Leeds and York Partnership NHS Foundation Trust

# Specialist eating disorder services

## Quality Report

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## Locations inspected

| Name of CQC registered location | Location ID | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| The Newsam Centre | RGD03 | Ward 6 Yorkshire Centre for Eating Disorders | LS14 6WB |

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

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

Where applicable, we have reported on each core service provided by Leeds and York Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Leeds and York Partnership NHS Foundation Trust.

# Summary of findings

## Ratings

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

### Overall rating for Specialist eating disorder services

| | |
|---|---|
| Are Specialist eating disorder services safe? | |
| Are Specialist eating disorder services effective? | |
| Are Specialist eating disorder services caring? | |
| Are Specialist eating disorder services responsive? | |
| Are Specialist eating disorder services well-led? | |

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

Overall, people received a good service from the YCED. The service had a clear vision and staff were positive about working towards this. The quality of the service delivered was also monitored on an ongoing basis. The service had developed research based practice and made improvement through engagement with patients and carers. The service was involved in peer review networks as well as contributing to the development of national guidance on assessing and treating eating disorders. Staff were supported in their roles and was supervised regularly and had a specialised knowledge of eating disorders. In addition, patients told us, and we observed that staff were caring and compassionate. There were some particular areas of outstanding practice in the service

The skills of staff were being developed to meet the needs of patients. Staff were allocated lead roles in specialty areas in order to support patients appropriately. The supervision structure helped staff to feel well supported and enabled lessons learnt to be shared. Clear working practices across the service and clear learning from incidents across the trust. There were well established working practices and good links with community team and outpatient services.

We found that this service was safe. The trust had systems in place which identified potential risks to the service and had processes to ensure that these were avoided where possible. Incidents were reported and there were governance systems in place to make sure learning from incidents took place, both in the service and across the trust.

The service used a number of specialist outcome measures to make sure that its effectiveness was assessed. The clinical governance structure in the service was strong and used learning from incidents, complaints, internal audits and research to improve the service offered. Staff had a good understanding of best practice and were aware of the evidence base of their work.

We found that the service met the needs of the patients who used it. Patients told us they were treated with kindness and empathy by staff, who were well-trained and aware of their needs. Patients told us staff treated them with respect and consideration, and the staff were experienced in understanding and treating eating disorders.

Patients praised the community and outpatients services and the links between inpatients and community services. The service understood the needs of different communities and was able to be flexible. However although the inpatients unit had disabled access, the environment was not suitably adapted for disabled people. We saw that staff worked closely with family members and were open to feedback from patients and their families or carers.

Staff we spoke with felt that the service was locally well-led and they understood the aims and values of the eating disorder service. They were able to deliver a good service and felt that they were supported by local managers to understand the aims and values of the trust. Staff said the trust provided information about staff engagement and the trust's improvement agenda, which was delivered locally by managers. However, senior management in the trust, other than the Chief Executive Officer, were not as visible and staff were not sure who they were.

# Summary of findings

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

**Are services safe?**
Staff at all levels understood safeguarding procedures and were able to demonstrate this. Incidents were reported and there were governance systems in place to make sure learning from incidents was used both in the service and across the trust. Clinical areas had identified risks and had processes in place to make sure that these were avoided where possible. However, the service should ensure it identified and recorded all environmental safety and infection control risks and feed these into the clinical governance system. Manages should ensure that patients and staff were not placed at risk of unsafe practice because evaluation of risks had been completed but were not acted upon.

**Are services effective?**
Staff had an in depth knowledge of clinical best practice and national guidelines. The service had developed research based practice on Body Awareness Therapy (BAT) and were using this as a treatment programme in the unit. The service was a member of a recognised peer network and contributed to national studies and guidance on eating disorders. It also used a number of specialist outcome measures to ensure that its effectiveness was assessed. Since 2010 patients; satisfaction with the service had increased by 100%. The service offered five treatment programmes recovery, intensive care, risk reduction, stepped-care, and symptom interruption. This programme was in excess of NICE guidance. Patients set goals with staff to reflect their individual treatment programme. The YCED was also involved in research and evaluation. The clinical lead was the chair of the Royal College of Psychiatrists' Eating Disorders Section.

**Are services caring?**
Patients told us staff were thoughtful, kind and respectful. We saw care being delivered in a compassionate, inclusive and responsive way. In addition, patients' needs were met regarding specific cultural, religious and gender-based issues. They also had access to information about the service and were involved in decisions taken about their care.

**Are services responsive to people's needs?**
The specialist eating disorders service had adapted the range of services offered to meet the changing needs of patients. The inpatient, community, outreach and outpatient services were focused on recovery at the pace determined by the needs of individual patients who used the service and we saw this through

# Summary of findings

the care planning documentation, which was clear and individualised. Groups were offered to support patients develop appropriate methods of expressing emotions as well as learning skills to improve their quality of life and self-management.

**Are services well-led?**

Staff in the service told us that they felt the local leadership was supportive. There were also strong local clinical governance frameworks in place which sought feedback from patients about the treatment options and range of therapeutic activities available to them. This made sure that information was passed from management to the staff who worked directly with patients, and information from the services was passed up to the management. We saw that learning from incidents, complaints and internal audits was used. However audit and improvement of the health and safety of the ward environment and the prevention and control of infection needed to improve. Staff were aware of who the Chief Executive Officer (CEO) and Director of Nursing and Governance were, but not the other members of the leadership team at Board level.

The service had its own research programme aimed at developing effective treatment programmes for adults with anorexia nervosa, bulimia nervosa and related eating disorders. The service has its own research team, led by the clinical lead and a PhD student investigating the relationship between autism spectrum disorder features and treatment completion in eating disorders. The service has published 17 research papers in 2013-2014.

# Summary of findings

## Background to the service

The Yorkshire Centre for Eating Disorders (YCED) offered a 19 bed in patient unit located on the third floor of the Newsam Centre. This specialist service was delivered through a multi-disciplinary team which consisted of Occupational Therapists, Dieticians, Clinical Psychologists, Health Support Workers, Specialist Nurses and Psychiatrists. Structural changes had been made to the inpatient environment to include a two bedded male area, which met the guidance for same sex accommodation. The male inpatient area had its own bathing/toilet facilities and lounge. These facilities were located at the opposite end of the unit to the female in patient accommodation

The inpatient unit offered five treatment programmes: recovery, intensive care, risk reduction, stepped-care, and symptom interruption. Individual treatment sessions offered psychological interventions to individuals with bulimia nervosa and anorexia nervosa, including cognitive behavioural and interpersonal therapies. The YCED also saw a high proportion of general hospital referrals, with the ability to manage complex associated medical needs including nasogastric feeding.

The inpatient eating disorder service was commissioned by NHS England and operated nationally as a seven day service in accordance with the national specification.

**Community**

The multi-disciplinary community service started in January 2013 and was based within the eating disorder service. It provided a specialist intensive community based service for adults with severe and enduring eating disorders registered with Leeds GPs. This followed a successful pilot of an outreach service in 2012. The findings showed the service was successful in facilitating reduced admission to hospital and supported patients through intensive specialised support in the community; which allowed patients to stay in familiar environments and with the family unit, particularly mothers with their children. The Community Treatment Service can offer limited intervention over a weekend and will be delivered by Health Care Support Workers. The Community Treatment Service operational hours are 08.00hrs to 18.00hrs.

The community service was commissioned following the successful outreach pilot. It became fully operational in January 2013. The service offers an intensive home intervention programme. The team worked alongside GPs, other primary care professionals, Leeds Teaching Hospital Trust, the voluntary sector and social services.

**Outpatient**

Most patients referred to YCED were treated on an outpatient basis. The outpatient service also offered treatment 7 days a week and outside of office hours if requested. Individual treatment sessions for patients with bulimia nervosa and anorexia nervosa were offered. There was access to cognitive behaviour therapy, interpersonal psychotherapy, dialectic behavioural therapy and cognitive analytic therapy.

## Our inspection team

Our inspection team was led by:

**Chair:** Michael Hutt, Chief Operating Officer, Cumbria Partnership NHS Foundation Trust

**Team Leader: Jenny Wilkes**, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Consultant occupational therapist specialising in eating disorders, specialist eating disorder nurses and mental health social worker.

## Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

# Summary of findings

## How we carried out this inspection

To get to the heart of people who use 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?

Before visiting, we reviewed a range of information we held about the Yorkshire Centre for Eating Disorders (YCED) and asked the trust to share information we requested from them prior to and during the inspection. We carried out an announced visit on 30 September and 2 October 2014. During the visit we spoke with a range of staff who worked within the service, such as nurses, doctors and therapists. We talked with five inpatients and observed how they were being cared for. We talked with a patient who was supported by the community outreach team and a patient who was treated on an outpatient basis. We reviewed care or treatment records of five inpatients and six community/outreach patients. We attended a multi-disciplinary team meeting as well as a community meeting involving both patients and staff. We also attended a staff handover and weekly team business meeting as well as observing patients being supported during a meal.

We spoke with two consultant psychiatrists, one associate specialist, one junior doctor, the Director of Nursing and Quality, operations manager, ward manager, community team manager, community nurse/ psychological therapist, community health support worker, research nurse, three staff nurses, inpatients health care assistant, occupational therapist, dietician and psychologist.

## What people who use the provider's services say

During our visit, we spoke with patients who used the inpatient services, community and outpatients services. All of the feedback we received was very positive and reported that the care provided was caring and responsive to their needs. Patients reported being involved in decisions about their care and treatment, which took account of their individual treatment goals. The services were described as improving the quality of patients' lives as well as flexible and discreet.

## Good practice

The service had developed a research framework specific to the service, which ensured staff were involved in the development of research based practice and had a programme to learn and understand issues specific to people with eating disorders.

The service undertook exit interviews for patients leaving the service which underpinned the review of outcome measures which the service used to quality assure service delivery.

Leeds and York Partnership NHS Foundation Trust

# Specialist eating disorder services

**Detailed findings**

## Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| Ward 6 Yorkshire Centre for Eating Disorders | The Newsam Centre |

## Mental Health Act responsibilities

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

We found that staff in the service were aware of their duties under the Mental Health Act (1983) and had received their mandatory training in this Act.

During our visit there were 18 in patients who were informal and not detained under the Mental Health Act.

## Mental Capacity Act and Deprivation of Liberty Safeguards

We found that staff on the ward, and in the community team, had policies and procedures related to the Mental Capacity Act and the inpatient manager had an awareness of the Deprivation of Liberty Safeguards and knew where they would be able to receive further advice if necessary were there to be a concern.

# Are services safe?

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

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

## Summary of findings

Staff at all levels understood safeguarding procedures and were able to demonstrate this. Incidents were reported and there were governance systems in place to make sure learning from incidents was used both in the service and across the trust. Clinical areas had identified risks and had processes in place to make sure that these were avoided where possible. However, the service should ensure it identified and recorded all environmental safety and infection control risks and feed these into the clinical governance system. Manages should ensure that patients and staff were not placed at risk of unsafe practice because evaluation of risks had been completed but were not acted upon.

## Our findings

**Safe and clean ward environment**

Patients were provided with care in a clean and hygienic environment. The ward areas were comfortably furnished and when we looked around them they were clean. The trust had a contract with a company 'Interserve' to provide domestic and catering services to the ward. We spoke with the domestic staff member on duty and looked at the cleaning schedule for the ward. We saw the domestic staff member had a cleaning schedule for the communal and bedroom accommodation as well as bathing and sanitary areas. Interserve were responsible for the ward kitchen hygiene and monitored fridge temperatures for food storage. We saw some patients' meals supplied as part of their treatment programme were stored in the fridges and labelled with the date of preparation.

We looked at the therapy kitchen and storage of food purchased by patients as part of their individual menu planning. The therapy kitchen was clean and was the responsibility of Interserve. However, the ward staff were responsible for monitoring fridge temperatures for the domestic fridge and freezer located in the therapy kitchen and for the labelling and disposal of food. We saw in the domestic fridge packets of opened cooked meat without a date of opening on it, although they were still within the date of use. We also saw a container of custard with a date of opening on it, where the ink had run and it was not possible to determine the date. We saw ward staff were monitoring the fridge and freezer temperatures and the ward manager told us staff emptied the fridge daily of food which patients had not labelled with a date of opening or date of use. When we observed the community meeting minutes going back to June 2014. We saw that patient food storage in the therapy kitchen was a regular topic of discussion. As a result we concluded staff were monitoring the safe storage of food in the therapy kitchen.

The ward had a fully equipped clinic room which was clean, though we noted the medicine trolley surface was dirty. Resuscitation equipment was available, in date and tested regularly. We saw the clinic room's cleaning schedule and records. Equipment was checked daily and this included emergency drugs and audit records; these provided evidence the clinical room and emergency equipment was checked daily. A health support worker showed us how the defibrillator and electrocardiogram (ECG) machine worked, and was trained to use this equipment.

Because of the shape of the ward, corridors, bedrooms, bathroom/toilet and lounge areas could only be observed from each end of the corridor or from the central point. The male lounge, bathroom and ward laundry room could not be observed directly from the central point of the corridor. Owing to the conditions patients were being treated for, the use of curved mirrors to observe blind spots was not deemed appropriate. Each bedroom door had a viewing panel, which as part of the patients' treatment programme had to be left open when their bedroom was occupied during the day.

There was an infection control lead based on the ward. The lead showed us the last infection control audit from May 2014. This highlighted a number of actions that needed to be improved upon regarding the cleaning of the ward environment and supplies of disposable hand towels from Interserve. During our inspection of the ward we noted that there was only one hand sanitising dispenser at the entrance to the ward, no soap or soap dispenser in the male bathroom/toilet and two toilets did not have foot operated bins for the disposal of hand towels. This meant patients and staff were at risk of or a source of infection

due to lack of suitable equipment. This had not been identified by the infection control lead for the ward. The clinical services manager took immediate action to ensure the infection control lead ordered the appropriate equipment. The ward infection control lead told us the trust infection control lead audited the ward environment. We requested and received the last infection control audit carried out by the trust in December 2013. There were no actions identified from the audit though there was non-compliance in the shower/toilet due to unclean and inappropriate equipment (wrong shower chair) and no privacy curtain. The audit identified toilets and bathrooms had foot operated pedal bins, which was not consistent with our findings. There were also issues identified from the audit with cleanliness of the kitchen as there was no cleaning schedule. During our inspection, we saw there had been an improvement in the cleanliness of the kitchen and appropriate cleaning arrangements were in place. The audit tool template used by the trust to record the findings of the infection control audit made reference to a number of published Department of Health guidance documents. However, it did not refer to Department of Health's publication: The Code of Practice for health and adult social care on the prevention and control of infections and related guidance. The infection control audit action plan completed in May 2014 had addressed a number of concerns around cleanliness which had been addressed through Interserve.

We looked at the ward's health and safety audit for May 2014. This was detailed but there were a number of requirements relating to load management, display screen equipment, personal protective equipment, hazardous substances and stress risk assessments for staff not met at the time. An action plan for completion had been provided to the ward. When we discussed the action plan with the operations manager and ward manager they confirmed the actions were still outstanding. This meant patients and staff were at risk of unsafe practice because evaluation of risks had been completed but were not acted upon.

The ward also had a specific ligature risk assessment which we saw which ensured that the areas identified as potential risks were rated according to the level of risk and a risk management plan determined. This meant that people were protected from environmental risks. There were identified ligature points related to hand wash basins in toilets and bathrooms with pedestal taps, which were a historic problem noted throughout other wards located in the building. We also noted a number of hazards in the ward as the toilet seats were plastic with raised fittings and mirrors on the ward were glass. The toilet seats, fittings and glass mirrors were not identified on the ligature or environmental risk assessment as being risk to patients. This meant risk assessment was not being carried out competently. A local risk register had commenced and the ligature points and other safety issues we raised were not recorded on this or the trust risk register when we were shown this. The trust risk management ligature policy stated the ligature risk assessment should be completed at six monthly intervals. The ward was completing the risk assessment at four monthly intervals. We looked at incident forms for July to September 2014 and three ligature incidents were recorded which related to one patient, which had resulted in no injury.

**Safe staffing**

We were told recent vacant positions had been recruited to and there was a full complement of permanent staff on the ward. In the community and outreach services there were no vacancies. The operations manager told us staffing levels displayed on the ward. were based on NHS England Guidance and the trust used an electronic recording system to report staffing numbers each day to the governance team so staffing numbers could be monitored. . The staffing figures displayed confirmed the minimum staffing levels were regularly exceeded and did not include the operations manager, ward manager or other health professionals. From this information we concluded safe staffing levels were provided.

The five patients we spoke with did not raise any concerns about staffing levels on the ward. One patients told us, "There are always enough staff if you need to talk, supervise meal preparation and for groups. Therapy is never cancelled".

We looked at the arrangements for staffing in the community/outreach service. The eating disorder community service was initially commissioned by NHS Leeds. It has a limited capacity to offer treatment over 7 days but weekend treatment interventions are delivered by Health Support Workers if required. The Community Treatment Service was commissioned following a successful pilot of an outreach service which had been commissioned by Leeds PCT. The Outreach Service continues to operate as part of the community treatment service**.** The YCED Local working instruction document set

out the operational hours for the service which could include evenings and weekends, but this had not been requested as yet by patients. The service operated until 18:00 hours. We looked at the trust lone working policy and the arrangements in place for staff in the service working outside of normal hours. We discussed the lone working policy with a staff member, who showed us how this worked in practice. We saw when staff were lone working they had to follow a strict protocol. This included updating their electronic diary and PARIS which was an electronic patient care record, if risks had been identified with individual patients and discussing this with their supervisor. An 'at a glance board' in the main reception office was completed with time of leaving, expected time of return, details of the visit and any known risks. This was monitored by the appointed administrator. In keeping with the trust lone working policy if staff did not return within the specified time they would be contacted by the administrator who would use a code word to check if the worker was safe. The staff member we spoke with was clear on the policy, procedure and code word to use.

**Assessing and managing risk to patients and staff**

We looked at individual records on the ward and found that risk assessments and risk management plans were completed and up to date, reflecting the specific needs of individual patients. We looked at the Functional Analysis of the Care Environment (FACE) assessment tools for ten patients in inpatient and community/outreach services. The FACE assessment was used to assess areas or risk related to patients such as substance misuse and mental capacity, and included risk indicators for the risk of violence, self-harm and self-neglect. We looked at records on the PARIS system. The FACE assessment was completed by the registered nurse or junior doctor on admission. The FACE assessment linked into other risk assessment, risk management and treatment plans for monitoring physical health and weight gain. Risk assessments were reviewed daily or more frequently dependent upon individual patients. For example, one patient expressed distress during our visit so their risk assessment was amended and their level of observation increased.

We asked all the ward staff about the use of restraint. They could not recall the last time restraint was used. They explained restraint would be recorded in individual patient records and an incident report form, or IR1, would have to be submitted to the operations manager. We looked at the IR1 forms for July to September 2014 and only one incident of restraint was recorded.

There was no seclusion room on the ward. The five patients we spoke with were aware the ward was not a 'locked ward' and as informal patients could leave at any time.

The YCED community treatment service 12 month report for 2013-2014 recorded three incidents. One related to the known concerns about parking arrangements at the Newsam Centre, which meant a staff member's car was blocked in and therefore could not provide a full visit to a patient. Two other incidents related to verbal abuse by patients who were in their own homes. As a result both incidents were looked at and lessons learned from the incidents: the patients were visited by two staff due to the risk, or the use of NHS premises were considered in which to conduct appointments with patients while the risk of future home visits were monitored.

We looked at medicine management arrangements on the ward, which included interviewing the clinical pharmacist covering the ward. We looked at 18 medicine administration records and observed two nurses administering medicines to patients. We observed two staff administered medicines in the morning as this was the busiest round and this arrangement reduced the likelihood of errors occurring. Medicines were prepared in the clinic room, one patient at a time, and then taken to each patient. We saw the nurse signed the administration record once they had witnessed the patient taking their medication. We saw medicine storage was well organised and clean. Medicines were stored securely and at the right temperature. The clinic room was air conditioned. We looked at emergency drugs and noted the resuscitation tray was due to expire in December 2014. This had a sealed tag to confirm this had not been opened. Guidance was available for the use of medication used for respiratory depression following the use of rapid tranquilisation, as well as adrenaline doses for anaphylaxis and cardiac arrest.

We noted the medication fridge thermometer was not one that showed a minimum or maximum operating temperature. This was not suitable for monitoring the fridge's accurate operational temperature. Staff administering medication said the thermometer had broken and they were using a 'super thermometer' which had been purchased. As a result, the medicines stored in

# Are services safe?

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

the drugs fridge were moved to another ward until a suitable thermometer had been obtained. We noted fridge temperatures were being monitored but there were some gaps in this.

We looked at the previous month's auditing of medicines, completed weekly, by the registered nurses on the ward. No concerns were identified in these audits. Since the audits had been introduced, previously identified 'gaps' in records had reduced. We noted that findings in medicine audits were discussed at the handover we attended. Of the 18 medicine administration charts we saw, we noted one possible recording error. As this was the first day of the chart being used accepted this may have been recorded on the previous chart in use before the new one was re written. No other shortfalls were noted.

We saw that the service had systems in place to ensure that medical emergencies could be dealt with on site with access to emergency medication, defibrillator and crash bag ready for use. The building, which was managed externally, had contingency plans in the event of power failure or telecommunication failures.

**Reporting incidents and learning from when things go wrong**

Staff we spoke with said they felt able to report concerns to their managers. We saw that incidents across the service, across specialist services based at The Newsam Centre and the trust were discussed in business team meetings with staff to ensure that learning was embedded. Staff gave us examples of trust wide learning being disseminated on the trust intranet. One staff member told us they could not specifically recall practice which had changed following incidents as there were not many serious incidents and said, "Any incidents are reported by the IR1, and discussed in handover or at weekly meetings. Incidents that are reported from other wards here or across the trust are shared. I think we cover incident reporting very well as it's encouraged".

Staff were able to explain previous incidents that had occurred in the service and what they had learnt from those incidents. There was a specified process to report incidents which staff were aware of and were able to explain to us. The ward manager checked and signed off every incident which was reported. We checked incidents which had been reported on the inpatient ward for the last three months and saw that they were completed and recorded on IR1 forms, which was the paper system which the trust used.

Staff had received training regarding safeguarding processes and awareness for adults and children. We spoke with staff about the identification and reporting of safeguarding concerns and they were able to explain the process, and had a good understanding, of safeguarding procedures and policy within the trust. A health care assistant (HCA) showed us the trust's intranet where the safeguarding adults and children policies and procedures are held for staff to access. The five staff we interviewed were able to identify who the trust's safeguarding children and adults leads were and that there had been a recent change to the adults lead. Another HCA showed us the ward safeguarding file which contained paper copies of the trust's safeguarding children and adults policy on how to recognise, respond and report suspicions of abuse or neglect. This also contained information about the Mental Capacity Act 2005 and had the documents and guidance on how to make a referral for a deprivation of liberty or for an independent advocate.

We saw that no recent safeguarding adults' referrals had been made. The ward had introduced a local tracker to record any safeguarding children or adult referrals. The inpatient service used the FACE and Care Programme Approach (CPA) assessment documents to identify any safeguarding children or adult risks to patients. The service undertook a periodical audit of a random number of patients to review these documents against the patients' current care plan to ensure this information was recorded. We saw the audit for June 2014, which identified that six patients, had historical risks identified in the FACE and / or CPA assessment but there were no current concerns related to their current care plan.

Trust level performance for safeguarding children training 2014-2015 was 81%. For the care group in which the eating disorder service was located the performance was green at 86%. Trust level performance for safeguarding adults training 2014-2015 was 80%. For the care group in which the eating disorder service was located the performance was amber at 81%. We looked at the individual staff training records for the service which reflected these figures. The service had recruited five new staff which may account for the figures but in looking at the grades of staff,

# Are services safe?

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

this included registered nurses and clinical psychologists who had been employed in the service for several years. As a result we concluded this was an issue for management supervision as the figures reflected a small number of staff who had not completed all the parts of their compulsory training.

# Are services effective?

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

Staff had an in depth knowledge of clinical best practice and national guidelines. The service had developed research based practice on Body Awareness Therapy (BAT) and were using this as a treatment programme in the unit. The service was a member of a recognised peer network and contributed to national studies and guidance on eating disorders. It also used a number of specialist outcome measures to ensure that its effectiveness was assessed. Since 2010 patients; satisfaction with the service had increased by 100%. The service offered five treatment programmes recovery, intensive care, risk reduction, stepped-care, and symptom interruption. This programme was in excess of NICE guidance. Patients set goals with staff to reflect their individual treatment programme. The YCED was also involved in research and evaluation. The clinical lead was the chair of the Royal College of Psychiatrists' Eating Disorders Section.

## Our findings

**Assessment of needs and planning of care**

Staff showed a good awareness of best practice in working with people with eating disorders, including current National Institute for Clinical Excellence NICE guidance. The service offered five treatment programmes recovery, intensive care, risk reduction, stepped-care, and symptom interruption. This programme was in excess of NICE guidance. We looked at FACE assessment documentation for patients on the ward and receiving support from the community/outreach team and saw that patients were assessed comprehensively on admission and referral to the service for the treatment programme of their choice. We saw patients had up to date, individual care plans which reflected their preferences and needs. Patients set goals with staff to reflect their individual treatment programme, for example to reach a target weight.

Information about up to date practice was disseminated through team meetings. We checked that capacity to consent was recorded appropriately and saw this was recorded on the PARIS system for both inpatient and community patients. All of the people we spoke with on the ward, community and outpatients told us that they felt they were engaged in decisions and care planning. One patient showed us they had a copy of their care plan and said, "This has been all of my words and work. I did not want the full recovery programme and this decision was discussed between me and Dr….I have been involved all along and set my own goals, which I have achieved. I passed my target weight and am ready for discharge. My discharge plan was discussed during my first CPA meeting after two weeks and again at CPA before discharge".

When patients were admitted to the ward their physical health needs were screened and this was frequently carried out during their admission. For example, on admission patients would have an ECG and full blood count check for every day during their first week of admission and then it would be monitored continuously depending on need. Patients also had a bone scan if one had not been completed within two years.

We were shown the ward and trust risk register regarding two risks the inpatient service had identified and that the risks had been reduced by existing controls and other controls/actions. For example; an identified risk was in relation to patients who fell below the recommended weight/BMI for treatment at YCED when they could become physically compromised. The medical monitoring of physical health, including ECG and blood on a daily basis for these patients, was a control associated with the risk. Also the service had an arrangement with Leeds Teaching Hospital Trust to transfer patients, who needed to be medically stabilised and for re-feeding, for up to 14 days. This meant the service recognised the risk that it could not meet the needs of these patients and had made suitable arrangements to ensure they had access to appropriate treatment. From the information we saw we concluded the controls in place were sufficient to manage the risks identified.

The psychologist told us that all inpatients received psychological assessments within two weeks of admission and received ongoing therapy. When patients were discharged from inpatient services they could still access psychological therapies if they were supported by the community or outreach services and for up to 12 months following discharge to outpatient services. A patient we spoke with who was treated on an outpatient basis told us they had benefitted from the 12 months of follow up and 'talking therapies' they had received and this included weight monitoring which was still ongoing.

# Are services effective?

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.

The service accepted direct referrals from GP Practices within Leeds if they had a patient with a body mass index (BMI) of 15 or below and had had a physical risk assessment indicating the need for admission to a medical ward was not necessary. Referrals were accepted from local community mental health teams if patients had a care coordinator and had moderate Anorexia Nervosa: for example, if their BMI was 15-17, where weight loss was induced by restriction of food intake, self-induced vomiting, self-induced purging, excessive exercise, use of appetite suppressants or diuretics. The service provided assessment, treatment and consultations for patients with an eating disorder that did not meet the referral criteria if they had complicating factors such as diabetes and pregnancy. The clinicians, operations, ward or community team managers were involved in joint assessment of these patients. This meant patient's were assessed by staff that had expert knowledge in eating disorders.

Specialist assessments were offered to new patients to the outpatient service. These assessments were carried out by medical staff, and usually involved clinical, carer, medical risk and motivational assessments. The average length of the specialist assessment was two hours. This meant patients received a thorough rounded assessment of their needs to determine which treatment programme was effective for them. 135 assessment appointments were offered and 99 patients attended their appointments, 22 (16%) cancelled and 14 (10%) did not attend their appointments. A number of service users cancelled (3) or did not attend (4) more than one appointment

**Best practice in treatment and care**

The trust provided us with information that between April 2013 and March 2014 the service received 280 referrals. 133 (47.5%) were from Leeds and 147 (52.5%) were from out of Leeds area. On average the service received 23 referrals per month. However, 93 (33%) referrals were not accepted because they did not meet YCED referral criteria. The average bed occupancy for the inpatients service was 15. From the data supplied by the trust we concluded that the effectiveness of treatment had improved. The length of stay had reduced from 79 days (11.3 weeks) in 2012- 2013 to an average length of stay of 8 weeks (56 days) 2013-2014.

During 1 April 2013 to 31 March 2014 the inpatient service had 71 discharges, which averaged at 6 discharges per month. Fifty two (74%) patients completed treatment and 18 (25%) patients took their own discharge. The data showed 11 (12.5%) patients took their discharge within the first four weeks and seven took their own discharge between 31 and 161 days. The length of stay was based upon which treatment programme option patients had decided upon and what their individual treatment goals had been. This meant that patients benefited from the range of treatment options and could opt for a shorter stay in hospital.

All discharged patients were offered appropriate follow up and as recommended by NICE guidelines. Patients were provided with 12 months outpatient follow up post discharge, where this was desired, by the patients' local services. Seventeen (24%) patients were offered follow up appointments at YCED, 11 (15.5%) by the YCED community team and the majority 43 (61%) by their local services. From this information we concluded the service activity had increased because of a greater number of referrals from a wider area for this specialist service.

The community treatment service from April 2013 to March 2014 treated 48 patients. 40 patients were new referrals and 8 patients were already being treated by the service prior to April 2013. There were 21 discharges during the same period. The average length of treatment was 136 days (19 weeks). This meant more patients were opting to be treated at home as an alternative to the inpatient service.

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The service's annual report for 2013- 2014 of the evaluation of all these outcome measures regarding physical outcomes and patient experience showed an increase in patients' satisfaction with the service they had received. Compared to data from 201 to 2014 there was a 100% increase in patient satisfaction. This data was used to look at the effectiveness and outcome of interventions. Patients were invited to complete outcome measures at the entry to and exit from the service. A 50% return rate was achieved from patients for 2013-2014. The data from the annual report demonstrated that patients' severity of symptom scores reduced at discharge in comparison to assessment/ admission scores. For example, on the Eating Disorders Examination – Q pre intervention the outcome measure was 47% and post intervention was 61%. Clinical Outcomes in Routine Evaluation pre intervention the outcome measure was 47% and post intervention 61%. Eating Disorders Quality of Life pre intervention the outcome measure was 47% and post intervention 61%. HONOS pre intervention outcomes were 76% and post intervention

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77%. These scores suggested patients had made improvements in their mental and physical health, their weight had increased, and their ability to function and deal with their eating disorders had improved through better psychological functioning and problem solving.

The clinical lead for the service was the author of outcome measures related to weights and Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidance which was used for the management of people when it was appropriate.

The YCED was also involved in research and evaluation. The clinical lead was the Chair of the Royal College of Psychiatrists' Eating Disorders Section as well as an appointed Member of Healthcare Quality Improvement Partnership (HQIP) Mental Health.

The research programme aims to develop effective treatment programmes for adults with anorexia nervosa, bulimia nervosa and related eating disorders. The service has its own research team, led by the clinical lead and a PhD student investigating the relationship between Autism Spectrum Disorder features and treatment completion in eating disorders. The service has published 17 research papers in 2013-2014.

The service also produced its own outcome measures for weight gain. The annual report for 2013-2014 recorded the National Institute for Clinical Excellent (NICE) Guidance recommended weight gain of 0.5 - 1kg per week. The service performance was within the recommended standard. The average weekly weight gain for inpatients was 0.5kg. Data provided was that on admission patients on average had a BMI of 15.1 and at discharge this had increased to 17.1.

The service was part of the College Centre for Quality Improvement (CCQI) peer network, run by the Royal College of Psychiatrists, specifically for eating disorders services.

In 2012 the YCED was the (b-EAT) Eating Disorder Association best clinical team of the year. We saw further examples of how the service was using best practice in treatment and care.

We saw the November 2013 clinical audit of service standards for eating disorders. This audit measured local practice against six outcomes:

Methods of measurement included: patient questionnaires, staff questionnaires, environmental checklist, audit tool to access policies/protocols/patients records and minutes of business meetings, review of external data to gather trust wide data about supervision, audit data and senior managers/clinical leads questionnaire comprising of outcome measures, complaints, exit interviews and appraisals. The audit was recommended to be completed every two years. Overall, the service had improved upon the previous 2011 audit. From this information we conclude the service was using a variety of methods to seek feedback form patients and staff about the effectiveness of the service delivered.

We saw evidence which showed the service was involved in an evaluation of manualised body awareness therapy, (BAT 10). BAT 10 was a treatment programme of ten weekly sessions, of 90 minutes duration, of group therapy using a cognitive behavioural approach, addressing thoughts, feelings, behaviours and perceptions, together with mirror exposure. The programme included motivation and goal setting, addressing self-defeating behaviours, distorted thinking and core beliefs. It emphasised behavioural experiments carried out as 'homework'. BAT-10 appeared to produce significant improvements in patients' body image related behaviours, cognitions and emotions. Feedback from patients was overall positive, which resulted in no patients dropping out of treatment. Patients' feedback was the treatment was very effective as behavioural changes were rapidly noticed.

**Skilled staff to deliver care**

Information available to inpatients and patients in receipt of the community treatment service described the range of staff which made up the whole service. This included a range of staff from psychiatrists, mental health nurses, health support workers, dieticians, psychologists, psychological therapists, occupational therapists and administrative staff. There was an explanation of the specific roles of the staff within these teams. Patients in receipt of community services did not have access to occupational therapist staff.

Staff told us that they had access to compulsory mandatory and specialist training. We saw there was regular in service training sessions for staff based at the YCED, which had been developed as part of research. For example staff were trained on BAT 10 and Bat 4 groups that were part of the patients' treatment programme and developed at the YCED. BAT 10 consisted of ten weekly sessions, of 90 minutes duration, of group therapy using a

cognitive behavioural approach, addressing thoughts, feelings, behaviours and perceptions, together with mirror exposure. There were a maximum of eight patients in each group, facilitated by two trained therapists.

In addition we saw the trust's compulsory training figures for the eating disorder service. This included staff from all grades. Trust performance levels for compulsory training were rated as amber for all compulsory training. Service specific figures for the care group in which the eating disorder service was included performed better than the trust level figures for the first quarter of 2014-2015 :

1. Moving and handling: Trust level 79% and Specialist and Learning Disabilities care group 83%
2. Prevention and management of violence and aggression: Trust level 70% and Specialist and Learning Disabilities care group 79%
3. Fire safety: Trust level 78% and Specialist and Learning Disabilities care group 79%
4. Resuscitation: Trust level 68% and Specialist and Learning Disabilities care group 67%
5. Food safety: Trust level 77% and Specialist and Learning Disabilities care group 77%
6. Infection control: Trust level 76% and Specialist and Learning Disabilities care group 77%
7. Clinical risk management: Trust level 56% and Specialist and Learning Disabilities care group 55%
8. Safeguarding children: Trust level 81% and Specialist and Learning Disabilities care group 86%
9. Information governance: Trust level 74% and Specialist and Learning Disabilities care group 78%
10. Equality and diversity: Trust level 84% and Specialist and Learning Disabilities care group 87%
11. Health and safety: Trust level 84% and Specialist and Learning Disabilities care group 86%
12. Safeguarding adults: Trust level 80% and Specialist and Learning Disabilities care group 81%

We were shown local records for the inpatients and community services in relation to staff supervision and appraisal. All but two staff members had an appraisal completed in 2014. Staff in all areas of the service received regular supervision and felt supported in carrying out their jobs. We saw local records, for those registered nurses on the ward who had been trained to insert a nasogastric tube, which showed they had completed their annual refresher training. Patients told us that staff were competent and understood their roles.

The trust provided us with the training figures for all services, including the eating disorder service. This included staff from all grades. Trust performance levels for compulsory training were rated as amber for all compulsory training. Compulsory training included moving and handling, prevention and management of violence and aggression, fire safety, resuscitation, food safety, infection control, trust induction, clinical risk management, safeguarding children, information governance, equality and diversity, health and safety, and safeguarding adults.

**Multi-disciplinary and inter-agency team work**

The specialist services for eating disorders accepted patients referred through the single point of access team via secondary mental health services: for example, through their Community Mental Health Teams (CMHTs). Patients told us there were no delays in their referral to the service and there was a consistent pathway into the service.

Five members of staff told us there were good links with community mental health teams. For example, a health care support worker in the community team told us how they jointly supported a patient with a community mental health nurse.

We looked at the care and crisis plans for the two patients we spoke with who were supported by the outpatient and community team. We also looked at four care and crisis plans for four patients supported by the community and outreach teams. The plans included the details of the community mental health team and the crisis plan had the details of the out of hour's crisis team to contact if needed. There were details of how patients would utilise their own coping strategies to reduce their level of distress and anxiety, as well as using other individual distraction techniques identified with the team. At the multi-disciplinary team meeting we observed, representatives of the community mental health services were present to discuss individual patients. This meant the community mental health teams had consistent support from staff with a specialist understanding of eating disorders. The clinical services and community team manager told us they had attended community mental health team meetings when needed to share information and told us that when they had done this, it had led to better outcomes and working relationships for patients.

We spoke with one patient treated on an outpatient basis and one who attended an outpatient clinic. One person

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told us, "This is my first experience of this service; I hope it is my last but I would use it again. I thought the doctors and nurses understanding of me was amazing, but realised they know so much about …. (Diagnosed eating disorder) they were just talking about the condition and all the behaviours and not about me. They have helped me understand I don't have to go through this alone".

The inpatient service consisted of nursing staff, clinical psychologist, occupational therapist and assistant, dietician and assistant. When we visited there was an identified gap in psychology. The psychologist told us this had been discussed with the clinical lead and clinical services manager. This had been raised with the clinical governance committee and a decision to employ an additional psychologist had been agreed. The vacancy had been filled.

We spoke with the clinical pharmacist covering the ward. They told us they visited the ward once or twice a week to top up stock items and check medicines. The pharmacist clarified that all patient's medicines were reconciled on admission using NICE guidelines. They clarified they did not attend the MDT meetings, but a new clinical pharmacist had been appointed and would be attending the weekly medication review meeting which took place each Thursday.

Staff told us that they worked with other agencies through the inpatient pathway as well as in outpatients. However, there were varying relationships with local teams which could affect the pathways through the service for patients depending on their understanding of the specialist services for eating disorders. One example provided by a patient was when a referral had been delayed by community mental health team (CMHT) which affected their care access to the service. This was recognised by the community team who liaised with the patients' GP and CMHT care coordinator and the delay resolved.

The community treatment service was made up of psychiatrist, clinical team manager, primary nurse/key worker, health support workers, dieticians, psychologist/ psychological therapist and administration team. Therapists in the community treatment service were supported by the psychology services. They told us this was consistent in providing communication between services when patients were discharged and continued with psychological therapies.

**Adherence to the MHA and the MHA Code of Practice**

During our visit, no patients were detained under the Mental Health Act. We checked that the required paperwork was available on the ward, which it was. We saw that staff had received training relating to the Mental Health Act and were aware of the Code of Practice as it applied to their service. The 2013-2014 annual report provided to us by the trust recorded that ten (11.4%) patient were admitted formally under a section of the Mental Health Act. This figure was higher than the previous year.

Staff had training and understanding related to the use of legislation such as the Mental Health Act and the Mental Capacity Act to ensure that their actions in protecting people from harm remained lawful.

# Are services caring?

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

## Summary of findings

Patients told us staff were thoughtful, kind and respectful. We saw care being delivered in a compassionate, inclusive and responsive way. In addition, patients' needs were met regarding specific cultural, religious and gender-based issues. They also had access to information about the service and were involved in decisions taken about their care.

## Our findings

Are Specialist Eating Disorder Services caring?

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

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**CARING**

**Kindness, dignity, respect and support**

We spoke with five patients who used the service on the ward, one supported by the community team and one out patient. We also observed a multi-disciplinary team meeting, and community meeting involving patients and staff, as well as patients being supported during a meal. All patients spoke very positively about the care which they had received. Patients told us they were treated with respect. One person who was receiving treatment told us that things were explained to them and because of the explanations by staff they were reassured and understood their treatment, which helped them make decisions. Patients who used community/ outreach and outpatient services told us staff were friendly and respectful and listened to their concerns. One person told us, "I felt uncomfortable going into the outpatients' area and asking to see [a particular staff member]. When I explained how I felt and we discussed this I was offered to be met in person and did not have to ask to see [particular staff] as people might know why I was there. This helped me to carry on with treatment and not worry about people knowing why I was there".

We observed care was provided with empathy and explanations were given to people. Staff listened and responded to people they were supporting.

Patients we spoke with told us they felt supported by the service. We saw that, when appropriate, carers' assessments were carried out on the ward and there was a carer's support group. When it was indicated that families would benefit from education around eating disorders, this was facilitated as a result of carers' assessments and/or the carer's support group.

Staff had a good understanding of the different needs that patients had on the basis of gender, race, religion, sexuality, ability or disability. We saw that there was information available on the ward about access to a chaplaincy service, contact details for chaplains, as well as the option to request chaplains from religions which were not named on the leaflet (which covered access to Christian, Muslim and Roman Catholic chaplains). There was also information in the outpatient area about transgender support groups and helplines.

We spoke with staff who displayed understanding and awareness of different dietary needs relating to religious requirements. For example, ward staff and the dietician explained the trust had access to halal food if this was needed.

The service had access to interpretation services as required.

**The involvement of people in the care they receive**

All of the patients we spoke with told us they had been involved in planning their care although not all of them were specifically aware of a 'care plan' document. People on the inpatient ward had a named worker and the opportunity to have one to one sessions to discuss issues which related to them. We also sat in on a community meeting which was documented and minutes were available for patients to see. Responses to the issues raised were also followed up with comments and actions

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recorded so we could see these were being or had been addressed. For example, the ward manager was following up, via the governance process, issues raised by patients regarding the noise made by doors closing.

There was a comments box visible on the ward where patients could leave anonymous feedback if they did not wish to use the communal meeting.

The use of patient exit interviews allowed the service to gather a more detailed and qualitative evaluation of patients' satisfaction. The findings of the exit interviews were discussed in the YCED business meetings. The interviews were conducted by one of six members of staff using a standard interview schedule covering the following areas:

- Service user experience of the service
- Service user involvement in their care
- Views on individual session
- Views on group programmes
- Awareness of services such as PALS
- Views on accommodation

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Thirty-seven (52%) out of 71 patients were interviewed before they were discharged from the unit. The majority of patients stated their experience of the inpatient stay had been positive. Patients indicated the boundaries of the programme provided a safe environment. The positive aspects of their experience were support from staff and peers, attending groups, one to one sessions, regular meals, information on the effects of eating disorders, multidisciplinary team meetings and nutritional rehabilitation. This was consistent with the views of the five patients we interviewed in the inpatients service.

Service Users' Involvement in their Care: The findings of these interviews showed that patients were involved in their care and most of all felt safe during their stay on the ward. 37 patient responses received. The findings of the interview showed that patients were involved in their care and the majority felt safe during their stay on the ward.

Patients' views were sought on individual and group therapy. The reports recorded that all inpatients were offered one to one psychological support as all staff were skilled in facilitating self-help skills based on cognitive behavioural therapy or psychotherapy. Nearly all patients had weekly structured sessions and found this beneficial. The report also found that patients commented when the ward was busy and staff did not have times for their individual sessions, which were rearranged and not cancelled.

Comments included:

"Really helpful/really good. Structured, e.g. Self-esteem/ anxiety management".

"Valuable and helpful. Individual time to discuss concerns about weight and flexibility with diet."

"Good, helpful, advice sessions"

"Good OT input, especially initially. Little involvement more recently".

"Really good/really lovely. Structured".

The report found that some groups were not attended as patients thought they were optional and were not aware of how integral groups were to their treatment. Patients commented that more should be done to ensure they understood the importance of groups. The report identified this information was available to patients in the patient booklet as well as notifications on the ward. Patients requested the information should be reviewed to provide clarity on which were mandatory. The figures for nonattendance at groups were also looked into and some of these groups were not running at the time. As a result a review of the programme took place.

Awareness of Services such as PALS: All patients stated that their dignity, privacy, independence, confidentiality and human rights were respected during their stay. Responses were that information about the complaints procedure; PALS and Advocacy Service were in the patient information booklet and on the notice board in the communal area of the ward. This information was also displayed in patients' bedrooms. Patient's commented that they did not know about the services because they did not have the need to use them.

Ideas for Improvement: Some of the main areas for improvement included better menu options as a menu change had not been looked upon favourably (such as having to pair pasta with potatoes as a vegetarian option). There were comments regarding the general decor, such as "dark and dingy" when referring to the stage 1 dining room.

# Are services responsive to people's needs?

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

## Summary of findings

The specialist eating disorders service had adapted the range of services offered to meet the changing needs of patients. The inpatient, community and outpatient services were focused on the improvement of patients' quality of life and recovery at the pace determined by the needs of individual patients who used the service and we saw this through the care planning documentation, which was clear and individualised. The outreach service focused in improvement of quality of life and offered the recovery care pathway if requested by the patient. Groups were offered to support patients develop appropriate methods of expressing emotions as well as learning skills to improve their quality of life and self-management.

## Our findings

**Access, discharge and bed management**

Access to both inpatient and community treatment services were via the single point of access team, inpatient referral to community/ outpatients and vice versa as well as the children's and adolescent mental health transition team.

The inpatient services based on Ward 6 of The Newsam Centre were available for patients of working age. At the time of our inspection, there were no inpatients under the age of 18.The service offered 19 beds for inpatient treatment with two of these beds available for male patients. The ward could accommodate 20 patients if needed, but the service manager said the use of the additional beds was rarely used. The inpatient, community and outpatient services were focused on the improvement of patients' quality of life at the pace determined by the needs of individual patients who used the service and we saw this through the care planning documentation, which was clear and individualised. The outreach service focused in improvement of quality of life and offered the recovery care pathway if requested by the patient. Adjustments to patients' care were made according to their individual risk, recovery and goals they had set along with their equality and diversity needs. The premises were accessible to people who had mobility difficulties, though the ward environment was not suitably adapted to care for patients with disabilities at the time of our inspection. When we visited the service, there were inpatients from outside of the local area as the service was a regional resource. The service was able to meet the needs of the local community and patients were mostly admitted from the local area.

The community treatment teams offered two different levels of services. Tier one services were offered by the community treatment team and were more traditional outpatient services. Patients had a lead professional or care coordinator and access to a monthly diet clinic. Tier one patients did not receive support from a psychological therapist or health support worker and therapy was delivered at the Newsam Centre. If more intensive support was needed patients could move to tier two. Tier two was home based treatment which focused on the psychological as well as practical aspects of treatment. For example menu planning, shopping or eating out. Tier two support was multidisciplinary team led and focused on support and treatment which mirrored aspects of inpatients treatment.

The total number of contacts for both outpatient and community were 2227. Of the contacts arranged, 103 patients failed to attend their appointment. The "did not attend" (DNA) rate (4.6%) was lower than national average of 14.1% for mental health services.

One hundred and forty three patients were discharged from the service. The figure included:

- 21 patients were discharged from the community service.
- 43 patients were discharged from the inpatient service following an episode of care.
- 79 patients were discharged from the outpatient service either after a clinical assessment or after an episode of care in outpatient.

The inpatient service used four clinical outcome measures: Health of the Nation Outcome Scales (HoNOS) to assess clinical effectiveness. Clinical Outcomes in Routine Evaluation (CORE), Eating Disorders Quality of Life (EDQOL) and Eating Disorders Examination Questionnaire (EDE-Q) which is a self-assessment questionnaire used with people who have eating disorders.

**The ward environment optimises recovery, comfort and dignity**

The inpatient ward bedrooms ensured patients' privacy and dignity was maintained. Consideration was given to

# Are services responsive to people's needs?

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the needs of genders to have separate space. There were separate quiet/ family rooms which women could use if they wanted privacy away from other patients. There were facilities for patients to make telephone calls in private both on and off the ward. The information given to patients was clear that mobile telephones could be used on the ward in their bedroom areas and there were no restrictions about general use unless engaged in therapeutic activities.

Structural changes had been made to the inpatient environment to include a two bedded male area, which met the guidance for same sex accommodation. The male inpatients' area had its own bathing/toilet facilities and lounge. These facilities were located at the opposite end of the unit to the female inpatient accommodation. Patients had access to outside space such as landscaped garden area.

The environment on the inpatient ward was suitable and met the needs of patients. Bedrooms did not have en-suite facilities but there were sufficient bathing facilities and toilets available for patients to access. If patients were identified as having a 'high dependency' need they could be allocated a bedroom adjacent to the nurses' office for closer observations.

We saw the group programme for the week commencing the 28th September. The ward offered a full programme of group activities and support sessions for patients. The groups included psychological and psychosocial therapy and practical support. Specific groups included aims and objectives, reflective leave, menu planning, thoughts and feelings. There was body awareness therapy, creative expression, mindfulness, community, recovery and dietetic groups. Groups ran Sunday to Saturday and offered post meal support following lunch and relaxation before the evening meal with post meal support after it.

The community treatment services offered individual and group programmes to patients. Group work for tier two patients was from different MDT members and based on the decision that the therapy would benefit the patient and the expectation that tier two patients would attend group therapy. The therapy programme could be tailored to offer individual treatment programmes to patients. Group therapy for tier one patients was optional and needed to be identified as part of their treatment programme. Groups were offered to supporting patients manage their issues around food and eating, weight and body image. Groups were offered to support patients develop appropriate methods of expressing emotions as well as learning skills to improve their quality of life and self-management, for example anxiety management.

Groups offered to community patients were:

- Dietetics group
- Community support group
- Eating out group
- Body Image awareness group
- Relapse prevention group
- Creative expression group

The community service also ran a carer support group which met every two weeks.

On admission to the ward patients were provided with a 59 page 'information for patients' booklet containing patients' experience of YCED written by an ex-patient. Information from staff about the inpatient service included: the team of people who work on the inpatient unit and their roles, general practices on the unit regarding multidisciplinary team meetings, individual and group programmes, family meetings, CPA and physical health checks. The information booklet also contained information about the treatment programmes which were available to patients and what this meant. There was also information, for example, about clinical audit, complaints, advocacy, spiritual and pastoral care, and support groups. The final section contained the different diaries patients could use to record their reflections on the effects of eating on their whole life, food and weight, body image, dealing with emotional distress, self-harm or injury, goal setting and problem solving as some examples. There were also forms for patients to complete regarding consent to treatment.

In addition, there was an information booklet about the community treatment service, which had similar information to the inpatients' booklet but was specific to the community service.

Three of the five inpatients we spoke with said there had been some concerns raised about the quality of food provided by Interserve. This was recorded in the inpatient community meetings minutes from April to August 2014. The patients said the concerns were about food portion size and menu choice, but since raising the concerns there had been an improvement. Patients were also supported to plan and prepare their own meals as part of therapy and

there was fridge and freezer storage in the therapy kitchen area. As a result of the amount of activity for meal preparation a larger freezer had been ordered and delivered.

**Ward policies and procedures minimise restrictions**

The five patients we spoke with were aware of their legal status whilst in hospital and described the ward as an 'open ward', meaning they could leave at any time without restriction. There were no blanket restrictions in place. Patients told us that they had to agree to their individual treatment programme but could withdraw from this if they wished.

Patients told us as part of their treatment they had to agree to certain measures and restrictions. This included:

- Being weighed daily but usually twice a week
- Gaining up to 1kg in weight (NICE guidelines)
- Choosing meals from the hospital menu
- Having three meals a day and a pint of semi-skimmed milk
- Completing each meal in time: breakfast 20 minutes and other meals 30 minutes
- Having 40 minutes rest following each meal
- Restricting physical exercise

This information was also set out in the 'information for patients' booklet.

**Meeting the needs of all people who use the service**

Information provided to us during the inspection included the service's 2013-2014 annual report. From the report we saw the service used a validated satisfaction questionnaire (CSQ-8) to evaluate the experience of patients who used the service. Sixty-five completed questionnaires were returned (38 inpatient, 8 community and 17 outpatients) between April 2013 and March 2014. Most patients (80%) were satisfied with the service provided.

We saw the results of a patient satisfaction survey. The satisfaction survey reflected high patients' satisfaction with the service with the lowest score of the eight questions being 70% for meeting patients' needs and 97 % for recommending the treatment programme to a friend.

There was also a range of measures for involving patients in the development of the service. One inpatient we spoke with said they had been asked to complete a satisfaction survey before they were discharged from the service and said, "This is my first experience of treatment and can only say good things about it. I have had everything explained to me throughout and now I'm ready for discharge, they want to know about my experience. It's been a good experience for me". An outpatient told us, "In my exit interview I would say I have regained control over my life. The support has been self-affirming and [staff have] listened to me and valued all I have said. I haven't just blurted everything out and that was it. It's been talking therapy that has unpicked why I'm this way, done with dignity and respect and my self-esteem has grown".

There was information about a weekly support group which offered an informal 'drop in' where patients experiencing eating disorders could meet and talk about their difficulties. The group was facilitated by staff from the community team. We saw information about a carer support group displayed on a board in the inpatient unit. This offered carer training and support.

We attended a community meeting which involved both patient and staff. This was an informal meeting held weekly to discuss housekeeping rules, exchange information and share requests from patients and staff about events taking place in the ward: for example, patients reminding staff about closing doors quietly during the night and patients being reminded to label or throw away out of date food in the therapy kitchen fridge.

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We saw patients were involved in the evaluation of groups they were attending as part of their therapy. For example, from the July 2014 anxiety management group comments received included: 'Listening to others in the group and realising they had exactly the same issues and learning possible ways of dealing with our anxieties and getting our motivation back was the most useful', 'I've only done two sessions, but the learning/ theory side has been very helpful. I like having sheets to work on' and 'hearing other's thoughts and realising that I'm not alone in my panic/ habits'. We saw the residential unit newsletter, which provide information to patients about the research projects going on within the service, information about the service and support groups available.

Comments received from the 'Eating Out' group in June 2014 included: 'Ready to try and have a meal out with family and maybe then a friend. The group has helped my self-esteem and I feel more relaxed about treating myself

# Are services responsive to people's needs?

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

and more open to doing it', 'I definitely have come to understand feelings of fullness much more and shared this when going out for fish and chips' and 'I have found this a very useful group and gained so much from it'.

The operations manager told us information available to patients could be made available in different languages or formats on request, for example an easy read version for adults with a learning disability. There was also a telephone interpreter service available for patients.

**Listening to and learning from concerns and complaints**

We saw that information about how to make complaints was available on the ward. The service and the trust had a complaints policy which was clear. People told us they were aware of how to make complaints. We saw complaints were discussed in the weekly business and community meetings we observed to ensure that staff were aware of complaints made in the service and were able to respond to them through changing the service delivery where necessary. On the ward, there were information leaflets about the trust's Patient Advice and Liaison Service (PALS) as well as how to make a complaint using the trust's complaints procedure. We looked at two complaints made to the service. One from an outpatient and one on behalf of an inpatient. We saw, as a result, that the trust offered apologies for any distress or inconvenience experienced as a result of the complaints made. We saw the trust had learned lessons and made adjustments to the service as a result. For example, a patient felt it was punitive for psychological therapy being delayed because of the appointment system and the 72 hour 'period of reflection' (when a patient takes reflective leave to decide if they want to continue with their treatment programme). As a result of this feedback, the psychologist introduced an appointment card system and the exit interview questionnaire was amended to include a question about the period of reflective leave. This change in the service would be reviewed after six months to determine its effectiveness.

We saw the patient information booklets for inpatient and community services included details regarding PALS with a contact number and how to access further information regarding their service. The operations manager told us this information could be made available to patients in other languages or formats on request, such as an easy read version for patients with learning disabilities.

All patients we spoke with said they were aware of the complaints procedure but had not needed to use this. One community patient told us, "[staff] suggested I could complain about the CMHT when I had difficulties with my referral from them, but I did not consider this at the time. The YCED service has been really good and if I needed to complain the first person I would speak to is [staff name] as she is the only person I see from there".

The service's 2013 – 2014 annual report stated the service welcomed and listened to patients' feedback. We attended a business meeting on the ward and patients' feedback was discussed. One example used from the 2013- 2014 report of change made as a result of patient feedback was patients requesting to have more time to choose their treatment programme. On admission, patients had been asked to present their choice of programme within two weeks following admission. The service responded by moving the decision to select a treatment programme to the time the patient reached a BMI (body mass index) of 15.

# Are services well-led?

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## Summary of findings

Staff in the service told us that they felt the local leadership was supportive. There were also strong local clinical governance frameworks in place which sought feedback from patients about the treatment options and range of therapeutic activities available to them. This made sure that information was passed from management to the staff who worked directly with patients, and information from the services was passed up to the management. We saw that learning from incidents, complaints and internal audits was used. However audit and improvement of the health and safety of the ward environment and the prevention and control of infection needed to improve. Staff were aware of who the Chief Executive Officer (CEO) and Director of Nursing and Governance were, but not the other members of the leadership team at Board level.

The service had its own research programme aimed at developing effective treatment programmes for adults with anorexia nervosa, bulimia nervosa and related eating disorders. The service has its own research team, led by the clinical lead and a PhD student investigating the relationship between autism spectrum disorder features and treatment completion in eating disorders. The service has published 17 research papers in 2013-2014.

## Our findings

**Vision and values**

Staff at all levels and in all areas of this service said they felt that local leadership in the service were supportive of them. Staff told us that they felt proud to work for the service and for the trust. Staff received information about the trust via the intranet. Two staff told us they had met the trust's chief executive, who had visited the Newsam Centre, but were not specific when this was. One staff member told us, "I know who the CEO is; he visited here some time ago. He also sends out his blogs and invites staff to email him with ideas and comments and service. He seems like a nice person. I don't know anyone else really apart from the director of nursing, who is approachable and talks to staff. Our managers are really supportive. [The lead clinician] is down to earth and he sees this is a team effort and praises his staff. [As for the operations, ward and community team managers] you just couldn't ask for better managers. It's the ones above them who I don't know as we never see them".

The managers in the service whom we spoke with had a clear understanding of where the service's strengths and weaknesses were. Managers were able to identify them as well as recognise areas to focus upon for future service development.

**Good governance**

The operations manager, inpatient and community team manager had regular weekly meetings with the team. The operations manager told us they attended a three monthly clinical governance meeting which they had requested; this had been revised and was going to be monthly with a patients' representative.

We saw local clinical governance was very well developed and there was overwhelming evidence of patient and carer involvement in their treatment.

We saw local training records for supervision and appraisal which clarified nearly all staff had an annual appraisal. We were also shown records for staff completing nasogastric tube feeding, and the Royal College of Psychiatrists CCQI Accreditation for Inpatient Mental Health Services (AIMS) for 2014, which covered a range of mandatory standards the service had to meet to gain accreditation. We saw the completed documentation for submission/award of AIMS which recorded that staff had met the standards for AIMS to be awarded. For example:

- All staff received an annual appraisal and personal development planning or equivalent.
- Clinical supervision occurred at a minimum of every eight weeks, or more frequently as per professional body guidance.
- The ward/unit had a clear system of monitoring and auditing supervision. This was reviewed every 12 months.

The trust provided us with data about staff compulsory training: the 'Statutory and Mandatory Learning Programme'. The trust had a compulsory training policy, which was supplied as part of the trust's data pack, and a full action plan was in place. The action summary stated that the main objective was for the trust to be 85% compliant for all compulsory training, statutory and

mandatory learning by April 2014, and rising to 90% compliance by April 2015. The compliance of compulsory training was also an item monitored through the Risk Register. In April 2014 the trust reported a compliance level of 78%, which was rated as 'Amber' for staff training, both statutory and mandatory training.

The trust's compulsory training project had delivered the following improvements:

- curriculum reviews of resuscitation, moving and handling, infection control, personal safety theory based upon a risk based approach
- Risk assessed and increased refresher periods for PMVA and moving and handling
- Increased access to compulsory training data to individuals, line managers, Directorates and trust governance to increase performance

The trust's Compulsory Training Project still needs to deliver the following improvements:

- Curriculum reviews for Fire Safety and all PMVA during Q2-3
- An options appraisal on the e-learning system to determine whether to move from the information received through electronic staff records (ESR) to a commercial product with increased usability

We spoke with the clinical services manager and Director of Nursing and Quality about the recently introduced quality dashboard which we were shown. The Director of Nursing clarified this was an initiative recently introduced and had to be agreed by the governance committee before it could be rolled out. It was introduced to monitor local service performance against sickness absence, stress, nursing day and night hours, health care assistant day and night hours, budget control, serious incidents, CPA 12 month reviews, percentages of patients with an agreed care plan, nutritional screening within 72 hours and delayed discharge. As a result, we concluded the trust had recognised that local governance needed to be developed and monitored. For example, in the YCED the level of clinical governance was exceptional, yet the inpatient patient audits of the environment, health and safety practice and the prevention and control of infection needed to improve. We saw the service had developed a local risk register but there were risks missing from the ligature and infection control and risks assessments, which should have been noted and placed on the trust's risk register prior to the local risk register being introduced. Examples of missed risks included glass mirrors and plastic toilet seats in use on the ward. In addition the health and safety action plan had not been met.

Clinical governance on the ward was fed back through the weekly business meetings and this included information, from a range of audits carried out, being fed back to the staff. This ensured that staff had a good awareness of the strengths and weaknesses of the service provided and were able to identify the areas that required further improvement. The service produced an annual report of incidents from information provided by the risk management department. The service reported 287 incidents during the year April 2013 to March 2014 and all were graded as low using the trust's severity rating criteria score with scoring having been as one or two on a five point scale. This severity rating was mapped against the National Reporting Learning Service (NRLS) grading of no harm or minimal harm. The reporting of incidents was broken down as follows:

- Accident: 61% (25 incidents) of accidents reported affected patients.
- Clinical: 31% (29) of clinical incidents were medication incidents. 13% (18) of clinical incidents related to patients attempting to abscond (one patient was involved in 17 of these 18 incidents). 27% (25) of clinical incidents related to restraint of patient to give treatment or medication (one patient was involved in 23 incidents).
- Self-harm: 76% (86 incidents) of self-harm/attempted self-harm incidents related to one patient. All self-harm/attempted self-harm incidents resulted in no injury or only minor injury.
- 42% of all incidents related to one patient (121 incidents) and all occurred from April- August 2013.

The ward manager told us there was an 'occasional' audit of care notes and medical records and annual audits of documentation including PARIS, but we did not see evidence of this. We saw there were weekly audits of medicine administration records which had reduced the number of signature errors on the ward.

**Leadership, morale and staff engagement**

Staff in the service had a good understanding of the leadership both at a local and organisational level. Staff told us that they were aware of procedures if they wished to

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raise concerns internally and told us that they would feel confident in doing so. Staff across the service displayed an understanding and respect for colleagues and expressed confidence in the service delivering a good level of care. All staff told us that they felt the service was supported by the management team and that the trust was a good place to work.

Staff were aware of developments in terms of increasing their engagement with the trust; for example, the route via the trust intranet, to report concerns and issues directly to the chief executive. Staff also told us that they were aware of the trust wide listening into action initiatives. Although we were told that they had not had time to engage with this, despite wishing to, they felt it was a positive process.

There were routes available for patients to comment on the services they received. The inpatient ward had feedback and comments cards available. There was information on display about accessing PALS and the complaints mechanisms. There were weekly community meetings to ensure feedback could be gathered from patients regarding living together as a community. Patients we spoke with told us that they felt listened to locally and by the organisation. Patients had access to advocates.

The trust provided us with data about staff sickness and vacancy rates, which was supplied as part of the trust data pack. Staff sickness rates at the trust had been consistently above the England average for mental health and learning disability trusts over the two years between April 2012 and March 2014. However staff sickness rate in March 2014 was 4.6% which was 0.1% below the trust's target of 4.7% (2013/14) Compared to all NHS organisations across Yorkshire and Humber for the most recent quarter. The trust's average for January to March 2014 was 0.17 percentage points lower than the average for Yorkshire and Humber across all NHS organisations. The trust's sickness rates had consistently been lower than other mental health and learning disability trusts within the Yorkshire and Humber area. The ward manager monitored staff sickness rates for the eating disorder inpatients facilities and supplied us with the current staff sickness rates of 2.2%, which was significantly below the trust's average. The trust reported the total workforce on 30 June 2014 was 2961.8. There had been 382 substantive staff leavers in the last 12 months with a staff turnover of 12.91% and an 8.84% vacancy rate (excluding secondments). The trust provided details of all nursing vacancies across wards and locations at Leeds and York Partnership Trust. From the data submitted, there were around 80 vacancies for qualified nurses across the entire organisation. There were around 90 vacancies for health care assistants across the entire organisation. Eating disorder service figures for Newsam Ward 6 was a qualified nurse vacancy rate 0.46 and health care assistant 2.5. We were aware that there had been a turnover of staff due to retirement and promotion. There were no vacancies at the time of inspection.

**Commitment to quality improvement and innovation**

Across the service, we saw that local auditing of procedures, such as medicines management, infection control and health and safety were completed. Gaining feedback from patients about the treatment programme and services offered was a large part of how local improvements were achieved.

The service produced an annual report on overall service delivery. This was produced in conjunction with information received from the trust's Risk Management Department. The service also evaluated the treatment programme through patient exit interviews and satisfaction surveys. The governance process was able to collate outcome measures which looked at the effectiveness of the service. This information was then translated into the annual report. This meant that the team was focused on service improvement.

Carers were asked to complete a feedback questionnaire following their family member's discharge from the unit. The questionnaire had eight questions and carers were asked to rate their experience on a scale of one to four. Eleven (31%) completed questionnaires were returned. The findings showed the changes implemented following the 2012-2013 feedback were having a positive effect on carers' experience of the service. In addition, attendance at carers' support group had increased.

As a result of the innovative work in the service guidance leaflets had been developed for carers about the support groups available to them. The service had also developed guidance around driving and eating disorders. This was aimed at educating patients and the public about driving with a low body mass index and the dangers of low blood sugar, low blood pressure, risk of hypothermia and imbalance of minerals. The guidance provided information about these factors, which can all contribute to one another and increase the risk of accidents while driving.