

Coventry and Warwickshire Partnership NHS Trust

Aspen Centre

Quality Report

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This report describes our judgement of the quality of care at this location. It 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

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Summary of findings

Overall summary

The Aspen Centre is a purpose-built unit providing specialist treatment for people aged 16 and over who are living with a severe eating disorder. The unit has 16 inpatient beds (one of which is reserved for emergency admissions) with facilities for psychological therapies at the Dover Street location. Inpatient treatment usually involves a programme of re-feeding or dietary stabilisation with group and individual therapy. Family work is also offered to some people. The outpatient service is offered Monday to Friday during office hours.

People received an effective service from all of the eating disorder teams to help them understand, as well as manage, their illness to stay healthy. People had personalised programmes of care when they were admitted as an inpatient, and they could choose to have their family work with them to help reach their therapeutic goals.

Staff across the service demonstrated a good understanding of safeguarding issues and there were many examples of good identification of and response to concerns. We found that this was not always recorded clearly in files. A better system was needed to ensure risk assessments were always used, concerns were highlighted and shared across the team, and that someone had responsibility for overseeing practice and outcomes around safeguarding.

All of the specialist eating disorder services we visited provided caring support to service users. People told us that they felt that staff were supportive while recognising that the treatment regime may at times needed to be

strict. We found that care plans could be improved by being more personalised, and more consideration given to activities for people on the inpatient unit in addition to the therapy programme.

There was a lack of clarity in the staff guidance and training on use of passive restraint and promoting people's privacy and dignity when restraint was being used.

Family therapy was not routinely considered for family members although this is recommended in national guidelines. It was not always clear that people, particularly those aged under 18 years old, had given informed consent to treatment.

People with eating disorders got a good, responsive service and benefited from the link between the inpatient and outpatient service at the Aspen Centre. People's needs were well monitored and followed up, helping ensure that the service could identify and respond to their changing needs quickly. There was a good range of therapeutic support for people and staff ensured people were offered help to meet their emotional and psychological needs even when they were extremely unwell.

The service was well-resourced and staff felt valued and supported with good access to supervision and training, although there was no single overall manager for the Aspen Centre. This hampered the coordination of the service; for example there was no clear lead who could lead improvements across the multi-disciplinary team in the areas for development we identified. Arrangements for quality assurance and monitoring of practice also needed to be strengthened.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Equipment was sufficient and safe, although some environmental risks were not fully assessed.

Staffing levels in the inpatient unit met the needs of people using the service.

Training about the use of restraint was in place and used proportionately although there was some lack of clarity on dignity and privacy in the use of restraint with the potential to impact on wellbeing. But people using services did not indicate this had happened.

Safeguarding concerns were raised and referred appropriately, but records did not always make it clear how these were followed through. Risk assessment forms were available, but they were not used consistently. This meant some risks to people's safety may not be assessed effectively by staff.

Are services effective?

People told us their treatment was effective, and it followed national good practice guidelines. People also told us that decisions about treatment involved people's families, but it was not clear in policies that this was routine. Advocacy services were offered to people, but details about advocacy and leave were not always completed in records.

However, we saw exemplary records were at Dover Street.

Although the service's policies in areas such as visiting and access had 'blanket' restrictions, we saw in practice that there was some flexibility.

Are services caring?

People felt their treatment fully met their needs and preferences, and that they were consulted about it. However, staff and people using services felt differently about when more activities were needed.

More work was needed to make people's rooms more user friendly.

Are services responsive to people's needs?

The service was very good at promptly identifying and responding to different people's needs. The service promoted consistent care, monitoring and support of people who moved between outpatient and inpatient care.

Are services well-led?

Staff felt valued and supported, and received awards for good service. The unit was resourced to meet clinical needs.

However, the fact that there was no clear lead across all the various disciplines reduced the service's overall effectiveness.

Summary of findings

What we found about each of the main services at this location

Specialist eating disorders services

People received an effective service from all of the eating disorder teams to help them understand, as well as manage, their illness to stay healthy. People had personalised programmes of care when they were admitted as an inpatient, and they could choose to have their family work with them to help reach their therapeutic goals.

Staff across the service demonstrated a good understanding of safeguarding issues and there were many examples of good identification of and response to concerns. We found that this was not always recorded clearly in files. A better system was needed to ensure risk assessments were always used, concerns were highlighted and shared across the team, and that someone had responsibility for overseeing practice and outcomes around safeguarding.

All of the specialist eating disorder services we visited provided caring support to service users. People told us that they felt that staff were supportive while recognising that the treatment regime may at times needed to be strict. We found that care plans could be improved by being more personalised, and more consideration given to activities for people on the inpatient unit in addition to the therapy programme.

There was a lack of clarity in the staff guidance and training on use of passive restraint and promoting people's privacy and dignity when restraint was being used. There is a unit specific care plan for the use of passive restraint when using Naso Gastric feeding.

Family therapy was not routinely considered for family members although this is recommended in national guidelines. It was not always clear that people, particularly those aged under 18 years old, had given informed consent to treatment.

People with eating disorders got a good, responsive service and benefited from the link between the inpatient and outpatient service at the Aspen Centre. People's needs were well monitored and followed up, helping ensure that the service could identify and respond to their changing needs quickly. There was a good range of therapeutic support for people and staff ensured people were offered help to meet their emotional and psychological needs even when they were extremely unwell.

The service was well-resourced and staff felt valued and supported with good access to supervision and training, although there was no single overall manager for the Aspen Centre. This hampered the coordination of the service; for example there was no clear lead who could lead improvements across the multi-disciplinary team in the areas for development we identified. Arrangements for quality assurance and monitoring of practice also needed to be strengthened.

Summary of findings

What people who use the location say

Areas for improvement

Action the provider **SHOULD** take to improve

- Family therapy was not routinely considered for family members, although this is recommended in national guidelines.
- It was not always clear that people, particularly those aged under 18 years old, had given informed consent to treatment.
- Although there were many examples of good identification of and response to concerns, these were not always recorded clearly in files. A better system was needed to ensure risk assessments were always used, and concerns highlighted and shared across the team.
- No-one had overall responsibility for overseeing practice and outcomes around safeguarding.

Action the provider **COULD** take to improve

- Each discipline within the teams had different management reporting lines. The Centre did not have a system that coordinated and oversaw the unit as a multi-disciplinary whole. This limited communication and information sharing in some areas and had the potential to limit the effectiveness of an otherwise good service.
- Some people were concerned that there were not enough activities at certain times. These times were different to staff's views of when there were not enough activities.

Good practice

- The service was very good at identifying people's needs early and responding, including prompt admission where necessary. There was good consistency in the monitoring and follow up of people who moved between out- and inpatient care. There was good information sharing and prompt responses to changing needs and the emergency bed was a valued resource that added to the flexibility of the service.
- We heard consistently positive comments from people using the inpatient service at the Aspen Centre. At Dover Street, we saw an excellent example of well-ordered and clear case records supporting and reflecting good practice.
- We saw examples of positive practice in planning transition from inpatient care back to the community, where people were supported through stages.
- Staff at all levels we spoke with felt positive about their role, valued as practitioners and well supported.

Aspen Centre

Detailed findings

Services we looked at:

Specialist eating disorder services

Our inspection team

Our inspection team was led by:

Chair: Professor Patrick Geoghegan OBE

Team Leader: Jackie Howe, Care Quality Commission

The team included 2 x CQC Inspectors, a specialist consultant and a psychologist.

Background to Aspen Centre

The trust has a total of 21 active locations serving mental health and learning disability needs, including three hospitals sites: Brooklands, St Michael's Hospital and Caludon Centre.

The trust provides a wide range of mental health and learning disability services for children, young adults, adults and older adults as well as providing a range of community services for people in Coventry.

Coventry and Warwickshire Partnership NHS Trust has been inspected 21 times since registration. Out of these, there have been 12 inspections covering five locations which are registered for mental health conditions. Aspen Centre is a location which has not previously been inspected.

The Aspen Centre is a purpose-built unit that has 16 inpatient beds (one of which is reserved for emergency admissions) with facilities for an outpatient service.

Inpatient treatment usually involves a programme of re-feeding or dietary stabilisation together with group and individual therapy. Family work is also offered to some people. The outpatient service is offered Monday to Friday during office hours.

Most people receive outpatient treatment tailored to their needs with a range of psychological therapies. A small minority of people require a period of inpatient treatment which is also provided at the Aspen Centre.

Why we carried out this inspection

We inspected Coventry and Warwickshire Partnership NHS Trust during our wave 1 pilot inspection. The Trust was selected as one of a range of trusts to be inspected under CQC's revised inspection approach to mental health and community services.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, 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?

Detailed findings

- Is it well-led?

Before visiting, we reviewed a range of information we hold about the location and asked other organisations to share what they knew about the location. We carried out an announced visit on 23 and 24 January 2014. During our visit we talked with people who used the services and staff from all areas of the service. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who used the services.

We visited the Aspen Centre for one day, reviewing practice across the inpatient and outpatient service, with a

particular focus on the care of young people aged 16 to 18 years old, care of people detained under the Mental Health Act, and practice relating to 'Think Family' (promoting good outcomes for children and young people by co-ordinating care for the whole family).

We also visited the outpatient centre at Coventry (Dover Street). Dover Street offers a service to people in Coventry and North Warwickshire who are referred to them. They can refer people needing inpatient care and support to the Aspen Centre in Warwick. We were unable to speak with any users of the service during our visit, but spoke with two clinicians and looked at a sample of care records.

Specialist eating disorder services

Information about the service

Coventry & Warwickshire Partnership NHS Trust's Eating Disorders Service provides specialist treatment for people with severe eating disorders aged 16 or over. Referrals from South Warwickshire can be made by GPs, psychiatrists and other health professionals. Referrals for inpatient treatment from Coventry, North Warwickshire and Rugby should be made by a consultant psychiatrist. The service does not accept self-referrals. Outpatient treatment is provided to residents of South Warwickshire, and inpatient treatment is available to people in Coventry and Warwickshire from a specialist multi-disciplinary team.

Summary of findings

Staff across the service demonstrated a good understanding of safeguarding issues and there were many examples of good identification of and response to concerns. We found that this was not always recorded clearly in files, and a better system was needed to ensure that risk assessments were always used, concerns were highlighted and shared across the team, and that someone had responsibility for overseeing practice and outcomes around safeguarding.

The Aspen Centre inpatient service could benefit from some improvements in care plans, as well as clearer staff guidance and training on use of passive restraint and promoting people's privacy and dignity when restraint was being used.

People received an effective service to help them understand as well as manage their illness to stay healthy from all of the eating disorder teams. People had individualised programmes of care when they were admitted as an inpatient and they could choose to have family work to help them reach their therapeutic goals.

Family therapy was not routinely considered for family members where this was recommended in national guidelines. It was not always clear that people, particularly those aged under 18 years old, had given informed consent to treatment.

All of the specialist eating disorder services that we visited provided caring support to service users, and people told us that they felt that staff were supportive while recognising that the treatment regime may at times need to be strict. We found that care plans could be improved by being more individualised and more consideration given to activities for people on the inpatient unit in addition to the therapy programme.

People with eating disorders got a good, responsive service and benefited from the link between the inpatient and outpatient service at the Aspen Centre. This supported good admission and discharge transition processes. People's needs were well monitored and followed up. This helped ensure that the service could identify and respond to their changing needs quickly. There was a good range of different types

Specialist eating disorder services

of therapeutic support for people and staff ensured that people were offered help to meet their emotional and psychological needs even when they were extremely unwell.

The service was well-resourced and staff felt valued and supported with good access to supervision and training. There was no single overall manager for the Aspen Centre, which hampered the co-ordination of the service. For example there was no clear lead who would have authority to lead improvements across the multi-disciplinary team in the areas for development that we identified. Arrangements for quality assurance and monitoring of practice also needed to be strengthened.

Are specialist eating disorders services safe?

Environment

The inpatient unit was well-equipped and there were good records indicating regular health and safety checks, for example on clinical and resuscitation equipment and storage of medicines. We observed that there were potential ligature points throughout the unit which were a potential hazard. We advised that individual risk assessments should be done in relation to these.

Staffing levels

Staffing levels in the inpatient unit were proportionate to meet the needs of people using the service. Additional agency staff were used when any people using the service needed a higher level of observation.

Restraint

We were told that restraint was not used on the unit, although therapeutic holding was used when staff needed to keep people from behaviour that would lead to harm. Targeted training was arranged in these circumstances so that staff had clear instructions on how to manage the individual person's behaviour in a safe and appropriate way.

Privacy and dignity

We saw examples of records indicating that people had at times needed passive restraint, for example to prevent people removing naso-gastric tubes. We saw no risk assessments or care plans in place for how this was to be done by staff. It was unclear how agency staff coming in to manage the care of the person would get sufficient direction in undertaking this restraint, and there was a potential risk that this could lead to lack of continuity of care or inappropriate intervention. Records we saw had no indication of how to promote the privacy and dignity of people needing holding or restraint, nor guidance for staff to ensure that protective intervention did not become seclusion or deprivation of liberty where this would have been appropriate. People we spoke with did not indicate they had been treated in a manner that unduly undermined their dignity or privacy.

Safeguarding and risk

People we spoke with told us that they felt safe. We found a number of examples on case records that we reviewed where staff had appropriately identified risk and

Specialist eating disorder services

safeguarding concerns. In these cases, staff had appropriately sought advice from safeguarding leads, shared information, made referrals to social care where necessary and recorded the intervention in the case files.

Records and documents relating to safeguarding concerns were not consistently filed in the relevant section of files and in some cases it was hard to track the action that had been taken or what the outcomes had been, including whether or not the risk remained. There was no clear line of responsibility for anyone to have oversight of the progress of safeguarding concerns across the multi-disciplinary team, and this created a potential for information to get lost. Neither the paper files nor the electronic recording system had a 'flagging' system to highlight on the file that there was a safeguarding concern so that all professionals who had contact with the person, would be aware and able to take the concerns into consideration.

Risk assessment forms were available for staff to use. These included sections on identifying risk to others including to children and young people, but the overall assessment process did not provide clear prompts to staff to 'Think Family' – that is, to actively identify and record details of any young people that the person was in contact with and ensure their wellbeing including consideration of any potential impact of the person's illness on them. The risk assessment forms available were not being regularly completed which undermined their effectiveness in prompting staff to consider potential risks more proactively.

Staff at Dover Street told us there had been no incidents in the past 12 months. Staff showed good knowledge of and use of links with local safeguarding teams. They also demonstrated a good awareness and use of safeguarding protocols to ensure that areas of risk were dealt with safely. Our sampling of care records confirmed this.

At Dover Street there were clear processes in place to ensure concerns were managed appropriately. For example, someone did not arrive for a scheduled appointment while we were there. The nurse explained how this was followed up. There was a clear process and understanding of what triggered concerns and how they were followed up.

Are specialist eating disorders services effective?

(for example, treatment is effective)

Effective treatment

People we spoke with who were inpatients at the Aspen Centre told us that they were sensitively supported by staff to develop insight into and understanding of their illness. People told us how the programme of therapy at the unit had helped them to work from a position of being 'in denial' to recognising the need for admission and treatment, including where this had included forced feeding. People said that having an individualised programme of therapy helped them to make positive progress, sometimes over a short period of inpatient admission. Each person was allocated a named nurse who had individual sessions with them in addition to group sessions. Staff encouragement to talk about their feelings was identified as being of particular help.

Person focussed treatment

Families were kept informed about the progress of inpatients on a weekly basis if the person agreed to this, and we saw consent to share information forms that had been completed and signed by people on their files. This work focused on the therapeutic needs of the person, for example, how the family can support the person and manage their return home, which is in line with national guidance for eating disorder services (NICE guidelines).

Support for families

People told us that they felt that their families were well supported. Family meetings were offered when the person met their target healthy weight, and again when they were preparing to go back home. Family therapy (more intensive, specialist therapeutic work) could be offered if the need was identified to help the progress of the person receiving treatment. The NICE guidelines state that for young people with anorexia nervosa, "the therapeutic involvement of siblings and other family members should be considered in all cases because of the effects of anorexia nervosa on other family members". There was no clear policy on the unit to ensure that this was routine practice.

Treatment for under 18s

The inpatient unit had a specific policy and a supporting set of documents for staff to use when any person under the age of 18 was admitted to the ward. We saw that prompt notifications were made to the Trust safeguarding leads when this happened, in line with that policy. In

Specialist eating disorder services

relation to the care of people under 18, we found several records indicating that consent to admission and to treatment had only been obtained when the young person had been told that they would be detained under the Mental Health Act if they did not. Other records indicated that where there was disagreement between the wishes of the young person and a person with parental responsibility, insufficient consideration had been given to the process for determining consent as set out in the Mental Health Act Code of Practice. Clearer practice guidance, recording and monitoring would better ensure that issues around consent from young people aged 16 to 18 years old were clearly understood by staff, and that young people were giving informed consent to treatment or admission.

Advocacy

We saw there was evidence at the Aspen Centre of people being offered access to advocacy and tribunals where appropriate. We saw there were some gaps in the records relating to people detained on a section of the Mental Health Act. For example, the ward file did not contain copies of all the current leave forms, and there were no details of the independent Mental Health Act advocate (IMHA) on one form. Legal documentation was found to be spread across old and new case files, making tracking and monitoring difficult. Risk assessments, review and conditions relating to overnight leave for detained patients were not always clearly recorded.

Restrictions

There were blanket policies for all people using services restricting access to mobile phones and visiting times. We did however see examples of flexibility in this, for example there was access to a safe computer to support studies and suitable on line use and one person was able to visit family members when they were unwell. Policies around restrictions for people not detained under the Mental Health Act, should be reviewed to ensure compliance with 'least restriction' principles as set out in the Mental Health Act Code of Practice.

Dover Street

At Dover Street, staff showed a good awareness of individual and group needs and sensitivity towards individual needs that supported effective treatment. We saw evidence, through discussion and records, of

professionals using their judgement based on clinical experience to assess urgency and need. We saw an example of well-ordered and clear case records supporting and reflecting good practice. These were exemplary.

Are specialist eating disorders services caring?

Understanding

We heard consistently positive comments from people using the inpatient service at the Aspen Centre. People told us that they felt listened to and had choice in decisions relating to their care. Treatments for eating disorders can require stringent measures including forced feeding and most people we spoke to were able to recognise that they had benefited from intervention that they may have previously resisted, and they told us how the therapy had helped them recognise this. One person did describe staff as 'harsh' but the majority of people described staff as 'strict but caring'. Other comments included that staff were 'approachable', 'supportive', 'encouraging', 'gentle but effective'. People told us that they were able to 'go at my own pace' but with staff encouragement to stretch themselves. Two people told us that the centre was 'the best NHS service I have been in' although one added 'even though it is very strict!' At Dover Street, the two health professionals we spoke with showed a commitment to their work and to helping the people they worked with. They showed a good understanding of general and individual needs and demonstrated an ability to work sensitively with them.

Consultation

People had copies of their care plans and told us that they were consulted about their treatment plan. This was not reflected in the care plans we saw. There was no evidence of the person's participation and they were not linked to individualised outcomes. Some staff told us that better care planning would improve communication across the team. There were no care plans for specific interventions such as managing obsessional-compulsive disorder. Care plans for this aspects of care and support would assist staff to ensure best practice and consistency of care.

Preferences

Staff were observed to very discreetly and sensitively encourage reluctant people to drink at meal times. We saw records that showed people were given the opportunity to

Specialist eating disorder services

eat in their room supervised, rather than dining room, in the early days of admission if they chose to do so. People told us that their diet preferences were respected within the framework of their treatment programme. Records confirmed that menus were adapted to accommodate some personal preferences. The menu plan had recently been updated to provide a better range of healthy eating choices.

Activities

People on a therapeutic programme had a number of group and individual sessions during the day, but activities for others were minimal and some people we spoke with complained of boredom. We discussed this with the ward manager, who reported that action was being taken to improve activities at the weekend. People who used the service told us that they felt that activities were better at the weekend, as staff had more time to spend with them to talk or play games. Greater consideration needed to be given to activities during the week.

Environment

We saw a number of bedrooms were generally sparsely decorated and furnished. There was a sign on the noticeboard telling people that they could only put posters or pictures on the board and not on walls. As most people would have an inpatient admission of several months, more could be done to help them personalise their rooms and create a warmer and more homely environment.

Are specialist eating disorders services responsive to people's needs?
(for example, to feedback?)

Inpatient and outpatient care

Comments from people using the inpatient service, and a review of case files across both inpatient and outpatient services at the Aspen Centre indicated that the service was very good at early identification of need and response including prompt admission where necessary. The service benefited from having the same team across both services which promoted consistency, monitoring and follow up of people who moved between out and inpatient care. There was good information sharing and prompt responses to changing needs. The emergency bed was a valued resource that added to the flexibility of the service.

We saw examples of positive practice in planning transition from inpatient care back to the community, where people were supported through graduated stages. These included having a cooking session in their home before discharge. Families were well engaged in planning transition to optimise successful outcomes. People could attend the centre as a day patient as part of a planned progression towards discharge, which helped ensure that treatment outcomes would be maintained when they left.

The therapeutic framework of the inpatient service meant that there were blanket policies based around people reaching a target weight before being allowed freedoms such as leave, and around visiting policies. We did find examples of flexibility including that visiting times were changed to allow one person to have visits from their children at a time more appropriate for them.

Responding to different needs

The service offered a range of therapeutic intervention from a multi-disciplinary team, in line with NICE guidance. At the time of this inspection there were some gaps due to turnover in medium level doctors and long-term leave in another clinical post which had had an effect on capacity. The medical posts were being recruited to. Staff at the unit strived to maintain therapeutic input when people were extremely unwell. For example, where people needed very high levels of observation and passive restraint for forced feeding in order to improve their weight from critical levels, the psychologist continued to see them regularly.

At Dover Street, we saw in records and in discussion that the service responded to individual needs and was flexible and understanding of varying approaches depending on individual circumstances and needs.

Staff showed a good understanding of geographical and other factors that influenced the numbers and types of referrals and were able to tailor services accordingly.

Are specialist eating disorders services well-led?

Valuing staff

Staff at all levels that we spoke with felt positive about their role, valued as practitioners and well supported. Senior staff reported that the service was valued and well-regarded within the directorate and by the Partnership Trust overall; this was reflected in several nominations and

Specialist eating disorder services

awards for good service. These were prominently displayed in the unit, and showed nominations voted for within the Trust but also included those for national awards in recognition of quality of practice by individual staff.

Resources

The unit was well-resourced, with requests for equipment responded to promptly. The Aspen Centre had not been affected by the organisational restructuring that is being implemented by the Trust, although there was some concern expressed by staff about the future as restructuring was taking place affecting the Coventry service.

Staff supported

Staff told us they were well supported with clinical and management supervision. Interim supervision had been arranged to cover for long-term absence where needed. They told us that clinical judgements relating to a person's need led the service. There was some concern as to whether restructuring might alter this, although staff felt confident that management were attentive to clinicians' views.

Management of the Centre

The ward manager at the Aspen Centre had managerial responsibility for the nursing staff as well as the day-to-day management of the inpatient unit, but each discipline within the teams based there had different management reporting lines. The Centre did not have a system that co-ordinated and over saw the unit as a multi-disciplinary whole. This limited effective communication and information sharing in some areas. For example, when areas for development were identified in this inspection around care planning, recording and safeguarding, we were told that there was no clear lead who would have the authority to drive improvement across all of the different disciplines. This had the potential to limit the effectiveness of an otherwise good service. While we saw evidence that the service provided regular reporting on performance indicators, there was no lead for quality assurance of practice based on review of records and care planning.