

Good 

Nottinghamshire Healthcare NHS Trust

Specialist eating disorders service

Quality Report

Tel: 0115 969 1300

Website: www.nottinghamshirehealthcare.nhs.uk

Date of inspection visit: 30/04/2014

Date of publication: 31/07/2014

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Thorneywood Unit	RHAPB	Specialist eating disorder service	NG3 6AA

This report describes our judgement of the quality of care provided within this core service by Nottinghamshire Healthcare 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 Nottinghamshire Healthcare NHS Trust and these are brought together to inform our overall judgement of Nottinghamshire Healthcare 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 Specialist eating disorder service (Mental Health)

Good 

Are Specialist eating disorder service (Mental Health) safe?

Good 

Are Specialist eating disorder service (Mental Health) caring?

Good 

Are Specialist eating disorder service (Mental Health) effective?

Good 

Are Specialist eating disorder service (Mental Health) responsive?

Good 

Are Specialist eating disorder service (Mental Health) 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

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the service and what we found	5
Background to the service	7
Our inspection team	7
Why we carried out this inspection	7
How we carried out this inspection	7
What people who use the provider's services say	8
Good practice	8

Detailed findings from this inspection

Locations inspected	9
Mental Health Act responsibilities	9
Mental Capacity Act and Deprivation of Liberty Safeguards	9
Findings by our five questions	11

Summary of findings

Overall summary

Nottinghamshire Healthcare NHS Trust provides a specialist eating disorder service. This includes community and clinic-based treatments for adults with a severe eating disorder.

We found that the eating disorders services provided by Nottinghamshire Healthcare Trust were delivered in a safe and caring environment.

Comprehensive risk assessments, which involved the people who used the service, were completed. These included assessments of the person's medical and psychiatric health care needs.

There were enough staff to meet the needs of the people who used these services.

Services provided were effective, and treatments were delivered in line with NICE (National Institute for Clinical Excellence) guidance. The trust measured the service's outcomes, including gathering feedback from people who used the service.

Observations and discussions confirmed that the services provided were caring. This was supported by evidence we found in individual treatment records, as well as the trust's and external agencies' quality monitoring systems. We also saw good examples of individualised and person-centred care being provided.

The service responded well to people's needs. Care and treatment records showed how the service had reviewed and amended treatments to meet people's changing needs. During the inspection, we also reviewed some good examples of responsive and patient-centred care.

Local leadership was proactive and we saw good examples of leadership that led to effective service delivery. Staff told us that they felt well supported by their line manager.

Summary of findings

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

Are services safe?

The provision of these services was safe. The trust had good systems in place to ensure that staff received appropriate safeguarding training, and that they were supported to provide safe care.

People's treatment records clearly identified current concerns and risks, which were reviewed after each treatment episode. Comprehensive risk assessments were completed and included assessments of the person's medical and psychiatric health care needs. People who use the service were involved in these assessments, for example developing alternative coping and other strategies.

There were enough staff to meet people's needs. The environment of the drop-in centre was also well maintained and welcoming.

Good



Are services effective?

Services provided were effective and treatments were delivered in line with NICE (National Institute for Clinical Excellence) guidance. The trust measured the service's outcomes, including gathering feedback from people who used the service.

We saw examples of the service working well with external organisations and other partners, such as the University of Nottingham, service commissioners and GPs. Staff said that they had received their mandatory training, and we saw examples of some team members receiving additional training.

Good



Are services caring?

Staff told us, and we observed that, services provided were caring. This was supported by evidence we found in individual treatment records, as well as the trust's and external agencies' quality monitoring systems. We also saw some good examples of individualised and person-centred care being provided.

Staff were actively engaged at a local level, and people told us that they were caring and supportive.

Good



Are services responsive to people's needs?

The service responded well to people's needs. Care and treatment records showed how the service had reviewed and amended treatments to meet people's changing needs. During the inspection, we also reviewed some good examples of responsive and person-centred care.

Good



Summary of findings

There was an effective complaints management system in place, and staff told us that actions were taken locally to address any informal complaints quickly. We also saw examples of positive feedback from people who used the service.

Are services well-led?

Local leadership was proactive and we saw some good examples of service leadership that led to effective service delivery. Staff said that they felt well supported by their line manager, and we also saw evidence that the eating disorders and drop-in service team had been recognised by external organisations.

Good



Summary of findings

Background to the service

Nottinghamshire Healthcare Trust provides a specialist eating disorder service. This had not previously been inspected by the Care Quality Commission or the Mental Health Act team.

The service provided community and clinic-based treatments for adults with a severe eating disorder. After discharge, people who used the service were cared for by their local adult mental health teams. This included people who had not responded to treatment in primary or secondary care.

Community services worked closely with inpatient services and maintained close contact when people were admitted for specialist psychiatric inpatient care.

The service also worked closely with acute healthcare providers when needed. Support and advice was also provided for carers.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott – Deputy Chief Inspector for Hospitals (Mental Health) Care Quality Commission

Team Leader: Jenny Wilkes, Care Quality Commission

The team that inspected this service was a CQC inspector, a Child and Adolescent Mental Health Services (CAMHS) consultant psychiatrist, a senior CAMHS nurse consultant and a social worker.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental and community health inspection programme.

How we carried out this inspection

To get to the heart of people who use the services' experience 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?
- Is it well-led?

We visited the specialist eating disorder service at Nottingham Healthcare NHS Trust between 29 April and 2 May. Before visiting, we reviewed information from the

provider and considered feedback from relevant local stakeholders, including the local Healthwatch organisation, advocacy services and focus groups held with people who used the service.

During the visit, we spoke with community-based staff and with people who used the services in the specialist 'drop-in' service. We observed how people were treated in the 'drop-in' service, examined treatment plans and spoke with senior community-based clinicians, lead therapists. We also met with a person who used these services. We reviewed the trust's systems for obtaining feedback from other people who had used this service, which gave us a view of their experiences.

Summary of findings

What people who use the provider's services say

Before our inspection we used focus groups to speak with people who used the services.

During the inspection, we spoke with one person who used this service and reviewed feedback from a number of others. We also reviewed the provider's quality monitoring systems to give us a view of people's experiences.

This feedback showed us that people felt safe and respected by the service. We saw that individuals were involved in their care and treatment, and had the opportunity to discuss these with their therapist and other staff.

People told us that the service was caring and that their therapist was supportive and that their views were treated seriously. They also confirmed that they knew how to complain.

We saw examples of compliments and thank you cards that the service had received from people. These demonstrated to us that the service was responding to and meeting people's needs.

Good practice

The Eating Disorder Drop-In Service (EDDIS) was an innovative and effective bespoke service. Provided jointly with other key stakeholders, it addressed the needs of the local population.

Nottinghamshire Healthcare NHS Trust

Specialist eating disorders service

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
University of Nottingham Eating Disorders Drop In Service (EDDIS).	Duncan Macmillan House (Trust Headquarters) Porchester Road Mapperley Nottingham Nottinghamshire
Mandala Centre Gregory Boulevard Nottingham	Duncan Macmillan House (Trust Headquarters) Porchester Road Mapperley Nottingham Nottinghamshire

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.

None of the people who used these services were detained under the Mental Health Act. Staff spoken with confirmed that they had attended mandatory training about this Act. They were aware of its implications for their professional practice.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

None of the people who used these services required the protection of this Act. Staff spoken with confirmed that they had attended mandatory training regarding these safeguards for people. They were aware of its implications for their professional practice.

Are services safe?

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

Summary of findings

The provision of these services was safe. The trust had good systems in place to ensure that staff received appropriate safeguarding training, and that they were supported to provide safe care.

People's treatment records clearly identified current concerns and risks, which were reviewed after each treatment episode. Comprehensive risk assessments were completed and included assessments of the person's medical and psychiatric health care needs. People who use the service were involved in these assessments, for example developing alternative coping and other strategies.

There were enough staff to meet people's needs. The environment of the drop-in centre was also well maintained and welcoming.

Our findings

Track record on safety

Staff reported a positive and inclusive culture within this service and that any previously identified concerns had been appropriately addressed. The service's specific risk register was updated and reviewed by management as required.

The trust's serious incident data showed us that no 'never events' had been reported between February 2013 and January 2014. The figures obtained from the National Reporting and Learning Service (NRLS) showed the trust was reporting incidents effectively and within the expectations for a trust of this size and configuration. This was supported by our inspection of this service. Staff told us that the lessons learnt from these incidents had been discussed within their specific team and disseminated through the trust.

We saw that people's treatment records clearly identified previous risks and behaviours as well as current assessed concerns and risks. These had been reviewed based on an evaluation of each specific treatment episode.

The evidence seen demonstrated to us that the service had a proven track record on safety and had learnt from incidents which had taken place. We saw that trust wide learning had been recorded and disseminated.

Learning from incidents and improving safety standards

Staff confirmed that the trust had an on-line reporting system to report and record incidents and near misses. We saw that staff had access to this system via 'password' protected computer systems.

Staff confirmed that individual concerns were discussed at their team meetings and they were encouraged to report incidents and 'near misses'. People told us they were comfortable in raising their concerns with staff.

Systems were in place to review incidents and near misses which included a formal debrief for staff and discussion during clinical and managerial supervisions for front line staff. Staff confirmed that they had received mandatory safety training and felt well supported by their line manager following any incidents or near misses.

Wider trust learning was evidenced through the trust 'Risky Times' publication. This was a bi monthly newsletter issued by the trust's risk and governance committee and included updates and 'key messages' for staff. Staff were aware of the availability of this publication.

The evidence seen showed us that the trust had effective systems in place to learn from untoward incidents and had improved safety standards as a result.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

The trust had identified safeguarding vulnerable adults and safeguarding children leads and staff told us that they were aware of their roles within the trust. Staff were aware of the trust's safeguarding and other policies and records seen showed us that they had received current safeguarding training. Staff told us they knew how to raise any safeguarding concerns and reported close links and partnership working with the Local Authority's safeguarding team. Staff were aware of the trust's whistleblowing policy and confirmed that they felt able to raise concerns with their direct line manager.

This was demonstrated by those individual treatment records seen. These showed us that any potential

Are services safe?

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

identified safeguarding concerns had been reported appropriately and pro-actively by staff. People told us that they felt safe in the service and this was supported by those individual feedback forms reviewed at random.

The evidence seen demonstrated to us that the trust had reliable systems, processes, and practices in place to keep people safe and safeguarded from abuse.

Assessing and monitoring safety and risk

The evidence seen showed us that staff were aware of the risks associated with their specific role and any concerns were discussed within the weekly caseload allocation meetings. Evidence was seen of staff taking proactive risk management strategies. For example, when planning initial assessments and subsequent treatment episodes.

Examples seen were the use of open access computer based diaries and the use of mobile phones to keep in touch with colleagues and management. Staff told us that they had received induction and training to prepare them for their specific role and felt well supported by their line manager.

Care and treatment records seen showed us that robust risk assessments were carried out on initial assessment and that these were reviewed at each appointment by the clinician and the person using the service.

Staffing levels were satisfactory and arrangements in place to provide short term cover from within the core staff

group. Longer term absences were covered from within the trust by the use of staff familiar with the service. We noted a stable staff group that provided a flexible and supportive service for people.

Staff attended weekly team meetings and clinical discussions during which any concerns were highlighted and shared by the team. We saw that monthly managerial and clinical supervisions took place. Some staff chose to access external clinical supervision and this had been supported by the trust.

The evidence seen meant that the trust was effectively assessing potential risks to people who used this service and monitoring the safety of their own staff.

Understanding and management of foreseeable risks

We saw that the trust had a contingency plan in place and staff told us that they were aware of this. Staff told us that good communication systems were in place and these were used to inform people of any delays or changes in appointment times. The trust had robust systems and processes in place to manage any foreseeable risks to continued service provision.

The evidence seen showed us that the trust effectively anticipated and managed any potential risks to the service.

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

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.

Summary of findings

Services provided were effective and treatments were delivered in line with NICE (National Institute for Clinical Excellence) guidance. The trust measured the service's outcomes, including gathering feedback from people who used the service.

We saw examples of the service working well with external organisations and other partners, such as the University of Nottingham, service commissioners and GPs. Staff said that they had received their mandatory training, and we saw examples of some team members receiving additional training.

Our findings

Assessment and delivery of care and treatment

From the evidence inspected and discussions with managers and front line staff, the trust was able to demonstrate that the people who used this service received care and treatment in line with the current best practice guidance.

We saw different psychologically based therapies being used in partnership with people who used the service. Staff were able to describe to us the primarily psychological treatments provided. For example we saw that, 'Mindfulness', 'Acceptance and Commitment Therapy' (ACT) and 'Motivational therapy' were all being used to treat people with moderate to severe eating disorders. Staff confirmed that they had received the relevant training in order to offer these and other therapies as part of individual treatment programmes.

We saw that individual care and treatment records reflected the specific therapy being provided and that these were being reviewed as required by the relevant therapist. The records seen showed us that people's specialist physical healthcare needs were being addressed by the person's General Practitioner and where necessary by admission to the local acute NHS trust.

The records seen showed us that staff based at the Mandala centre had an average case load of between 15 –

20 people. Senior staff told us that caseloads were reviewed at the weekly allocation and clinical discussion meeting. Staff told us that these caseloads were usually equitable and manageable.

Caseloads at the eating disorders drop in service were between six and 18 but with flexibility being built in due to the nature of the service being provided. Staff at this service confirmed that caseloads were manageable.

Evidence was seen of local based audits. For example a monthly care plan audit was carried out of five care and treatment records and the findings were fed back to staff as part of their monthly managerial supervision. Staff spoken to confirmed that changes had been implemented as a result of these audits and shared with the wider team.

Senior staff confirmed that trust wide audits were also carried out. These findings were disseminated by the trust's risk and governance committee through specific trust management cascade information and via the 'Risky Times' publication.

Outcomes for people using services

The records, and other evidence seen, showed us that the trust was involved in the monitoring and measurements of quality and outcomes for people. For example, we saw that people completed a eating questionnaire at the beginning of treatment and completed this again at the end of their course of treatment. These results were evaluated by the care team and monitored by senior staff.

Evidence was seen of other person reported outcome measures (Proms) in individual care and treatment records as part of the evaluation of the care being provided by this service. We noted that the service measured outcomes for people by using the Health of the Nation Outcome Score (HoNOS). Evidence was noted of positive outcomes as recorded in individual treatment satisfaction surveys completed by people at the end of their treatment programmes.

We saw that the eating disorder drop in service was a pilot and was currently under a Clinical Commissioning Group (CCG) led review by another local Mental Health NHS trust. Whilst the outcome was unknown we were informed that initial feedback from this review had been positive. This reflected our findings during our inspection.

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.

Staff, equipment and facilities

The records and evidence seen showed us that the trust ensured that adequate staffing, equipment and facilities were available to promote the effective delivery of care and treatment for the people who used this service.

The training records seen showed us that staff had attended their mandatory training and other extended professional skills training. Staff confirmed the trust provided support to enable them to attend this additional training. Senior staff told us that training attendance was monitored and non-attendance reviewed through the trust's training department.

We saw current examples of professional skills training being undertaken by staff in order to provide them with the necessary clinical expertise to meet the needs of the people who used the service. Staff told us they had received an initial induction to the service. Evidence was seen of weekly staff meetings and monthly clinical and managerial supervision sessions.

We saw records that demonstrated to us that the trust had completed the required risk assessments and maintenance on the equipment used by the service. Adjustments had been made to meet the access needs of people with mobility difficulties and those with a sensory impairment.

The eating disorder drop in service was being provided in premises supplied by the University of Nottingham. These were of a good standard and located adjacent to the University's primary medical service centre. We saw that there were a number of private rooms available for individual therapies and consultations.

Staff confirmed that the service based at the Mandala centre was mainly an outreach service and there was flexibility as to where consultations would be held with people. However, there were private therapy rooms available at this location if necessary.

Multi-disciplinary working

We saw that the trust worked effectively with other providers and partners in the provision of this service. For example, we saw evidence of close and collaborative working with the mental health care team working for the University of Nottingham. This included the sharing of information and the provision of 'joined up care'.

The records reviewed showed us that people, and where applicable their families, had been actively involved in their care. We saw good examples of individual involvement in the drawing up of personalised care plans.

Evidence was seen of close working relations with the campus medical centre and the General Practitioners working for the University. This included the provision of advice and the reviewing of people with associated physical healthcare needs.

Close links were noted with third sector partners including local self-help and individual advocacy groups such as BEAT (Beating Eating Disorders).

We noted close links with the local acute NHS trust. This included providing support and advice to staff, caring for people who required physical health care treatment, as a result of the side-effects of their eating disorder.

Further medical advice and support was provided by a consultant psychiatrist and the person's own General Practitioner.

Are services caring?

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

Summary of findings

Staff told us, and we observed that, services provided were caring. This was supported by evidence we found in individual treatment records, as well as the trust's and external agencies' quality monitoring systems. We also saw some good examples of individualised and person-centred care being provided.

Staff were actively engaged at a local level, and people told us that they were caring and supportive.

Our findings

Kindness, dignity and respect

The trust provided good evidence to demonstrate that people were treated with kindness, dignity, respect, compassion and empathy. This was supported by our discussions with front line staff and people who used the service. We noted that the feedback about the service from people was positive and they were generally satisfied with the care and treatment received. Any concerns identified had been addressed by senior staff and managed through weekly clinical discussion and monthly supervision meetings.

We noted a high level of individual engagement with the treatments being offered. For example, the eating disorder drop in service had a 'did not attend' rate of below ten percent. These episodes were followed up by the use of letters and phone calls where appropriate.

Staff were noted to be actively engaging with people who used the service. Those treatment records seen showed us that the service had adopted a holistic approach towards the assessed needs of people.

Private consultation rooms were available, if required, at both locations visited and staff spoken with were aware of the need to protect the privacy and dignity of people.

People using services involvement

The evidence reviewed, our discussions with staff and the feedback seen from the people who used this service showed us that people were involved as far as possible in their own care and treatment.

We saw good examples of individual involvement in records reviewed and of active participation by people in their psychologically based therapies. This demonstrated to us that people received person centred treatment according to their individual needs.

Information provision was good across those locations visited and we saw examples of useful information for carers and families about local 'self-help' groups. Information around any identified complaints was available. For example in the form of the trust's 'Patient Advice Liaison Service' (PALS) leaflets and other contact information. Staff confirmed that where required they had access to interpreters and information in different formats for people who used the service.

Emotional support for care and treatment

The records and other evidence reviewed showed us that people received the correct level of care and treatment required. Staff informed us they would advocate on behalf of people where this was appropriate.

People told us they felt well supported by the services provided. They told us that they felt well supported by their therapist and could ask them any questions that they wanted. This was supported by those individual treatment feed-back forms reviewed. These showed us that people felt well supported by the service.

Are services responsive to people's needs?

Good 

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

Summary of findings

The service responded well to people's needs. Care and treatment records showed how the service had reviewed and amended treatments to meet people's changing needs. During the inspection, we also reviewed some good examples of responsive and person-centred care.

There was an effective complaints management system in place, and staff told us that actions were taken locally to address any informal complaints quickly. We also saw examples of positive feedback from people who used the service.

Our findings

Planning and delivering services

Evidence was seen that showed us that the trust was planning and delivering these services in response to the assessed needs of the local population. We saw that the trust provided this service in other locations throughout Nottinghamshire in line with the needs of the local population.

Evidence was seen of collaborative working with commissioners, other providers and stakeholders. For example, the service had worked closely with other local groups around the eating disorders awareness week during February 2014.

Examples were seen of how the eating disorder drop in service had worked closely with the University of Nottingham to address identified need within the student population. This included service opening times and partnership working with the University's primary health care services.

Care and treatment records seen showed us that staff from this service had attended the relevant multi-disciplinary team meetings. They had also attended other reviews of

people who had been admitted to specialist eating disorder inpatient facilities elsewhere in the country. This helped to ensure continuity of care and promoted better outcomes for people accommodated in these services.

Right care at the right time

We saw records and other evidence that demonstrated to us that people could access these services in a timely manner. We saw that there was single point of access to the service within Nottingham City and via other community services as required elsewhere within the county of Nottinghamshire. We saw that referrals had been accepted from General Practitioners, community Mental Health teams and the Increased Access to Psychological Therapy (IAPT) service.

We noted that weekly allocation and clinical meetings were held at both locations visited. These meetings ensured that every referral and self-referral in the case of the 'drop in centre' was allocated by the team based on assessed clinical need and associated risks

Staff confirmed that people were seen as promptly as possible and within 28 days of referral as agreed with their commissioners. Senior staff confirmed that any delays in seeing people would be documented and raised as an exception report to the trust. They reported that such exceptions were usually due to a delay in accessing the appropriate information from other services in order to make the required assessments of clinical need.

Care Pathway

The care and treatment records reviewed showed us that the service took account of individual needs and wishes when assessing, planning and delivering care and treatment to people who used this service.

Clear records seen showed us that people were involved in making choices where ever possible. Prompt actions had been taken when specific concerns were identified by people who used the service.

Learning from concerns and complaints

We saw that there was plenty of information available at both locations visited regarding how to make a complaint and the support available for people should they wish to do so.

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.

Summary of findings

Local leadership was proactive and we saw some good examples of service leadership that led to effective service delivery. Staff said that they felt well supported by their line manager, and we also saw evidence that the eating disorders and drop-in service team had been recognised by external organisations.

Our findings

Vision and strategy

Staff spoken with confirmed that they were aware of the trust's vision and strategy. They confirmed that they were aware of trust wide communication strategies such as the 'Positive' trust wide magazine and felt listened to by senior trust management.

Clinical discussion meetings were held weekly and staff felt these provided an opportunity to discuss any concerns that they may have and to receive managerial updates from the trust.

Responsible governance

We saw clear governance arrangements in place at a local level and an emphasis on person centred care delivery. Front line staff were clear about their clinical responsibilities and understood the importance of their role in direct care delivery.

The training records reviewed showed us that staff had received mandatory and job specific additional training to prepare them for their role.

The care and treatment records examined showed us that the service managed the clinical risks to the people who used this service proactively and in partnership with local stakeholders where appropriate.

Leadership and culture

Staff told us that they were well supported by their line manager and could approach them if they had any concerns or questions about their case load or other professional concerns. We saw evidence of monthly clinical and managerial supervisions for staff. Staff told us that there was a good team spirit within this service and that short term staff absences were covered from within the team.

The front line staff spoken with were aware of the trust's whistleblowing policy and told us that they knew how to raise any issues through this process.

The care and treatment records seen were well completed and individual risk assessments had been reviewed and updated appropriately. Evidence was seen that treatment outcomes were monitored through the weekly allocation and clinical discussion meeting.

Engagement

Staff told us that people had access to independent advocacy and were supported to make complaints where applicable. This was supported by the provision of locally based information seen during the inspection.

Senior staff confirmed that any concerns were dealt with appropriately via local resolution and the trust's NHS complaints procedures.

Performance Improvement

Staff told us that they were aware of their own professional objectives and that these were reviewed as part of their monthly clinical and managerial supervision opportunities.

We saw examples of how the trust had recognised the achievements of this service. For example, we noted that the 'eating disorders drop in service' had been a finalist in the 2013 Mental Health team of the year competition that was open to Mental Health Services throughout the country. The team had also been featured in the trust's 'Positive' magazine and had been used as an exemplar service to the rest of the trust.