Good

Central and North West London NHS Foundation Trust

Central and North West London NHS Foundation Trust

Quality Report

Vincent Square Eating Disorders Service
South Kensington and Chelsea Mental Health Centre
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London
SW10 9NG
Tel: 02032145700
Website:
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV332	South Kensington and Chelsea Mental Health Centre	Vincent Square Eating Disorders Service	SW10 9NG

This report describes our judgement of the quality of care provided within this core service by Central and North West London NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Central and North West London NHS Foundation Trust and these are brought together to inform our overall judgement of Central and North West London NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Overall summary

We rated the service as **good** because:

- Improvements had been made following the serious incident that occurred in June 2018 in which a patient was injured after fixing a ligature. The window fixtures had all been replaced. Changes had been made to the admission process so that both a doctor and a nurse made a joint initial assessment of patients. Additional checks were made during each shift to ensure the alarm system was working.
- Overall, the service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents. Staff and patients were debriefed and offered support following incidents.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Comprehensive assessments were completed on admission to the service. Care plans were personalised, holistic, included the patient's views and were regularly reviewed and updated. Staff monitored patients' physical health and took appropriate action when needed. Outcome measures were used to measure the effectiveness of treatment programmes. Regular clinical audits were completed.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There were always enough staff to safely deliver care and treatment.
- The service made sure staff were skilled and competent for their roles. Managers appraised staff's work performance and held regular supervision meetings with them. The service provided mandatory and specialist training in key skills to all staff and made sure everyone completed it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service assessed and managed individual patient risks appropriately. An individualised approach meant that patients were not subject to blanket restrictions.
- Staff gave patients specialist care to ensure their nutrition and hydration needs were met safely and their health improved. They used special feeding and hydration techniques when necessary and staff were trained in these areas.
- The service prescribed, gave, recorded and stored medicines safely. Patients received the right medicines at the right dose at the right time. A pharmacist visited the ward each week and completed a regular audit to check that medicines were managed and administered safely by staff.
- Staff of different disciplines worked together as a team to benefit patients. The service also worked well with external teams and professionals.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff cared for patients with compassion. Patients were partners in their care. Staff worked hard to involve patients' families and carers, despite some of them living far away.
- People could access the service when they needed it. Most patients were admitted to and discharged from the unit to the outpatient part of the service. Staff planned effectively for patient discharge and worked well with other professionals and teams to ensure effective transfers of care.
- The service had suitable premises and equipment and looked after them well. The service was clean and well maintained and staff followed infection, prevention and control procedures. The facilities promoted comfort, dignity and recovery.
- The service took account of patients' individual needs and staff worked hard to meet the diverse needs of the patient group. This included providing support to make LGBT+ patients feel welcome and protect their needs. Staff supported patients' engagement with ongoing education opportunities and important relationships.

Summary of findings

- The service had managers at all levels with the right skills and abilities to run the service effectively. Staff also told us that senior leaders had been especially supportive following the serious incident that took place in June 2018. Managers across the service promoted a positive culture that supported and valued staff. Staff achievements were recognised by local leaders and through a trust wide annual awards ceremony.
- Governance systems to ensure the effective running of the service were in place. The trust had effective systems for identifying risks and managing and reducing these. The service treated concerns and complaints seriously. Staff understood their responsibilities regarding complaints and made sure information was available for patients.

However;

- Whilst appropriate arrangements were in place to protect patients against the risks associated with ligature anchor points, the unit ligature risk assessment did not include some ligature anchor points and did not clearly state how staff should mitigate the risks that had been identified. This was escalated to the manager at the time of the inspection.
- Whilst overall the service managed patient safety incidents well, further improvements were needed to ensure that lessons learnt were always consistently shared with the whole staff team.
- The induction process for temporary staff was not formalised which meant there was no assurance that temporary staff could consistently meet the specific needs of the patient group.
- A small number of patients said that some temporary staff had occasionally acted in an abrupt manner.
- Staff we spoke with were not aware of who the trust's freedom to speak up guardian was or how to contact them.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement 

We rated safe as **requires improvement** because:

- Whilst appropriate arrangements were in place to protect patients against the risks associated with ligature anchor points, the unit's ligature risk assessment did not include some ligature anchor points and did not clearly state how staff should mitigate the risks that had been identified. This was escalated to the manager at the time of the inspection.
- Whilst overall the service managed patient safety incidents well, lessons learnt were not always shared consistently with the whole staff team.

However;

- The service had made improvements following the serious incident that occurred in June 2018 in which a patient was injured after fixing a ligature. The type of window fixtures that were used in the incident, that were previously understood to be anti-ligature, had all been replaced. Changes had been made to the admission process so that both a doctor and a nurse made a joint initial assessment. Additional checks were made during each shift to ensure the alarm system was working.
- Overall, the service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and when things went wrong, staff apologised and gave patients information and support. Staff and patients were debriefed and offered support following incidents.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. All vacant nursing posts had recently been filled, but the service faced an ongoing challenge in recruiting a specialist registrar, which meant that other doctors had an increased workload.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Summary of findings

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff had been trained in appropriate restraint techniques, particularly in patients with a low body mass index.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service assessed and managed individual patient risk appropriately. This individualised approach meant that patients were not subject to blanket restrictions. Staff were confident in using verbal de-escalation techniques and explained how this helped minimise the use of restrictive interventions such as restraint.
- The service prescribed, gave, recorded and stored medicines safely. Patients received the right medicines at the right dose at the right time. A pharmacist visited the ward each week and completed a regular audit to check that medicines were managed and administered safely by staff.
- The service had suitable premises and equipment and maintained them well. The service was visibly clean and well maintained and staff followed infection, prevention and control procedures. Staff carried our regular environmental checks. Suitable spaces were available to prepare and administer nasogastric feeds. Staff had easy access to specialist equipment to help manage pressure sores, although there was a delay in the delivery of new padded seats for the dining room.

Are services effective?

Good

We rated effective as **good** because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- The service took a truly holistic approach to assessing the needs and planning care for patients. Comprehensive assessments were completed on admission to the service. These covered the full-range of patients' needs including physical and mental health needs. Care plans were personalised, holistic and included the patient's views. These were regularly reviewed and updated. Staff monitored patients' physical health and maintained professional links with specialists in the neighbouring acute hospital which meant patients could access physical health specialists easily if needed.

Summary of findings

- All staff were actively engaged in activities to monitor the effectiveness of care and treatment and used findings to improve them. Outcome measures were used to measure the effectiveness of treatment programmes. Regular clinical audits were completed.
- Staff gave patients specialist care to ensure their nutrition and hydration needs were safely met and their health improved. They used special feeding and hydration techniques when necessary and staff were trained in these.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. The manager appraised staff work performance and held regular supervision meetings with them. Staff accessed specialist training and drew from each other's professional experience.
- Staff of different kinds worked collaboratively to benefit patients. A range of multidisciplinary staff worked at the service and had input into patients' care and treatment. This included physiotherapist with a background in eating disorders, a family therapist and a dietitian. A peer recovery worker worked with patients and motivated them to take ownership of their own recovery. Staff worked hard to deliver joined-up care to people using the service. They held regular, productive clinical discussions. External colleagues from places such as community mental health teams were invited to attend clinical discussions, particularly when preparing for discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However;

- The induction process for temporary staff was not formalised, meaning there was no assurance that all temporary staff could consistently meet the specific needs of the patient group.

Are services caring?

Good

We rated caring as **good** because:

- Staff cared for patients with compassion. Patients were positive about their relationships with staff and were engaged with their care and treatment. They reported specific examples where

staff had provided them with tailored, emotional support. Staff spoke about patients in a dignified, respectful manner and maintained patient confidentiality. We observed positive interactions between patients and staff.

- Staff involved patients and those close to them in decisions about their care and treatment. Patients were partners in their care. They were actively encouraged to participate in discussions during ward rounds and their views and opinions were included in their care plans. Staff worked hard to involve patients' families and carers, despite some of them living far away. For example, video-links were used during some clinical discussions involving family members.
- Staff provided emotional support to patients to minimise their distress.

However;

- A small number of patients said that some temporary staff had occasionally acted in an abrupt manner.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- People could access the service when they needed it. Bed occupancy over the previous 12 months was just over 90%. The service emphasised the importance of continuity of care. Most patients were admitted to and discharged from the ward to the outpatient part of the service. This meant that most patients developed longstanding therapeutic relationships with therapists and other staff such as the dietitian that they could continue to build on after discharge.
- Staff planned effectively for patient discharge. There were no delayed discharges during the 12 months before our inspection. Staff worked well with other professionals and teams to ensure effective transfers of care.
- The facilities promoted comfort, dignity and recovery. There were plenty of pleasant spaces available for individual patient consultations and group activities.
- The service took account of patients' individual needs and staff worked hard to meet the diverse needs of the patient group. This included providing support to make LGBT+ patients feel

Summary of findings

welcome and protect their needs, and promoting individual religious needs. We received mixed feedback about the quality and variety of food available to patients. Staff were working with patients to make improvements in this area.

- Staff supported patients' engagement with ongoing education opportunities and important relationships. Patients were also supported to access the trust wide recovery college.
- The service treated concerns and complaints seriously. Staff understood their responsibilities regarding complaints and made sure information was available for patients.

Are services well-led?

Good

We rated well-led as **good** because:

- The service had managers at all levels with the right skills and abilities to run the service effectively. Most local leaders had been appointed during the last year and staff said they were supportive and approachable. Staff also told us that senior leaders had been especially supportive following the serious incident that took place in June 2018.
- The service had a vision for what it wanted to achieve. Staff had a good understanding of the trust's vision and values and demonstrated these in their day-to-day work.
- Managers across the service promoted a positive culture that supported and valued staff. Staff reported that the culture at the service had improved and the team worked very well together. Staff achievements were recognised by local leaders and through a trust wide annual awards ceremony.
- The service collected, analysed, managed and used information well. Robust governance systems to ensure the effective running of the service were in place. Additional training had been put in place to support staff with a planned move to a new electronic patient record system.
- The trust had effective systems for identifying risks and managing and reducing these. The local risk register correlated to staff concerns. There were systems in place to escalate risks to the board. A business continuity plan was in place to ensure the service could continue to operate during an emergency.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and accreditation as a specialist service.

However;

Summary of findings

- Staff we spoke with were not aware of who the trust's freedom to speak up guardian was or how to contact them.

Summary of findings

Information about the service

Vincent Square eating disorder service is located at the South Kensington and Chelsea mental health centre. The service provides inpatient treatment for up to 15 men and women aged 18 and over who have a complex eating disorder. The service also provides care and treatment for up to 12 day patients. Patients using the service receive an intensive treatment programme and the service can support patients with nasogastric feeding if necessary. A specialist eating disorders outpatient department also forms part of the service. Vincent Square eating disorder service made up the entirety of the trust's eating disorders service provision.

This was a focussed unannounced inspection following a serious incident that took place at the inpatient unit in June 2018. During this inspection, we inspected the inpatient unit and day patient provisions at the service and did not inspect the outpatient department. This was the first time the service had been inspected.

The service is registered to carry out the following regulated activities:

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

Our inspection team

The team comprised three CQC inspectors, one CQC assistant inspector and one specialist advisor who was a nurse with specialist experience in eating disorder services.

Why we carried out this inspection

The inspection commenced on Monday 10 September 2018 and was unannounced.

The inspection was prompted in part by the notification of an incident where a patient sustained a serious injury following a suicide attempt using a ligature anchor point. This incident is subject to a formal investigation and as a result this inspection did not examine in detail the circumstances of the incident.

However, information shared with CQC about the incident indicated potential concerns about the management of ligature risks and how individual patient risks, for example, risk of suicide and self-harm, were mitigated and managed.

This was our first inspection of the service.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff were caring for patients
- carried out a specific check of how medicines were managed on the ward
- spoke with six patients
- spoke with a recovery peer support worker
- spoke with the ward manager, service manager and service director

Summary of findings

- spoke with 12 other staff members including registered nurses, a healthcare assistant, a clinical psychologist, dietitian, occupational therapists and doctors
- reviewed seven patient care and treatment records
- attended a multidisciplinary clinical management round
- attended a nursing handover
- observed a lunchtime meal and attended a post-meal support group
- attended a staff business meeting
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

The feedback we received from patients was generally positive. We spoke with six patients who were currently using the service. Patients told us they had positive relationships with staff and staff treated them professionally and with respect. All patients had a good awareness of their care plan and understood their treatment and the medicines they were taking. Information on how to make a complaint was readily available at the unit.

Two patients also said that they would like the opportunity to complete a more detailed feedback survey about the service, because the friends and family test was brief. One patient felt that the admission process was rushed and disorientating, and another patient reported that some temporary staff were abrupt at times.

Areas for improvement

Action the provider MUST take to improve

- The provider must review their ward ligature risk assessment to ensure all ligature risks are correctly identified and that sufficient detail is available to staff about what actions they should take to mitigate the identified risks.

Action the provider SHOULD take to improve

- The provider should consider how to improve the local staff induction process to help ensure that temporary staff working on the ward know about environmental risks and risks that are specific to this patient group including the signs and symptoms of re-feeding syndrome. Inclusion of the trust's values should also be considered to improve patient experience when interacting with temporary staff.
- The provider should consider how they can encourage more feedback from patients.
- The provider should ensure that lessons learned from incidents on the ward and in the wider organisation are shared with staff so that necessary changes can be implemented promptly.
- The provider should ensure staff understand how to contact the

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Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Vincent Square Eating Disorders Service	South Kensington and Chelsea Mental Health Centre

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

Staff had a good understanding of the Mental Health Act (MHA) and the MHA code of practice. Although training in the MHA did not form part of the trust's mandatory training programme, training and advice was available for staff where needed.

All necessary paperwork relating to the MHA was in order, including treatment authorisation forms.

Patients received information about their rights under the MHA and could access the support of an Independent Mental Health Advocate (IMHA) if they needed to. Staff referred patients to the IMHA or patients could contact them themselves; their details were displayed for patients to refer to.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a good understanding of the Mental Capacity Act (MCA) and explained that capacity should be presumed unless there was reason to believe that an individual lacked capacity. Staff understood that in these circumstances a decision specific assessment under the MCA would be necessary.

Detailed findings

The trust had a policy in place relating to the use of the MCA and staff could access this using the trust intranet.

Records relating to the assessment of patients' capacity to consent to specific decisions was detailed. Doctors had clearly documented how they had come to the final decision about the individual patient's capacity.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Safety of the ward layout

- Staff completed a daily environmental check to ensure the ward was safe for patients. This was allocated to a staff member on each shift and any identified risks were discussed during handover, along with the measures to manage and mitigate them.
- Staff could not easily observe patients because the layout of the ward did not provide clear lines of sight. Although the main communal areas and bedroom corridors were visible from the nursing office the blinds were routinely kept closed. However, this risk was appropriately mitigated using routine hourly observations, where all areas of the unit were checked by staff and each patient was accounted for. Where individual patients were identified as being at risk, increased observations, including one-to-one were used.
- Action had been taken immediately following the incident in June 2018 to remove the ligature anchor point used in the serious untoward incident.
- Whilst appropriate measures were in place to ensure the safety of patients (through the use of general and increased observations, including one to one), the units ligature risk assessment required further work. This ligature risk assessment did not include all potential ligature anchor points throughout the unit. Ligature anchor points are objects that can be tied to, thereby enabling patients to self-harm. We identified numerous anchor points that did not feature on the ward's ligature risk assessment including a door closer that faced into the female shower room and drain pipes in the garden. There was a risk that staff may not routinely check these specific areas and that opportunities to reduce the number of ligature anchor points were missed.
- Actions were taken immediately following our inspection to review the ward ligature risk assessment and consider additional works that could be undertaken to eliminate some of the newly identified ligature points such as the door closer inside the female shower room.
- The ward complied with guidance on eliminating mixed-sex accommodation. The smaller corridor was designated as a male corridor when needed, with a separate male bathroom. A multi-purpose room was designated as a female lounge when needed. There were no male patients during the time of our inspection. Female bathroom facilities were located on the larger corridor, which would be designated as a female-only area if males were admitted to the ward.
- All staff carried alarms to summon assistance from colleagues if needed. However, during a serious incident in June 2018 the staff alarm failed to sound. Action had been taken following the serious incident to ensure that, as well as testing individual alarms, the central alarm panel was checked during each shift to assure staff that the system was working.
- During our inspection staff were informed that the alarm system was temporarily out of service. This was because of ongoing work that was taking place elsewhere in the building that had caused the alarm system to stop working. This was escalated to the building manager as a matter of urgency and the issue was rectified within a few hours. Whilst the alarm system was unavailable, staff presence in communal areas was increased.
- Fire safety arrangements were in place. All drills and servicing of fire safety equipment was recorded in a fire folder. Sixty-five percent of eligible staff were up to date with inpatient fire safety training. The staff who had not yet completed this training were new in post and had been booked to attend. Although no patients required personal emergency evacuation plans during the time of our inspection, staff were alert to the need to develop these for patients who may require assistance to leave the building in an emergency.

Maintenance, cleanliness and infection control

- All areas of the ward were visibly clean. Cleaning records were kept and maintained by an external company that provided domestic support and catering to the provider.
- Staff adhered to infection control principles including hand washing. Information about the correct technique for hand washing was available to staff. An infection prevention and control audit was completed in July

2018 and action was taken following this audit to ensure staff complied with the correct hand washing techniques. Staff received mandatory training in infection, prevention and control, and staff were routinely offered necessary vaccinations.

Clinic room and equipment

- Equipment in the clinic room was visibly clean and stickers were displayed showing when staff had last cleaned the equipment. Staff conducted a weekly inventory of medical devices including weighing scales, oxygen cylinders, emergency medicine and the defibrillator. These checks ensured that all clinical equipment was working and had been cleaned. Service dates were monitored using this inventory, so equipment requiring servicing or re-calibration was identified in a timely manner.
- Patients requiring nasogastric feeding were fed in the clinic room. Staff stored equipment for nasogastric feeding appropriately and there was plenty of space for staff to prepare feeds. None of the patients required nasogastric feeds during the time of our inspection.
- At the time of our inspection there were no hoists or other specialist equipment in use. Staff could obtain pressure-relieving mattresses and top-up mattresses easily for individual patients, if required, to prevent the risk of pressure ulcers developing.

Safe staffing

Nursing staff

- The provider had established safe staffing levels and ensured that these were met on each shift. There were no staffing vacancies and ward managers were able to increase staffing to safely meet individual patient needs, for example one-to-one observations.
- The ward had an establishment of 11 registered nurses and five non-registered nurses. An additional two band 6 registered nurses acted as deputy ward managers. The establishment for non-registered nurses was five. At the time of our inspection there were no vacant posts. Staff had calculated the number and grade of nursing staff required to deliver safe care and treatment on the ward. This was two registered nurses and two non-registered nurses during the day, and two registered nurses and one non-registered nurse at night.
- The number of staff working on each shift matched the pre-determined staff establishment levels. The ward manager could recruit additional staff according to patient mix. For example, additional staff were often used to provide enhanced individual patient observations if individual patient risks were heightened. Additional staff were sourced from the trust's staff bank or an external agency.
- The overall staff sickness rate during the 12 months leading up to our inspection was 2%.
- Staff turnover during the 12 months leading up to our inspection was 24%. Some staff had changed jobs within the service following a change to the nursing staff structure and some staff had left the service to pursue career development opportunities elsewhere.
- Staff shortages were rare and we did not identify any instances where escorted leave or ward activities were cancelled due to low staffing levels. The ward manager reported that they managed staff sickness through using bank or agency staff.
- During the 12 months leading up to our inspection a total of 1468 nurse and healthcare assistant shifts could not be filled by permanent staff. This was due to factors including increased staffing levels when the ward temporarily relocated to allow for major plumbing works to be undertaken, covering staff vacancies and sickness. Ninety-one percent of vacant nursing shifts were filled by bank staff, 5% were filled by staff from an external agency. Four percent of shifts were unfilled, although minimum safe staffing levels were maintained.
- Each patient had a named nurse. We identified that patients regularly spent one to one time with their named nurse.
- There were enough staff to safely carry out physical interventions if needed, including nasogastric feeding. However, physical interventions including nasogastric feeding rarely took place. All permanent staff received training in delivering nasogastric feeding and safe restraint techniques.

Medical staff

- There was adequate medical cover day and night and a doctor could attend quickly in an emergency. There was one full time consultant psychiatrist, who was also the

clinical director. There was also a long-term locum staff grade doctor, and two junior doctors currently on placement at the service. The service faced an ongoing challenge in trying to recruit a specialist registrar.

- A duty doctor rota was in place for staff to summon assistance from a doctor out of hours. During the day the duty doctor was based on-site. Between 9pm and 9am the duty doctor was based at St Charles Hospital, not on-site, and was easily contactable.

Mandatory training

- The trust had a programme of mandatory training courses for staff to complete to ensure they had the appropriate knowledge and skills to carry out their roles safely. Mandatory training covered a range of subject areas including emergency life support, moving and handling, health and safety, safeguarding and information governance.
- The training compliance across the service averaged at 90%. However, seven staff were awaiting training in fire safety and fifteen staff were awaiting training in preventing radicalisation and extremism. Staff awaiting training were booked to attend the next available session.

Assessing and managing risk to patients and staff

Assessment of patient risk

- During this inspection we reviewed seven patient care and treatment records. Each patient received a detailed risk assessment on admission to the service. This was completed collaboratively by a doctor and a nurse. Risk assessments were updated regularly, and as risks changed, for example following incidents or changes in physical or mental health presentation.
- Risk assessments were comprehensive and covered physical and mental health. For example, the risk of re-feeding syndrome was explicitly flagged in one patient's risk assessment due to risk factors identified in their past medical history. A mental state examination was completed on admission, which helped staff to determine whether there were risks of suicide or self-harm.
- Risk was considered on an individual basis which lessened the extent to which patients were limited by blanket restrictions. For example, access to cutlery, drinks and snacks, the internet and use of room searches were considered on an individual basis.
- The Waterlow pressure ulcer risk assessment was completed for patients at risk of developing, or in the early stages of developing, pressure ulcers. Staff considered using this assessment on a case-by case basis following initial skin-integrity checks. However, because this was considered on a case-by-case basis it was not always clear to staff what the expectations were in terms of how frequently skin integrity should be checked. We raised this during our inspection and staff developed a clearer protocol about assessing and monitoring skin integrity.

Management of patient risk

- Staff monitored the physical health of patients regularly using National Early Warning score (NEWS) charts which is a guide used by professionals to quickly determine the degree of physical illness of a patient. Staff were aware of specific risk areas and acted to mitigate these risks. Staff used Waterlow pressure ulcer risk assessment to monitor pressure ulcers. Specialist equipment including pressure relieving mattresses were put in place to help minimise the risk of skin breakdown.
- Routine hourly observations were undertaken, during which each patient was accounted for. This check was performed to help mitigate environmental risks. Patients at heightened risk of self-harm were subject to more frequent observations, or one-to-one observations if necessary which staff clearly recorded. During the first 48-hours of admission all patients were subject to checks by staff every 15 minutes. This helped mitigate the risk of re-feeding syndrome developing in the early stages of treatment.
- Blanket restrictions were not in place. Patients were individually assessed to ensure they were subject to the lowest level of restriction possible. Searches of patients and their bedrooms did not take place routinely. Staff only searched patients if they had reason to believe they were concealing an item that could cause harm.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Searches were occasionally made routine for patients if documented in their care plan. For example, routine searches could be implemented for patients with an identified risk of hiding food.

- The service adhered to the trust's smoke free policy. Where possible, patients looked after their own smoking paraphernalia. If needed, staff stored smoking items in a safe place for patients. Patients were only able to smoke during allocated times when they could safely go off-site, avoiding meal times. All staff were trained in smoking cessation and nicotine replacement therapies were offered to all patients who smoked on admission.
- Informal patients were made aware if their right to leave the ward at any time. However, they were encouraged to discuss their intention to leave with staff as it would likely be against medical advice. This was detailed in the patient information pack and on a notice beside the entrance to the ward. Staff were clear about their ability to use nurse holding powers under Section 5 (4) of the MHA if they were concerned about the safety of informal patients who were leaving the ward.

Use of restrictive interventions

- There were no incidents of seclusion or long-term segregation reported during the 12 months before our inspection. There were no facilities available on-site for nursing patients in seclusion.
- During the 12 months leading up to our inspection there had been 24 incidents of restraint. Sixteen of these incidents related to the administration of nasogastric feeds which had required supportive holds. None of the incidents of restraint were performed in the prone position or resulted in the use of rapid tranquilisation and most were performed whilst the patient was seated.
- When restraint incidents were reported details were given about the duration of the restraint, which staff were involved and in which position the restraint was performed.
- Staff reported that they used physical interventions as a last resort if verbal de-escalation failed. We observed staff constructively using verbal de-escalation techniques during an incident of aggression on the ward.
- Staff had been specially trained to perform restraint techniques on patients with a low body mass index.

Safeguarding

- Ninety-five per cent of staff working on the ward had been trained in safeguarding adults and safeguarding children. Staff understood how to make a safeguarding alert using the incident reporting system.
- Staff discussed types of abuse or alleged abuse that would lead them to make a safeguarding alert. A local safeguarding flowchart prompted staff to make an alert as soon as abuse or suspected abuse was identified. The flowchart then prompted staff to act to ensure vulnerable adults were protected if the risk of abuse was still present.
- A named nurse acted as the local safeguarding lead. Staff knew to contact them to discuss any queries relating to safeguarding concerns or how to contact the Royal Borough of Kensington and Chelsea directly.
- Staff followed safe procedures for children visiting the ward. The ward visitors room was normally used for this purpose. If it was necessary to keep the child away from the ward either due to an incident or because patients on the ward were particularly unwell, rooms elsewhere in the building could be booked for visiting purposes.

Staff access to essential information

- All information needed to deliver patient care was available to all staff, including agency staff. Managers could source login details for agency staff if it was their first time working at the service.
- Staff were preparing to move to a new patient records system in the months following our inspection. They were in the process of ensuring records were stored correctly to enable a smooth transition to the new system. A specialist team had been set up to work with staff to help design a more meaningful, service-specific version of the new records system.

Medicines management

- Staff followed good practice in medicines management. Medicines were stored appropriately. Controlled drugs were locked in a secure drugs cabinet and signed in and out accurately using a controlled drug recording book. Ambient room and fridge temperatures were checked daily to ensure medicines were stored at the correct temperature. A pharmacist also checked each week that medicines were stored appropriately.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Appropriate systems were in place to dispose of medicines. However, we identified a controlled drug, Oxycodone, that was still being stored in the controlled drugs cabinet despite not being required since July 2018. We raised this with the pharmacist so that it could be disposed of as soon as possible.
- Patient medicine charts were completed accurately and relevant treatment authorisations were attached to medicine charts for staff to refer to.
- A pharmacist attended the ward at least once per week. They completed a medicine audit to ensure all medicines were in date, being stored appropriately, recorded correctly and that treatment authorisations were in place. All nursing staff received medicine management training. Some staff had received additional training following incidents of inaccurate controlled drugs recording, which were picked up during the pharmacy audit.
- Staff carefully considered patients' body mass index when establishing appropriate doses of medicine to prescribe. All prescribing at the time of the inspection was well within British National Formulary limits.

Track record on safety

- One serious incident had taken place during the 12 months leading up to our inspection. Other incidents that were not classified as serious were appropriately identified and reported by staff.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them using the electronic incident reporting system. We reviewed the most recent incident reports relating to the service and saw that staff had reported all incidents they should report. These included incidents relating to restraint, medicine errors and incidents of aggression.
- Staff understood their duty of candour and knew that they needed to be open and honest with patients and relatives following incidents that affected them directly, such as medicine errors.
- Following a serious incident in June 2018, staff were given opportunities to attend a debrief immediately after the incident and discuss in reflective practice sessions. Staff were also made aware of the trust's people at work scheme and the occupational health department. Whilst the formal investigation into the incident was still underway, staff had identified immediate learning from this incident and changes had been made as a result. For example, both a nurse and doctor now completed initial risk assessments collaboratively. The panic alarm system was now checked routinely during daily environmental checks and alcometers, used to determine the volume of alcohol a person has consumed, were now routinely used when patients had been drinking before admission to measure the level of alcohol intoxication so this could be considered as part of the initial risk assessment on admission.
- Although the recent serious incident had been discussed in depth with ward staff, other less serious incidents were not routinely discussed or reflected on by staff after they were reported. For example, an incident in August 2018 that led to a restraint resulted in an action that staff should be notified of the procedure around restrictive interventions and that restraints should be used only as a last resort. We identified that this incident did not feed in to a discussion with staff.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- During the inspection we reviewed seven patient care and treatment records. Staff completed a comprehensive physical and mental health assessment within a few hours of admission to the service. Joint assessments were carried out with nursing and medical staff. Initial assessments were comprehensive, outlined the presenting problem, risks, physical health condition and plan of care.
- Staff assessed and supported patients with their physical health needs and worked collaboratively with specialists when needed. Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included close and regular monitoring of blood samples, heart rate, pulse, urine tests, temperature, weight monitoring and electrocardiogram (ECG). An ECG checks the hearts rhythm and electric activity and is important to ensure patients receive the right medicine. Bone density scans were completed for patients who needed them. Staff spoke about the positive working relationships they had with other professionals at the local acute hospital including gastroenterologists and cardiologists. GPs were informed about follow up investigations required for day patients.
- Staff developed care plans that met patients' needs. Care plans were personalised, holistic, recovery-oriented and regularly reviewed. Care plans reflected the views of patients and their relatives about their care and treatment.

Best practice in treatment and care

- During the inspection we reviewed seven patient care and treatment records. Staff delivered treatment in line with best practice and evidence based guidance. They used the 'Management of really sick patients with anorexia nervosa' (MARSIPAN) guidelines. The MARSIPAN tool is approved by the Royal College of Psychiatrists and Royal College of Physicians and helps staff to carry out safe re-feeding, risk management and monitoring.
- Both group and individual psychological therapies were available. Patients could access dialectical behavioural therapy, cognitive behavioural therapy and cognitive analytic therapy to help them develop coping skills when distressed. Patients could attend an understanding emotions group and a cognitions group on the ward. The service had plans to introduce cognitive remediation therapy soon to help patients build an awareness of their own thinking style in relation to behavioural changes.
- Patients received input from a dietitian either at weekly group sessions or during one to one sessions. However, the dietitian worked in the service two days per week and expressed the view that more dietic input would be beneficial to patients.
- Staff had positive working relationships with other professionals at the neighbouring acute hospital including gastroenterologists and cardiologists. Patients requiring an emergency admission through the accident and emergency department were granted fast-track admission. Staff liaised with patient GPs, keeping them up to date and for day patients, requesting follow up investigations when required.
- Patients who were identified as being at risk of water loading had their hydration monitored effectively by staff. Water loading is where individuals consume large quantities of water so they feel less hungry or to increase their weight before being weighed. It can lead to dangerous consequences including water intoxication which can lead to seizures.
- Patients were supported to lead a healthy lifestyle. A physiotherapist worked with patients. They had specialist training in working with people with an eating disorder and ran a group about body image and facilitated one to one sessions with patients about healthy exercise.
- The hospital premises were smoke-free and patients who needed to smoke did so at allocated times off the hospital premises. All nursing staff were trained in smoking cessation and could easily source nicotine replacement therapies.
- Outcome measures were used to monitor patient outcomes and provide assurance that the treatments and interventions being used were having a positive effect on patients' recovery. For example, the eating

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disorder examination questionnaire (EDEQ) was used at regular intervals to measure the range and severity of eating disorder features. A health of the nation outcome scale (HONOS) was also completed on admission and at the point of discharge. This measure documents changes in health or social status of patients.

- Staff completed regular clinical audits on care plan documentation, care programme approach (CPA) compliance and risk assessments. Actions were identified in these audits for staff to follow up. For example, timeliness of CPA meetings and the need for sufficiently detailed risk management plans relating to the risks identified in patient risk assessments.

Skilled staff to deliver care

- The team included a full range of specialists to help meet the needs of patients on the ward. This included occupational therapists, psychologists, a dietitian and a family therapist. The pharmacist was present on the ward at least once per week. Patients could meet with the pharmacist for information and advice about their medicines.
- A peer recovery worker visited the ward every week. Their role was to provide groups and one to one sessions with patients. They discussed their own experience of being a patient at an eating disorders service and aimed to inspire the patients to commit to their own recovery journeys.
- Staff were experienced and qualified and had the skills and knowledge to meet the needs of people with an eating disorder. Staff had extensive experience working in the eating disorders field. All senior nursing staff had been recruited from more junior roles within the service. All nursing staff were specially trained to safely carry out nasogastric tube insertion and enteral feeding. Staff received ongoing specialist training and shared their skills during continuing professional development sessions. This included training in areas specific to eating disorders, such as re-feeding syndrome.
- Permanent staff received a formal induction to the ward. However, the local induction for bank and agency staff needed further development to ensure it was consistent and thorough. Permanent staff reported that they gave a tour and highlighted the key operational information about the ward to bank or agency staff, but this had not been standardised. This posed a risk that staff working on the ward were not made aware of environmental risks to patients presented by blind spots and ligatures and the measures in place to mitigate and manage them.
- The absence of a standardised staff induction for bank and agency staff also meant that they may not be aware of the clinical risk issues that were unique to the patient group, such as the signs and symptoms of re-feeding syndrome. Re-feeding syndrome may occur in patients when nutrition is reintroduced and they are severely malnourished. This can lead to serious cardiac, pulmonary and neurological complications.
- Staff received regular supervision. Staff were expected to attend clinical and management supervision sessions each month. Supervision compliance between April and September 2018 was 92%. Reasons why supervision sessions were missed were clearly recorded, including extended periods of annual leave or sickness.
- Weekly reflective practice sessions were also arranged for staff. This gave staff an opportunity to hold clinical discussions and ask for advice from colleagues about how to engage patients with more complex clinical histories. Staff also reported that reflective practice sessions had helped them to learn from the serious incident that took place on the ward in June 2018.
- Seventy-eight per cent of non-medical staff had received an appraisal during the 12 months to August 2018. Staff reported that they found their appraisals useful and that they discussed career development and specialist training opportunities.
- Managers explained how they worked to support staff through periods of poor performance, initially through one to one staff supervision sessions by using goals and objectives for staff to meet.
- The service did not use volunteers.

Multidisciplinary and interagency team work

- We attended a weekly multidisciplinary team (MDT) review meeting. During this meeting, staff provided updates on each patient. Weekly ward rounds also took place. Each patient was discussed in detail every three weeks. We observed that different members of the MDT were listened to by colleagues and their input valued.

Are services effective?

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- We attended a nursing handover between shifts. This was detailed, and an update on each patient and events that had taken place on the ward was given to nursing staff starting their shift. This included emerging risks and changes in presentation.
- Staff invited care-coordinators from community mental health teams to take part in discharge planning to help facilitate a smooth and timely discharge back to the community. Staff also worked closely with teams at the local acute hospital and provided detailed handovers if patients were transferred.

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

- Staff had a good understanding of the Mental Health Act (MHA) and associated code of practice. Training in the MHA was not part of the trust's mandatory training programme. However, training was available to staff who required it, although training compliance was not measured.
- Staff reported that they could easily access support and legal guidance from a MHA administrator. Policies and procedures relating to the use of the MHA were readily available to staff.
- Patients had easy access to an independent mental health advocate. Their contact details were displayed in the communal area of the ward and they visited the ward in person at least once per week.
- Staff explained to patients their rights under Section 132 of the MHA in a way they could understand. This was clearly documented on admission and repeated on a regular basis. However, one patient who was detained under an order from the High Court of the Republic of Ireland reported that staff were not clear about their rights as a detained patient. Staff reported that they would discuss the patient's rights with them following our inspection.
- Monthly audits of the MHA were completed by a MHA administrator. This audit provided assurance that patients' Section 17 leave forms were in order, alerted staff to upcoming section expiry dates, ensured that treatment authorisations were in place and that patient rights under Section 132 were explained to patients in a timely manner.

Good practice in applying the Mental Capacity Act

- Training in the Mental Capacity Act (MCA) did not form part of the provider's mandatory training programme, although training was available to staff if necessary, but was not measured. However, staff had a good understanding of the MCA and provided examples of instances when capacity assessments relating to specific decisions would be required.
- There had been no Deprivation of Liberty Safeguards applications made during the 12 months before our inspection.
- Policies and procedures relating to the use of the MCA were readily available to staff on the trust's intranet system.
- We saw detailed capacity assessments relating to consent to treatment.
- Staff supported patients to make decisions and always presumed they had capacity to make decisions in the first instance. When patients lacked capacity, staff made decisions in their best interests, which recognised the importance of the person's wishes, feelings, culture and history.
- The service did not currently complete audits in relation to the use of the MCA.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, privacy, dignity, respect, compassion and support

- We observed positive staff interactions with patients. Patients reported that staff were respectful and provided them with emotional support. We observed staff verbally de-escalating an agitated patient discreetly and with respect.
- Patients reported that staff helped them manage and understand their condition and treatments. Care plans included discussions that had taken place with patients, and patients were encouraged to participate in discussions about their care during multidisciplinary team ward rounds. Patients who had queries about their medicines could be referred for a conversation with the ward pharmacist.
- Staff supported patients to access other services including physical health specialists. Staff explained that they often attended appointments with patients, and during our inspection staff were actively supporting a patient who had been admitted to the local acute hospital.
- Patients were generally very positive about their relationships with staff. They provided examples of times when staff made efforts to support and comfort them such as following the death of a close family member. However, one patient reported that some temporary staff had been abrupt and rude on occasion. Another patient had also made a similar comment in the friends and family survey when they were discharged a few months previously. Some patients also reported that temporary staff were sometimes inconsistent in applying the rules during meal times.
- Staff demonstrated a good understanding of the individual needs of patients. For example, during a multidisciplinary review meeting staff discussed specific dietary requirements and discussed arrangements for overnight leave on an individual basis given that some patients' homes were a long distance from the service.
- Staff reported that they could raise any concerns about disrespectful, discriminatory or abusive behaviour.
- Staff maintained confidentiality of information about patients. Information was stored electronically and was only accessible to authorised staff. Clinical notice boards containing patient identifiable information were displayed in a locked nursing office and were not visible from outside the office.

Involvement in care

Involvement of patients

- Patients received a welcome pack on admission to the service. This contained information about how to complain, therapies available, a background to eating disorders and an introduction to different staff members working in the service. One patient reported that the admission process felt rushed and disorientating. Staff acted on this feedback and met with them to apologise and ensure the patient was confident they knew all the necessary information about the service and way the ward operated.
- Patients reported that they contributed to discussions about their care plan with their key worker and during multidisciplinary ward rounds. Patients were routinely given a copy of their care plan.
- Staff involved patients in decisions about the service. Patients had joined staff members on staff interview panels. Staff also consulted with patients about whether they should introduce guidelines about appropriate conversations and conversation topics to avoid. Patients felt that introducing guidelines around appropriate conversations would be too restrictive.
- We identified that opportunities for patients to provide feedback about the service were limited. Patients provided feedback about the service during weekly patient business meetings or during their ward round. A booklet was kept for patients to add items for discussion. Updates were then given by staff about actions being taken to address the feedback. For example, maintenance issues were reported, as well as recommendations for menu changes.
- The friends and family survey for patients and carers was short and asked for limited feedback about the service. Two patients told us that they thought the friends and family survey was brief and they did not have an opportunity to provide more detailed feedback about the service.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- All patients could contact an advocate if needed. Details about how to contact the advocate were displayed for patients to see and staff actively referred patients to the advocate if required.

Involvement of families and carers

- Staff involved families and carers in their loved one's care when appropriate. Staff worked hard to involve families and carers of patients who were staying at the service from outside the local area. Video link calls were arranged so that families could attend meetings about their loved one's care easily without needing to travel. Staff had developed intensive family therapy sessions lasting a few hours for relatives who were not able to travel to the service on a regular basis.
- Feedback from relatives and carers was welcomed via the friends and family survey. A carers support group was also in place, and a session was scheduled for patients and carers to meet a non-Executive director and the chief executive of the trust to discuss the service. The carers support group provided a forum for discussion and peer support between carers, and helped provide carers with information about their loved one's condition.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

Bed management

- Average bed occupancy during the 12 months to August 2018 was 91%. Staff reported that this was lower than normal due to maintenance work that had been undertaken on the ward in recent months which required the ward to temporarily decant to alternative premises.
- The service provided inpatient care and treatment to patients from across the country. People from the Crown dependencies and Republic of Ireland also used the service. However, most came from London and Berkshire and local patients who had previously used the outpatient part of the service were prioritised.
- There was always a bed available for patients returning from overnight leave. Patients were only moved if this was required on clinical grounds. For example, occasionally patients needed to be transferred to the gastroenterology ward at the neighbouring acute hospital.
- When patients were moved or discharged from the ward, this happened during the day so that the necessary professionals and families could be involved.
- There were no examples of patients needing to be transferred to alternative mental health inpatient settings such as a psychiatric intensive care unit. However, staff had worked collaboratively with colleagues to provide day treatment to a patient staying as an inpatient on an acute mental health ward elsewhere in the trust.

Discharge and transfers of care

- There were no delayed discharges during the 12 months before our inspection and discharges were never delayed for reasons other than clinical reasons. Most patients were transferred from the ward to the outpatient part of the service. Those from outside the local area were normally discharged back to their local community mental health team.
- Staff planned for patients' discharge. Patients transferring to the outpatient service had continued input from professionals including the dietitian, psychology and family therapy following discharge from the ward. Staff communicated closely with care coordinators at community mental health teams to plan discharges back to the community. Care coordinators were encouraged to attend discharge CPAs and were sent multidisciplinary team reports on patients when appropriate.
- Staff explained that they put emphasis on collaboration and continuity of care. Therapists normally continued to work with patients across the pathway from outpatient to inpatient and back to community services again. Staff explained that this was important in supporting positive risk taking and maintaining long-term therapeutic relationships with patients.
- Staff supported patients during transfers between services. For example, two patients had been transferred to the neighbouring acute hospital during the time of our inspection. Staff were in daily contact with colleagues at the acute hospital and were on-hand to provide staff there with advice and information about how to manage the patients' eating disorders.

Facilities that promote comfort, dignity and privacy

- Each patient had their own bedroom that they could personalise with items such as posters and soft furnishings.
- Patients held a set of their own bedroom keys. Personal items and valuables could be stored in locked bedrooms or stored securely in the nursing office.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care. This included a large dining room that could be divided into two sections depending on whether this was clinically necessary. A large, bright day patient room was available with direct access to the garden. There were two meeting rooms on the ward where both meetings and group therapy sessions took place. Smaller consultation rooms were available within the building for patients to meet independently with professionals.
- A clinic room was situated on the ward. If patients required nasogastric feeding, this was carried out in the

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

clinic room. There was plenty of space in the room to prepare and administer nasogastric feeds. A couch was available if physical examinations of patients were needed.

- Patients could meet visitors in communal areas of the ward, or in a designated room elsewhere in the building, particularly if children were visiting.
- There was a delay of a few months to the delivery of new, more appropriate chairs for the dining room. The chairs on order were more appropriate for people with a low body weight and reduced the risk of pressure ulcers developing. The delay had been caused by the manufacturer and staff were following the issue up with them regularly.
- Patients could make telephone calls in private either using their own mobile telephones or a cordless staff telephone. A pay phone was also available elsewhere in the building.
- During the time of our inspection the ward garden was out of bounds. This was due to building works that required scaffolding. However, under normal circumstances patients had unrestricted access to a pleasant ward garden area. Staff ensured that patients could access fresh air at regular intervals and escorted patients if needed.
- We received mixed feedback about the quality of food. Food was supplied to the ward pre-packaged and re-heated. Patients made recommendations about food they would like to be incorporated into menus during the weekly patient business meeting.
- Availability of drinks and snacks were considered on an individual basis and were agreed as part of patient meal plans. These were produced in collaboration with patients.

Patients' engagement with the wider community

- Staff supported patients to continue their education when necessary. Staff explained how they supported a patient undertaking a college course to keep up with their studies whilst staying on the ward.
- Staff supported patients to maintain contact with their families and carers. Where patients consented, families and carers attended care programme approach meetings and ward rounds.
- Staff actively promoted patients' relationships with people who mattered to them. Occupational therapists worked specifically with patients around tackling social isolation. For example, one patient had received support from staff to get back in touch with friends. A plan had been developed to first by send text message and then gradually build up contact thereafter.

Meeting the needs of all people who use the service

- The ward was located on the ground floor and was fully accessible to patients who may have mobility needs. A physiotherapist worked closely with patients and identified physical needs. Staff were alert to the need to develop personal emergency evacuation plans for future patients with mobility needs.
- Notice boards contained a range of information for patients. This included information about the activity programme including therapeutic activities, sessions with the dietitian and lifestyle groups including support with managing exercise, relationships and body image.
- Information about the trust's recovery college was also available to patients. Through the recovery college patients could attend courses about understanding specific mental health conditions including eating disorders. Staff were also able to provide patients with leaflets about their treatments and medical condition. This information could be sourced in alternative languages or easy-read format if needed.
- Staff reported that, although rarely needed, interpreters could easily be arranged to attend the ward in person.
- A chaplain visited the ward each week and staff reported that they could access religious texts if needed. A multi-use room was often designated as a multi-faith/prayer space for patients to use. The chaplain routinely put patients in touch with other ministers of religion that were more appropriate to their needs. For an example, an imam and rabbi had also visited specific patients on the ward. Patients were encouraged to worship if they wanted to. Staff escorted patients to worship, for example at local churches, if patients were not granted unescorted leave.
- Staff were alert to the need to support patients who identified as lesbian, gay, bisexual or transgender (LGBT+). Staff had recently provided resources to a

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

patient in the early stages of gender transition about support that was available to them. All patients had been encouraged to attend LGBT+ pride if they were well enough to attend. Staff who also identified as LGBT+ made themselves available to have supportive conversations about sexual orientation and gender with patients when required.

Listening to and learning from concerns and complaints

- During the 12 months before our inspection no complaints were received that related to the inpatient service.
- Details about how to contact the patient advice and liaison team were provided in the patient welcome information. Leaflets about how to make a complaint were also available to patients. Staff were confident they knew how to support patients who wanted to make a complaint and what their responsibilities were.
- Complaints were first reviewed centrally at the trust's patient advice and liaison service and arrangements were then made for senior staff elsewhere in the division to investigate and respond if they were upheld. Senior staff in the service therefore had experience of investigating complaints that were made about services elsewhere in the division. They reported that this experience quipped them to also manage and resolve informal complaints locally.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and could explain how the team was working hard to deliver high quality care. Senior nurses including the ward manager, senior nurse and service manager had been appointed within the last year. All had prior experience of working in similar settings.
- Leaders were visible in the service and approachable to patients and staff. Patients and staff explained that following the serious incident in June 2018, the most senior leaders in the trust attended the ward to check in with staff and patients and ensure that support was available to them.
- Leadership development opportunities were available to staff. Staff reported that the trust supported them to progress and provided them with opportunities to attend NHS leadership academy courses, root cause analysis training and a leadership programme for newly qualified nurses with the Royal College of Nursing.

Vision and strategy

- Staff knew and understood the trusts vision and values and demonstrated these in their day to day work. Staff accessed specific training and leaflets in the trusts values, which were compassion, respect, empowerment and partnership.
- Senior staff reported that they sought input and views from newly qualified staff and staff that had worked in similar services about service development.

Culture

- Staff felt respected, supported and valued. Staff reported that they felt positive about their jobs and that over recent months morale and team dynamics and communication between team members had improved.
- Staff reported that they could raise concerns without fear of retribution and they felt that the trust respected their views. For example, a workshop had recently been set up for staff to discuss priorities for developing the service.
- The trust's whistleblowing policy was easily available for staff to access on the intranet system. However, staff were not aware of who the trust's freedom to speak up guardian was.
- Managers dealt with poor staff performance appropriately when needed. Performance issues were initially addressed during to one-to-one supervision sessions and goals and objectives were introduced for staff whose performance needed to be improved.
- Staff had access to support for their own physical and emotional health needs. Staff were put in touch with the trusts people at work scheme for ongoing emotional support following the serious incident that occurred on the ward in June 2018. An occupational health service was also available to staff.
- The provider recognised staff success. The trust held an annual hidden gem awards ceremony. Colleagues nominated each other for the hidden gem awards. Staff also reported that their achievements were recognised during managerial supervision and they often received messages from colleagues to thank them for their hard work.

Governance

- A governance system which included performance monitoring was in place to support the delivery of the service, identify risk and monitor the quality and safety of service provision. Senior managers were aware of areas where improvements could be made and were committed to improving care and treatment for patients. Although work was needed to ensure the ligature risk assessment was accurate, environmental risks were adequately mitigated using routine environmental observations. There were sufficient staff on duty to meet the assessed needs of patients safely and additional staff could be rostered if needed. Staff were trained, supervised and appraised appropriately. Staff ensured patient outcomes and clinical effectiveness.
- Although there was a clear framework about what should be discussed at the senior management team meeting in relation to incidents and service performance, this structure did not extend to the staff meeting that took place on the ward.

Are services well-led?

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By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Recent incidents and complaints were not routinely discussed by staff on the ward. This meant that learning points were not shared amongst the staff team and staff who we spoke with struggled to identify learning from recent incidents. This included both incidents within the service and elsewhere in the trust. We attended a monthly staff business meeting which did not contain a discussion about recent incidents and complaints. This meeting had only recently started to be minuted and there was no standard agenda.
- Staff had attended specially arranged sessions to reflect on the serious incident that took place on the ward in June 2018 and changes had been made to the service following this incident.
- However, whilst learning was identified from incidents that were reported on the incident reporting system, these lessons learned were not always shared with staff. For example, the need to inform staff that restraint should be used as a last resort was identified following a recent restraint incident. This learning was not discussed with staff.
- Staff completed local clinical audits in relation to care and treatment records, risk assessments, the care programme approach process and use of the Mental Health Act. These audits identified areas for improvement and staff acted on their recommendations.

Management of risk, issues and performance

- Staff were aware of the main risks in relation to the service they were providing. The service manager could access the directorate risk register and participate in discussions about entries. Current risks included the upcoming transition between electronic patient record systems and the need for this to be managed appropriately to avoid loss of information and staffing challenges, which were continuing to improve.
- The service had plans for emergencies, for example, if there was a mass staff sickness or building failure. The service manager was preparing to attend a business continuity table-top exercise with colleagues, where they would reflect on and improve business continuity plans.

Information management

- Staff had access to the equipment and information technology needed to do their work. The information technology and telephone system worked well and all staff could easily locate the patient care and treatment records they needed.
- The service was preparing to transition to an alternative patient treatment records system. A project group was working with staff to ensure the new system was designed to meet the needs of the service and training in the new system was being introduced.
- All records systems maintained patient confidentiality. Records could only be accessed by staff that had been authorised to do so. Staff received annual information governance training as part of the trust's mandatory training programme, which 94% of staff had completed during the year leading up to our inspection.
- The ward manager and service manager had access to information that supported them with their management role. This included key information such as an incident reporting dashboard and indicators relating to training compliance, staffing levels and audit results.
- Staff knew when they needed to make notifications to external bodies including the Care Quality Commission.

Engagement

- Staff received regular updates about the work of the provider through intranet bulletins and emails.
- Patients and carers were encouraged to provide feedback about the service using the friends and family survey and patients could provide feedback during weekly patient business meetings, although some patients felt that a more detailed survey would have been more appropriate.
- Carers events were organised which included an opportunity to meet with the trusts senior directors.

Learning, continuous improvement and innovation

- Staff were given time to support and consider opportunities for improvement and innovation. For example, staff and patients were consulted with about improvements to the menu choices and developing rules and a code of conduct for the dining area.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Staff were encouraged to participate in research projects that interested them. For example, the lead therapist was undertaking a research project to better understand the 'anorexic voice' and better differentiate it from psychotic experiences. Staff had recently measured the positive effect of early interventions to treat early psychosis in patients.
- The service used recovery peer support workers to offer emotional support and advice to patients both in groups and during one to one sessions. They supported patients to work towards their recovery.
- Staff working at the service took part in peer reviews of similar wards and explained how they learned from these reviews and implemented good practice on their own ward.
- The ward had been accredited by the Royal College of Psychiatrists Quality Network for Eating Disorders. Although this accreditation had recently lapsed, a review visit had taken place and staff hoped they would receive renewed accreditation in the weeks following our inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** The provider did not ensure that the premises were safe to use for their intended purpose because the ligature risk assessment required further development. **This is a breach of Regulation 12 (2) (d)**