Requires improvement

Barnet, Enfield and Haringey Mental Health NHS Trust

Specialist eating disorders services

Quality Report

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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)
RRP46	St Anne's Hospital	Phoenix Wing	N15 3TH

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield and Haringey Mental Health NHS 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.

Where applicable, we have reported on each core service provided by Barnet, Enfield and Haringey Mental Health NHS Trust and these are brought together to inform our overall judgement of Barnet, Enfield and Haringey Mental Health NHS 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	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
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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Summary of findings

Overall summary

We rated the service as **requires improvement** because:

- Although the trust had made improvements to address the concerns we raised at our previous inspection in February 2017, we found new areas for improvement.
- The trust did not ensure that patients were protected from potential ligature risks in all areas of the ward. Bathrooms and toilets had been identified as potential ligature risks on the ligature risk assessment and were to be kept locked. During our inspection, this was not the case and on four occasions these were found to be open. This meant that measures in place to manage and mitigate these risks were not being followed.
- The ward environment did not promote comfort, dignity and privacy. The main communal lounge was located in the middle of the corridor. Patients had their post meal support group in this area and staff regularly walked through the group to access the clinic room and managers office. The dining rooms were not conducive to people's eating experience and the therapy rooms were bare and being used to store equipment
- Mandatory training compliance with basic life support and information governance was at 59%.
- Staff did not always update patient care plans promptly when there had been a change in risk.
- Patient feedback was mixed, and we heard concerns about poor staff attitude and that they were not treated with dignity and respect.

However:

- At this inspection, we found that the trust had taken appropriate action to improve the service and had addressed all previous breaches of regulation and all of the previous recommendations. The service had made improvements in staffing and ensuring that there were enough staff on duty to meet the needs of patients, including one-to-one time with staff and ensuring that staff had undertaken and completed training on how to care for patients with an eating disorder. Blanket restrictions in relation to bathing and shower times had been reviewed and used only in response to individual patient risk. The service had also made improvements to patient risk assessments so that they were comprehensive and updated following incidents. Care plans were person centred and developed in collaboration with patients so that their views were included. Patients' individual meal plans and requests were mostly met. Where staff were unable to accommodate this, an alternative agreed with the patient was provided. Staff carried out robust monitoring of food provision with the support of the dietetics team.
- The wards were clean and well maintained. Furnishings were in good condition. Staff had undertaken infection control training and followed infection control practices. Emergency equipment in the clinic room was checked regularly.
- The trust had an on-going programme of staff recruitment and had carried out a staffing review so that they could bench mark themselves against other inpatient eating disorder services.
- The service protected patients from the risk of abuse and avoidable harm. There were clear, open and transparent processes for reporting and learning from incidents. Records showed that staff apologised to patients and family members when things went wrong.
- There were systems in place to ensure that patients consistently received their medicines safely and as prescribed.
- Patients' care and treatment was planned, delivered and reviewed regularly, in line with best practice guidance.
- Patients were involved in their treatment and had been included in decisions about their care. The multidisciplinary team had specialist skills in eating disorders which supported the effective delivery of care and treatment.
- The trust had acted on the findings of our inspection in February 2017 and had developed an action plan

Summary of findings

to address the shortfalls identified. The appointment of the ward manager and changes in the senior management team for the service had a positive impact on the service.

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:

- The trust did not ensure that patients were protected from potential ligature risks in all areas of the ward. Bathrooms and toilets had been identified as potential ligature risks on the ligature risk assessment and were to be kept locked. During our inspection, this was not the case and on four occasions these were found to be open. This meant that staff were not mitigating the risk of patients ligaturing in these areas.
- Mandatory training compliance with basic life support and information governance was at 59%.

However:

- In February 2017, we found that there were blanket restrictions in relation to the times that patients could use the bathing and shower facilities. At this inspection, improvements had been made. Care plans detailed how individual bath and shower needs would be met.
- In February 2017, we found that improvements were required to ensure that risk assessments were comprehensive and updated following incidents. At this inspection, improvements had been made. Risk assessments were comprehensive, person centred and updated following incidents. Staff had undertaken training in risk management and recording.
- In February 2017, we found that improvements were required to ensure that there were sufficient staff to ensure that patients received planned one-to-one time with staff. At this inspection, improvements had been made. Patients reported that they received regular one-to-one time with staff and records viewed confirmed this.
- In February 2017, we recommended that medicine administration records were fully completed. At this inspection, improvements had been made and all records were fully completed.
- Patients received care in a clean and hygienic environment. Staff followed infection control procedures.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe. There was an active recruitment and retention programme.
- Staff were aware of incident reporting procedures. Staff confirmed they had received feedback from incidents.

Summary of findings

Are services effective?

Good

We rated effective as **good** because:

- In February 2017, we found that not all staff had attended the specialist training programme for staff working with people who had an eating disorder. At this inspection, improvements had been made and all staff had attended the training sessions which enabled them to support patients with an eating disorder.
- In February 2017, we found that some care plans were not comprehensive, did not identify all patient needs and did not incorporate the patient's view. At this inspection, we found that improvements had been made. Care plans were comprehensive, person-centred and included the patient voice.
- Staff completed a comprehensive assessment of patients' needs upon admission in a timely manner.
- Robust arrangements to ensure that patients' physical healthcare were met. Where required patients were referred to specialist services and professionals.
- Staff delivered care and treatment in line with current guidance and best practice. Psychological therapies were offered and where appropriate patients could access family therapy and counselling.
- Patient's specialist nutrition and hydration needs were met effectively. The dietetics team worked collaboratively with patients so that re-feeding was carried out safely.
- Staff were appropriately skilled to deliver care and disorders. There was good evidence of MDT and interagency team work.
- Staff had a good understanding of the Mental Health Act and Mental Capacity Act.

However:

- Patients were not supported to write down information provided at the MDT meeting.
- Care plans were not always updated promptly when there had been a change in patient risk.

Are services caring?

Good

We rated caring as **good** because:

Summary of findings

- Patients were involved in making decisions about their care and treatment.
- Staff understood the individual needs of patients.
- We observed positive interactions on the ward between staff and patients.
- Patients had access to an independent advocate.
- Carers were provided with information and support. They were involved in patients care where appropriate and had opportunity to attend reviews of care.
- Patients reported that their physical health was well managed and that the ward manager had made improvements to the ward.

However:

- Some patients reported that their privacy and dignity was not maintained and that some staff had a poor attitude and that communications regarding restrictions within the service were poor.

Are services responsive to people's needs?

Requires improvement

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

- The ward environment impacted on patients' experience because the environment did not promote comfort, dignity and privacy. The main lounge area was in the middle of the corridor. The therapy rooms were used for storage, and were bare and unwelcoming.
- Two patients were concerned about raising concerns or complaints and that they would not be listened to and their complaint acted upon.
- Patients reported that there were fewer activities at the weekend.

However:

- In February 2017, the provision of food for snacks did not always meet patients' individual meal plans. Food choices that were included in individual meal plans were either unavailable

Summary of findings

or stock was limited. At this inspection, improvements had been made and food provision including snacks met patients' individual needs. The dietician worked in collaboration with patients so that their individual food preferences were accommodated.

- In February 2017, we recommended that the main entrance door to the ward protect patients' privacy and dignity at all times. At this inspection, improvements had been made and the clear panel was now covered with frosted glass.

- Staff supported patients to maintain contact with their families, carers and others that were important to them.
- The service had access to interpretation and translation services for patients who did not speak English.

Are services well-led?

Good

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

- Since the last inspection in February 2017, the trust had taken appropriate action to improve the service and had addressed all previous breaches of regulation and all of the previous recommendations.
- Governance and performance arrangements were in place that supported the delivery of the service, identified risk and monitored the quality and safety of the services provided.
- Staff were positive about working for the trust. They reported that they could approach managers with any concerns.

- There was effective leadership at a local and service level. The senior leaders within the service had a good knowledge of the eating disorders service and knew where improvements were required to ensure that patients received safe and effective care that was person-centred and of high quality.
- Staff were provided with opportunities to develop their clinical and management skills.

Summary of findings

Information about the service

Phoenix Wing is located at St. Ann's Hospital and provides specialist inpatient treatment to men and women aged over 18 who have an eating disorder. The ward offers a high dependency, intensive treatment for patients with complex eating disorders and can support patients with nasogastric feeding.

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

Team Leader: Rekha Bhardwa Inspector (mental health) Care Quality Commission

The team that inspected this service comprised two inspectors, two inspection managers, one pharmacy inspector, one pharmacy clinical fellow, one specialist advisor who was a nurse with specialist experience in eating disorders services and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses similar mental health services.

Why we carried out this inspection

We undertook this inspection to find out if Barnet, Enfield and Haringey NHS Trust had made improvements to this service since our last focused inspection in February 2017. This is the first time we have rated this service.

Following the February 2017 inspection, we told the provider it must take the following actions to improve its services:

- The trust must ensure that the blanket restriction that relates to set bath and shower times is reviewed and only used in response to a current individual patient risk.
- The trust must ensure that there are an adequate number of staff available on the ward at all times to ensure patient safety.
- The trust must ensure patient risk assessments are comprehensive and are updated following incident.
- The trust must ensure that patients have comprehensive care plans in place that incorporate their views.
- The trust must ensure that there are adequate food provisions on the ward in order to meet patients' individual meal plans and requests.
- The trust must ensure that staff have completed the training to support them to care for patients with an eating disorder.

This related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9: Person-Centred Care
- Regulation 12: Safe care and treatment
- Regulation 18: Staffing

We also told the trust that it should take the following actions to improve specialist eating disorder services:

- The trust should ensure that medicine administration cards are fully completed and there are no gaps.
- The trust should ensure that the main entrance door to the ward protects patients' privacy and dignity at all times.

Summary of findings

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?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited Phoenix ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients who were using the service
- spoke with one carer
- spoke with the acting manager of the ward
- spoke with 11 other staff members: consultant psychiatrist, occupational therapist, family therapist, lead psychologist, health care assistants, dietician, nurses, domestic staff and social worker
- interviewed the director of nursing, service manager and operational managerwith responsibility for this service
- attended and observed one multi-disciplinary meeting
- observed one lunch time meal and two post meal support groups
- collected feedback from two patients using comment cards
- looked at six treatment records of patients
- carried out a specific check of the medication management on the ward
- 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

We received mixed feedback from patients about the care, treatment and support they received. We spoke with seven patients and one carer. Most patients told us that staff were professional and reported that the ward was a safe and secure environment. Patients reported that their physical health care needs were well managed and there had been some improvements to the ward following the appointment of the manager.

All seven patients reported concerns regarding inconsistent staffing levels especially at nights and at the weekends, the high use of bank staff and the poor attitude of staff which included careless comments about food. Other concerns identified by patients included poor communication, restrictive treatment regimens, insufficient contact with the consultant and lack of activities at the weekend.

We collected two comment cards. Both were negative in their feedback, which included poor staff attitude and the quality of food provided.

Good practice

- Staff provided carer skills training based on the New Maudsley Method 'Skills-based learning for carers for a loved one with an eating disorder.' The training was evidence based. The course consisted of several sessions and was run twice a year.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that assessed ligature risks are mitigated so that care and treatment is provided in a safe way.
- The trust must ensure that the premises are suitable for the purpose for which they are being used and promote the comfort, dignity and privacy of patients.

Action the provider SHOULD take to improve

- The trust should ensure that staff complete the planned mandatory training on basic life support and information governance.
- Patients should be supported to write down information provided at the MDT meeting.
- Care plans should be updated promptly when there has been a change in patient risk.
- The trust should ensure that staff treat patients with appropriate levels of dignity and respect, including when staff wish to enter patients' rooms.
- The trust should ensure they provide a range of activities to meet patients' need at the weekend.
- The trust should ensure that patients are supported to make a complaint when they wish to do so.

Barnet, Enfield and Haringey Mental Health NHS Trust

Specialist eating disorders services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Phoenix Wing	St Anne's Hospital

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 in relation to their practice. They had undertaken training and were aware of how to access advice.
- Staff received support from the trust's MHA office and approved mental health professionals (AMHP) who worked in the service.
- We found that all necessary paperwork relating treatment forms were attached to medicine records as required and were completed accurately.
- Patients were given information about their rights under the Mental Health Act regularly and this was recorded. Patients could access Independent Mental Health Advocates (IMHAs) for support and advice. Contact information was displayed in the ward and also available in the patient welcome pack

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of the Mental Capacity Act (MCA) and confirmed that capacity was assumed unless proven otherwise.
- The trust had policies and procedures in place in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). Staff could access these on the intranet.

Detailed findings

- Staff could contact the MCA and DoLS leads within the trust when they required additional support and guidance. One of the two psychiatrists on the ward had a specialist interest in this area.
- We saw detailed records relating to the assessment and understanding of capacity across the service where decision specific assessments had been made and the best interests of the individual considered.
- Staff obtained consent from patients before providing care. They understood their legal obligations on how to support people who could not consent to their own care and treatment. All six patient records had detailed assessments regarding people's capacity to make informed decisions about their care and treatment. For example, a patient had provided consent for the insertion of a nasogastric tube. Where patients were informal, we saw that they consented to an in-patient admission programme which had been fully discussed with them before admission.
- When patients lacked capacity, staff made decisions in their best interests, which recognised the importance of the person's wishes, feelings, culture and history. Where appropriate staff involved the patient's family members to obtain further information.

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 carried out regular risk assessments of the care environment to ensure that patients were safe. This was allocated to a member of staff on each shift and discussed during the handover.
- The layout of the ward did not allow for clear lines of sight for observing patients. This risk was mitigated by staff carrying out regular safety checks, observations and engagement with patients. A convex mirror had been installed in the rear lounge area so that staff could view the blind spot in that area.
- The ward had a ligature point (fittings to which patients intent on self-injury might tie something to harm themselves) risk assessment and management plan in place, which had been completed in March 2017. The ligature risk assessment identified the ligatures in all rooms and communal areas including the bathrooms. Notices were affixed to the bathroom doors to remind staff to keep the doors locked. However, we found four separate occasions where the bathroom doors were open. We also found that the small therapy room which contained several ligature anchor points was not locked throughout the inspection. This meant that
- There was an ongoing refurbishment plan to address ligature risks throughout the ward, which included replacing taps and windows.
- Phoenix wing was a mixed gender ward. The ward had 20 beds. At the time of the inspection there were 19 female patients on the ward. The ward was able to accommodate male patients and
- Nurse call alarm systems were in place in individual bedrooms, bathrooms, toilets and communal areas.

Maintenance, cleanliness and infection control

- Patients were provided with care in a clean and hygienic environment. All areas we inspected were visibly clean. Furnishings and equipment were well maintained and appropriate for the patient group.
- Staff followed infection control procedures to keep patients safe. Disposable gloves, aprons and liquid gel were available.
- Hand hygiene and infection control audits were completed and up to date which meant that patients were protected from infections. The most recent audit which was displayed showed that the ward had achieved 98% for cleanliness and good hand hygiene was 100%.
- Fire safety arrangements were in place. Equipment was serviced and 95% of staff had undertaken fire safety training.

Clinic room and equipment

- The clinic room was tidy with hand washing facilities available.
- Emergency medicines (including flumazenil and glucagon) were stored in the clinic room. There was a tamper evident emergency bag available (which included adrenaline and a defibrillator) for use during immediate life support. Staff checked the emergency bag weekly.
- Staff recorded minimum, current and maximum fridge temperatures daily, as well as ambient room temperatures. When the readings were out of the required range, we saw that appropriate action was taken. The temperature readings provided assurance that medicines were stored at the correct temperatures to remain effective.
- The weighing scales had been tested to ensure they were fit for purpose. Staff calibrated the blood glucose testing kit on a weekly basis. The ward had an electrocardiogram (ECG) machine and both doctors and some nurses were trained to use it.

Safe staffing

Nursing staff

- In February 2017, we identified that there were insufficient staff to meet the needs of the patients. Patients did not always receive planned one-to-one time with staff. Improvements had been made to patients having one-to-one time with their keyworkers.

Requires improvement

Are services safe?

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Care records demonstrated that regular one-to-one sessions with staff were taking place. Weekly audits of the number of one-to-one sessions undertaken were carried out by the manager. Co-keyworkers were undertaking one-to-one sessions when the keyworker was not available. Most patients we spoke with told us there had been an improvement in this area.

- The ward had an establishment of 13 qualified nurses and thirteen healthcare assistant posts. There were three vacancies for band five nurses and one vacancy for a health care assistant post. The manager reported that in conjunction with the trust recruitment team a bespoke recruitment programme had been developed for the ward to recruit band five nursing staff.
- Any staff shortages were responded to appropriately. To ensure continuity of care for patients, staff that were familiar with the ward were booked to work. The trust reported that 1,120 shifts had been filled by
- All seven patients reported concerns regarding inconsistent staffing levels especially at night, weekends and the high use of bank staff. Patients also said that there was a lack of catering cover when catering staff were on leave which added more pressure to staff that were preparing and serving food.
- Safe staffing levels for the ward were usually met. Where staffing levels fell below the safe number staff reported this as an incident. The trust reported that there were 20 shifts which were not
- The overall staff sickness rate in the 12 month period leading up to our inspection was 2.8%.
- The service had undertaken a staffing review as part of an Optimal Staffing Project, which involved benchmarking staffing levels with other eating disorder services. At the time of the inspection, data had been submitted to the project for analysis.
- The ward manager planned and reviewed the staffing skill mix to ensure patients received safe care and treatment. The ward had a minimum of qualified and unqualified staff on duty. Staffing was determined by the number of patients on the ward, their assessed needs and the resources required to meet this.
- The ward manager confirmed that he could adjust the staffing levels as required to ensure that patients received care and treatment safely. For example,
- To ensure continuity of care, staff that were familiar with the ward were booked to work. New agency and bank staff undertook an induction to the ward which provided them with essential information for their shift.
- We observed that both unqualified and qualified staff were available in the communal areas to assist patients, engage in activities of daily living and spending one to one time. Patients were attended to promptly when they required assistance or support.
- The manager reported that there were no instances of the cancellation of patient activities or leave due to a shortage of staff.
- There were enough staff on duty to carry out physical interventions safely, and they were trained to do so. Staff were trained to carry out physical intervention, this included training in how to restrain a person with a low body weight safely and during nasogastric feeding.

Medical staff

- The ward had appropriate medical cover day and night. There were two part-time consultant psychiatrists that covered the ward from Monday to Thursday. There was no consultant for the ward on a Friday, and the manager informed us that the medical director for the service could be contacted if required. A new full-time consultant for the service was due to start in December 2017. There was a ward doctor and specialist registrar. Access to doctors out of hours was via an on call system.

Mandatory training

- The trust had ten specific mandatory training areas for staff to complete so that they had the appropriate skills and knowledge to carry out their roles and responsibilities safely. Mandatory training covered a range of subjects including health and safety, information governance, moving and handling and infection control. The compliance rate for most areas averaged over 80%. However, training in resuscitation level 2, which included basic life support, and information governance was at 59%. Where staff had not undertaken training, this was being followed up by the ward manager and staff booked to attend.
- Staff responded to regular simulated emergency situations on the ward, which allowed them to practice the skills they had learned during life support skills training in a more life-like situation.

Requires improvement

Are services safe?

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

Assessing and managing risk to patients and staff

Assessment of patient risk

- At our inspection in February 2017, we found that staff did not always complete thorough risk assessments or update them regularly. At this inspection we found that improvements had been made. We reviewed six patient records and found that all patients had a comprehensive risk assessment which was up to date. For example, where a patient who had been assessed at high risk of self-harm the risk intent of the patient was thoroughly assessed. This meant that patients were protected from the risk of receiving unsafe or inappropriate care because they had their individual needs risk assessed.
- The manager had carried out risk assessment training with nursing staff. Weekly and monthly audits on risk assessment and management plans were carried out to ensure they were comprehensive and updated. Where shortfalls were identified during the audit this was addressed with nursing staff responsible.
- Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies and monitoring or changes in behaviour. Individual risks were discussed in multi-disciplinary meetings, individual reviews, handovers and best interest meetings. Assessments included the patients mental and physical health needs such as Waterlow pressure ulcer risk assessment, hypothermia, body mapping and falls assessments.

Management of patient risk

- Risk management plans were in place for assessed risks. For example, for one patient who had restricted mobility the risk assessment detailed the use of a wheelchair when assessing the garden. Where patients had been identified as being at risk from pressure ulcers we saw that they had access to specialist equipment such as pressure relieving mattresses and height adjustable beds. Staff had access to the tissue viability nurse if they required additional advice and support. Mobility and falls risk assessment were carried out by the physiotherapist.
- Staff identified and responded to changing patient risks. For example, a patient was referred and admitted to the general hospital due deterioration in their physical health condition. For another patient we saw that the psychologist had notified other members of the MDT where the risk of self-harm had increased.
- Staff carried out various levels of observation on the ward to ensure effective risk management. Staff completed a minimum of hourly checks on patient location and increased this if the risks were greater. Additional staff were rostered on duty where required.
- At our inspection in February 2017, we found that there was a blanket restriction in place regarding set times to use the bath and shower facilities. At this inspection, we found that improvements had been made. Where patients required restricted access due to current risk this was clearly recorded in the risk assessment and associated care plan. Where patients had been assessed as having unrestricted access this was discussed with the patient and clearly recorded in the care plan.
- There were some other restrictions in place in relation to accessing food and drinks due to the impact on patient's health and recovery process. These restrictions were recorded and part of the dietician's nutritional assessment and patients risk assessment.
- The trust had a smoke free policy. Smoking cessation programmes were available if required.
- Staff ensured that informal patients understood their right to leave the ward when they wished. Informal patients told us they were aware of their rights, but raised concerns regarding whether they would be allowed to leave the ward if they wanted to.

Use of restrictive interventions

In the 12 months before the inspection:

- There were no incidents of use of seclusion reported in the last 12 months.
- There were no incidents of use of long term segregation in last 12 months.
- In the 12 months up to 31 August 2017, there had been 27 incidents of restraint on eight different patients. None of the incidences used prone restraint or the use of rapid tranquilisation. We viewed five records of restraint

Requires improvement

Are services safe?

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

and found that each incident of restraint was recorded, and detailed the length and type of restraint used. Most incidents of restraint related to patients who required nasogastric feeding and involved hand holds.

- The trust had a restrictive interventions reduction programme. Staff confirmed that they used physical intervention as a last resort and used this only after preventative strategies such as de-escalation had failed.
- Staff we spoke with had a good understanding of the use of preventative strategies and that physical intervention was a last resort. Staff had been trained to carry out physical interventions for people with a low Body Mass Index.
- At the time of the inspection there were no incidences of restraint under the Mental Capacity Act.
- Staff were aware of the need to follow NICE guidance when using rapid tranquilisation. At the time of the inspection, none of the current patients had received rapid tranquilisation.
- The service did not have facilities for nursing patients in seclusion.

Safeguarding

- Staff had undertaken training around safeguarding adults and children and demonstrated a good understanding of the procedures that they would follow to raise a safeguarding alert. Safeguarding information with contact details was displayed in the nursing office and available in booklet form for patients.
- Staff had a good understanding of the different types of abuse and possible harm patients could experience. Staff took appropriate steps to report and record any safeguarding concerns. Within the last 12 months the service had made four safeguarding referrals.
- Records for one patient demonstrated that the service had taken appropriate action when they had identified the patient as being placed at risk of harm. Staff worked closely with the local safeguarding team to make sure that concerns were fully investigated and to implement protection plans if required. The records showed that the patient was involved in the safeguarding process.
- Children were not permitted to visit the ward. Any visits involving children would be discussed at the MDT and appropriate arrangements made off the ward.
- Equality and diversity training was part of the mandatory training within the service 92% of staff had completed the training. Staff were aware of the different types of discrimination that could occur. One staff member told us they were confident in confronting homophobia or transphobia and encourage staff to use appropriate language when speaking to or about patients. They were aware that transgender patients should be treated according to their preferred gender.

Staff access to essential information

- Staff used a combination of electronic and paper records. Patient information was easily accessible and there was a good flow of information in the electronic record which was the main record the staff used. For example, the number of restraint incidents could be tracked.
- Staff used paper records to record readings from physical observations such as blood pressure and temperature.
- There were no concerns reported with accessing information and staff knew where patient information was held. Staff were able to access information when patients moved between teams. For example, referral information from GPs and outpatient appointments was available on the trust electronic system.

Medicines management

- The service had good systems in place to safely support people with the management of their medicines. In February 2017, we recommended that medicine administration records (MAR) were completed fully. At this inspection, improvements had been made. There were no unsigned doses on the 14 prescription charts we looked at. Medicines were stored securely in locked cupboards and a locked fridge within a locked clinic room. Staff recorded minimum, current and maximum fridge temperatures daily, as well as ambient room temperatures. When the readings were out of the required range, we saw that appropriate action was taken. The temperature readings provided assurance that medicines were stored at the correct temperatures to remain effective. There was only one controlled drug (CD) on the ward at the time of this inspection. We could see from the CD register that it was checked three times a day by two members of staff.

Requires improvement

Are services safe?

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

- The prescription charts that we looked at had patient identifiable data, and allergy status completed for all patients.
- We saw that medicines reconciliation was conducted for patients. (Medicines reconciliation is the process of ensuring that the list of medicines a person is taking is correct.) Pharmacy technicians dealt with ward stock provision.
- Staff reviewed the effects of medicine on patients' physical health regularly and in line with NICE guidance. This was undertaken at the MDT meeting and with the ward pharmacist who attended the ward twice a week. A pharmacist had screened the prescription charts and had made appropriate clinical interventions.

Track record on safety

- No serious incidents had been reported for this service in the last 12 months.

Reporting incidents and learning from when things go wrong

- Staff had a good understanding of what kind of incidents and near misses to report, and they knew how to report them on the trust's electronic recording system.
- Staff reported all incidents that needed reporting. For example, staff had reported an incident where patients' bloods had not been checked before their discharge. Incidents were reviewed by the ward and operational manager to monitor for themes and trends weekly.
- Staff understood the duty of candour and described the need to be open and honest with patients when something goes wrong. For example, we saw a letter of apology that had been sent to a patient following an incident around their legal status.
- Staff received feedback from investigations of incidents both within and external to the service. Staff reported that learning from incidents was shared in a number of ways. This included feedback at individual supervision, staff meetings and clinical governance meetings.
- Staff were aware of the importance of reporting incidents and how it fed into the improvement of the service. For example, following an incident where a patient could not return to the ward due to the passenger lift breaking down, new procedures had been implemented so that a second lift in the building could be accessed in an emergency.
- Staff were debriefed following incidents, informally or formally, depending on the type and seriousness of the incident. Patients were also supported to debrief following an incident.

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

- We reviewed six patient care and treatment records and saw that on admission patients had a comprehensive holistic assessment of their mental and physical health needs in a timely manner. Staff involved the patient and their representative where appropriate.
- Patients received high quality physical healthcare in a coordinated way. Staff assessed patient's physical health needs in a timely manner after admission. Each patient had a thorough recorded medical assessment on admission.
- Comprehensive physical healthcare records showed that there was on-going monitoring of health conditions and healthcare investigations to ensure patients were cared for safely. This included close and regular monitoring of bloods, heart rate, pulse, urine, temperature, weight monitoring and electrocardiography (ECG). An ECG checks the hearts rhythm and electric activity and is important to ensure patients receive the right treatment and medicine.
- At the inspection in February 2017, we found that staff did not always complete care plans that addressed all the needs of patients and demonstrated their involvement. At this inspection, we found that improvements had been made. All six care plans were comprehensive, holistic and based on the assessed needs of the patient. Patients had been involved in the planning and reviewing of their care and the records clearly reflected the patient's voice. For example, we saw that staff had discussed the risks of sub-optimal weight and physical health deterioration with a patient who wanted an early discharge and the dietician had discussed the risk of re-feeding syndrome with another patient. However, for one patient we saw that whilst the risk assessment and management plan had been updated in line with changing risk their corresponding care plan had not been updated promptly.

Best practice in treatment and care

- The staff team planned and delivered care and treatment interventions based on best practice and evidence based guidance. The staff team followed guidance based on the Management of really sick patients with anorexia nervosa (MARSIPAN) guidelines. These guidelines provide guidance on the clinical management and care of really unwell patients with anorexia nervosa. This tool is approved by the Royal College of Psychiatrists and the Royal College of Physicians and staff used this to carry out safe refeeding, risk management and monitoring.
- Medical staff were aware of and used the best practice guidelines relating to prescribing medicines which were established by the National Institute for Health and Care Excellence (NICE).
- Patients had access to a wide range evidence based of psychological therapies as recommended by NICE, including group and individual support. This incorporated cognitive behavioural therapy, cognitive remediation therapy, focal psychodynamic therapy, art therapy and family therapy.
- Patients received ongoing assistance with physical healthcare throughout their admission. Staff referred patients to specialists whenever necessary and worked closely with the acute hospital. This included referrals to cardiologists, dentists, tissue viability nurses and physiotherapists.
- The lead dietician and staff carried out comprehensive nutritional and hydration assessments for all patients upon admission to the ward to ensure that refeeding was carried out safely including nasogastric feeding. Staff adhered to NPSA guidance relating to safe insertion and nasogastric feeding.
- Staff helped patients to live healthier lives by offering nicotine replacement products to patients who smoked and supporting them to stop smoking. The hospital was a smoke free environment. The dietician ran a fortnightly nutrition education group for patients.
- Outcomes for patients using the services were monitored and audited. The staff used health of the nation outcome scales (HONOS), to record the severity of each patients needs and their outcomes as their treatment progressed. The Occupational Therapist used the model of human occupation screening tool (MOHOST) and the psychologist used the Eating Disorder Questionnaire (EDQ) to assess patients and measure their progress.

Are services effective?

Good

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- Staff used technology effectively to support patients. For example, all medical and nursing staff were able to access results of investigations electronically including blood test results so that any changes to a patient's treatment plan could be made promptly.
- Staff participated in clinical audit and quality improvement initiatives. Staff carried our regular audits on care plan documentation, risk assessments, nutrition, CPA and health and safety. Where shortfalls were identified, action plans were in place to ensure that improvements were made.

Skilled staff to deliver care

- Patients had access to a full range of specialists and disciplines to aid their recovery, including specialist eating disorder consultants, medical, pharmacy, occupational therapy, psychologist, assistant psychologist, physiotherapists, family therapist, social worker, care and nursing staff. Domestic and administrative staff supported the ward.
- Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of people with an eating disorder. The consultants, consultant psychologist and lead dietician had specialist expertise in working with people with eating disorders. The ward manager had recruited band six nurses who had experience in working with patients with eating disorders.
- All nurses on the ward were trained to take bloods and most were trained in safe nasogastric tube insertion and enteral feeding.
- The trust had a comprehensive induction programme for new staff which included the care certificate for healthcare assistants. The ward had a specific induction programme for bank and agency staff. Bank staff could access training provided by the trust.
- Staff had an annual appraisal of their work performance. Information provided demonstrated that between September 2016 and September 2017 that 25 out of 31 permanent non-medical staff had an annual appraisal.
- Staff received appropriate supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development). Staff confirmed that they received regular clinical and managerial supervision and described good communication and support. The percentage of staff that received regular supervision was 94% as at the 1 September 2017. Staff had access to regular team meetings, reflective group supervision and had a daily debrief with the psychologist at each handover. Doctors could also access a 'Balint' reflective practice group weekly which allowed clinicians to present and discuss patient cases.
- In February 2017, we found that nursing staff and healthcare assistants had not received specific training on caring for people with an eating disorder. At this inspection, we found that improvements had been made and all nursing and care staff had completed the training which provided them with the necessary specialist training for their role.
- Staff confirmed that professional development and other training opportunities were offered to develop their skills and knowledge. For example, training in cognitive behavioural therapy and nasogastric tube insertion. All staff undertook a range of mandatory training.
- The manager confirmed that policies and procedures were available to deal with staff performance effectively.
- The ward did not have volunteers.

Multidisciplinary and interagency team work

- Staff held regular multi-disciplinary team (MDT) meetings on the ward, including ward rounds and MDT handover meetings. We observed one MDT meeting. Patients attended these meetings, along with family members and other carers, and they were involved in making decisions where appropriate. Prior to the ward round patients could complete a feedback sheet which detailed their views on their progress and any areas of their care and treatment they wanted to discuss. However, during our observation of the MDT meeting we found that a patient was provided with a lot of information regarding their medicines prior to their discharge. We noted that the patient was not provided with materials to write the information down, and where actions were identified such as weighing the patient there was no verbal confirmation as to who would carry this out.

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- The staff team carried out a handover at each shift change to share information about patients, including any changes in their condition and any risks that they presented with. For example, staff communicated blood test results and any changes in care and treatment.
- Staff in the service maintained effective relationships with other services and organisations such as social services, general practitioners and the eating disorders outreach team to ensure that patients received on-going care and treatment when they were discharged from the hospital. For example, we saw that staff were working with external providers to support a patient's feeding regime when discharged.

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

- Staff were trained in and had a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles. Eight patients were detained under the MHA at the time of our inspection.
- Staff were aware that they could seek advice regarding the Mental Health Act if necessary and were aware of where they could go for advice, either to the Mental Health Act office or one of the approved mental health professionals who worked in the service.
- Staff could access the policies and procedures and latest guidance through the trust intranet.
- Patients had access to an independent mental health advocate (IMHA) to support them whilst they were detained. An
- Patients had their rights explained to them on admission and thereafter at regular intervals. This was clearly and comprehensively recorded in individual care records. For a patient whose first language was not English we saw that MHA information had been translated into their spoken language. This ensured that the patient was not disadvantaged because they did not speak English.
- Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly. These records were available to all staff that needed access to them. We found that all necessary paperwork, relating treatment forms were attached to medicine records as required and were completed accurately. Staff requested an opinion from a second opinion appointed doctor when necessary. Staff supported patients where appropriate with their Section 17 leave.
- Regular audits took place to ensure that the MHA was being applied correctly and to identify any concerns promptly.

Good practice in applying the Mental Capacity Act

- Staff had a good understanding of the Mental Capacity Act (MCA) and confirmed that capacity was assumed unless proven otherwise.
- The trust had policies and procedures in place in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). Staff could access these on the intranet.
- Staff could contact the MCA and DoLS leads within the trust when they required additional support and guidance. One of the two psychiatrists on the ward had a specialist interest in this area.
- We saw detailed records relating to the assessment and understanding of capacity across the service where decision specific assessments had been made and the best interests of the individual considered.
- Staff obtained consent from patients before providing care. They understood their legal obligations on how to support people who could not consent to their own care and treatment. All six patient records had detailed assessments regarding people's capacity to make informed decisions about their care and treatment. For example, a patient had provided consent for the insertion of a nasogastric tube. Where patients were informal, we saw that they consented to an in-patient admission programme which had been fully discussed with them before admission.
- When patients lacked capacity, staff made decisions in their best interests, which recognised the importance of the person's wishes, feelings, culture and history. Where appropriate staff involved the patient's family members to obtain further information.

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

- Interactions between staff and patients were positive and professional. We observed staff to be discreet, respectful and responsive, providing patients with help, emotional support and advice.
- Staff supported patients to understand and manage their care, treatment and condition. Care plans detailed discussions that members of the MDT had with the patient relating to their physical and dietary needs. Patients told us staff supported them to understand and manage their condition.
- Staff directed patients to other services where appropriate and if required, supported the patient to access them. For example, patients reported that staff supported them to access services at the general hospital and attended appointments with them. The ward had a range of leaflets and information for patients and carers about local services and how these could be accessed.
- We received mixed feedback from patients about the care, treatment and support they received. We spoke with seven patients and one carer. Most patients told us that staff were professional and reported that the ward was a safe and secure environment. Patients reported that their physical health care needs were well managed and there had been some improvements to the ward following the appointment of the manager.
- All seven patients reported concerns regarding poor staff attitude which sometimes included careless comments about food. Three patients reported that their privacy was not respected and that staff knocked on their door and entered without waiting for a response. One patient reported that they had seen their consultant individually on five occasions for 15-20 minutes in 17 weeks. They said this was supposed to be 30 minutes every two weeks. Overall there was not enough contact with the consultant. Patients reported that communication regarding restrictions within the service were inconsistent.
- Staff demonstrated a good understanding of the individual needs of patients on the ward. We observed staff discussing patients in the multi-disciplinary meeting and during our interviews. This was done in a respectful manner and recognised people's individual needs.
- Staff reported that they could raise any issues about disrespectful, discriminatory or abusive behaviour
- Staff maintained the confidentiality of information about the patients. Information was stored electronically and could only be accessed by staff authorised to do so. Any patient discussions were in closed rooms.

Involvement in care

Involvement of patients

- Staff used the admission process to inform and orient patients to the ward. Patients received a welcome pack upon admission. This contained information on the service, treatment and care provided and essential information about the ward, including meal times, MDT, visiting arrangements and complaints procedure.
- Staff involved patients in care planning and risk assessment. Patients confirmed they were involved in their care planning, risk management and review through care planning meetings, one to one sessions with their therapist, nurse and ward rounds. Care records detailed whether a copy of the care plan had been given to the patient.
- Staff on the ward explored effective ways to communicate with patients with communication difficulties so that they understood their care and treatment. For example, staff had accessed the support of one of the doctors in the service for a patient whose first language was not English.
- The service involved patients and carers when appropriate in decisions about the service. Patients had co-produced the ward welcome pack and the guidelines for community living.
- Patients could give feedback on the service they received through meetings and surveys. A community meeting, where patients and staff met together, was held once a week. Patients were encouraged to meet together prior to the community meeting and decide on the agenda. The meeting was attended by members of the multidisciplinary team. Minutes were available and

Good

Are services caring?

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displayed on the notice board. These detailed the feedback and requests that patients had made. However, one patient told us that feedback was not always responded to. For example, little progress had been made with some items such as the television aerial and the availability of cold water in their bedroom.

- The service was due to start a peer support group for patients from the inpatient ward, the eating disorders day programme and outpatients. The trust had recruited two experts by experience to run the group at a venue in a community venue. Patients had been asked to submit ideas for peer led activities.
- Staff ensured that patients could access advocacy. Advocacy information was available on the ward and in the guidelines for community living. Patient advocates visited the ward on a regular basis. However, two patients told us they were not aware of the advocacy service. Other patients told us that they were aware but did not require advocacy support.

Involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed. Staff told us that carers and relatives were invited to patient's care programme approach meetings if the patient wished them to attend. Staff kept in touch with relatives by telephone if they could not attend the ward in person.
- The service held welcome meetings every four weeks. These meetings were an opportunity for relatives to ask questions about the service, staff roles, care and treatment. The meeting was held out of business hours so that more people could attend.
- The service held a carers' support group on a Monday evening during term time. This was run as an open discussion and allowed carers and relatives to share their experiences in respect of eating disorders.
- Staff provided carer skills training based on the New Maudsley Method 'Skills-based learning for carers for a loved one with an eating disorder.' The training was evidence based. The course consisted of several sessions and was run twice a year.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

Bed management

- The ward operated a national eating disorders service and some patients came from outside London. There have been no
- Referrals were received into the service and assessed at the weekly clinical forum meeting. There was a RAG rating prioritisation referral system to ensure that patients who required inpatient services were assessed and admission arranged as soon as possible.
- Staff told us there was always a bed available on the ward when patients returned from leave.
- Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. The manager reported that patients were only moved if they required admission to the general hospital.
- When patients were moved or discharged from the ward, this happened during the day.
- There had been no instances where a patient required a bed in a psychiatric intensive care unit.

Discharge and transfers of care

- Patient discharges from the ward were sometimes delayed because there was a lack of provision in local areas. A patient had been on the ward for two years due to their individual care needs and no specialist eating disorder beds being available in their local area.
- Where patients were ready for discharge, care and treatment records contained good liaison with care co-ordinators and other services. For example, staff had offered to give advice and train staff in a community placement on eating disorders and feeding. The staff team worked collaboratively with local hospitals, community mental health teams, eating disorder teams and other agencies to support the transition from an inpatient stay through to discharge.
- Staff supported patients during referrals and transfers between services. For example, staff described how they had supported a patient who required admission to an acute medical ward for care and treatment.

Facilities that promote comfort, dignity and privacy

- In February 2017, we recommended that the trust ensure that the main entrance door to the ward protect patients' privacy and dignity. At this inspection, improvements had been made. The clear glass panel on the main ward door had been covered and patients could no longer be seen down the corridor.
- All bedrooms were single and patients could personalise their bedrooms if they wished. Some bedrooms we viewed were personalised with pictures and photographs.
- The ward environment did not fully support the care and treatment of patients. The ward lounges were located along the main corridor and were too small to accommodate all the patients when the ward was full. The two dining rooms were not homely, and the first stage dining room contained a mixture of dining tables and chairs, which was not conducive to people's eating experience. The manager reported that new dining tables and chairs had been ordered. The therapy room was being used to store wheelchairs, and it was bare and unwelcoming. The small therapy room was bare and staff had stored three old telephones in there. These were removed during our inspection. We observed two post meal support groups which took place in the middle lounge area. On the second day of the inspection we attended and observed the post meal support group which was facilitated by the psychologist. We noted that staff walked through the group to access the clinic room, manager's office and patient bedrooms. Where patients were distressed in the group, they could be seen by people who were not part of the group. This impacted on patients experience because the environment did not promote comfort, dignity and privacy.
- There was also a therapy kitchen on the ward. The occupational therapist ran a weekly breakfast club where patients were supported to make their own breakfast.
- The clinic room was small and did not have a couch for patient examinations. Staff told us that physical examinations were carried out in individual bedrooms.

Are services responsive to people's needs?

Requires improvement

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

- There were quiet areas on the ward and room where patients could meet visitors. We observed patients using the dining rooms to see their visitors.
- Patients could make use their own phone or the ward phone to make a call in private.
- Patients had access to outside space which was a small garden area with a bench on the ground floor. We saw that patients accessed this area twice a day with the support of staff. Staff confirmed that if assessed as suitable by the physiotherapist, patients can visit the bench at other times with family members etc. We observed staff carrying out one of these visits and saw that some patients were allowed to go for a walk around the grounds, either on their own or accompanied; others were supported to go to the bench. Where patients required the use of a wheelchair, staff supported them with this.
- The lead dietician worked with the external catering company which supplied pre-packaged meals to the ward where they were re-heated. We received mixed feedback about the quality of the food. One patient reported that meals were often overcooked and dry. Another reported that portions were variable.
- All snacks and drinks required by the patient were assessed by the dietician and incorporated into individual meal plans which had been prepared in collaboration with individual patients.
- Patients had access to group activities on the ward which were facilitated by members of the MDT. Group attendance was assessed on an individual basis; for example, patients had to meet the recommended BMI before being considered for group activity. Patients said there were fewer activities available at the weekends. The provider reported that they worked within the Quality Eating Disorders standards in relation to weekend activities. At the weekend staff provided support groups after each meal and nursing led activity groups such as arts and craft and board games. Peer led activities such as quiz night, film night and bingo were also available for patients.

Patients' engagement with the wider community

- Staff supported patients to maintain contact with their families, carers and others that were important to them. Care records demonstrated that regular contact was maintained with family members and carers as agreed with the patient.
- The service held welcome meetings every four weeks. These meetings were an opportunity for relatives to ask questions about the service, staff roles, care and treatment. The meeting was held out of business hours so that more people could attend.

Meeting the needs of all people who use the service

- The ward was located on the first floor. Lift access was available. Assisted bathrooms and bedrooms to meet the needs of people with physical disabilities were available. Upon admission the physiotherapist risk assessed all patients for any mobility difficulties.
- The ward had a number of notice boards which displayed a range of information for patients and carers, including information about how to complain, safeguarding, eating disorders, carers support, local services and advocacy services.
- The manager confirmed that information was available in community languages and easy read format on request.
- Staff could access interpreters when required. Interpreters were available if required for people whose first language is not English. For example, staff had arranged for an interpreter for a patient during their assessment and care programme approach meeting. Staff showed us information they had translated for the patient regarding their care and treatment. Staff within the service who had specific linguistic skills that met the needs of the patient and provided support where appropriate.
- Meals were available to meet cultural, religious or dietary requirements. In February 2017, we found the food provision did not meet the needs of the patients' individual meal plans. At this inspection, improvements had been made. All patient meal plans detailed an alternative option for all items, in the event that a preferred item was not available. Nursing staff carried out a daily audit of the number of meals delivered and recorded if there were any shortfalls. Records we viewed

Are services responsive to people's needs?

Requires improvement

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

confirmed this. The lead dietician met with caterers monthly and used information from the in-patient catering satisfaction survey to inform the menu. She also attended the weekly community meeting to gain feedback from patients and upon admission each patient completed information on their food preferences so that individual needs could be met.

- Staff ensured that patients had access to appropriate spiritual and religious support. For example, staff were able to contact a number of spiritual leaders that supported the hospital upon request.

Listening to and learning from concerns and complaints

- From 1 September 2016 and 1 September 2017 the ward had received one formal complaint, which had been investigated and not upheld. No complaints were referred to the Ombudsman. Two informal complaints had been received by the service and investigated.
- From 1 September 2016 to 1September 2017 the ward received nine compliments.
- The ward provided patients with information on how to make a complaint. Patients we spoke with knew how to make a complaint or raise concern. Two patients reported that they were unsure whether staff would listen to their complaints and act upon them.
- Patients received feedback in response to any complaints or concerns they made. For example, we saw that a written response had been sent to a complainant.
- A member of staff from the trust patient experience team attended the community meeting.
- Complaints were received, recorded and managed appropriately by staff. They were reviewed and monitored on a regular basis by the ward manager and service manager to ensure that any themes and trends were identified and improvements made. Staff learnt from complaints, investigations and findings through their team meeting.

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

- There was effective leadership at a local and service level. Leaders had appropriate skills, knowledge and experience to perform their roles. The senior leaders within the service had a good knowledge of the eating disorders service and where improvements were required to ensure that patients received safe and effective care that was person-centred and of high quality.
- The ward manager had been in post since February 2017 and had experience, skills and knowledge of working on an eating disorders unit. The manager reported that they were supported by senior leaders within the service.
- Staff knew who the senior leaders in the trust were and said they were visible and approachable. All staff reported that there had been an improvement in the leadership support for the ward since the last inspection. For example, staff spoke about senior members of the MDT supporting post-meal support groups.
- The service encouraged leadership development throughout the staff team. The ward manager confirmed they were undertaking additional training in leadership and management.

Vision and strategy

- Staff on the wards had a good understanding of and supported the trust's vision and values

  and understood how they were applied in the work of their team. For example, staff spoke about the trust value 'working together' and how important this was in the delivery of quality care through their practice and team work. The organisation's vision and values were available on its intranet, website and through posters and information available on the ward.
- The ward manager and staff confirmed they were involved in discussions about the strategy for the service. For example, staff contributed to re-development plan for the mental health site at the hospital including the purpose built eating disorder unit and quality improvement programmes for the service.
- Staff were working to deliver high quality care within the budgets available. For example, staff were aware that staffing vacancies had an impact on the staffing budget and that staffing levels were reviewed and monitored in line with the acuity of the ward and patient needs. To address the band five vacancies in the service, managers had developed a bespoke recruitment campaign with the human resources team.

Culture

- Staff confirmed they felt respected, supported and valued by the ward manager and senior leaders within the trust. Staff described changes in the ward since the inspection in February 2017. The ward routines had become less task focussed. Patients had a named nurse and associate staff who ensured that patients' progress was monitored effectively. Staff were allocated to patients at each shift rather than focussing exclusively on completing tasks during a particular shift. This meant care provision was more patient centred. Staff reported that they enjoyed their work and the improvements within the service
- Staff told us that they felt able to raise concerns without fear of retribution. They said they knew how to use the trust's whistleblowing procedures and felt confident raising issues.
- Staff performance issues were addressed appropriately. The ward manager confirmed that the human resources department and senior leaders within the service provided support to ensure that any poor performance was addressed in line with performance management procedures.
- Staff reported that there had been an improvement in staff morale, management support and better team working. For example, the lead dietician held monthly meetings with to discuss and support staff with patient's nutrition and meal plans.
- Appraisals were undertaken annually. Information provided by the trust showed that 81% had received an appraisal in the 12 months leading up to our inspection. This process supported staff with their personal development plan, role and career progression.
- The provider promoted equality and diversity in its day to day work and in providing opportunities for career

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progression. Staff within the team came from diverse backgrounds and had access to career progression opportunities. The trust had an equality forum which staff could attend and contribute to.

- Staff had access to support for their own physical and emotional health needs through an occupational health service and access to an employee assistance programme. The programme offered confidential independent help, information and guidance to staff. Other support included dignity at work and wellbeing advisors and guardian of safe working hours for junior doctors.
- Staff success was recognised, with an annual celebrating excellence awards ceremony and also employee of the month awards. Staff also received feedback on compliments received by the service.

Governance

- Governance and performance arrangements were in place within the service that supported the delivery of the service, identified risk and monitored the quality and safety of the services provided. The senior management team were aware of areas for improvement and were committed to improving care and treatment for patients. Patients were cared for in a clean and mainly safe environment. There were sufficient staff on duty to meet the assessed needs of patients safely. There was an ongoing recruitment process to fill staff vacancies across the service. Patients were cared for by staff that was trained, supervised and appraised. There was a strong multi-disciplinary focus across the ward which supported patients' recovery. Staff measured patient outcomes and clinical effectiveness.
- Complaints, incidents and patient feedback were used to improve the safety and quality of the service. Learning from incidents and complaints was shared and discussed at team meetings and clinical improvement groups. Staff could also access information about incidents across the trust through the quality briefing on the staff intranet.
- Staff undertook or participated in regular clinical audits to identify areas of improvement and monitor standards on the ward. Staff acted on the results where shortfalls were identified so that improvements could be made. For example, medicine audits identified gaps in recording which were addressed with staff through supervision and team meetings.
- The staff team worked in collaboration with internal and external teams, professionals and stakeholders to meet the needs of patients. For example, staff worked closely with the psychiatric liaison team at the local hospital and internally with the step down day programme team who supported eligible patients to transfer from the ward to the programme. Senior leaders regularly met with commissioners to discuss service provision.

Management of risk, issues and performance

- The ward had a risk register and the manager and staff team knew the key risks on the ward. The manager demonstrated a good understanding of the risks and the management plans in place to address them. The manager confirmed that concerns could be escalated when required. For example, concerns about medical staffing were on the risk register.
- The ward manager was aware of trust contingency plans for emergencies. For example, adverse weather or a flu outbreak. Major incident and emergency plan details were available to staff on the intranet.

Information management

- Staff had access to the equipment and information technology needed to do their work and access information easily.
- Staff easily accessed patient information from the electronic records. Information governance systems included confidentiality of patient records. Patient records could only be accessed by staff that had been authorised to do so. Each member of staff required a swipe card and password to log into the electronic record system. Staff were required to undertake annual information governance training so that they were up to date on information security.
- The ward manager had access to information to support them with their management role. The ward used a 'heat map' which captured key information about the ward such as staffing, training and audit results. Key performance information was available to the manager and senior leaders through the trust dashboard.

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- Staff were aware of the circumstances in which they were required to make notifications to external bodies, such as the Care Quality Commission.

Engagement

- The trust provided staff with information through the intranet, staff magazine, bulletins and team brief. The trust made good use of their website and social media to keep the public informed of the work they were undertaking to support patients.For example, the trust used social media to advertise the NHS flu fighter campaign.
- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. For example, patients and carers could give feedback about their experience of the service through questionnaires, carers, community and welcome meetings. Feedback was reported to staff at team meetings so that changes and improvements could be made in the service. For example, changes had been made to the snack menu by the dietician following feedback from the patients.
- Directorate leaders engaged with external stakeholders, such as commissioners and Healthwatch through contract monitoring meetings, reviews and trust board meetings.

Learning, continuous improvement and innovation

- The provider demonstrated a commitment to quality improvement and innovation. The ward had achieved accreditation as part of the Quality Network for Eating Disorders. This accreditation was awarded by the Royal College of Psychiatrists.
- The ward was one of the sites participating in the trust's quality improvement projects working in partnership with Salford's innovation and improvement centre. The quality improvement project focused on improving staffing.
- The lead dietician was part of the London dietetics group and the lead psychologist was secretary of faculty of eating disorders. This enabled them to share information from these groups with the staff team on the ward.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The trust did not ensure that patients were protected from potential ligature risks in all areas of the ward environment.** **Bathrooms and the small therapy room which contained ligature risks were left open.** **This was a breach of Regulation 12 (1)(2)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The trust did not ensure that the premises were suitable for the purpose for which they were being used and properly used.** **The main lounge area was in the middle of the corridor. The therapy rooms were used for storage, bare and unwelcoming. This impacted on patient experience and did not promote comfort, dignity and privacy.** **This was a breach of Regulation 15 (1) (c) (d)**