support the child or young person during periods of home leave, and once they have been discharged.

Access to psychology in the community prior to admission is inconsistent, affecting continuity of care and early intervention.

Young people with experience in other inpatient units noted that those services used different care models, adding to uncertainty about the model of care at Skye House.

4.3.7 Care and Other Work Processes

The care process is characterised by high emotional intensity for young people, families, and staff. In order to move away from a "one size fits all" model, teams must adapt care to individual needs, often without the specialist frameworks or training required to do so safely and confidently.

Outcomes

System Performance

Wanted: Weight restoration and stabilisation, to eat safely in the home environment so that the young person can be supported to stay at home.

Unwanted: Trauma for young people, families, and staff; inconsistent care; reduced resilience.

Human Wellbeing: Wellbeing is currently a challenge for all groups involved. Staff experience stress and anxiety; young people experience distress and fear; families feel overwhelmed and disempowered.

Summary

The SEIPS analysis demonstrates that the challenges in delivering safe, effective eating disorder care at Skye House arise from interacting system factors: environmental constraints, training gaps, emotional load, organisational culture, and external pressures. These factors influence care processes and contribute to both desired and undesired outcomes.

This understanding provides a foundation for targeted improvement recommendations, focusing on system redesign, workforce development, environmental adaptation, and strengthened psychological safety.

These recommendations are developed to work towards a coherent, system-wide improvement strategy that:

- Builds specialist capability through an accredited evidence-based module
- Supports families with clear, compassionate pre-admittance preparation and opportunities to discuss and feedback reducing concern/complaints.
- Improves the physical environment and care processes.
- Strengthens organisational culture and reduces fear-based practice.
- Enhances regional consistency and sustainability.

Recommendations arising from key findings 4.3:

We make the following eight systems-based recommendations for improving eating disorders care.

4.3 Recommendation one: Workforce Capability and Specialist Training. There should be nationally commissioned accredited postgraduate-level eating disorders modules through Public Services Delivery Scotland (NHS Education Scotland). The modules should:

- Be grounded in the latest research, Medical Emergencies in Eating Disorders (MEED), RCPsych PEACE Pathway (Pathway for Eating disorders and Autism developed from Clinical Experience), emerging evidence on trauma-informed ED care, and NAIT neuroaffirmative good practice guidance (National Autism Implementation Team);
- Include competencies in formulation, risk management, NG feeding, restraint minimisation, and neuroaffirmative practice;
- Be accessible to all Greater Glasgow & Clyde CAMHS, paediatrics, mental health, and community teams across all health boards;
- Offer stackable credits to support career progression and retention;
- Consider including simulation-based learning and supervised practice to reduce staff anxiety and variability.
- Consider how the inpatient team can work collaboratively with parents/carers and the community eating disorders team through involvement in mealtime interventions, home leave and other family interventions to minimise the length of admission and support transition to home.

Rationale: This will address the current absence of recognised training, reduce performance variability, and equip Skye House with a sustainable specialist workforce.

4.3 Recommendation two: Family Support and Pre-Admittance Preparation.

Skye House should develop a Standardised “Preparing for Inpatient ED Care” Family Programme. This should include a structured, evidence-based family support package that can be delivered pre-admittance or at the point of referral.

This should be aligned with resources to support referrals and the expectations of referrers into Skye House. The programme should include:

- A clear explanation of the inpatient model, expectations, and boundaries.
- Information on NG feeding, meal support, safety procedures, and the rationale behind them.
- Guidance on the emotional impact of admission and how families can support recovery.
- A trauma-informed explanation of why community treatment may not have been sufficient.
- Peer-led components involving families with lived experience.

Consider a digital version (videos, animations, FAQs) to ensure accessibility across the region.

Rationale: This will reduces distress, improves collaborative engagement, and mitigates the "loss of control" families experience at admission.

4.3 Recommendation three: Environmental and Infrastructure Improvements. The Health Board should consider using the reduced bed base as an opportunity to redesign the physical environment. It should:

- Redesign dining and treatment spaces.
- Adapt dining rooms to be neurodiversity-friendly (lighting, acoustics, sensory modulation) and involve young people in this work.
- Improve the location and design of NG feeding and treatment rooms to reduce distress and improve flow (include temperature control).
- Introduce calming, therapeutic aesthetics aligned with eating disorders best practice.

Rationale: This will help create a physical environment that reduces distress for both staff and patients to help deliver therapeutic goals.

4.3 Recommendation four: Organisational Culture and Psychological Safety.

The Health Board should undertake the following to improve psychological safety of staff and patients.

- Establish a regional eating disorders clinical governance framework. This would mean that all eating disorders services across the region would operate within a single, coordinated system for decision-making, learning, quality assurance, and improvement, and would replace isolated, site-specific approaches with a regional, collaborative model. Create a shared governance structure across the region to standardise practice, reduce fear of criticism, and promote learning. This would have multi-disciplinary representation from all services, with collaboratively developed (including with input from young people and their families) and shared clinical standards, pathways, and protocols; common outcome measures and a regional dashboard for key metrics; and quarterly governance meetings to review data, identify themes, and set improvement priorities. Crucially, it would have a shared understanding of system pressures. There are models of provider collaboratives in UK mental health services which have achieved success in such areas.

- Embed 'System Thinking' principles to ensure learning and not blaming.
- Introduce regular reflective practice and supervision and consider Schwartz-style rounds for staff.

Rationale: This will reduce staff anxiety, improve consistency, and strengthen system resilience.

4.3 Recommendation five: Care Process Standardisation and Improvement. The Health Board should undertake the following to standardise pathways and reduce unwarranted variation.

- Develop a regional evidence-based model of care.
- Co-produce a standardised inpatient eating disorders pathway aligned with national guidance.
- Include clear protocols for NG feeding, restraint minimisation, meal support, and escalation.
- Ensure flexibility for individualised care while maintaining core safety standards.

Rationale: Addresses the "one size doesn't fit all" challenge while reducing unwarranted variation.

4.3 Recommendation six: Strengthening Community–Inpatient Interfaces. The Health Board should undertake the following to improve the whole care pathway.

- Improve Access to Pre-Admittance Psychology.
- Commission additional psychology capacity to ensure early formulation and continuity of care.
- Introduce joint community–inpatient formulation meetings to agree rationale and goals of admission, before admission where possible.

Rationale: This will reduce crisis-driven admission and improve therapeutic alignment.

4.3 Recommendation seven: External Influences and System-Level Coordination. The Health Board should undertake the following to improve the whole care pathway.

- Regional review of food provision.
- Work with catering services to ensure consistent availability of appropriate food choices and appropriate escalation/oversight that does not require local leaders to intervene.
- Align menus with ED nutritional guidelines and sensory needs.

Rationale: Food variability undermines therapeutic consistency and increases distress.

4.3 Recommendation eight: Monitoring, Evaluation, and Continuous Learning. The Health Board should undertake the following to develop and embed continuous learning.

- Implement a SEIPS-Aligned Quality Dashboard (or similar systems model)
- Track system performance (weight restoration, safety events, restraint use, length of stay).
- Track human wellbeing indicators (staff burnout, family satisfaction, patient experience).
- Use data to inform improvement cycles.

Rationale: This will ensure the system learns continuously and transparently and reacts to feedback.

Key finding 4.4. Co-occurring conditions and general therapeutic milieu.

Inpatient adolescent units such as Skye House are highly specialist units. They are for young people with serious mental disorders and significant complexity whose treatment needs and risks cannot be managed in a community setting. Most young people admitted to Skye House are detained under the MHA. Many of the young people are neurodivergent with histories of complex trauma and are admitted in crisis. Some have intellectual (learning) disability or may require an intensive level of psychiatric care. They are often admitted and cared for in the general adolescent inpatient environment of Skye House because of a lack of specialist learning disability CAMHS inpatient facility, or adolescent IPCU (Intensive Psychiatric Care Unit).

We heard from several families that they do not feel that young people with eating disorders should be placed alongside those with other difficulties, however other families reflected that it is not possible to have a specialist unit for every diagnosis. Several young people commented that they were exposed to traumatising practices, such as seeing other distressed young people engage in self-harm or aggression, or hearing them in distress, which they had not seen previously.

Skye House consistently cares for young people with complex, high-risk needs, yet its environment, staffing, skill-mix and governance arrangements are not set up to support safe and effective care.

The issues of organisational support and governance are addressed later in Key finding 4.6 - Governance.

The loud acoustics in the ward environment mean that young people are greatly impacted by the sound of other young people's distress. One young person described this as a significant trigger to traumatic thoughts relating the restraint and NG feeds.

We heard that, due to the high proportion of young people with eating disorders and disordered eating, there is sometimes not enough focus on young people with mental illness, due to the resource and time-intensive nature of eating disorders.

Similarly, the care model is not adequately adapted to meet the needs of neurodivergent young people, as their needs are not always recognised, nor reasonable adjustments made.

Young people described staff responses to self-harm as unpredictable, and very dependent on which staff were available. Some staff were described as compassionate and supportive, and providing time for reflection. Others were described as blaming, critical and lacking in warmth, adding to the sense of shame experienced by some young people.

The young people spoke of having 15 minute checks throughout the day and night. They said that while they understood why this might be necessary, it could feel intrusive and could sometimes wake them up at night. We heard that all young people have observation levels tailored to their needs as described in the 'Safe & Supportive Observation Policy & Practice Guidance' – however, this policy was interim at the time of our review and is not specific to Skye House. We are advised by NHSGGC that in addition to 15 minute checks, Skye House also carries out tailored interventions and individual support when required; however, it does not appear that this is understood by young people. In addition, these observations are completed on paper forms and therefore an examination of paper forms will show that all young people had their observations completed exactly at, for instance, 10.00 pm, 10.15 pm, and so on. However, these times do not reflect the actual times at which observations are completed, as it takes time for the nurse completing observation to physically walk from one bedroom to the next. The latest evidence indicates that therapeutic observations are most effective when they are relational, co-produced, and responsive to young person's specific neurotype. Traditional observation models that rely on fixed levels and passive monitoring are increasingly recognised as insufficient for ensuring safety or supporting recovery. Skye House needs to have a clear, agreed, audited and documented approach to safety checks and observations in the ward.

We heard that although the service has recognised that there is an increasing cohort of young people who are neurodivergent, there is not yet a culture of all delivery of treatment and care being neuro-affirmative.

A neuro-affirmative approach is one that recognises neurodiversity as a natural and valuable part of human variation; avoids pathologising neurodivergent traits; adapts environments and expectations rather than trying to "normalise" the child; prioritises safety, autonomy, and dignity; interprets behaviour as communication; assumes distress, not defiance; and values lived experience and co production.

Recommendations arising from key finding 4.4.

We make the following recommendations.

4.4 Recommendation one: There should be a review of the unit's model for the reduction of self-harm, and the support provide to young people after an act of self-harm.

4.4 Recommendation two: see recommendation from Key finding section 4.3 Clinical Model- '4.3 Recommendation three.'

4.4 Recommendation three: The services should consider reviewing the model and nature of 'observation' and consider the Enhanced Care Guiding Principles (Scotland-wide) developed by the National Mental Health & Learning Disability Nurse Directors Forum; these principles are the closest equivalent to England's Enhanced Therapeutic Observation and Care.

These principles focus on

- Replacing "observation" with enhanced care
- A therapeutic, person-centred approach
- Least-restrictive practice
- Strong governance and leadership
- A national four-level training framework
- Regular review and reduction of enhanced care

The aim is for engagement over surveillance, achieving safety through therapeutic connection and developing consistent national standards.

When agreed, these should be discussed with each young person as part of their initial care planning at the point of admission into hospital.

Skye House should also review its approach to recording enhanced care observations, for instance through using electronic devices rather than paper forms, to support accurate reporting of times that observations were completed.

The current interim policy should be reviewed and updated in line with the above; and consideration should be given to Skye House developing its own policy that meets the specific needs of their young people.

Key finding 4.5 Approach to Restrictive Practices.

The reviewers were struck by the young people's strong sense of justice; they spoke with clarity of their own experiences, and what they had observed. The young people were remarkably well informed about their rights, and the rights of the other young people on the unit. They were often thoughtful and compassionate about the care received by others, and also the challenges faced by staff, especially the nurses. Many of the young people had an appreciation that sometimes what they wanted was not necessarily in their best interests because they were unwell. However, they spoke of the value of being listened to respectfully and having the opportunity to have as much choice and opportunities for autonomy as possible.

We found that there was an inconsistent approach to the use of restrictive practices on the unit. This meant that there were variations in exploring and capturing the wishes of young people in advance, upon their admission to the unit, regarding any future need to use restrictive interventions to maintain safety.

Where such advance wishes were documented in care plans, there was variation in acting on these advance wishes. After the use of restrictive interventions such as restraint, NG tube feeding under restraint, or rapid tranquillisation, the provision of post-incident debriefs for young people was inconsistent. There was similar variability in the provision of reflective practice and post-incident debriefs for staff involved. We found that not all restrictive interventions were adequately captured in the patients care record or reported in incident forms, and we found variability in the follow-up of incident forms.

We found a mixed picture in relation to use of restrictive interventions. Some staff spoke with compassion about the challenges of delivering care to young people with eating disorders who are not consenting to treatment, and we saw examples in the notes where staff had clearly attempted to act in the least restrictive and most respectful way possible. A nurse said, "We need to support the young people to have agency, that's why we need to use the least restrictive practice – this needs to be at the heart of a care plan."

A young person described physical holding for NG feeding with five staff – one on each limb and another watching their head. "It's really difficult when everybody leaves suddenly at the end of the holding. It's better for me when a nurse stays on afterwards. Sometimes I want to talk and sometimes I don't, but I want to be asked if I want company." The young person said they were often visibly distressed after the hold, but "it depends on whether nice staff were on duty" whether anyone paid attention to this.

Whilst we found some very compassionately described care we also identified instances where documentation was limited or absent, even when young people or families had raised concerns about staff actions. While feeding under safe-holds is often unwanted by the young person and yet essential for the preservation of life, it is required that staff can describe their decision-making for the use of restrictive interventions and this is recorded clearly. These highly restrictive interventions leave both staff and patients in a vulnerable position, and gaps in documentation suggest that the significance of this vulnerability may not always be fully recognised.

We also noted a tendency for some staff to assume that allegations made by young people during or after restrictive interventions were untrue. It is vital that the concern of the child is heard and believed, due to the distress, fear, and loss of control inherent in these interventions; young people are unlikely to feel comfortable at the time, and their accounts may be shaped by trauma, perception, or sometimes misunderstanding. It is therefore virtually impossible to distinguish, without objective evidence, between a necessary intervention delivered professionally and compassionately, and an intervention that may not have fully met required standards. Assumptions – either that an allegation is true or untrue – without examining the issue – are unsafe. What protects both staff and young people is a culture of curiosity, transparency, and robust review.

4.5.1 Safeguarding / child protection

We also heard from staff that when they reported child protection concerns to the young person's responsible Local Authority, the response and thresholds for action differed by the Local Authority. This variation creates uncertainty for staff, increases the risk of inconsistent safeguarding decisions by Local Authorities and may unintentionally introduce bias into how allegations are managed. Whilst all Health Boards use the same national child protection framework of the Children's Act Scotland, we were told and saw evidence that the two boards had separate policies which makes it harder for staff to act confidently and safely, and it reduces the reliability of the safeguarding response for young people and families.

One young person told us that a nurse had repeatedly offered unsuitable high calorie snacks to all young people at dinner time which they found awkward. The young person said that the nurse then invaded the young person's personal space while asking them again if they wanted the snack. The young person told us that they found this humiliating and distressing.

There were historical incidents of use of electronic devices by staff whilst on duty and social media by young people, which had been experienced as intrusive and psychologically unsafe for young people and staff. The unit had sought advice from the Mental Welfare Commission in use of specified person approach to restricting access to mobile phones and recording devices. Young people described mixed feelings about these restrictions.

Summary

We found significant inconsistency in how restrictive practices were planned, delivered, documented, and reviewed within the unit, creating avoidable risks for young people and staff. Advance wishes were not reliably explored or acted upon, post-incident debriefs for young people and staff were variable, and some restrictive interventions were not fully recorded or followed up. While we saw examples of compassionate, least-restrictive practice, we also identified cultural risks, including a tendency in some cases to dismiss young people's accounts during or after restrictive interventions.

This undermines the rights-based expectations of the MHA, GIRFEC, UNCRC incorporation, and The Promise, all of which require that children's views are heard, taken seriously, and responded to with curiosity and transparency.

Safeguarding Child protection processes were also inconsistently applied, particularly where responses differed depending on the young person's home Health Board, increasing the risk of inequitable or unsafe decision-making. Overall, the variability in practice, documentation, and safeguarding responses indicates a system that cannot yet provide reliable assurance that restrictive interventions are always necessary, proportionate, trauma-informed, and rights-compliant.

Recommendations arising from key findings 4.5:

We make the following recommendations. Many of these themes are cross-cutting.

4.5 Recommendation one : Please see '4.2 Recommendation one' in the section- Key findings arising from findings 4.2.

4.5 Recommendation two: The use of restrictive interventions should have a documented policy for each patient, recorded in care plans, case notes, and reviewed regularly by the MDT. This also applies to NG feeding and associated restraint and must include full documentation, with diagrams of safe holds used. After incidents, individual debriefing sessions should be conducted promptly for both staff and young people, with joint sessions arranged where appropriate. Staff debriefs are required irrespective of personal preference and may take place within the context of supervision.

4.5 Recommendation three: The service should explore the opportunity to provide trauma-informed debriefs for families after the use of the restrictive intervention on their child. (NB currently the checklist of who to inform post restrictive intervention does not include parents).

4.5 Recommendation four : We recommend the implementation of CCTV within appropriate therapeutic areas—excluding patient bedrooms—to enhance safeguarding measures for both patients and staff. This should be supported by a clear, robust policy governing the storage, access, and use of footage to ensure that no additional safeguarding risks are introduced. The policy should explicitly outline:

- how CCTV will be used when incidents or complaints are reported
- how footage can support fair, transparent review of practice
- How young people provide consent and their families are consulted and informed
- How it may contribute to staff learning, including improving the use of safe holds

4.5 Recommendation five: The service should routinely capture the wishes of young people at the point of admission to Skye House regarding the possible use of restrictive interventions in an advance wishes care plan, which is an expectation in the MHA Scotland.

4.5 Recommendation six: The MHA Scotland is clear that the welfare of the child and least restrictive practice are priorities for care. In line with Scottish child protection guidance, GIRFEC, and the principles of the UNCRC, the unit should ensure that the voice of the child is central to all reviews of restrictive practice. Where a child or young person reports that an incident felt harmful, unsafe, or abusive, this should be taken seriously, recorded, and responded to in accordance with child protection procedures. The starting point should be to listen, acknowledge the child's experience, and ensure their immediate safety, before moving into formal assessment and review.

4.5 Recommendation seven: The unit should undertake a review of the data currently collected in relation to restrictive practice and develop a proportionate set of metrics that reflect both quantitative activity and qualitative experience. This work should be guided by the principles set out in relevant Scottish legislation and policy — including the Mental Health(Care and Treatment) (Scotland) Act 2003, the Scottish Government's Policy Position on the Use of Restraint, the Children and

Young People (Scotland) Act 2014, and Scotland's human rights based approach (PANEL/FAIR).

a) As an initial minimum, the unit should ensure it is able to monitor:

- basic activity data (e.g., number and type of restrictive interventions) including the use of rapid tranquilisation
- young person and staff experience of incidents
- evidence of prevention and de-escalation efforts
- percentage of families/carers informed within required timescales.

b) Over time, this dataset should be expanded in a manageable way to support learning, identify patterns, and ensure practice remains rights based, trauma informed, and developmentally appropriate.

c) The data should be displayed in a simple, accessible format and include longitudinal data and made available to staff within the unit to support reflective practice, team learning, and continuous improvement. This should be an ongoing process culture of continuous improvement, rather than a one off event.

4.5 Recommendation eight : The service should undertake a piece of reflective work with the multi-disciplinary team to review their understanding of child protection and safeguarding. This should include a review of training to ensure that staff are equipped to understand the implications of child protection failings. This can be part of a programme of continuous improvement.

4.5 Recommendation nine : The service should consider improving lines of sight, – such as globe mirrors in T corners in Lewis and Harris wards - to provide a necessary layer of safety for staff and young people.

4.5 Recommendation ten: We recommend that all Health Boards urgently come together to agree a single, unified child protection process for this service. This should include clear, directive guidance on the actions required when allegations of abuse are made, ensuring that the response is consistent, timely, and supportive to staff, young people, and families. A shared process will reduce ambiguity, strengthen safeguarding practice, and ensure that decisions are based on transparent criteria rather than geography or interpretation.

Key finding 4.6 - Governance

A very significant issue for Skye House is that it has been expected to provide an ill-defined service for a significantly increased number of young people with increasingly severe, complex and high-risk presentations. This increase in demand has been well documented over the last 10 years, and yet, until the recent public exposure and allegations in the BBC documentary, there has been little or no effective action by NHSGGC to ensure that the unit environment and staffing complement are able to provide safe, evidence based practice that meets the needs of the young people and families it serves.

The review team used the following definition of clinical governance. "Clinical governance, in its widest sense, can be understood as a framework through which UK National Health Service (NHS) organisations and their staff are accountable for continuously improving the quality of patient care. NHS staff need to ensure that the appropriate systems and processes are in place to monitor clinical practice and safeguard high quality of care. Clinical governance is central to the UK and Scottish Government's agenda to ensure that quality of care becomes a key driver in the development of health services. "

Prior to starting the review, we wanted to understand how clinical governance works in Skye House. We therefore asked for a range of documents to understand what information was available to the staff team and various management structures. As outlined in section 2.2 Approach To The Review.

We also carried out a case notes review. We were sent a large number of documents for the cases selected, which included many empty and repeated documents. However, despite this, we found that overall, there was evidence of compassionate and responsive care. We also noted a large volume of forms and documents, many of which were incomplete, undated, or appeared to have been copied from previous versions.

We were unclear as to why there were so many forms trying to capture the same information. The notes that we were sent were in poor order and this made reading the journey and progress difficult to follow.

Among the documents supplied was an internal investigation carried out after the BBC documentary.

While this provided some useful information, it did not amount to a comprehensive internal review and the analysis was limited. This was on the basis that the IRS team had been requested to carry out a more wide-ranging review, and the IRS report itself would form the basis of an ongoing piece of work to improve quality and safety.

Whistleblowing

In the information provided for phase 1 of this review, there was mention of a whistleblowing incident. When we requested further information from the senior executive team, they questioned whether a whistleblowing incident had occurred.

In November 2021 a stage 1 response was provided from the service to the following concerns that had been highlighted from a whistleblower regarding Skye House-Clinical Decision making; COVID-19; culture; staffing; low morale from nursing perspective; exclusions from unit decisions; leadership; and specific exclusions from unit decision making. All areas highlighted were responded to from the service.

Recommendations included a staff survey to capture staff concerns and a review of Skye House's clinical decision-making processes and structures to determine whether they are adequate or require strengthening.

This review was to be completed by December 2021 and shared with the team. Finding a solution to the staffing issues where the management team will review staffing formally to ensure that safe staffing levels are in place and in the context of bed closures that were in place was also recommended. The review also recommended that staffing reviews should be ongoing, and fluid based upon patient cohorts in the unit and the management team will continue to recruit to all vacancies as they arise.

On 25th February 2022, an email was received expressing concerns about Skye House, with the concerns being specifically related to staffing levels and non-adherence to medications dispensing protocols.

We found that previously at Skye House, there has been an over-reliance on the service manager and professional leads to escalate issues to the clinical director and executives.

We also heard that issues had been escalated with little or no response from senior service and Board management.

In the last year, there appears to be a lot more engagement and raising of issues at governance meetings. We were told - "For example, we've escalated restrictive practice to the Mental Health Governance Group. We're using the resources right across the board, and we're trying to support staff to do their jobs using best practice. We're trying to do this as quickly as possible."

We were told by individual clinicians that they did not feel that they were given information, despite providing extensive quality, safety and assurance information up through management structures. We were told that as the over-arching organisation is a large Health Board, and the Specialist Children's Services directorate (the directorate within which Skye House is located) feeds into Mental Health and the Health and Social Care Partnership (HSCP) for East Dunbartonshire, which in turn feed into the overarching organisational Executive Board. There appears to be a flow of information upward, but little flow download back to the service, specifically the clinicians providing care.

We did not find a cohesive approach to clinical governance in Skye House. There were individual meetings and forums where aspects particular aspects of clinical governance were being looked at; however, there was no single meeting that encompasses all aspects of clinical governance. We heard about a range of meetings, attended by different groups, but these remain separate.

In summary, the review highlights a broader challenge within the service's governance arrangements: information is being collected in multiple places but is not being brought together in a way that supports meaningful oversight or learning. Data tends to be viewed within individual operational areas rather than as part of a whole-system picture, which limits the Health Board's ability to identify emerging risks, understand interdependencies, or draw reliable conclusions about quality and safety.

In addition, the absence of data displayed over time means the service cannot easily track trends, evaluate the impact of changes, or provide assurance that improvements are sustained. Without a longitudinal view, governance discussions risk becoming reactive rather than informed by patterns, trajectories, or early warning signals.

Recommendations arising from key finding 4.6

We make the following three recommendations:

4.6 Recommendation one: The service should come together to review its overarching governance function and structure to develop a cohesive framework which enables quality assurance, flow of information up and down, and allows the staff team to take ownership of their data and their practices. To strengthen governance, the service should move toward a more integrated and transparent approach to information. This includes reviewing what data is currently collected, agreeing a core minimum dataset, and developing simple mechanisms for making this available to staff, perhaps through the creation of a dashboard. Making this accessible to teams will support reflective practice, improve situational awareness, and create the conditions for continuous improvement across the service.

4.6 Recommendation two: The service should consider using a Quality Improvement approach to collecting aggregated data and learning over time. It is key that this is designed with and used by staff primarily for understanding all aspects of their own practice.

4.6 Recommendation three: The service should continue to engage with QNIC. This will allow the team at Skye House to remain up to date with new ways of working in inpatient CAMHS and provide them with opportunities to learn from and network with staff from other similar services. It will also provide NHSNHSGGC a mechanism to get regular independent feedback on the quality of the service and support the implementation of the recommendations from this report.

Key finding 4.7 - Multi-disciplinary Interface and Workflow Considerations

As part of our review of governance, we wanted to explore how the wider MDT were able to work together, and how each part of the MDT understands its own role and the roles of other members.

In conversations with staff, we repeatedly heard about tensions between the nursing staff and the wider multi-disciplinary team, including the medical team.

There was a similar disconnect described between clinical staff and ward, service and Board management.

We found that nursing staff are located in the clinical areas in one building, while the rest of the multi-disciplinary team is based in a different building. The nursing staff have expressed their views on the separation as 'doctors do not know what life is like on the wards and how demanding the work is for nurses as doctors rarely spend any time on the wards. Also, management rarely visit the wards.' The separation of buildings on the Skye House site created amplified divisions and left the nurses feeling particularly vulnerable in the clinical space.

"The MDT is not functioning as a unified team. A 'them and us' culture has developed, which is impacting psychological safety, shared accountability, and the quality of clinical decision-making."

We did however hear overwhelmingly positive feedback about some members of the MDT, especially a senior psychiatrist and two nurses, as well as the physical health eating disorders nurse.

An examination of these issues through the SEIPS lens shows the following.

Physical environment:

The ward where the young people and nursing team are based is physically separate from the other building where the remainder of the multi-disciplinary team is located. There is a separate school building. This leads to a sense of 'them and us'.

This leads to each discipline working separately to the other, and manifests in, for example, separate patient care plans being created by each discipline.

Organisation of work:

We found that staff are under such pressure that they are forced to focus on completion of individual tasks rather than being able to think about the overall purpose of their work with young people. We also found that over time, this had crystallised into a practice of focusing on tasks, even when there was capacity to consider more global purpose. This resulted in parallel working rather than integrated care. These task pressures and workload differences, which can fuel resentment ("we're doing more", "they don't understand our workload"), is compounded by the physical separation of nursing staff from other members of the multi-disciplinary team. This leads to a sense of isolation, emotional fatigue and a fear of speaking out, and a culture of not questioning poor practice.

This is further complicated by governance structures that review issues by discipline rather than as a whole system. Escalation pathways are not cohesive.

External influences:

A very significant external issue is the massive increased demand on community CAMHS, special education and care provision, resulting in more referrals to Skye House, and delays in discharge.

There is a shortfall of resource to employ enough psychological therapies professionals, as well as a shortage of qualified mental health nurses, child and adolescent psychiatrists, specialist dieticians and other disciplines.

There are significant albeit understandable regulatory pressures. There are important inequalities in the provision of education. One young person said they were from an area of Scotland where the council didn't fund full education sessions at the Skye House school, and they found it difficult that they could not attend school as much as their friends.

Tools and technology:

This has been described elsewhere in this report – for example, there are no shared data dashboards, and training is completed by each discipline separately.

Governance arrangements:

Another issue is the lack of clear governance arrangements within NHSGGC. Staff in Skye House remain unclear regarding the flow of information and concerns between Skye House and the NHSGGC Board.

Summary:

Our overall conclusion here is that sustained staffing pressures have contributed to a culture where teams are operating in a survival mindset rather than a collaborative one. When staffing levels are stretched, individuals and professional groups naturally narrow their focus to the most immediate tasks and risks within their own remit. This reduces capacity for shared thinking, joint problem-solving, and proactive practice and communication. Over time, this reactive mode of working reinforces a "them and us" dynamic, as each discipline becomes more protective of its workload, boundaries, and decision-making space.

In this context, staff are often doing their best under difficult circumstances, but the system conditions make it harder to maintain the relational, reflective, and integrated ways of working that underpin effective MDT practice. The result is a team that is functioning in parallel rather than together, with reduced psychological safety and fewer opportunities for shared understanding.

Recommendations arising from key finding 4.7

4.7 Recommendation one: here should be a review of the clinical governance model used in Skye House, alongside a review of the clinical model. This redesign work should involve staff, young people and their families.

4.7 Recommendation two: The service should explore ways of developing more cohesive multi-disciplinary working, with protected time for all disciplines to contribute. This may include, using shared biopsychosocial clinical formulation that bring together the perspectives of all disciplines, the young person and their family; making decisions collectively, not sequentially; and achieving clarity on the roles of each professional discipline, a shared understanding of professional boundaries and an agreement on how roles complement one another.

5. Conclusions

The review team found that Skye House had already embarked on a programme of improvement of several aspects of the service. Additional funding has been made available, enabling new staff to be recruited; a new service manager has started in post; and support meetings for parents and young people have been established. These are overseen by an Executive Oversight Group which meets fortnightly.

Post BBC documentary, there is a need to build confidence with the public and wider stakeholders.

There is an ongoing review of the purpose and model of specialist children and young people's inpatient mental health services in Scotland. Such services provide essential and highly specialist assessment and treatment for the most complex, unwell and at risk children and young people. Crucially their purpose must focus on those young people with mental illness, as this will gives clarity of purpose within a structure which provides evidence-based and rights-based care. Skye House now has an opportunity to redefine its purpose and to make clear and realistic expectations of the service it provides. It will be important to emphasise and communicate the purpose and the expectations to the wrap around services for Skye House, the staff and management, patients, parents and carers. To support NHSGGC and Skye House in this, they will need an actively integrated approach across Scottish Government, Health Boards and Councils to take a holistic approach to understanding and providing for the needs of the most complex and vulnerable children, young people and their families.

The review team has made specific recommendations to improve a number of aspects of recruitment of staff with the right attributes, planning, delivery and governance of the service, with a particular focus on improving the involvement of young people and families in their treatment and care, use of restrictive interventions and child protection, and the development of a specific model of care for eating disorders and young people with complex comorbid conditions. These in turn will enable the service to foster a culture of curiosity, transparency, and robust review, which will protect young people, their families and staff.

6. Appendices

Appendix 1 - Terms of reference

This review had two distinct phases.

Phase One: Review of Governance
The first phase will begin with a meeting with senior leaders and unit staff. The review of governance will use Quality Network for Inpatient CAMHS (QNIC) standards as well as other relevant regulator standards and policies. There will be monthly meetings between commissioners of the review, the IRS team and lead reviewer to monitor progress.

This phase includes:

- An initial meeting with senior leaders to finalise terms of reference and scope of work.
- A review of internal investigation documents
- A review of all recent safeguarding alerts, complaints, serious incidents and whistleblowing, along with relevant policies.
- A review of information regarding staff organisation, e.g. staffing numbers and processes relating to staff support and supervision.
- A review of internal quality assurance processes, including evidence of action plans and learning
- Group discussions with senior management and multi-disciplinary team

This phase will also conclude with an initial feedback meeting with senior leaders, and a check in before the next phase commences.

Phase Two: Review of Care and Treatment
Phase two will involve a review of current and past patients, with a particular focus on feedback from patients and their families and case notes, followed by a review of the culture of care within the unit.
There will be monthly meetings between commissioners of the review, the IRS team and lead reviewer to monitor progress.

This phase includes:

Case note Review

- A review of twelve randomly selected patients and their care notes; six from the current cohort and six who were discharged in 2024.
- Interviews with clinicians, patients and their families to gain feedback and explore any emerging themes from past or present incidents of care.

Culture of Care Review

- The review team to conduct a site visit to the unit.
- Reviewing recent feedback around culture of care, including patient safety, restrictive practices, and decision making in adverse events.
- Interviews with multi-disciplinary team, senior leaders, and patients and carers.

Reporting

A final report will be issued highlighting examples of positive practice, areas for improvement, and recommendations to support development.

The review will consider whether the service is safe now and how to ensure safety in the future. The review will consider some past episodes of care and will consider any emerging themes; however, it cannot provide assurance regarding all historical care delivered.

Phase Three: Six-Month Follow Up

Six months after dissemination of final report, the review team will review the progress of governance and culture of care within the unit. This will include measuring against report recommendations and gathering evidence of action plans. This would include a one-day meeting with senior representatives from the health board and Skye House.

Six Month Follow Up (Phase 3)

The invited review team will complete a follow-up review of the service approximately six months after the final report is sent to the service. This will involve a review of the progress to date and a meeting with NHSGGC senior leaders. The scope and format of this review will be finalised nearer the time.

Appendix 2 – Review Team

The invited review team consisted of five reviewers.

Dr Mayura Deshpande – Lead Reviewer

Mayura Deshpande is a consultant in forensic psychiatry. She is the National Specialty Advisor in secure care to NHS England and Improvement and chair of the Adult Secure Clinical Reference Group. She is the Caldicott Guardian at Southern Health NHS Foundation Trust in Hampshire, where she has previously held a number of senior management posts. She is also an honorary senior lecturer in the University of Southampton.

She is currently the College's Associate Registrar for Policy.

Ms Tracy Ward

Tracy is a Senior Registered General Nurse with a varied career most recently having extensive experience in patient safety and clinical leadership. She currently serves as Head of Patient Safety and Patient Safety Specialist at a Mental Health NHS Trust, where she leads strategic initiatives to improve safety culture, reduce harm, and embed human factors principles across the organisation.

Tracy also contributes nationally as Deputy Chair of the Colleges' Joint Accreditation Committee, where she supports the development and oversight of accreditation standards that promote excellence in patient care and safety.

Dr Leonie Boeing

Dr Leonie Boeing has been a consultant child and adolescent psychiatrist for almost twenty years and has worked clinically in Scottish community CAMHS tier 3 and intensive tier 4 services. She has been Lead Psychiatrist with Borders CAMHS since 2022. Leonie is also academic secretary and Co-vice chair of the Royal College of Psychiatrists in Scotland Child and Adolescent Psychiatry Faculty Executive Committee.

Ms Veryan Richards

Veryan is a Lay Reviewer on the Royal College of Psychiatrists Invited Review Service team. She has wide experience of representing the patient and public interest at strategic level in the areas of quality care, patient safety, and improving services.

She is particularly interested in the balance of evidence-based and values-based practice in the delivery of holistic person-centred healthcare. She contributed to embedding values-based practice and person-centred clinical care into the Royal College of Psychiatrists Revised Psychiatry Curriculum 2022 and the HEE Advanced Clinical Practice Core Capability Framework for Mental Health 2020.

Ms Ann Jones

Ann is a general and mental health nurse with a career focused in CAMHS. She holds a professional CAMHS qualification and has worked in both community and inpatient settings as a specialist practitioner supporting children, young people and their families.

Her career has included operational and strategic leadership roles, commissioning CAMHS services, and contributing to regional and national transformation programmes. During this work she collaborated with QNCC and QNIC on CAMHS reviews.

More recently, she has undertaken independent improvement projects across the NHS and independent sector, including the redevelopment of a young people's unit. She serves as a nurse reviewer for the RCPsych Invited Review Service, completing reviews across the four nations, and is Deputy Chair of the Young People's Advisory Service, a charity supporting the mental health and wellbeing of children and young people in Merseyside.

Appendix 3: Sources of Information

The review team met with over twenty staff members across disciplines, including nursing staff, medical staff, therapeutic professionals and ward management. They also met with members of the executive team. Interviews with young people were conducted both in person during the site visits and online, through individual and group sessions supported by independent advocacy. In addition, several families who had previously contributed to the BBC documentary were interviewed as part of this review.

Appendix 4 – Recommendations

All recommendations made in this report are reproduced below.

Recommendations from Key finding 4.1 - Involvement of Young People and Families in Care and Treatment

4.1 Recommendation one: The service should explore ways of providing more information about Skye House before the young person is admitted (where this is possible). This should include photographs and videos of the unit, and cover orientation to the unit by staff, exploring young people's and their families' hopes/fears/goals for the admission, an explanation of the purpose of different meetings and how decisions are made regarding care planning and passes/discharge etc, and a guide to raising concerns. A useful resource may be to consider inviting views from young people who have previously been admitted to Skye House, and their families. We recognise that this will not be possible for all admissions, such as for young people admitted in crises and out of hours; however, in such cases, the service should provide such information to the young person and crucially, to their families, as soon as possible after the admission. The current reduction in the number of beds presents an opportunity for Skye House to consider making this improvement.

4.1 Recommendation two : The service should strengthen its approach to gathering and responding to feedback from parents and carers, recognising that some families may currently feel unable to raise concerns until issues become unavoidable. This suggests a lack of psychological safety and relational trust, which is inconsistent with the expectations of GIRFEC, UNCRC incorporation, and The Promise. The service should develop proactive, relational, and low-barrier mechanisms for families to share thoughts/concerns early, and ensure that raising feedback is experienced as safe, welcomed, and influential.

This will enable:

- Earlier identification of emerging issues
- Stronger partnership with families for a truly collaborative approach

- Improved alignment with rights-based and relational practice
- Reduction in escalation-driven complaints
- Qualitative feedback from families on psychological safety

4.1 Recommendation three: The above should involve opportunities for the wider multi-disciplinary team to hear first-hand from young people and families.

4.1 Recommendation four: We saw some excellent examples of feedback to young people from issues raised in care review meetings. And we recommend that these are extended to other meetings where treatment and care decisions are made.

4.1 Recommendation five: The current care-planning template within the electronic patient record requires review, as the voice of the child and young person is not clearly reflected. In line with GIRFEC, UNCRC incorporation, and the commitments of The Promise, the service should explore ways to ensure that care plans meaningfully capture what matters to the young person, their views, preferences, and aspirations. This includes using rights-based and recovery-focused language that positions the young person as an active partner in their own care. The service may wish to consider using goal based outcomes to capture the aims of treatment from the young person's perspective.

4.1 Recommendation six: There should be a "communication with carers/families" care plan agreed at the point of admission for every young person, to include title and name of the parent/carer and how they wish to be addressed, the method and frequency and mode of contact, and any other reasonable adjustments that need to be met.

Recommendations from Key finding 4.2 - Staffing Numbers, Attributes, Skill-Mix and Well-being

4.2 Recommendation one: The service should undertake an urgent review of staff whose interactions with young people have involved insensitive or inappropriate language or 'humour'. This review should be supported through close supervision and management oversight to understand the underlying factors contributing to these behaviours — including the impact of workload, stress, or burnout — and to distinguish these from conduct that falls below expected professional standards. Clear actions should then be taken to ensure that all staff interactions align with trauma-informed, rights-based practice and uphold the dignity and wellbeing of young people.

4.2 Recommendation two: The service should be enabled to continue with a reduced bed base and use the opportunity to review the model of care together with the environment improvements needed.

4.2 Recommendation three: This should include a review of the multi-disciplinary establishment to align staffing numbers and skill with the high complexity and acuity of patients. Management must ensure there are adequate staffing levels to allow for protected time for mandatory and specialist training for all staff.

4.2 Recommendation four: Some gaps in skill-mix need urgent attention, such as dietetics, activities coordinator for school holidays and weekends, and psychological therapies provision.

4.2 Recommendation five: The unit should review and adapt both its clinical model and its therapeutic environment to ensure they are responsive to the needs of neurodiverse young people. This includes embedding neuro-affirming principles into assessment, formulation, communication strategies and intervention; ensuring sensory-friendly and predictable environments; and strengthening staff capability to recognise and respond to neurodiversity within mental health presentations.

4.2 Recommendation six: The service should urgently review and address the causes of ongoing staff loss across disciplines, including psychiatry, and put in place a clear retention plan that responds to longstanding concerns about understaffing and its impact on safe practice.

4.2 Recommendation seven: The service should explore incorporating value-based and safety based recruitment in order to develop a culture that

empowers all staff to speak out about unsafe, concerning or disrespectful practices.

4.2 Recommendation eight: The Health Board's communications team should develop a communications plan to share improvement progress and strengthen public and stakeholder confidence.

Recommendations from Key Finding 4.3- Clinical model of care

4.3 Recommendation one: Workforce Capability and Specialist Training. There should be nationally commissioned accredited postgraduate-level eating disorders modules through Public Services Delivery Scotland (NHS Education Scotland). The modules should:

- Be grounded in the latest research, Medical Emergencies in Eating Disorders (MEED), RCPsych PEACE Pathway (Pathway for Eating disorders and Autism developed from Clinical Experience), emerging evidence on trauma-informed ED care, and NAIT neuroaffirmative good practice guidance (National Autism Implementation Team);
- Include competencies in formulation, risk management, NG feeding, restraint minimisation, and neuroaffirmative practice;
- Be accessible to all Greater Glasgow & Clyde CAMHS, paediatrics, mental health, and community teams across all health boards;
- Offer stackable credits to support career progression and retention;
- Consider including simulation-based learning and supervised practice to reduce staff anxiety and variability.
- Consider how the inpatient team can work collaboratively with parents/carers and the community eating disorders team through involvement in mealtime interventions, home leave and other family interventions to minimise the length of admission and support transition to home.

4.3 Recommendation two: Family Support and Pre-Admittance Preparation.

The Health Board should develop a Standardised "Preparing for Inpatient ED Care" Family Programme. This should include a structured, evidence-based family support package that can be delivered pre-admittance or at the point of referral. This should be aligned with resources to support referrals and the expectations of referrers into Skye House. The programme should include:

- A clear explanation of the inpatient model, expectations, and boundaries.
- Information on NG feeding, meal support, safety procedures, and the rationale behind them.
- Guidance on the emotional impact of admission and how families can support recovery.
- A trauma-informed explanation of why community treatment may not have been sufficient.
- Peer-led components involving families with lived experience.
- Consider a digital version (videos, animations, FAQs) to ensure accessibility across the region.

4.3 Recommendation three: Environmental and Infrastructure Improvements. The Health Board should consider using the reduced bed base as an opportunity to redesign the physical environment. It should:

- Redesign dining and treatment spaces.
- Adapt dining rooms to be neurodiversity-friendly (lighting, acoustics, sensory modulation) and involve young people in this work.
- Improve the location and design of NG feeding and treatment rooms to reduce distress and improve flow (include temperature control).
- Introduce calming, therapeutic aesthetics aligned with eating disorders best practice.

4.3 Recommendation four: Organisational Culture and Psychological Safety.

The Health Board should undertake the following to improve psychological safety of staff and patients.

- Establish a regional eating disorders clinical governance framework . This would mean that all eating disorders services across Greater Glasgow and Clyde would operate within a single, coordinated system for decision-making, learning, quality assurance, and improvement, and would replace isolated, site-specific approaches with a regional, collaborative model.
- Create a shared governance structure across Greater Glasgow & Clyde to standardise practice, reduce fear of criticism, and promote learning . This would have multi-disciplinary representation from all services, with collaboratively developed (including with input from young people and their families) and shared clinical standards, pathways, and protocols; common outcome measures and a regional dashboard for key metrics; and quarterly governance meetings to review data, identify themes, and set improvement priorities. Crucially, it would have a shared understanding of system pressures. There are models of provider collaboratives in UK mental health services which have achieved success in such areas.
- Embed 'System Thinking' principles to ensure learning and not blaming.
- Introduce regular reflective practice and supervision and consider Schwartz-style rounds for staff.

4.3 Recommendation five: Care Process Standardisation and Improvement. The Health Board should undertake the following to standardise pathways and reduce unwarranted variation.

- Develop a regional evidence-based model of care.
- Co-produce a standardised inpatient eating disorders pathway aligned with national guidance.
- Include clear protocols for NG feeding, restraint minimisation, meal support, and escalation.
- Ensure flexibility for individualised care while maintaining core safety standards.

4.3 Recommendation six: Strengthening Community–Inpatient Interfaces. The Health Board should undertake the following to improve the whole care pathway.

- Improve Access to Pre-Admittance Psychology.
- Commission additional psychology capacity to ensure early formulation and continuity of care.
- Introduce joint community–inpatient formulation meetings to agree rationale and goals of admission, before admission where possible.

4.3 Recommendation seven: External Influences and System-Level Coordination. The Health Board should undertake the following to improve the whole care pathway.

- Regional review of food provision.
- Work with catering services to ensure consistent availability of appropriate food choices and appropriate escalation/oversight that does not require local leaders to intervene.
- Align menus with ED nutritional guidelines and sensory needs.

4.3 Recommendation eight: Monitoring, Evaluation, and Continuous Learning. The Health Board should undertake the following to develop and embed continuous learning.

- Implement a SEIPS-Aligned Quality Dashboard (or similar systems model)
- Track system performance (weight restoration, safety events, restraint use, length of stay).
- Track human wellbeing indicators (staff burnout, family satisfaction, patient experience).
- Use data to inform improvement cycles.

Recommendations from Key finding 4.4. Co-occurring conditions and general therapeutic milieu

4.4 Recommendation one: There should be a review of the unit's model for the reduction of self-harm, and the support provide to young people after an act of self-harm.

4.4 Recommendation two: see recommendation from Key finding section 4.3 Clinical Model- 4.3 recommendation three.

4.4 Recommendation three: The services should consider reviewing the model and nature of 'observation' and consider Enhanced Care Guiding Principles (Scotland-wide) Developed by the National Mental Health & Learning Disability Nurse Directors Forum, these principles are the closest equivalent to England's Enhanced Therapeutic Observation and Care.

- Replacing "observation" with enhanced care
- A therapeutic, person-centred approach
- Least-restrictive practice
- Strong governance and leadership
- A national four-level training framework
- Regular review and reduction of enhanced care

Engagement over surveillance, safety through therapeutic connection, and consistent national standards. And discuss this with each young person as part of their initial care planning at the point of admission into hospital. It should also review its approach to recording enhanced care observations, for instance through using electronic devices rather than paper forms.

Recommendations from Key finding 4.5 Approach to Restrictive Practices

4.5 Recommendation one : Please see 4.2 Recommendation one in the section- Key findings arising from findings 4.2.

4.5 Recommendation two: The use of restrictive interventions should have a documented policy for each patient, recorded in care plans, case notes, and reviewed regularly by the MDT. This also applies to NG feeding and associated restraint and must include full documentation, with diagrams of safe holds used. After incidents, individual debriefing sessions should be conducted promptly for both staff and young people, with joint sessions arranged where appropriate. Staff debriefs are required irrespective of personal preference and may take place within the context of supervision.

4.5 Recommendation three: The service should explore the opportunity to provide trauma-informed debriefs for families after the use of the restrictive intervention on their child. (NB currently the checklist of who to inform post restrictive intervention does not include parents).

4.5 Recommendation four : We recommend the implementation of CCTV within appropriate therapeutic areas—excluding patient bedrooms—to enhance safeguarding measures for both patients and staff. This should be supported by a clear, robust policy governing the storage, access, and use of footage to ensure that no additional safeguarding risks are introduced. The policy should explicitly outline:

- how CCTV will be used when incidents or complaints are reported
- how footage can support fair, transparent review of practice
- How young people provide consent and their families are consulted and informed

How it may contribute to staff learning, including improving the use of safe holds

4.5 Recommendation five: The service should routinely capture the wishes of young people at the point of admission to Skye House regarding the possible use of restrictive interventions in an advance wishes care plan, which is an expectation in the MHA Scotland.

4.5 Recommendation six: The MHA Scotland is clear that the welfare of the child and least restrictive practice are priorities for care. In line with Scottish child protection guidance, GIRFEC, and the principles of the UNCRC, the unit should ensure that the voice of the child is central to all reviews of restrictive practice. Where a child or young person reports that an incident felt harmful, unsafe, or abusive, this should be taken seriously, recorded, and responded to in accordance with child protection procedures. The starting point should be to listen, acknowledge the child's experience, and ensure their immediate safety, before moving into formal assessment and review.

4.5 Recommendation seven: The unit should undertake a review of the data currently collected in relation to restrictive practice and develop a proportionate set of metrics that reflect both quantitative activity and qualitative experience. This work should be guided by the principles set out in relevant Scottish legislation and policy — including the Mental Health(Care and Treatment) (Scotland) Act 2003, the Scottish Government's Policy Position on the Use of Restraint, the Children and Young People (Scotland) Act 2014, and Scotland's human rights based approach (PANEL/FAIR).

a) As an initial minimum, the unit should ensure it is able to monitor:

- basic activity data (e.g., number and type of restrictive interventions) including the use of rapid tranquilisation
- young person and staff experience of incidents
- evidence of prevention and de-escalation efforts
- percentage of families/carers informed within required timescales.

b) Over time, this dataset should be expanded in a manageable way to support learning, identify patterns, and ensure practice remains rights based, trauma informed, and developmentally appropriate.

c) The data should be displayed in a simple, accessible format and include longitudinal data and made available to staff within the unit to support reflective practice, team learning, and continuous improvement. This should be an ongoing process culture of continuous improvement, rather than a one off event.

4.5 Recommendation eight: The service should undertake a piece of reflective work with the multi-disciplinary team to review their understanding of child protection and safeguarding. This should include a review of training to ensure that staff are equipped to understand the implications of child protection failings. This can be part of a programme of continuous improvement.

4.5 Recommendation nine : The service should consider improving lines of sight, such as globe mirrors in T corners in Lewis and Harris wards - to provide a necessary layer of safety for staff and young people.

4.5 Recommendation ten: We recommend that all Health Boards urgently come together to agree a single, unified child protection process for this service. This should include clear, directive guidance on the actions required when allegations of abuse are made, ensuring that the response is consistent, timely, and supportive to staff, young people, and families. A shared process will reduce ambiguity, strengthen safeguarding practice, and ensure that decisions are based on transparent criteria rather than geography or interpretation.

Recommendations from Key finding 4.6 - Governance

4.6 Recommendation one: The service should come together to review its overarching governance function and structure to develop a cohesive framework which enables quality assurance, flow of information up and

down, and allows the staff team to take ownership of their data and their practices. To strengthen governance, the service should move toward a more integrated and transparent approach to information. This includes reviewing what data is currently collected, agreeing a core minimum dataset, and developing simple mechanisms for making this available to staff, perhaps through the creation of a dashboard. Making this accessible to teams will support reflective practice, improve situational awareness, and create the conditions for continuous improvement across the service.

4.6 Recommendation two: The service should consider using a Quality Improvement approach to collecting aggregated data and learning over time. It is key that this is designed with and used by staff primarily for understanding all aspects of their own practice.

4.6 Recommendation three: The service should continue to engage with QNIC. This will allow the team at Skye House to remain up to date with new ways of working in inpatient CAMHS and provide them with opportunities to learn from and network with staff from other similar services. It will also provide NHSNHSGGC a mechanism to get regular independent feedback on the quality of the service and support the implementation of the recommendations from this report.

Recommendations from Key finding 4.7 - Multi-disciplinary Interface and Workflow Considerations

4.7 Recommendation one: here should be a review of the clinical governance model used in Skye House, alongside a review of the clinical model. This redesign work should involve staff, young people and their families.

4.7 Recommendation two: The service should explore ways of developing more cohesive multi-disciplinary working, with protected time for all disciplines to contribute. This may include, using shared biopsychosocial clinical formulation that bring together the perspectives of all disciplines, the young person and their family; making decisions collectively, not sequentially; and achieving clarity on the roles of each professional discipline, a shared understanding of professional boundaries and an agreement on how roles complement one another.

Appendix 5 – Methodology

The review team examined twelve case files: six from current inpatients (as of autumn 2025) and six from young people discharged in 2024. To ensure randomisation, the team was provided with 18 numbered case files across the agreed cohorts, from which six were randomly selected from each group.

Template used for case note review:

Case note Review Tool

7.1 Decision Making and Clinical Reasoning

- Evidence of clear decisions: What decision was made, why, and by whom?
- Rationale recorded: Assessment data, risk formulation, alternatives considered.
- Documentation prompts: “Decision stated?”; “Rationale explicit?”; “Next steps clear?”
- Rating: 0 None; 1 Partial; 2 Mostly; 3 Clear and replicable.

7.2 Culture and Tone of Notes

- Language: Is the tone respectful, non-stigmatising, and strengths based? Look for neutral language about behaviour and emotions, avoidance of labels.
- Voice: Are young person and family perspectives recorded in their own words?
- Prompts: “Does the note reflect curiosity rather than judgement?”; “Is trauma informed language used?”

7.3 Restrictive Practice Description

- Clarity and justification: Is any restrictive practice (seclusion, restraint, medication restriction) described with clear justification, least restrictive rationale, and alternatives tried?
- Recording of consent, debrief and monitoring: Are post event reviews and safeguarding steps documented?

- Prompts: “Was the restrictive practice identified and explained?”; “Is there evidence of review and learning?”
- Context: Documentation should follow national expectations to identify and reduce restrictive practice and to record person centred care.

7.4 Collaborative Care Plans

- Co production: Is the care plan co-produced with the young person and family, with goals stated in their language?
- Specifics: Are responsibilities, timelines, and measurable goals recorded?
- Prompts: “Evidence of shared decision making?”; “Plan updated after review?”
- Best practice: Co produced plans are central to good transitions and care planning guidance.

7.5 Information to Families and Communication

- Clarity: Are communications to families documented (what was said, by whom, and family response)?
- Consent and confidentiality: Is information sharing rationale recorded?
- Prompts: “Was family given accessible information and support options?”

7.6 Safety, Risk and Follow Up

- Risk formulation: Is risk clearly articulated and linked to the care plan?
- Follow up actions: Are contingency plans and crisis contacts recorded?

7.7 Documentation Quality and Practicalities

- Timeliness, legibility, and structure (SOAP/HEADSS etc.)
- Use of templates and outcome measures where appropriate.

Appendix 6 – References

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- Rights and Limits to Freedom March 2021
- Human Rights and Mental Health Services May 2017
- Nutrition by artificial means July 2024
- Supported Decision Making October 2024
- Preparation of care plans for people subject to compulsory care and treatment Oct 2021
- Working with independent advocates Sept 2017

NICE Guidelines : Violence and aggression: short term management in mental health, health and community settings May 2015

The Promise Scotland: supporting change for children and care experienced adults

In line with the Academy of Medical Royal Colleges (AOMRC) Invited Review Service (IRS) framework, this report underwent an internal governance check by the College's Head of Governance. In addition, an external governance review was carried out by Dr Dasha Nichols, Professor of Child and Adolescent Psychiatry.