Aspen Centre

Quality Report

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Date of inspection visit: 1-2 February 2018
Date of publication: 20/04/2018

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 and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Aspen Centre as requires improvement because:

- The governance structure for the service was unclear to staff. Some told us they did not know who led their service beyond ward manager or consultant level and felt the trust lacked of ownership of the service. They did not know to whom they should go to get things agreed. Local managers did not have the authority to effectively deal with issues such as a lack of action over consecutive fire safety audits dating back over nine years. The service had not included relevant risk areas on the risk register. Staff had ongoing issues with the e-rostering system, which the trust had failed to deal with. The trust had not engaged with staff to reduce the negative impact resulting from rumours that the unit was about to be relocated.
- The trust had continued to redeploy nursing staff into the service who had no specialist eating disorder experience. All but twoone of the experienced nurses had left the service, one of whom was on maternity leave. The service continued to rely upon bank and agency nurses to fill a large number of shifts. Patients and staff reported that new and temporary staff were unfamiliar with the nuanced behaviours associated with complex eating disorders, how to identify them and how to maintain the boundaries that helped to make patients feel safe. This was also reflected in feedback the service had gathered from patients. One patient told us this meant some patients knew "what they could get away with" in terms of the behaviours they could adopt, which only the experienced staff were skilled to interpret. The risk associated with a lack of skilled and experienced staff was not on the risk register. Staff morale amongst the nursing team was mixed.
- The trust had not put in place a timely induction programme to provide new nursing team staff with the necessary support, training and professional development to undertake their duties. The wider multidisciplinary team had developed and presented a bespoke training package for new staff, but some of the nursing team could have been working on the unit for up to six months by the time the training sessions were held. Only one healthcare assistant and two nurses had attended each of the most recent learning sessions and one of those nurses had not yet started working at the service. There was only one nurse within the service who was sufficiently trained to deliver nasogastric feeding. This was not on the risk register.
- The service was slow to respond to maintenance problems and patient requests. Patients consistently reported the same problems with maintenance, sometimes waiting more than eight months for issues to be resolved. This disheartened patients, who felt they were not listened to, and created unnecessary work for staff as they continually chased the requests they had logged.
- The service routinely sought patient feedback but did not act to analyse and resolve issues in a timely manner. There were consistent themes throughout the 2017 patient feedback surveys, which included staffing pressures, staff knowledge and understanding of eating disorders.

However:

- Patients were involved and engaged with the overall treatment programme. They were involved in developing and updating their treatment plans and were encouraged to attend the weekly multidisciplinary ward meeting. Patients could invite family members to review meetings.
- Aspen Centre was a comfortable and suitable facility for patients. There was a secure garden and door entry system to prevent unwanted visitors to the ward. Staff undertook risk assessments for each patient. The trust provided training for staff in safeguarding children and adults and staff reported safeguarding concerns to the local authority. Aspen Centre had a good track record on safety. Staff knew how to report incidents, which managers investigated. The ward had safe systems to manage medication. There was an ongoing recruitment programme to fill vacancies.
- Staff supported patients to address their physical healthcare needs as well as their mental health needs. The different professionals worked well together to assess and plan for the needs of their patients. Staff used specialist tools to assess the severity of patients' eating disorders and treatment plans focused on

Summary of findings

recovery, stabilisation and rehabilitation. There were different treatment programmes to suit individual patient needs. To aid their recovery, patients had access to specialist therapies such as family therapy, psychosocial, psycho-education, relaxation, coping skills and body awareness. Each treatment programme included individualised therapeutic goal setting. Patients had access to social activities, including arts and crafts sessions, flower arranging, knitting, crocheting and board games.

- Staff demonstrated their responsibilities under the Mental Capacity Act 2005 and the Mental Health Act 1983. There were improvements in the number of staff who had attended Mental Health Act training. Staff completed and stored Mental Health Act paperwork effectively. The trust had recently carried out an audit relating to Mental Health Act paperwork and had made recommendations to local managers. Staff routinely carried out mental capacity assessments with patients.
- Managers knew how to deal with performance management issues and staff received regular supervision and annual appraisals. Managers carried out regular audits of patient records, infection prevention and control, mattress safety and medication management. We found improvements in the way patient records were ordered and they were easier for staff to navigate as a result.
- There was only one formal complaint about the service but a number of compliments.
- The service was committed to becoming accredited with the Royal College of Psychiatrists' Quality Network for Eating Disorders. Staff had completed a self-assessment of their service and the nurse leaders were scheduled to attend a national peer review event.

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Background to Aspen Centre

Aspen Centre provides specialist treatment for adults and young people over the age of 16 who have a diagnosed eating disorder. It is part of Coventry and Warwickshire Partnership NHS Trust eating disorders service.

The service is commissioned by NHS England and admits patients from the local area and elsewhere. The trust has been commissioned to provide an inpatient eating disorder service since 1995. Following a change in contractual arrangements, the current configuration began in April 2010, when Aspen Centre was known as Woodleigh Beeches. The service became known as Aspen Centre in January 2012.

Aspen Centre is located in Warwick, on the Warwick Hospital site. The building is single storey with a small secure garden at the rear. The unit has pay and display car-parking facilities and is accessible by public transport.

Aspen Centre is registered with the Care Quality Commission to carry out the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury

The unit has 15 beds. Admissions were restricted to 12 in March 2016 because of staff shortages within the nursing team. The service had recently increased admissions to 13 and planned to further increase to 14. There were 13 patients admitted to the unit when we carried out our inspection. Two patients were detained under the Mental Health Act and two patients were away from the unit on leave. There were no patients subject to a Deprivation of Liberty Safeguards authorisation under the Mental Capacity Act 2005.

The site houses both the inpatient and community eating disorder services. The two services are distinctly separate but do share some core members of the wider multidisciplinary team. This inspection looked only at the Aspen Centre inpatient service.

CQC last inspected Aspen Centre in May 2017 when we rated the service as Requires Improvement. The ratings were: Safe – Requires Improvement, Effective – Good, Caring – Good, Responsive – Good and Well Led – Requires Improvement.

Following the inspection in May 2017, CQC issued the trust with requirement notices under the following regulations:

- Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014 Good Governance
- Regulation 18 Health and Social Care Act (Regulated Activities) Regulations 2014 Staffing

We told the trust they must put effective governance systems in place, to monitor the quality and safety of the service and to drive improvements. This was because the service had been short staffed for some time, relying heavily upon bank and agency workers to fill shifts in the nursing team. The trust had redeployed a number of staff from a rehab service that had closed down but the staff had no specialist eating disorder experience and they made up half of the nursing team. Managers had not routinely provided feedback to staff when they had logged incidents and there had been no team meetings or governance meetings in the service for many months. Managers had not identified areas for improvement in the audits where staff had identified shortfalls.

We also told the trust the should improve in these areas:

- The trust should ensure all staff are up-to-date with training in the Mental Health Act and Mental Health Act Code of Practice.
- The trust should ensure that staff are supported to learn from incidents and receive feedback about incidents they have reported.
- The trust should ensure that newly recruited staff are given the relevant learning and development opportunities to effectively work in an eating disorders service.
- The trust should ensure that patient records are easy for staff to navigate, so they can find the information they need in a timely manner.

Summary of this inspection

- The trust should ensure the service resumes regular team meetings and governance meetings to keep staff appraised of developments and risks.
- The trust should routinely gather and analyse feedback from patients about their experience of the service, so they can identify themes to address.
- The trust should ensure that all staff receive a thorough induction when they are recruited to the service, which considers the specific needs and risks of patients with eating disorders.
- The trust should ensure that routine maintenance issues are dealt with in a timely manner.
- The trust should consider ways to integrate the old and new nursing team.
- The trust should ensure patients and families know how to make a complaint about the service.
- The trust should ensure that all staff knock patient bedroom doors before entering.
- The trust should ensure that patients have access to meaningful activities seven days a week.

As a result of being issued with these requirement notices and recommendations, the trust were instructed to provide CQC with an action plan, to show how they would make improvements to the shortfalls the inspection had identified. The trust sent CQC the action plan they developed to address the issues identified in requirement notices.

The Care Quality Commission last carried out a scheduled Mental Health Act monitoring visit in July 2016 and issued the trust with the report in August 2016. The trust supplied the Care Quality Commission with their provider action statement by the due date of 20 September 2016. A provider action statement details what actions a provider will take as a result of the monitoring visit.

Our inspection team

Team leader: Claire Harper, Inspector, CQC

The team that inspected Aspen Centre comprised two CQC inspectors, a CQC inspection manager, a specialist eating disorders nurse manager and an expert by experience. An expert by experience is a person with experience of using services or caring for someone using services.

Why we carried out this inspection

We carried out this inspection to check that improvements had been made following the last inspection in May 2017. This was an unannounced inspection, focused on this single service.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information we held about Aspen Centre.

During the inspection visit, the inspection team:

Summary of this inspection

- visited Aspen Centre to look at the quality of the environment and observed how staff were caring for patients
- spoke with four patients
- looked at 10 patient care and treatment records
- spoke with the ward manager and the inpatient service general manager
- spoke with 16 other staff members; including healthcare support workers, doctors, nurses, therapists, a dietitian, an occupational therapist, and a pharmacist
- attended and observed a ward round and a nursing team shift handover
- observed a therapeutic craft session for patients
- carried out a specific check of the medication management on the unit; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

The ward was unsettled when we carried out this inspection and only two patients were willing to speak in detail with a member of the inspection team. Two other patients spoke very briefly with us.

Feedback was mostly positive about the care and treatment provided by Aspen Centre but one patient told us they did not feel safe because staff no longer understood the boundaries that were required to keep patients with an eating disorder safe.

One patient wanted only to tell us how great they thought the staff were at Aspen Centre. All the patients told us staff were supportive and kind.

Patients understood their care and treatment plans, of which they held copies but they did not recognise the term care plan and said they did not have copies of care plans. They enjoyed the activities and therapy sessions available to them and said these were rarely cancelled.

Patients said that resolving repairs and maintenance was a very slow process and they repeatedly reported the same issues, sometimes for many months. Issues included very poor television reception, problems with the showers and non-functioning electrical sockets.

Patients also told us that access to the internet was a problem on the unit. It is common for eating disorder services to limit access to the internet as part of the therapeutic programme. However, there was a list of sites patients could access and they had requested access to a list of additional sites but had been waiting a long time for this to be actioned by staff. They were unable to access sites of support including specialist eating disorder sites and the independent advocacy site. They found this frustrating.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

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

- The service had not dealt with issues identified on the fire safety audit. Some of these issues had been highlighted as requiring action since 2009.
- The nursing team was no longer significantly understaffed but there was continued high use of bank and agency staff to fill shifts across the nursing team.
- One patient told us that the lack of skilled staff to enforce safe boundaries meant they did not feel safe.
- There was only one suitably skilled and experienced member of staff who could deliver nasogastric feeding for patients.
- Staff turnover in the nursing team had reduced but remained high, above 20%.
- Patients said the service was slow to resolve routine maintenance problems. They had reported broken electrical sockets and foul smelling showers for over eight months.
- Service risks were not identified or included on the risk register.

However:

- The unit was visibly clean and clutter free.
- Staff knew how to protect patients from avoidable harm. The service had policies to protect staff and patients from avoidable harm.
- Staff understood how to recognise and report safeguarding concerns.
- Staff carried out appropriate risk assessments to keep patients safe.
- Staff completed their mandatory training and managers monitored their attendance to ensure compliance. Compliance rates were high at 89% but below the trust target.
- The unit had good medication management policies in place and the pharmacy team carried out regular visits.
- Staff knew how to report incidents or risks of harm. Staff logged appropriate incidents and managers provided staff with feedback following their investigation.

Are services effective?

Good 

We rated **effective** as good because:

Summary of this inspection

- The multidisciplinary team planned and delivered patient care and treatment in line with current guidelines, such those from the Royal College of Psychiatrists and the National Institute for Health and Care Excellence (NICE).
- In line with NICE guidelines and the Mental Health Act Code of Practice (2015), patients received thorough physical health checks and ongoing medical support to promote their overall wellbeing.
- The unit provided a multidisciplinary service by employing a range of professionals to meet the needs of their patients. The unit had a mix of staff including nurses, support workers, occupational therapists, a dietitian, therapists and psychiatrists.
- Therapy plans were up-to-date, showed patient involvement and staff regularly updated them. Staff used outcome measures to monitor patient progress.
- The wider multidisciplinary team developed individual and group therapy programmes for patients, which gradually increased independence. As they got better, patients could manage their own meal preparation and be prepared for activities such as eating out socially.
- Psychological therapies, such as cognitive behavioural and family therapy were available for patients. There were no waiting lists for patients to see a therapist.
- Staff stored confidential and legal paperwork correctly and safely.
- Staff routinely obtained patient consent to treatment, then effectively recorded and stored it. Staff supported patients with decision making.

Are services caring?

Good

We rated **caring** as good because:

- We observed staff supporting patients with kindness and treating them with dignity and respect.
- Staff involved patients as partners in their care, treatment and rehabilitation.
- We observed kind, humorous and caring interactions between staff and patients.
- Staff responded quickly and compassionately to patients.
- Patients were encouraged to develop their independence. Staff supported them to manage their nutrition, their physical health and their emotional needs.
- Patients understood their treatment plans and held copies of them.

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- There was an independent mental health advocacy and a generic advocacy service to support patients.

Are services responsive?

Good

We rated **responsive** as good because:

- Staff assessed patients for the service in a timely manner. They kept patients, families and referrers informed about the referral and assessment process.
- The multidisciplinary team supported patients to achieve their goals and develop a better understanding of their needs.
- The pathway toward discharge was clear for patients and their families to understand from the outset.
- The unit was a comfortable environment and patients could personalise their bedrooms to suit their own tastes.
- Patients enjoyed the therapies and activities that were available.
- Patients could access the right care at the right time because they had a range of professionals available to support them.

Are services well-led?

Requires improvement

We rated **well led** as requires improvement because:

- The trust did not ensure that effective governance was in place to monitor the quality and safety of the service or to drive improvements.
- Issues pertaining to risk were not identified on the risk register.
- The trust had not supported staff to deal with recurring fire safety audit recommendations, some of which dated back to 2009.
- The service collected data but did not analyse and effectively respond to patient feedback. There were no action plans to support staff to learn or to change the way they did things based on the feedback they received from patients. Patients were not given meaningful updates about the issues they raised, some of which were problems they had reported for eight months.
- The trust did not support staff to deal with recurring feedback themes, such as poor response times to maintenance requests.
- Local managers did not have the authority to deal with problems relating to service level agreements and senior managers had not taken ownership of the issues or secured improvements on their behalf.
- Senior managers had not carried out an impact assessment before filling half of the nursing team with redeployed staff in 2017. This had caused problems within the service and almost

Summary of this inspection

all of the existing, experienced eating disorder staff had left. Senior managers were planning a further redeployment of staff from another service without carrying out an impact assessment.
- Only one nurse with the skill and experience to deliver nasogastric feeding remained in the service.
- Morale amongst the nursing team was mixed.

However:

- Local managers had led some improvements since the previous inspection. These included improvements in feedback to staff about incidents they had reported, improvements in compliance rates for Mental Health Act training, the reintroduction of ward based governance meetings and staff meetings for the nursing team and the introduction of a weekly ward manager's audit, which included the quality of patient records.
- Staff routinely identified and reported safeguarding concerns.
- Staff were confident they could speak up if they had concerns.
- Local managers were visible and available to support staff, families and patients.
- Staff routinely carried out regular ward based audits.
- The service was in the process of working toward accreditation with the Royal College of Psychiatrists' Quality Network for Inpatient Eating Disorders.

Detailed findings from this inspection

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.

- Adults who are in hospital can only be detained against their will if they are sectioned under the Mental Health Act or if they have been deprived of their liberty under the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (MCA DoLS). If patients are not subject to the Mental Health Act or the Mental Capacity Act, they can leave the unit, so they need to know their rights. Patients we spoke to knew their rights. They knew they were free to leave the unit if they wanted to. Staff displayed signs on the unit advising patients of their right to leave.
- Aspen Centre admitted some patients who were detained under the Mental Health Act but most patients were treated informally. There were two detained patients on the unit when we carried out this inspection.
- Staff knew how to get advice about the Mental Health Act if they needed it. A worker from the trust Mental Health Act office regularly visited the unit.
- Staff stored Mental Health Act paperwork securely and could access it when they needed to. The legal paperwork we looked at was in good order.
- Staff knew they were required to inform patients of their legal rights under the Mental Health Act. They did this and recorded it effectively in the records we inspected. This showed improvement from the last trust audit of section 132 rights in August 2017.
- The trust carried out regular audits to establish how well the service complied with its responsibilities under the Mental Health Act. Two audits had been carried out in recent months and there was a planned schedule of future audits. The audit process identified what was working well as where improvements were needed.
- The trust provided a Mental Health Act training programme for staff. Since the previous inspection, the number of staff who had attended this training had increased. Records showed when staff were due to undertake their refresher training.
- Arrangements were in place for the provision of an independent mental health advocacy service. Staff displayed advocacy posters in prominent areas of the ward. Unfortunately, the advocacy website was not on the permitted list of accessible websites. Managers were aware of this and had been dealing with the issue for some time. The advocate had been regularly attending the unit but there had been some gaps in recent provision. One patient told us they were disappointed about this because seeing the advocate had been helpful.

Mental Capacity Act and Deprivation of Liberty Safeguards

- When we carried out this inspection there were no patients subject to a Deprivation of Liberty Safeguards authorisation. All patients on the unit were either detained under the Mental Health Act or were there informally.
- In line with the Mental Capacity Act, staff assumed patients had the mental capacity to make their own decisions unless there was cause to doubt it. Most recording of capacity related to consent to treatment. However, we did see examples of staff supporting patients with specific decisions.
- Staff showed a good understanding of the Mental Capacity Act and could give examples of decision specific assessments. Doctors completed and reviewed mental capacity assessments with patients.
- As part of their induction, staff received Mental Capacity Act training including Deprivation of Liberty Safeguards. They received updates thereafter. Training records showed when staff were due to undertake their refresher training.

Detailed findings from this inspection

- Staff knew who to contact for further advice and guidance about issues relating to the Mental Capacity Act.

Requires improvement

Specialist eating disorder services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are specialist eating disorder services safe?

Requires improvement

Safe and clean environment

- There was a secure entrance to Aspen Centre. Staff let people in and out of the unit. The main entrance and reception area was shared with the outpatient eating disorder service. The rear entrance had an intercom system, which staff used before allowing entry to the unit. Staff used swipe card to access non-patient areas.
- Staff carried out annual environmental audits of ligature risks. These identified areas of risk within the building. A ligature is an anchor point that someone could tie something to in order to harm themselves. The last two audits did not identify any new risks. The audits detailed action plans to manage identified risks. The unit had one bedroom which was identified as a reduced ligature room and was used for patients with a known risk.
- Staff carried out regular risk assessments for individual patients to monitor their safety within the ward environment. Staff provided increased levels of observations in response to increased patient risk.
- The ward layout allowed staff to observe all parts of the ward.
- Staff managed the clinic room and treatment room safely and effectively. The rooms were visibly clean and well ordered. Cleaning log checklists were up-to-date, with no gaps. Nurse managers carried out audits to ensure staff performed these checks.
- To reduce incidents of injury and infection, staff disposed of sharp objects appropriately. There were identified disposal facilities for used needles and syringes and these were not overfilled.
- Emergency equipment, including defibrillators and oxygen, was accessible to staff and they checked it to ensure it was fit for purpose and ready to use. Staff maintained and serviced equipment in line with manufacturers' guidelines.
- The unit was visibly clean and well ordered. The 2017 Patient-Led Assessment of the Care Environment (PLACE) score for cleanliness was 100%. This was higher than the trust average of 99% and the national average of 98%. PLACE assessments are annual appraisals of the non-clinical aspects of NHS and independent/private healthcare settings. They are carried out by teams made up of staff and members of the public (known as patient assessors). The teams must include a minimum of 50% patient assessors.
- Corridors were clear and clutter free. The main communal lounge was cluttered and access to the computer chairs was restricted by a sofa and some beanbags. Records showed that maintenance and repairs to the unit were not carried out in a timely manner. Patients regularly reported the same issues such as foul smelling showers, broken electrical sockets and faulty television reception. However, the 2017 PLACE score for condition, appearance and maintenance was 98%, which was slightly higher than the trust average score of 97% and higher than the national average of 94%.
- Patients were responsible for keeping their rooms in order but domestic staff carried out the cleaning. The bedrooms we looked at were visibly clean.

- Staff encouraged good hand hygiene in the unit. They displayed hand hygiene signs and there were sinks for patients, visitors and staff to use. To protect against the risk of infection, staff carried out regular infection prevention and control audits. The service routinely scored 100% for their hand hygiene audits.
- Specialist staff regularly inspected and cleaned the water supply system to make sure it was clean and safe for patients and staff to use.
- Staff arranged regular safety tests for portable electrical items and had up-to-date copies of electrical installation and gas safety certificates.
- The trust provided annual fire safety assessments of the building and there were staff within the service who were identified as trained fire marshals. There had been no simulated evacuation exercises in 2017 or 2018. The annual fire safety audit carried out in July 2017 contained a number of outstanding recommendations from previous fire risk assessments and annual audits. Some of these had been identified in 2009, 2013, 2015 and 2016 yet remained un-actioned. The ward manager was able to action relatively minor recommendations such as disposing of equipment with damaged electrical cabling but was unable to action structural issues such as changes to the external escape route, which was over a sloping grassed surface. As a consequence of staffing changes, the ward manager did not have access to the previously completed fire safety assessments. Delays in dealing with the recommendations of fire safety experts put both staff and patients at potential risk of harm.
- Nursing staff carried personal alarms to summon help in an emergency. Toilets and bathrooms had call alarms so patients could summon help. Other members of the staff team and visitors could obtain a personal alarm from reception. Reception staff managed the testing and charging of these alarms.
- The service complied with the November 2010 Department of Health and Social Care guidelines on same sex accommodation. This meant there were separate bathrooms and lounge areas available for female patients.

Safe staffing

- The staffing establishment for the service was 11.8 nurses and 11 healthcare support workers. Planned staffing levels for day shifts were three nurses and three healthcare support workers. For night shifts it was two nurses and one healthcare support worker. Records showed that when these needed increasing to meet demand associated with heightened patient risk, managers were able to increase these staffing levels. At the time of the inspection, 1.4 nursing and 3.7 healthcare support worker posts were vacant. The service had successfully interviewed but then halted the appointment of three healthcare support workers. This was due to further planned redeployment from another service.

- The use of bank and agency staff had reduced slightly since the May 2017 inspection when 729 shifts had been filled by bank staff and 751 by agency. Between January and December 2017, 622 shifts were filled by bank staff and 703 by agency. The number of shifts that went unfilled reduced from 180 to 43. Managers told us that to reduce the negative impact on patients, when they could, they used bank and agency staff who had worked on the ward on a regular basis. There were three long-term contracts in place for agency nurses.

- The service had reduced patient admissions from 15 to 12 in 2016 because of short staffing in the nursing team. This had recently increased to 13 with further plans to increase to 14.
- At the time of the last inspection in May 2017, half of the nursing team had been redeployed from another service. Some of those staff had since left but more importantly, almost all of the staff with experience of working with people with eating disorders had also left. Only two experienced eating disorders nurses (one of whom was on maternity leave) and several healthcare support workers remained working at the unit. Key members of the new nursing team did not accept that a specialist service required a core of staff with specialist knowledge and skills. When we asked one nurse leader about this, they minimised the relevance of specialist knowledge and told us they had a nursing qualification and knew how to care. The lack of specialist, experienced and skilled staff did not appear on the risk register.

- Staff turnover in the 12 months prior to the inspection was high. Between April 2017 and January 2018, three nurses left the service, which represented a quarter of the nursing establishment. Two nurses had left to work

in other specialist eating disorder services. Only two nurses (one of whom was on maternity leave) and several healthcare support workers with experience in the specialism remained in the service.

- Staff told us there was adequate medical cover day and night to provide routine and emergency care.
- Staff had undertaken mandatory training relevant to their role, including safeguarding children; safeguarding adults; fire safety; health and safety; moving and handling; Mental Capacity Act; Mental Health Act; basic and immediate life support; infection control; and management of potential or actual aggression.
- At the time of the inspection, mandatory training compliance was 89% compared to the trust target of 95%. This had fallen slightly from 93% at the previous inspection.
- New staff received an induction to the trust and to the service. New staff worked on a supernumerary basis for the first two weeks, during which time they spent three days meeting members of the wider multidisciplinary team to gain an understanding of how each professional role was involved in the treatment programmes. To support new staff in their understanding of eating disorders, the ward consultant and members of the multidisciplinary team ran four half-day sessions between October and November 2017. However, at the time of this inspection, only two members of the nursing team had attended all four sessions.
- The service gathered feedback from patients in the form of satisfaction questionnaires. Feedback from January to October 2017 was positive overall. However, it indicated that the experienced staff were very helpful in terms of providing support but some staff showed little understanding of eating disorders and others required more training to prepare them for the role. There was also reference to temporary staff falling asleep or using their mobile telephones during mealtime supervision. A patient also told us that some staff did not demonstrate a basic understanding or insight into eating disorders. The service had not developed any action plans for staff to deal with the implications of this patient feedback.
- We saw no evidence of therapeutic activities having been cancelled due to short staffing.

Assessing and managing risk to patients and staff

- Aspen Centre did not practice seclusion or long term segregation.
- There were no recorded incidents of restraint in the 12 months leading up to this inspection.
- One patient told us that they did not feel as safe with the staff who did not understand eating disorders as they did with staff who were experienced. This was because they felt experienced staff understood the importance of firm boundaries to support patients to manage their condition.
- Staff used a recognised risk assessment tool to assess patient risk. In all but one record we looked at, risks assessments were thorough and including all known risks.
- Staff had all received training in safeguarding adults and children. Staff routinely considered safeguarding and sent safeguarding concerns to the local authority when necessary. There were no ongoing safeguarding enquiries at the time of this inspection.
- Staff used handovers to share information about risks and incidents. They used a handover book to record information for each patient, which they passed to staff beginning the next shift. They also used a ward round book which captured details of the weekly multidisciplinary meetings, which staff then used to complete electronic entries in the patient records
- The service had an observation policy, which staff used to ensure they monitored patient risks while on the unit.
- The service had policies to manage risk, such as a search policy, use of the internet and personal mobile telephones, a list of items that were not allowed on the unit and safeguarding.
- The service operated some blanket restrictions. This means there were restrictions that applied to all patients, regardless of their individual risk. These restrictions were in place to support patients with managing their eating disorder and to increase the likelihood of patients reaching a healthy weight. Restrictions included mealtime supervision, restrictions on things such as excessive exercise and drinking large quantities of fluids before being weighed, locked door access to the garden, limited access to the internet and mobile telephones on the ward. The restrictions were justified for the purposes of supporting patients through complex treatment programmes for people with eating disorders. Staff discussed restrictions and individual risk assessments with patients prior to and on admission the unit.

Requires improvement

Specialist eating disorder services

- We reviewed the medicine administration records of 13 patients on the unit. Staff managed and audited these records effectively. Incident reporting data showed that if staff made errors in medication administration, they recorded these as incidents.
- Aspen Centre received regular visits from the pharmacy team who provided oversight of their medication management system and guidance when requested.

Track record on safety

- There were no serious incidents that required investigation during the last 12 months.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents of harm or risk of harm. They were confident they could report incidents without fear of reprisal. Managers had made improvements in investigating and providing feedback to staff following incident reporting.
- The trust sent out quarterly learning alert newsletters. These kept staff informed of recent lessons learned within the trust. The service had also reintroduced regular governance meetings, which included lessons learned as a point of discussion for staff.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- The wider multidisciplinary team carried out thorough individualised patient assessments. They used specialist assessment tools designed to meet the needs of patients with eating disorders. Treatment plans were individualised. Staff reviewed and updated the treatment plans regularly. Patients also had nursing care plans, which supported their overall therapy programme. Each element of the multidisciplinary team worked together with patients to provide the therapy programme, which was led by the allied health professionals and the doctors. Each patient had a named nurse and designated times were allocated for them to meet.
- The multidisciplinary team worked together to plan and deliver patient care. Nurses provided direct care and support in the ward environment and the wider multidisciplinary team planned and directed individual and group therapy programmes. The team maintained contact with the patients' home teams, commissioners, GPs, colleges and families. Treatment and therapy plans were clear.
- During the day, nurses and other members of the wider multidisciplinary team supported patients to attend activity and therapy sessions. The nursing team supported patients at meal times and with post mealtime supervision. However, staff told us there was no specific training to guide staff on what was expected of them to perform these tasks effectively. Meal times can provoke high levels of anxiety for patients with an eating disorder and patients often use a wide range of subtle and nuanced behaviours to either limit their calorific intake or burn calories to compensate for the nutritional intake. One member of staff told us that inexperienced colleagues believed evidence of an empty plate was evidence of a successful mealtime.
- Staff from the wider multidisciplinary team supported newer colleagues in the nursing team to understand the rationale for restrictions the therapy programmes placed upon patients. This was important because not all staff in the nursing team understood that it was not safe or clinically appropriate for some patients to go for a walk and to go swimming on the same day. Some of the nursing team associated such activities with social stimulation and community engagement rather than an evidence based therapeutic approach to dealing with a complex physical and mental health condition. The wider multidisciplinary team were not critical of less experienced staff; they were supportive and keen to ensure patients received the right level of therapeutic support and management.
- Nursing staff used a patient "at a glance white board" in the staff office. This contained essential patient information. The board had doors, which protected personal and confidential information. Staff stored patient records securely using a mix of electronic and paper files. Some staff told us that updating the new electronic patient record system took up a disproportionate amount of their time. The trust was supporting staff to learn how to use the new system and

had a work based champion within the unit. We found the service had made improvements to the way patient records were ordered. Staff reported no problems navigating the files.
- Staff supported patients to engage in leave away from the unit. However, there were inconsistencies in the way staff recorded this which made it difficult to understand patient leave arrangements.

Best practice in treatment and care

- In line with the National Institute of Health and Care Excellence (NICE), staff followed "Eating disorders: recognition and treatment" (May 2017) and "Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition" (2006) prescribing guidelines.
- The service provided a range of psychological and family therapies for patients, employing psychologists, therapists and a nurse therapist. There were no waiting lists for psychological interventions. Patients could access cognitive behaviour based therapies that were designed for people with eating disorders. These were available as individual and group therapies.
- Therapy staff supported patients to develop relaxation strategies, coping skills and to use psycho education groups as ways of developing resilience to support their recovery.
- In line with NICE guidelines and the Mental Health Act Code of Practice (2015), nursing and medical staff identified and managed patients' physical healthcare needs. Staff made sure that patients were referred for specialist investigations and treatment when they needed it. To manage risk of falls and pressure ulcers, patients could access physiotherapy and tissue viability services when they needed to. The service provided pressure relieving mattresses if patients needed them. There was regular support from a physiotherapist who prescribed safe levels of activity for patients which was linked to their individual physical health needs.
- The service used standardised and specialist assessment tools such as MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa) and the Eating Disorder Examination Questionnaire (EDEQ). They used Health of the Nation Outcome Scales (HoNOS), CORE outcome measure (CORE-OM) and Diabetes Quality of Life Measure (DQOL). Therapy staff completed the Eating Disorder Examination Questionnaire when patients were admitted and again when they were discharged. This meant patients and staff could measure the outcomes of treatment plans. However, the service had not been given authority to recruit to a vacant trainee psychology post, so there was limited analysis of patient outcomes.
- The service admitted patients requiring nasogastric feeding and there was a competency based training programme for new nursing staff. Staff had to undertake three supervised procedures before they were able to carry it out independently. None of the new staff had done this. This had been identified at the previous inspection and remained a risk. Since the last inspection, all but one of the nurses with the skill and experience to insert and manage nasogastric feeding had left the service. This was not on the risk register.
- Clinical staff carried out regular clinical audits which included medication management, hand hygiene and patient records.
- The unit had a no smoking policy. Patients could access smoking cessation support if they wanted to.

Skilled staff to deliver care

- The staff working in the service came from a range of professional backgrounds including occupational therapy, physiotherapy, nursing, medicine, therapy, dietetics, hospitality and family therapy. Out of hours medical care was provided using the local on call rota. There was a dietitian and a part time dietetic assistant to support patients with meal prescription plans and nutritional guidance. However, when the dietitian was on leave, there was limited cover for the role. Occupational therapists who worked closely with patients to support them through their treatment programme and a physiotherapist regularly attended the unit to assess and support patients with safe levels of activity. Patients could access a tissue viability service and some of the nursing team acted as champions.
- New staff received an induction to the unit, which included a two-week supernumerary period with time spent with each professional discipline to understand the role of the wider multidisciplinary team. During March 2017, the ward consultant and other senior members of the multidisciplinary team devised and ran three half-day training sessions for a large intake of new staff. Seven nurses and five healthcare support workers attended these sessions. A further four half-day sessions were run between October and November 2017. However, only one healthcare support worker and one

nurse attended all four sessions. One other nurse attended each session but they had not yet started working on the ward. The wider multidisciplinary team showed commitment to supporting the professional development of the nursing team and were keen to offer their support and share their experience.

- Some staff told us they were able to attend professional conferences and learning events but other staff told us there was limited funding available for them to attend such events. The multidisciplinary team had a planned schedule of monthly continued professional development sessions which were advertised amongst the staff group.
- The service operated a supervision tree arrangement. This meant that staff received supervision from a colleague in the grade above. Staff were also able to access clinical supervision. If there was no one within the trust to provide supervision for an allied health professional, perhaps because they were the most senior grade, the trust arranged for an outside agency to provide the supervision. We looked at a sample of supervision records and saw that staff were receiving regular supervision.
- All eligible staff had received an annual appraisal. Managers were able to tell us how they dealt with issues of poor staff performance when they needed to.
- Healthcare support workers could study toward the Care Certificate. The Care Certificate was introduced in 2015 and aims to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care. Two members of staff had completed the Care Certificate.

Multidisciplinary and inter-agency team work

- Multidisciplinary meetings (MDTs) and Care Programme Approach meetings (CPAs) took place regularly and patients were routinely invited and supported to attend. The multidisciplinary team met twice every week, so each patient received a weekly review of their treatment. Patients were included in these meetings and were encouraged to provide written summaries of their week, their concerns and any special requests they wanted staff to consider. Families and carers attended the CPA meetings if patients wanted them to be included.
- We observed a multidisciplinary patient meeting and staff demonstrated that they worked well together and considered patients holistically. Patient records confirmed there was effective multidisciplinary team working taking place.
- Staff maintained close links with patients' GPs and community teams, keeping them up-to-date with essential information. Staff sent clear notifications to GPs when they admitted and discharged patients from the service.
- The different professions appeared to work well together and showed mutual respect for each other. However, some staff told us that the large intake of staff into the nursing team from a different service had led to some integration problems in 2017, which had not been fully resolved. Some staff were concerned about the lack of specialist knowledge and skill within the nursing team, particularly as all but two of the specialist nurses had left the service within the previous 12-18 months. Several staff told us that patients had raised concerns about this too, noting that there were less staff who were able to manage the tight boundaries that patients needed to support their treatment.

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

- Adults who are in hospital can only be detained against their will if they are sectioned under the Mental Health Act or if they have been deprived of their liberty under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS). If patients are not subject to the Mental Health Act or the Mental Capacity Act, they can leave the unit, so they need to know their rights. Patients we spoke to knew their rights. They knew they were free to leave the unit if they wanted to. Staff displayed signs on the unit advising patients of their right to leave.
- Aspen Centre admitted patients who were detained under the Mental Health Act but most patients were treated informally. There were two detained patients on the unit when we carried out this inspection.
- Staff knew how to get advice about the Mental Health Act if they needed it. A worker from the trust Mental Health Act office regularly visited the unit.
- Staff stored Mental Health Act paperwork securely and could access it when they needed to. The legal paperwork we looked at was in good order.

Requires improvement

Specialist eating disorder services

- Staff knew they were required to inform patients of their legal rights under the Mental Health Act. They did this and recorded it effectively in the records we inspected. This showed improvement against the last audit of section 132 rights in August 2017.
- The trust carried regular audits to establish how well the service complied with its responsibilities under the Mental Health Act. Two audits had been carried out in recent months and there was a planned schedule of future audits. The audit process identified what was working well as where improvements were needed.
- The trust provided a Mental Health Act training programme for staff and training records showed when staff were due to undertake their refresher training.
- Arrangements were in place for the provision of an independent mental health advocacy service. Staff displayed advocacy posters in prominent areas of the ward. Unfortunately, the advocacy website was not on the permitted list of accessible websites. Managers were aware of this and had been dealing with the issue for some time. The advocate had been regularly attending the unit but there had been some gaps in recent provision. One patient told us they were disappointed about this because seeing the advocate had been helpful.

Good practice in applying the Mental Capacity Act

- When we carried out this inspection there were no patients subject to a Deprivation of Liberty Safeguards authorisation. All patients on the unit were either detained under the Mental Health Act or were there informally.
- In line with the Mental Capacity Act, staff assumed patients had the mental capacity to make their own decisions unless there was cause to doubt it. Most recording of capacity related to consent to treatment. However, we did see examples of staff supporting patients with specific decisions.
- Staff showed a good understanding of the Mental Capacity Act and could give examples of decision specific assessments. Doctors completed and reviewed mental capacity assessments with patients.
- As part of their induction, staff received Mental Capacity Act training including Deprivation of Liberty Safeguards. They received updates thereafter. Training records showed when staff were due to undertake their refresher training.
- Staff knew who to contact for further advice and guidance about issues relating to the Mental Capacity Act.

Are specialist eating disorder services caring?

Good

Kindness, dignity, respect and support

- We observed staff interacting with patients in a caring and compassionate way. Staff responded to patients in a calm and respectful way.
- Patients told us staff treated them with kindness and respect. Patient feedback to the trust reflected this.
- We talked to staff about patients and they discussed them in a respectful manner.
- We saw that patients approached staff freely.
- One patient told us that some temporary staff did not always knock their bedroom door before entering.
- The PLACE score for privacy, dignity and wellbeing was 93% which was marginally lower than the trust average of 94% but higher than the national average of 84%.

The involvement of people in the care they receive

- For planned admissions, staff provided patients and their families with information about the service before they were admitted. The service was included on the trust website's list of services but the information provided there was limited to the patient group and how to find and park at the location.
- Patients agreed a written list of people they were willing for staff to share information with and this was easily accessible to staff in the patient records.
- Occupational therapy and dietetic staff encouraged patients to be involved in developing their care plans and in goal setting. Patients were less familiar with the term care plan but clear about their treatment programme. Patients had copies of their treatment programme and knew which stage they were at. Patient records showed if patients had accepted or declined a copy of their nursing care plan. We observed a multidisciplinary patient meeting. We saw evidence that patients were encouraged to provide written and verbal feedback about their progress. These meetings took place each week.

Requires improvement

Specialist eating disorder services

- Families were welcome to visit the unit. Visiting hours were prominently displayed. Patient feedback gathered by the service showed that patients were able to involve their families.
- Nursing staff and patients held weekly community meetings. Nurses made a written record of the meeting. We found that patients had repeatedly brought a number of issues to the meeting during the preceding three months, including foul smelling showers, limited television signal and non-functioning electrical sockets. Patients had raised some issues for over eight months. However, we saw that patients had requested the flower arranging session be moved to another day and staff had arranged for this to happen.
- We looked at patient satisfaction surveys covering January to October 2017. They were positive overall. The August-October survey showed 75% of patients reported being very satisfied or quite satisfied with the support of the staff team. The figure was 90% for January to July. However, there were some comments the service could use for service development initiatives. These included a lack of commitment by staff to attend the community meetings and a lack of progress in resolving the issues patients raised, unhelpful staff behaviours, suggestion that some staff would benefit from having a greater understanding of eating disorders or having more training in what the role required and a lack of consistency in approach. There was also mention of some staff using their mobile telephones and falling asleep at work. There was no action plan in place for staff to address issues of patient dissatisfaction. Neither the ward governance meeting nor the nursing team meeting, which took place after the results of the survey were released, referred to the patient satisfaction surveys.
- Apart from minutes relating to the community meetings, we found very little evidence of "You said, We did" so we asked the trust to provide details of how, apart from community meeting minutes, they had responded to patient feedback. Unfortunately, the trust sent us copies of the community meeting minutes along with a photograph of a "You said, We did" card. Only one out of the seven issues recorded showed an actual outcome for patients. All other responses showed an action, such as "jobs reported to estates or email sent". This meant that it was not easy for patients to know when the issues they raised had or would be dealt with.
- Patients were not involved in the running of the service. However, two patients had returned to the unit to provide talks to the other patients in 2017. There was also a plan to develop volunteering opportunities for patients who had been discharged from the service. One patient told us they thought it would be really helpful if patients could be involved in interviewing prospective staff to work on the unit.
- The service had worked with the trust patient engagement team to deliver a weekly "listening clinic" at the unit. However, the first scheduled meeting for February 2018 was cancelled due to sickness.

Are specialist eating disorder services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- Most patients were admitted from the local area but the unit also accepted patients from other parts of the country. Staff carried out home based pre-admission assessments. The senior occupational therapist and senior specialist nurse did these assessments. Patients also met with the dietitian prior to admission. The ward consultant arranged ward based pre-assessments for out of area patients. The service was able to arrange emergency admissions if necessary.
- The average length of patient stay at Aspen Centre was roughly 103 days in 2017 (trust data was missing figures for two months within the period).
- There were no reports of patients not having access to their room when they returned from leave and no reports of patients having to move rooms for non-clinical reasons.
- Staff planned discharge arrangements in collaboration with patients and their families as well as with their community teams. There were no reported delayed patient discharges but staff said these could occasionally arise if there were difficulties for community teams to arrange community support or accommodation. If such delays did occur, these were due to circumstances beyond the control of the service. Staff planned patient discharges to take place at appropriate times of the day.

Requires improvement

Specialist eating disorder services

The facilities promote recovery, comfort, dignity and confidentiality

- Aspen Centre had a full range of rooms and equipment suitable for the environment and patient group. This included space for therapeutic activities, relaxation and treatment. The rooms were light and spacious. Furniture was comfortable and modern and some had recently been replaced. Staff displayed some patient artwork on the unit.
- There was a communal lounge where patients could meet with each other, sit and read or play board games. There was also small lounge area patients could use for activities or quiet space. When there were male patients on the ward the small lounge was designated a female only lounge in line with Department of Health and Social Care guidelines (2010). This lounge had been newly converted from a staff office. It provided a safe and comfortable facility in sight of the staff office and off the main ward thoroughfare.
- Patient visiting usually took place in patient bedrooms because this is what they preferred. Patients could also use the garden area with their visitors and if they needed a private room, staff could arrange this.
- Therapy rooms and offices had good sound proofing which meant private conversations could not be overheard.
- Four bedrooms were ensuite with a toilet, sink and shower. The service had designed one large bedroom for a patient with highly complex physical health needs should they require specialist equipment in the room. They had designed another with low-ligature fittings. There were bathrooms and toilets for rooms without ensuite facilities. Outside of designated meal and therapy time, patients could access their rooms freely. Patients could personalise their rooms and use their own bedding if they wished to.
- Patients could lock away private possessions.
- Patients could manage their own laundry in the laundry room if they wanted to. The trust provided guidance on their website to relatives who were managing laundry for patients.
- There was a payphone in a corridor near the door to the garden. It was not a private area for patients to hold telephone conversations. It was a busy area near to the lounge, ward manager's office and the staff office. However, patients routinely had access to personal mobile telephones and there were designated times, outside of the therapeutic day, when patients could use their own telephones.
- The nature of the unit, and individual specialised treatment plans, meant patients were not able to have a wide choice in the menu. However, as is common in these services, patients were able to have a list of three "dislikes" foods and staff respected this. The dietitian also catered for patients who had additional special dietary requirements. Food was not freshly cooked on the premises but was frozen or reheated. There were no PLACE scores for food for this service. Therapy plans included time out in the community for patients to engage in therapeutic social eating.
- Patients who were progressing through their treatment programme could make meals and snacks with staff in the therapy skills kitchen. Staff supported them with meal planning, purchasing ingredients and preparing meals. The service had introduced a "come dine with me" programme for patients.
- In line with the treatment programme, patients did not have access to make drinks and snacks 24 hours a day. However, staff supported patients to manage their nutrition and hydration in line with their individualised treatment programmes and diet prescriptions.
- Patients could make suggestions for activities at the weekly community meeting. There were limited staff supported activities at evenings and weekends but the service had made improvements since the last inspection. Patients could continue with their art and modelling projects and the popular flower arranging activity had been moved to a Saturday in response to patient requests. Patients told us that activities and therapies had not been cancelled due to short staffing. Patients who were on a refeeding programme had limited access to activities because they were not on a therapy programme.
- Staff routinely supported patients with prescribed exercise activities such as guided walking and swimming.

Meeting the needs of all people who use the service

- The building was accessible for people who used wheelchairs. Some patients were physically weak when they were admitted so were assessed for mobility

Requires improvement

Specialist eating disorder services

equipment if they needed it. The PLACE score for the environment in relation to disability and accessibility was 83%. This was below the trust average of 86% but in line with the national average.

- Staff could arrange for leaflets and care plans translated into other languages if they needed to. They could also access trust wide interpreting and translation services. At the time of this inspection, there were no patients who required this. Trust feedback surveys showed that patients felt the service provided them with information they could understand.
- Staff respected patients' diversity and human rights. They received training in equality and diversity. At the time of the inspection, 96% of staff had completed this training. There was no multi-faith room on the unit but patients could use their rooms for private worship or staff could support them to use the local hospital multi-faith chapel if they wanted to, which was situated on the same site. Staff routinely supported patients to meet their spiritual needs and the trust chaplain visited the unit.
- The service could meet individual cultural and religious dietary needs within the treatment programme. They provided a vegan diet for patients who had a cultural need.
- The service was accessible to pregnant women and patients with complex physical health problems.
- Staff maintained a large noticeboard on the ward, which contained a variety of information including support options, complaints, advocacy and substance misuse services.

Listening to and learning from concerns and complaints

- Staff met with patients each week to hold community meetings. Recording of these meetings had improved significantly since the last inspection. However, there were recurring themes with the last inspection, particularly in relation to the very slow resolution of routine maintenance issues.
- Patients could raise concerns and complaints in the community meetings or by submitting a formal complaint. Patients could also raise concerns directly with staff.
- There was only one formal complaint recorded for the service in the 12 months leading up to this inspection. There was one compliment recorded for the service during the same period but we saw evidence of more compliments when we carried out the inspection.

Are specialist eating disorder services well-led?

Requires improvement

Vision and values

- Staff were clear their role was to provide good, person centred care and to support patients through their treatment programmes until they could be discharged. Staff were aware of the trust values: compassion in action, working together, respect for everyone and seeking excellence.

Good governance

- The trust had not supported staff to effectively manage a series of fire safety recommendations, some of which dated back to 2009. This had not been included on the risk register.
- Staffing within the nursing team had improved since the last inspection but there was continued high use of bank and agency staff, with over 1300 shifts being filled by temporary staff. However, the number of shifts which went unfilled almost halved during 2017 to 43. The number of incident reported because of staff shortages had also dramatically reduced during the same period.
- The nursing team remained short of staff with established skills and experience in the specialist field of eating disorders. Only one member of staff had the requisite skills to provide nasogastric feeding treatment to patients. This had not been included on the risk register.
- Patient feedback during 2017 and comments to the inspection team showed that patients were aware of the different skills base amongst the nursing team. One patient told us this made them feel unsafe because they knew that to manage their condition and succeed with their treatment plan, they needed clear and firm boundaries. The patient satisfaction questionnaire also

highlighted that some staff did not demonstrate a basic understanding or insight into eating disorders. There was no evidence that managers had listened to or acted upon this feedback.

- Managers failed to accept that a specialist eating disorders service would benefit from having a core nursing team with relevant skills and experience. Despite the problems the service had experienced with staffing and skills mix over the last year, the trust continued to redeploy staff from other wards into the service without carrying out an impact assessment.
- The service had access to a wide range of centralised trust policies to support with governance. These policies were designed to protect patients and staff. The trust had updated most of the policies we looked at by the scheduled review date. However, the nasogastric feeding policy had not been reviewed by the due date but records showed two members of the wider multidisciplinary team were dealing with this. Policies were easy for staff to locate on the trust intranet.
- Managers could access a dashboard, which showed staff compliance with statutory and mandatory training. There was a clear programme for this training. Trust data showed that compliance with this training was 89% for the nursing team. The trust did not supply data for the service as a whole.
- Managers made sure that staff had regular supervision and annual appraisals in line with trust policy.
- Staff had opportunities to take part in clinical audits within the service and carried out a number of routine audits relating to quality, safety and process. Since the last trust-wide inspection in June 2017, the trust had introduced a weekly audit for managers to complete which looked at patient engagement, physical health monitoring and case file recording. Aspen Centre staff had embedded this new process.
- Staff told us they felt able to report incidents and raise concerns without fear of recrimination. We looked at a sample of incident reporting from 2017-18. Staff regularly reported incidents and managers reviewed them and mostly provided feedback to staff. This showed significant improvement since the last inspection when we found high numbers of instances where managers had not responded to staff concerns.
- The trust sent out quarterly learning alerts to staff which supported with learning from incidents across the trust.
- The trust had a duty of candour policy, which staff understood and adhered to. The duty of candour requires providers to be open and transparent with patients when something has gone wrong. Staff understood that if they made a mistake, it was important to be open and transparent with patients. We saw evidence that staff adhered to their duty of candour responsibilities when they investigated incidents and carried out routine audits.
- Trust data showed the service had received one complaint about the service in the 12 months leading up to this inspection and had recorded one compliment. However, we saw evidence of more than one compliment when we carried out the inspection.
- The service staff carried out regular ward based audits. Audits included infection prevention and control, medication management, mattress quality, sharps, ligature risks, environmental, case recording and fire safety. We found improvements in the frequency and quality of outcomes with report to case file audits.
- The ward manager had enough time and autonomy to manage the nursing team effectively but lacked the power to positively influence issues such as the significant delays in resolving maintenance issues and moving forward with the long-standing fire safety audit recommendations. At the last inspection, they had identified that no staff team meetings or governance meetings had taken place for some time and they had positively resolved this.
- Doctors within the service noted significant pressures on their clinical time because of a reduction in the administrative support available to them and the inconsistent functionality of digital recording for the production of their reports and letters.
- Staff were able to submit items to the trust risk register but key issues such as the lack of action pertaining to consecutive fire safety audits and the shortage of nursing staff able to deliver nasogastric feeding procedures had not been recorded.

Leadership, morale and staff engagement

- Staff told us they could provide feedback locally within the service but there was a disconnect between them and senior managers within the trust. A large number of staff were anxious and expressed distress about

rumours they had heard which led them to believe the unit would be closed and the service transferred to another site. They felt senior managers were not hearing their concerns.

- There was evidence of clear leadership provided by the ward consultant. The ward manager had implemented a number of the recommendations made following the last inspection, including the re-introduction of team meetings and routine ward based audits. The leadership provided by the consultant was central to the cohesive functioning of the whole multidisciplinary team. The team worked well together and maintained stability through a difficult period of change within the nursing team. However, beyond the unit based leadership, staff remained unsure of who to go to when they needed answers and only a small number of staff could name the senior managers with responsibility for their service. Not all staff knew who their line manager was some told us the trust showed no ownership of the service, which made them sad because they were very proud of the work they did.
- Staff told us that the different professional roles within the wider multidisciplinary team had different managerial lines of accountability. This meant that staff had to negotiate a host of different senior managers to drive improvements and changes within the service as a whole.
- The ward manager and consultant were visible during the day-to-day provision of care and treatment and they were accessible to staff, patients and families. The ward manager was accountable to the pathway manager/ matron but this post was being covered temporarily due to a vacancy. The staff who were aware of this, said the person was supportive to the service but some staff did not know who was covering the role or what the future arrangements would be. Some staff knew there was an operations manager above this level but others did not. All staff knew the name of the chief executive who made occasional visits to the unit and staff were aware of these visits.
- Two deputy ward managers had been appointed to support the ward manager role, one of whom saw value in specialist knowledge within the field and was eager to develop their knowledge and skills.
- Morale within the service was mixed. Almost all staff told us they enjoyed working there and were committed to providing quality care and treatment to patients. The nursing team had almost recovered from the split they experienced in early 2017 because most of the experienced eating disorder staff had left the service. Matching uniforms had been issued to staff, more than 12 months after the teams merged, which served to reduce a visible marker of the division within the nursing team.
- There were no reported incidents of staff harassment or bullying. A number of staff told us they felt supported and valued by their immediate line manager but others felt their knowledge and skills were not valued.
- Some staff were upset because they had experienced problems with the e-rostering system since it was introduced. The issue resulted in some staff being recorded as owing the trust a significant number of work hours, which they claimed was in fact a calculating error. They felt managers had consistently failed to deal with the issue and they found this both frustrating and distressing.
- There were learning and development opportunities for staff. Nurses could study toward nurse prescribing, leadership and therapy qualifications. Healthcare support workers could train in venepuncture so they could take blood samples for patients. Staff could become champions for specific areas such as tissue viability and the trust provided training for this. However, uptake was low for the eating disorder specific training, which the multidisciplinary team had developed for those staff working at the unit who did not have a background in the specialism. The ward manager planned to carry out a training needs analysis for the nursing team.
- Staff knew about the whistleblowing process and felt confident they could use it if they needed to. They were confident they could raise issues of concern without fear of victimisation and some staff told us they had done so.
- Staff were kept up to date about trust wide developments with newsletters and email bulletins. The service was involved in a local multi-agency initiative to promote nutritional understanding and education.

Commitment to quality improvement and innovation

Requires improvement

Specialist eating disorder services

- The service had applied to become accredited with the Royal College of Psychiatrists' Quality Network for Eating Disorders. Since the last inspection the service had completed their self-assessment and three staff were scheduled to attend peer review training.
- Members of the wider multidisciplinary team were actively engaged in a variety of academic research projects. The ward consultant continued to publish in the field of eating disorders.
- Staff had produced an information guide to eating disorders for clinicians. The guide provided information about the different types of eating disorder, assessment and treatment. It provided references to further reading and useful contacts for patients.
- The service had developed a complex bulimia programme for patients with a history of substance misuse and/or self-harm. They wanted to evaluate the programme, which they believed to be the first of its kind in the country but did not have capacity to collect and analyse the data because there were no trainee psychology posts in the service. However, trust data showed the service had a whole time equivalent psychology trainee post. Had the team been aware of this post they could have driven forward improvements within the service, raised the profile of the service and contributed to national developments within the field.

Outstanding practice and areas for improvement

Outstanding practice

- The service had developed a complex bulimia programme for patients who had a history of substance misuse and/or self-harm.
- The service had recently produced an information guide to eating disorders for clinicians. The guide provided useful information about the different types of eating disorder, assessment and treatment. It provided references to further reading and useful contacts for patients.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that effective governance is in place to monitor the quality and safety of the service and to drive improvements. This includes providing effective and visible leadership to unit staff, supporting them to effectively deal with fire safety recommendations, supporting them to deal with issues resulting from service level agreements and supporting them to identify issues that should be included on the risk register.
- The trust must ensure that newly recruited staff attend a suitable and timely induction along with relevant learning and development opportunities to effectively deliver a specialist eating disorders service.
- The trust must ensure that routine maintenance issues are dealt with in a timely manner.
- The trust must ensure it analyses and effectively deals with patient feedback in a timely manner.

Action the provider SHOULD take to improve

- The trust should improve the recording of informal patient leave arrangements.
- The trust should address the difficulties staff described in having to navigate a complex management structure to get things done. They describe challenges such as not knowing who their line manager was, errors within the e-rostering system which caused some staff significant stress and lengthy waits to move forward with changes to the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust did not ensure there was effective governance in place to monitor the safety and quality of the service or to drive improvements. The trust did not act upon recommendations in consecutive annual fire safety audits dating back to 2009. The trust did not make these documents available to the new ward manager of the service, who was tasked to manage the issue for both the inpatient and outpatient service. The trust did not identify relevant issues to include on the risk register. The trust did not act in a timely manner to address patients' concerns. There were recurring themes including the length of time it took to resolve routine maintenance issues and these had an ongoing impact on patients. The trust did not support staff to deal with problems arising from service level agreements. This was a breach of Regulation 17 (1)(2) a, b, d(ii), e, f

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust did not ensure that the nursing team received the appropriate support, training and professional development or had the relevant specialist experience, knowledge and skills to deliver a specialist eating

This section is primarily information for the provider

Requirement notices

disorders service. The nursing team had only two nurses who were suitably experienced in eating disorders and trained to insert nasogastric feeding tubes. One of these nurses was on maternity leave.

Newly recruited nursing team staff waited a long time for a detailed service specific induction. There was no formal training to support them to undertake the important task of supervising meal times. The nursing team were not supported from the outset to understand and deal with the nuanced behaviours that patients with eating disorders were likely to engage in.

This was a breach of Regulation 18 (1) (2) a