Requires improvement

Surrey and Borders Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

18 Mole Business Park
Randalls Road
Leatherhead
Surrey KT22 7AD
Tel: 0300 55 55 222
Website: www.sabp.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXX22	Farnham Road Hospital (Mental Health Unit)	Health Based Place of Safety & Crisis Resolution Home Treatment Team – South West Hub	GU2 7LX
RXXHQ	Trust Headquarters	Crisis Resolution Home Treatment Team – Surrey Heath & NE Hants Hub Ridgewood Centre	GU16 9QE
RXXZ4	St Peter's Site	Health Based Place of Safety &	KT16 0QA

Summary of findings

		Crisis Resolution Home Treatment Team – NW Surrey Hub	
RXXHQ	Trust Headquarters	Crisis Resolution Home Treatment Team – Mid Surrey Hub Ramsay House	KT19 8PB
RXXHQ	Trust Headquarters	Crisis Resolution Home Treatment Team – East Surrey Hub Wingfield Resource Centre	RH1 4AA
RXX90	Crisis House	Crisis House, Great Meadows	RH1 6JJ

This report describes our judgement of the quality of care provided within this core service by Surrey and Borders 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 Surrey and Borders Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Surrey and Borders 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 the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated mental health crisis services and health based places of safety as requires improvement because:

- The outstanding compliance action from our previous inspection in 2014 concerning suitable systems to assess and manage risks had not been completely addressed. This was due to the recent introduction of a new database and lack of staff knowledge and understanding in its use.
- In some areas, rates of mandatory training were low, particularly around medicines management and we found that two patients had not had allergies recorded on documentation.
- There was inconsistency across the crisis resolution home treatment teams concerning completion of contingency plans, discharge planning and reporting incidents.
- There was inconsistency of staff completing the electronic risk assessment tool. The risk assessment tool did not have a system to identify the level of risk and was therefore dependent upon the clinical judgement of staff.
- There were inconsistencies in the systems used by the crisis resolution home treatment teams. We witnessed an ineffective use of resources due to the amount of time spent in meetings.
- A significant number of patients on caseloads were inpatients. The length of stay for inpatients was significant and often in excess of 12 weeks. This affected staff capacity for new referrals.
- The police liaison group meetings were attended by senior managers within the trust and we were told that this information was not always cascaded to staff in a timely or effective manner.
- There was a high level of agency staff used in the teams which could affect the staffing levels for the health based place of safety at Farnham Road Hospital, Guildford.
- There was a lack of cohesive support for patients who contacted the service outside of normal working hours and were diverted to the crisis line. There was mixed feedback from patients and carers regarding the effectiveness and helpfulness of the crisis line. Some patients told us that they found the Samaritans to be more helpful.

However:

- The trust had addressed most of the compliance action from the previous inspection in 2014 regarding risks in two of the units used as health based places of safety. These units were no longer in operation.
- We saw supportive and caring relationships between staff and patients within the crisis resolution home treatment teams and medical staff were actively involved in patient care.
- The crisis resolution home treatment teams had access to crisis beds to prevent acute hospital admission and staff worked closely with staff at Crisis House.
- All patients and carers in contact with the crisis resolution home treatment teams were given information packs about the service. Staff gathered feedback from patients and used the information to improve services.
- Some teams included nurse prescribers. Staff told us that there were opportunities for professional development including personality disorder training and non-medical prescriber training.
- All record keeping was electronic with no paper records.
- Staff demonstrated a sound understanding of the trust's lone working policies.
- Three crisis resolution home treatment teams had taken part in a University of London crisis resolution team optimisation and relapse study. Staff involved in the study had provided positive feedback. The trust was one of 14 NHS trusts throughout England taking part in this study.
- There was dedicated staffing at Farnham Road Hospital. The places of safety were clean and well maintained with sufficient lines of visibility. Staff treated patients in the places of safety with dignity and respect. In Farnham Road Hospital, patients could listen to the radio, watch television, engage in interactive activities and communicate with staff using the communication window.
- Both places of safety accepted patients of all ages and we observed staff efforts to engage a young person by

Summary of findings

using activities. Farnham Road Hospital was the designated place of safety for those aged under 18 but the Abraham Cowley Unit took under 18s where necessary.

- People who displayed difficult and challenging behaviour were not turned away and we observed such behaviour being well managed. Staff received annual training in de-escalation and the prevention and management of violence.
- The organisational policy concerning the health based place of safety had been updated in February 2016 to reflect the changes to the Mental Health Act 1983 Code of Practice 2015.
- The places of safety had a clear and comprehensive standard operational procedure which was based on the multi-agency agreement. There were good working relationships with the police and ambulance service at the senior level.
- There was a commitment and clear leadership at all levels to improve access to places of safety. The trust had signed up to the multi-agency agreement with Surrey police and was involved in the Surrey Mental Health Crisis Care Concordat. Ambulances were used to convey patients to a place of safety in a majority of cases.
- Efforts had been made at Crisis House to create a homely and non-restrictive environment and patients were involved in their care. Regular liaison took place between the staff at Crisis House and the referring crisis resolution home treatment team.
- There were two dedicated lines for incoming calls to the crisis line and contact could be made using text messaging.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There was an outstanding compliance action from our previous inspection. This related to assessing and monitoring the quality of the service by ensuring that there were effective systems to identify, assess and manage risks. The lack of staff knowledge concerning the new database meant that comprehensive risk assessments were not always completed.
- We found evidence that staff did not regularly review medicines despite the availability of non-medical prescribers in some teams.
- In some areas, mandatory training rates were low, particularly around medicines management and we found that two patients had not had allergies recorded on documentation.
- There was evidence that a number of patients on the crisis resolution home treatment team caseloads were inpatients which affected staff capacity to pick up new referrals.
- The skill mix of the crisis resolution teams was nurse led with no occupational therapy (OT) or psychology support within the crisis resolution home treatment teams.
- There were clear systems in place concerning the reception and management of health based places of safety. However, it was unclear how activity and trends were being monitored.
- A patient using the health based place of safety during our inspection told us they felt pressured by staff concerning administration of medication.
- There were blind spots in the en-suite and shower areas of the health based place of safety at Farnham Road Hospital. Staff mitigated risks by monitoring the length of time a patient used the bathroom. We saw health and safety and ligature risks at Farnham Road Hospital and the Abraham Cowley Unit. The resuscitation equipment available in the health based place of safety at Farnham Road Hospital had no evidence of checks being carried out.
- Minutes from team meetings at Crisis House recorded staff not receiving feedback from incidents.
- We found that people calling the crisis line were sometimes not called back. The crisis line received 1,529 calls between 1 and 29 February 2016 but only 62% were connected. The number of calls to the crisis line diverted to voicemail during February

Summary of findings

2016 ranged from two to sixty. However, further information provided from the trust showed that there was an 80% response rate of calls and audible voice mails between December 2015 and February 2016.

However:

- There was good understanding and knowledge of trust lone working policies and procedures. Staff used 'Skyguard' alarms and had a local and organisational policy to manage risk from patients'.
- The services had good medicine management with sufficient stock and no out of date medication.
- The crisis resolution home treatment team had a good record on safety.
- The crisis resolution home treatment teams completed safeguarding logs and liaised with health visitors regarding patients with children under five.
- Incidents were discussed during crisis resolution home treatment team meetings. Learning was shared and information displayed on some staff notice boards.
- Clinical alerts were cascaded from the senior management team.
- We observed staff at the place of safety managing violent and aggressive behaviour well.
- There was dedicated 24 hour staffing at both places of safety.
- Ambulances were used in a majority of cases to convey patients to the places of safety.

Are services effective?

Good

We rated effective as good because:

- Progress notes were comprehensive and detailed.
- There were regular handovers in the crisis resolution home treatment teams.
- Staff told us they were supported and encouraged to develop within their roles with access to specialised training including personality disorder and non-medical prescriber training.
- We observed good practice during an assessment under the Mental Health Act 1983.
- Physical health checks were completed during the early stages of assessment.
- Patients on the crisis resolution home treatment team caseloads were able to access intensive groups within the acute care pathway.
- Non-medical prescribers were available in some crisis resolution and home treatment teams.

Summary of findings

- The introduction of team swap days had been implemented as part of a CORE study with University College London.
- Processes had been put in place to engage and work with the travelling community.
- Staff demonstrated knowledge and understanding of the Mental Health Act.
- All referrals from the crisis line to the crisis resolution home treatment teams received a face to face assessment.
- Actions in the mental health crisis care concordat between the trust and stakeholders included actions to improve primary care support. For example, through early identification of mental health issues.
- A report into the trust's involvement in a pilot project with Surrey police stated that police deployment was avoided in 24% of cases. The report acknowledged that the introduction of a safe haven had reduced the number of people experiencing crisis. The safe havens were the highest rated service for customer satisfaction using the Your Views Matters surveys. We visited the safe haven in Woking during our inspection and were told that there were plans to open a safe haven in Redhill during March.
- The places of safety were well co-ordinated from a central point at Farnham Road Hospital.
- The health based place of safety at Farnham Road Hospital had an interactive communication window that patients used to watch television, play games, listen to music, draw and communicate with staff.
- Electronic records for patients in the health based place of safety were of a good quality.
- We saw evidence of joint assessments taking place between approved mental health professionals and doctors.
- The recent introduction of a rota for section 12 doctors had improved assessment times for the health based place of safety.

However:

- Care plans were not holistic or comprehensive. There was no overarching care plan for patients where multidisciplinary work was taking place. Some care plans recorded bullet points for staff rather than a holistic care plan for patients.
- The location of patient information was inconsistent on electronic records because of difficulties experienced in the migration from the previous system.
- There was a lack of clinical audit because the new electronic system was unable to generate audit reports.

Summary of findings

- The multidisciplinary team meetings in the South West home treatment team were ineffective due to the amount of staff resources and time spent within these meetings.
- Effective systems were inconsistent between teams and teams did not share good practice.
- Data and audits were collected at the health based place of safety with no indication of learning or developing services in response to this data.
- A person had been detained in excess of 72 hours in a place of safety due to inaccurate recording of the start time of the detention.
- There were two beds available in each place of safety. However, there were no processes in place to manage peak demand for patients that police had brought to the places of safety that were full, other than for police to wait with the person in A&E or drive them around until a bed became available.

Are services caring?

Good

We rated caring as good because:

- During the home visits, we observed caring, respectful and positive interactions between staff and patients. Staff displayed knowledge and understanding of their patients' needs.
- Staff demonstrated care and respect during a Mental Health Act assessment.
- Patients told us that their experiences of the crisis resolution home treatment team were kind and respectful.
- Carers told us that staff were kind and respectful to their relative and themselves.
- The Meridian 'Your Views Matter' tool was used to record feedback from patients to develop and improve services.
- Staff were attentive and responded to the needs of a patient within the health based place of safety during our inspection.
- Staff interacted and engaged positively with a person under the age of 18 in the health based place of safety during our inspection.
- Approved mental health professionals told us that staff in both health based place of safety were caring and kind to patients.
- Patients at Crisis House told us that staff were caring and treated them with dignity and respect.

Are services responsive to people's needs?

Good

We rated responsive as good because:

Summary of findings

- Information obtained from the use of data from 'Your Views Matter' was used to develop and improve services. An example of this included the introduction of a medication questionnaire for patients.
- The number of visits by crisis resolution home treatment team staff to patients was flexible, dependent upon risk and need. Apart from the South West team, staff mainly saw patients in their own home.
- The crisis resolution home treatment team had made efforts to engage the travelling community.
- Staff gave patients and carer's comprehensive information packs at their first appointment.
- Interpreters were used to support patients in crisis.
- Most patients told us that they knew how to complain and would feel confident in doing so.
- A section 12 approved doctor was on call for East and West Surrey.
- There was a service level agreement between Surrey and Borders NHS Foundation Trust and Sussex Partnership NHS Foundation Trust for access to a place of safety for patients in east Surrey to avoid travelling a long distance to access an assessment suite.
- The availability of approved mental health professionals had been increased to improve response to assessments.
- There was 24 hour access to places of safety.
- Efforts had been made at Crisis House to make the environment welcoming and homely.

However:

- Discharge planning was inconsistent between the crisis resolution home treatment teams.
- In-patients remained on some crisis resolution home treatment teams caseloads, despite having been in hospital over 14 days, which affected staff capacity for new referrals.
- There were delays for patients to access the places of safety during peak periods. There were delays in patient admission to hospital following a section 136 assessment due to the lack of availability of beds. There were delays in assessments for children and young people and for people with a learning disability because the services had difficulties in contacting section 12 doctors with a child and adolescent mental health service (CAMHS) or learning disability specialism.
- We received mixed feedback concerning the crisis line.

Are services well-led?

We rated well led as requires improvement because:

Requires improvement

Summary of findings

- Systems used by teams were inconsistent and staff did not share good practice. We observed ineffective use of time and resources because of the amount of time that staff from one team spent in multidisciplinary meetings.
- We observed one home treatment team meeting that appeared disorganised with little or no discussion concerning risk status, protective factors, mental state or discharge planning.
- The recent introduction of a new electronic recording system was unable to produce reports to measure performance and key performance indicators at the time of our inspection.
- Unanswered calls to the crisis line were diverted to Crisis House. This meant that when staff from Crisis House responded to these calls they were unavailable for patients.

However:

- Staff were aware of the whistleblowing policy.
- Staff told us that they felt supported.
- Staff involved in the University of London crisis resolution team optimisation and relapse study had provided positive feedback. The study involved improving the physical health of patients, employing peer support workers and increasing staff awareness of the work of home treatment teams.
- There was good, clear coordination of access to the health based place of safety.
- Staff from the health based place of safety told us that they had good access to the service manager.

Summary of findings

Information about the service

The crisis resolution home treatment team was a Surrey and Borders NHS service divided into five hubs – South West (Guildford), North East Hants and Surrey Heath (Frimley), North West Surrey (Abraham Cowley Unit, Chertsey), Mid Surrey (Epsom) and East Surrey (Redhill).

The crisis resolution home treatment team was a specialist team of mental health professionals who provided short term support to people experiencing a mental health crisis. Their aim was to prevent admission to a psychiatric hospital by providing treatment in people's own homes. The service operated 24 hours a day, seven days a week; although out of hours contact was via the crisis line. Referrals to the crisis resolution home treatment team by the crisis line received a face to face appointment.

The trust had two health based places of safety, each provided facilities for two patients at a time. The health based places of safety were based at Farnham Road Hospital in Guildford and the Abraham Cowley Unit at St Peter's Hospital in Chertsey. Health based places of safety are used for patients detained under section 136 of the Mental Health Act in order for a Mental Health Act assessment to be undertaken. Section 136 allows a police officer to remove a person they think is mentally ill and in immediate need of care or control from a public place to a place of safety in the interest of that person or for the protection of others. Health based places of safety are also used when police have executed a warrant under section 135(1) of the Mental Health Act. A section 135(1) warrant provides police officers with a power of entry to private premises for the purposes of removing the person to a place of safety for a mental health assessment or for other arrangements to be made for their treatment or care.

The Crisis House provided six beds for patients in crisis to provide short term intensive support alongside the home treatment team. The Crisis House also offered a step down from long hospital admissions for patients before returning to the community with support from the home treatment team or community mental health recovery service (CMHRS). All patients at Crisis House were admitted informally, although they were assessed under the Mental Health Act if appropriate. The average length of stay was one to two weeks.

The crisis line was an out of hour's telephone service for those experiencing crisis. Professionals frequently used the crisis line to make referrals and for advice.

The following compliance actions were outstanding for crisis services at Surrey and Borders Partnership NHS Foundation Trust, from a CQC inspection in July 2014; Regulation 23 HSCA 2008 (Regulated activities) Regulations 2010 Supporting workers; Regulation 10 HSCA 2008 (Regulated activities) Regulations 2010 Assessing and monitoring the quality of service and Regulation 15 HSCA 2008 (Regulated activities) Regulations 2010, Staffing.

Our inspection team

The team that inspected this core service comprised two Care Quality Commission inspectors, one Mental Health Act reviewer and two specialist advisors, a nurse specialist and a social worker specialist.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients using the service.

During the inspection visit, the inspection team:

- Visited both health based places of safety and the five hubs of the crisis resolution home treatment teams.
- Visited Crisis House and the crisis line.
- Spoke with nine people who use the service.
- Observed three appointments with people who use the service.
- Spoke with four families and carers.
- Reviewed 40 care records in the crisis resolution home treatment teams.
- Reviewed 19 section135 and section136 monitoring forms in the health based places of safety.
- Attended four handover meetings.
- Attended two multidisciplinary meetings.
- Attended two case conferences.
- Checked 34 prescription charts.
- Spoke with the service manager for each of the crisis resolution home treatment teams and Crisis House.
- Spoke with the co-ordinator for the health based places of safety.
- Reviewed 16 care records for people who had used the health based place of safety.
- Spoke with 28 other staff including consultant psychiatrists, qualified nurses, support workers and approved mental health professionals.
- Witnessed the management of disturbed behaviour in the health based places of safety.
- Observed a Mental Health Act assessment.
- Visited a safe haven cafe.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients and carers we spoke with were positive about the crisis resolution home treatment team. Patients said they were treated with respect by staff and were given flexibility with appointment times. Patients and carers told us that they knew how to complain.
- Feedback from 'Your Views Matter' included: 'They helped me stay safe at home' and 'excellent care'.
- Patients who used the service at Crisis House told us that the staff were caring and non-judgemental.
- However, we received mixed feedback concerning the crisis line. Some patients told us that advice received had included to make a cup of coffee or to go for a walk. Some patients told us that comments could often feel 'scripted' and that they preferred to contact the Samaritans for support.
- One patient who had used the health based place of safety told us that they had felt 'bullied' by staff concerning medication.

Good practice

Three crisis resolution home treatment teams had taken part in a University of London crisis resolution team optimisation and relapse study. The north west and east crisis resolution home treatment teams had been in the active group and the mid crisis resolution home treatment team had been in the control group. The study involved staff spending time in another team to improve working relationships and gain a greater understanding of the work of each team. The Surrey Heath and north

Summary of findings

east Hants crisis resolution home treatment team had taken part in a CORE project to employ peer support workers. The trust was one of 14 NHS trusts throughout England taking part in this study.

The crisis resolution home treatment team could refer patients to Crisis House for support during crisis to avoid admission to hospital and provide respite for carers.

The recent introduction of 'Safe Haven' services in Aldershot and Woking provided walk in support between 6pm and 11pm for those wishing face to face contact with qualified staff. The Safe Haven in Aldershot was delivered as a community café. In Woking, staff tried to encourage access for those wanting support that was more clinical. Both services were staffed by a qualified band six nurse and a support worker, with additional support available from the voluntary sector. The trust planned to open a new safe haven in Redhill in March and to have six safe havens open by 2017.

Interactive communication windows had been introduced in the health based place of safety at Farnham Road Hospital. Patients were able to listen to music, play activities, draw, watch television and communicate with staff by using the large interactive touch screen in the rooms.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure its risk assessment processes identify, assess and manage the risks to the health and safety of patients.
- The trust must ensure that calls from patients to the crisis line are responded to.
- The trust must ensure that allergies are appropriately recorded.
- The trust must ensure that staff receive the required mandatory training.

Action the provider SHOULD take to improve

- The trust should ensure that the electronic patient records system meets the needs of the trust and staff.
- The trust should provide adequate training for staff to ensure effective and comprehensive use of the electronic recording system to manage risk and ensure safe care and treatment for patients.
- The trust should ensure that holistic and comprehensive care plans are completed for all patients which demonstrate patient involvement.
- The trust should ensure that there are consistent processes between crisis resolution home treatment teams and that good practice is shared between teams.
- The trust should review processes to ensure effective use of time and resources for crisis resolution home treatment team staff. The trust should ensure that there are clear guidelines in place regarding content and time spent in meetings.
- The trust should review the criteria for case load management to ensure a true reflection of patients being worked with in the community. Discharge planning should be clear and consistent.
- The trust should review the skill mix of crisis resolution home treatment teams and ensure patient access to occupational therapy and psychological interventions is consistent.
- The trust should continue to actively recruit into vacant posts to reduce the use of bank and agency staff.
- The trust should ensure that regular checks of resuscitation equipment are recorded.
- The trust should track delays for accessing places of safety in order to develop and improve services.
- The trust should develop processes to reduce delays in assessments for children and young people and those with a learning disability at the places of safety.
- The trust should review staffing at the crisis line in order to reduce the number of unconnected calls and waiting times.

Surrey and Borders Partnership NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Crisis resolution home treatment team South West & Health based place of safety	Farnham Road Hospital (Mental Health Unit)
Crisis resolution home treatment team North East Hants and Surrey Heath	Trust Headquarters
Crisis resolution home treatment team North West & Health based place of safety	St Peter's Site
Crisis resolution home treatment team Mid	Trust Headquarters
Crisis resolution home treatment team East	Trust Headquarters
Crisis House	Crisis House

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.

- Mental Health Act training was a mandatory requirement for all trust staff. However, staff at Blake ward (which included place of safety staff at the Abraham Cowley Unit), Mid Surrey and North East Hampshire and Surrey Heath crisis resolution home treatment teams had not met the trust target for completing this training.

Detailed findings

- The trust had a Mental Health Act lead that staff could go to for advice and support.
- The interagency policy for the health based place of safety had been updated in February 2016 to reflect the new Code of Practice 2015 (Mental Health Act).
- Staff informed patients of their rights at regular intervals in the health based place of safety. The trust had policies and reminders about this.
- The availability of approved mental health professional's had been increased to improve access to this service. There was evidence of good joint working between approved mental health professionals and the trust.
- The trust policy target for people to be assessed in the places of safety was outside of the good practice guidance in the Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in the Mental Capacity Act and the Deprivation of Liberty Safeguards was mandatory for all staff. However, staff at crisis resolution home treatment team North West Surrey and South West Surrey had not met the trust target for completing this training.
- Capacity assessments were documented by the crisis resolution home treatment teams.
- The trust had a Mental Capacity Act lead that staff could go to for advice and support.

Requires improvement

Are services safe?

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

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

Our findings

Crisis Resolution and Home Treatment Team

Safe and clean environment

- The crisis resolution and home treatment teams saw patients in their own homes or somewhere convenient to patients. Staff from the South West crisis resolution home treatment team also arranged appointments to tie in with groups that patients were attending at the hospital and paid for a taxi for patients to and from the hospital.
- The office environments for all crisis resolution home treatment team teams had adequate room for staff with sufficient access to computers.
- The clinic rooms were clean, well-organised and well equipped with all stock accounted for and no out of date medication. Patients did not access the clinic rooms but staff could take physical health equipment into the community.
- The services carried out a monthly medication audit of all stocked medication and prescription charts, which recorded no discrepancies. The audit included all medication review charts and promoted good and safe prescribing practice. The fridge temperatures were in range and there was evidence of staff completing daily checks.
- There was no pharmacy on site and secondary prescribing was done out of hours when needed. There was a clear policy for this and evidence that it was used appropriately.

Safe staffing

- There was a rolling recruitment programme for staff. Band seven staff took part in interview panels as part of the recruitment programme and had authorisation to offer posts to candidates. Vacancies were filled by regular NHS Professionals staff where possible. The NHS Professionals staff were often permanent members of staff carrying out additional shifts. Where this happened, working hours were monitored by both NHS Professionals and managers.
- The shift pattern for the crisis resolution home treatment teams in the South West, North West and North East Hampshire and Surrey Heath, consisted of three shifts. 7am to 7pm for the Shift lead, 9.30am to 9.30pm for day staff and 7pm to 7am for night staff. Each crisis resolution home treatment team had four to five staff available during the day consisting of a band seven shift lead, two to three band six staff, one band five nurse and/or one to two support workers. The skill mix of shifts was dependent upon the caseload for the team.
- The shift pattern for crisis resolution home treatment team East Surrey and Mid Surrey was 8am to 8pm with a handover at 8.15am. The number of staff available was three to four, dependent upon caseload and need. There was one member of staff available during the night shift. The psychiatric liaison team for Epsom General Hospital and East Surrey Hospital were available until 3am.
- The establishment levels for qualified nurse's whole time equivalent (WTE) were: crisis resolution home treatment team Surrey Heath and North East Hants 10; crisis resolution home treatment team Guildford and Waverley 9; crisis resolution home treatment team North West Surrey 11; crisis resolution home treatment team East Surrey 8 and crisis resolution home treatment team Mid Surrey 10.
- The establishment levels for nursing assistants WTE were: crisis resolution home treatment team Surrey Heath and North East Hants 4; crisis resolution home treatment team Guildford and Waverley 2; crisis resolution home treatment team North West Surrey 4; crisis resolution home treatment team East Surrey 4 and crisis resolution home treatment team Mid Surrey 4.
- There were low numbers of vacancies for qualified nurses WTE which were: crisis resolution home treatment team Surrey Heath and North East Hants 0; crisis resolution home treatment team Guildford and Waverley 1; crisis resolution home treatment team North West Surrey 1; crisis resolution home treatment team East Surrey 2 and crisis resolution home treatment team Mid Surrey 3.
- There were low numbers of vacancies for nursing assistants WTE which were: crisis resolution home treatment team Surrey Heath and North East Hampshire 1; crisis resolution home treatment team Guildford and

Requires improvement

Are services safe?

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

Waverley 0; crisis resolution home treatment team North West Surrey 1; crisis resolution home treatment team East Surrey 0 and crisis resolution home treatment team Mid Surrey 0.

- Staff sickness rate % between 1st February 2015 to 31st January 2016 was: crisis resolution home treatment team Surrey Heath and North East Hants 8%; crisis resolution home treatment team Guildford and Waverley 1%; crisis resolution home treatment team North West Surrey 2%; crisis resolution home treatment team East Surrey 4% and crisis resolution home treatment team Mid Surrey 3%.
- Staff turnover rate % between 1st February 2015 to 31st January 2016 was: crisis resolution home treatment team Surrey Heath and North East Hampshire 36%; crisis resolution home treatment team Guildford and Waverley 10%; crisis resolution home treatment team North West Surrey 16%; crisis resolution home treatment team East Surrey 19% and crisis resolution home treatment team Mid Surrey 17%.
- The trust reported the following caseloads per team although these figures could fluctuate: crisis resolution home treatment team Surrey Heath and North East Hants 27; crisis resolution home treatment team Guildford and Waverley 24; crisis resolution home treatment team north west Surrey 16; crisis resolution home treatment team East Surrey 10 and crisis resolution home treatment team mid Surrey 25.
- Some patients who were counted on the crisis resolution home treatment team caseloads were inpatients. For example, 12 out of the 18 inpatients on Magnolia ward at Farnham Road Hospital were also included on crisis resolution home treatment team caseloads, which affected staff capacity to accept new referrals. We saw inconsistent reviewing of caseloads. Staff told us that inpatients remained on home treatment team caseloads if the expected length of stay was less than 14 days. However, a traffic light report recorded inpatients had been on the ward for between 13 and 235 days. At the South West crisis resolution home treatment team, patients were routinely kept on caseloads, which enabled patients to access day services such as coping skills and mindfulness groups.
- Consultant cover was provided by the wards where the crisis resolution home treatment teams were located within the local hospital. Staff reported consultants were responsive, available and accessible.
- The trust target for statutory and mandatory training was 95%. Information provided by the trust showed that the trust was not meeting its own target in the following:

North East Hants and Surrey Heath crisis resolution home treatment team

First Aid 36%

Mental Health Act 64%

Meds Management Qualified 67%

Prevention and management of violence and aggression 01/02 64%

North West Surrey crisis resolution home treatment team

Prevention and management of violence and aggression 01/02 44%

Medicines management qualified 67%

Mid Surrey crisis resolution home treatment team

Prevention and management of violence and aggression 03/04 67%

Medicines management 57%

- Managers told us that training was discussed and monitored during a monthly manager's meeting. The meeting was attended by all band 8A and band 7 nurses from the community mental health recovery service (CMHRS), crisis resolution home treatment teams and ward managers. Managers were sent a training matrix each month to monitor and address non-compliance regarding training.
- Staff told us that the completion of training such as safeguarding level two and the prevention and management of violence and aggression (PMVA) training was dependent upon availability of the training.
- Crisis resolution home treatment teams had been asked to refocus on crisis and contingency plans for patients, to support the effectiveness of the crisis line.

Assessing and managing risk to patients and staff

- Staff told us that the introduction of a new electronic database in November 2015 had affected the quality of the risk assessments. During our inspection we saw that there was no dedicated area or prompt within the electronic patient records system in which to complete an online risk assessment.

Requires improvement

Are services safe?

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

- We reviewed 18 risk assessments across the five crisis resolution home treatment teams. There were inconsistencies in how risk was identified and flagged. Risk assessments were present although there was no dedicated risk assessment tools to flag the level of risk. Risk was recorded as a description of risks and mitigating actions. Staff told us that risk assessments were completed at assessment and discharge and updated on an as and when required basis.
- Eleven of the 12 risk assessments reviewed at the crisis resolution home treatment team in North East Hampshire and Surrey Heath were very basic, with very little detail and only four had an identified rag rating. A rag rating is used to identify risk level as red for high risk, amber as medium risk and green as low risk.
- At Epsom home treatment team, all patients had a risk rag rating that was discussed daily at morning handover and updated when required. There were clear, detailed risk assessments in the 10 care records we looked at and all had review dates. The summaries were in-depth and included safeguarding concerns and detailed crisis contingency plans.
- The level and detail regarding risk discussed during handovers varied significantly between each team. For example, we observed a handover at the South West crisis resolution home treatment team where there was no discussion concerning risk, protective factors, mental state concerns or crisis plans. However, during a handover observed at Mid Surrey crisis resolution home treatment team, we observed comprehensive discussions which included risk, capacity, safeguarding and discharge planning.
- We observed a handover at North East Hampshire and Surrey Heath crisis resolution home treatment team, where a discussion took place concerning a patient who had been transferred to a home treatment team in another area. The ward had identified that the home treatment team should follow up and liaise with the team that the patient was being transferred to. Three days later, staff had not made contact and there was no clear plan or action to be completed. Therefore the patient was discharged from the ward to a new area with no confirmed liaison or follow up. Key findings in The National Confidential Inquiry into Suicide and Homicide by people with mental illness state that there is an increased risk of suicide following discharge from a non-local ward and that closer working with families could improve suicide prevention.
- Staff at the North West Surrey crisis resolution home treatment team used a smart screen during handover meetings. The current caseload was displayed and staff updated patient's progress notes during the meeting which included information regarding risk and actions.
- We saw evidence during MDT meetings and progress notes that staff had responded promptly to contact received by patients. However, patients wishing to contact the team out of hours had to use the crisis line.
- Staff at mid Surrey crisis resolution home treatment team told us that the medicines supply from the pharmacy was good, even though it had recently moved site.
- Local monthly medicines audit for stock and medicines cards took place which promoted safe practice. However this was not consistent across teams.
- At Mid Surrey crisis resolution home treatment team, there were clear records of medicines supplied to patients and/or their carers. Medicines were stored securely and safety alerts were dealt with appropriately. We observed a team handover and heard the team, including nurses and a psychiatrist, discuss side effect monitoring.
- We reviewed 34 medicine charts which showed that hypnotic medication was not routinely prescribed for over seven nights. Also it was rare for patients to be prescribed with more than one antipsychotic drug. There was good medicines management including monthly audits of medicines stocked. The North East Hampshire and Surrey Heath crisis resolution team completed monthly audits of prescription charts promoting safe prescribing practice. However, we found that 'as required' medication and hypnotics were not regularly reviewed.
- The Epsom crisis resolution home treatment team had two non-medical prescribers and regular medical cover and input. However, we found that 11 of 18 medicine charts reviewed had missing demographic information and the allergy status for two patients had not been recorded. The trust's pharmacy staff had issued clear guidance on allergy recording due to previous incidents.
- Mid Surrey crisis resolution home treatment team had comprehensive medical cover with flexible access to medical reviews which were completed regularly. The team had a responsive approach to a patient's fluctuating mental state and associated risks.

Requires improvement

Are services safe?

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- All 12 care records reviewed at North East Hampshire and Surrey Heath crisis resolution home treatment team had very clear and detailed crisis relapse and contingency plans.
- We found evidence of detailed progress notes which included risk assessment and review information.
- Staff demonstrated knowledge of the local and organisational lone working policy. Staff used 'Skyguard' personal alarm system when seeing patients in their own home which could be activated to alert risk.
- Staff we spoke to had a good understanding of how to identify abuse and how to make a safeguarding referral. We saw information for staff regarding safeguarding and MAPPA clients on notice boards.

Track record on safety

- The service had a good record on safety. A serious incident had occurred the week before our inspection which was the first serious incident for 14 months.
- Staff reported that following serious incidents they were debriefed and supported individually and as part of the team. Staff gave examples where psychology staff had provided a debrief after serious incidents.

Reporting incidents and learning from when things go wrong

- The datix incident reporting tool was used effectively to report, review and sign off incidents.
- Staff were able to give examples of incidents to report. Staff told us that incidents were discussed during team meetings. Information about learning from incidents was displayed on some crisis resolution home treatment team notice boards.
- A root cause analysis had been completed following a complaint made to the service.
- Lessons learned were discussed at team meetings and information disseminated from managers.

Health-based places of safety

Safe and clean environment

- The health based place of safety at Farnham Road Hospital was purpose built to accommodate two people detained under sections 136 and 135(1) of the Mental Health Act. There were two entrances with the most direct access via a door close to the main entrance of the hospital. However, we were told that although this entrance was the most direct it was rarely used because it was overlooked by the main hospital entrance. The health based place of safety itself was located next to the South West Surrey home treatment team.
- The health based place of safety at Abraham Cowley Unit did not have its own private entrance but it was accessed by a dedicated courtyard with individual doors into the place of safety facility.
- All staff within the places of safety carried personal alarms that were linked to the office and other wards in the hospital.
- The places of safety were clean and well maintained. The furniture was safe and in good condition in both assessment suites. The suite in Farnham Road Hospital was cleaned at least twice a day and could be cleaned more frequently if required.
- Clinic rooms were clean, tidy and well equipped. No examination couch was available in Farnham Road Hospital; however a bed was available in the place of safety. The stocked medicines were in good order with all medicines in date and accounted for. There was a good system in place at Farnham Road Hospital to record that patient drugs were taken and disposed of. Resuscitation equipment was present at Farnham Road Hospital. However, there was no evidence of systems in place to record checks taking place.
- Cameras in the bedrooms at Farnham Road Hospital were fixed and could not be moved from the observation screens in the nursing office. There were blind spots in the en-suite toilets, shower and shared toilet.
- Emergency equipment was regularly checked and cameras in the bedrooms at the Abraham Cowley Unit could be remotely moved to cover all aspects of the room. We saw a nail in the wall of the suites at the Abraham Cowley Unit. Staff told us that the nail was used to hang a clock which had to be removed following risk of damage from the previous occupant of the room. The nail could pose a safety risk to patients using the room.

Safe staffing

- Both places of safety provided 24 hour cover. Staff for the place of safety at Farnham Road Hospital were co-located with the South West home treatment team. The rota for the place of safety consisted of two dedicated staff that covered a 12 hour shift system over a 24 hour period. Qualified nursing support was provided by the

Requires improvement

Are services safe?

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South West crisis resolution home treatment team. The staffing for the place of safety at the Abraham Cowley Unit was integrated into the Blake ward staffing. Two additional staff were rostered into the ward numbers over a 24 hour period. Staff were allocated to the suite on a shift by shift basis. Permanent staff that were registered with NHS Professionals were used to fill shifts wherever possible.

- There was a coordinator for the suites who was located at Farnham Road Hospital. There was good coordination of the suites with processes in place to promote effective access for patients.
- The trust had a system in place to ensure that if the nearest place of safety for the patient was full, the alternate place of safety would accept a patient if a place was available.
- Police officers needed to make one telephone call to the Farnham Road Hospital assessment suite to ascertain which place of safety was available.
- Training data for health based place of safety Farnham Road Hospital was combined with the South West crisis resolution home treatment team and showed that the trust target had not been met in the following: fire, information governance, equality and diversity, Mental Capacity Act and Deprivation of Liberty Safeguards, prevention and management of violence and aggression and medicines management.
- Mandatory and statutory training data for the health based place of safety staff at Abraham Cowley Unit was combined with staff from Blake ward and showed that the trust target had not been met in the following areas: health and safety, information governance, basic life support, Mental Health Act, prevention and management of violence and aggression, medicines management and medicines management dispensing.
- Staff told us that it could feel isolated at the Abraham Cowley Unit because there were no other mental health wards on the site.

Assessing and managing risk to patients and staff

- Staff explained to patients the reason why they were at the place of safety. Staff informed patients of their rights and explained their rights to them. Staff gave patients a brief guide which explained their rights and what to expect during their stay. We were told that this guide was helpful for patients who were often in a state of distress when they first arrived, so that they could read it when they were more able to understand the information.
- Staff contacted a duty doctor when a person had been received into the place of safety. The duty doctor should complete a healthcare screening within one hour of the person's arrival. We saw evidence of patients being seen promptly by a doctor.
- The interagency policy regarding health based places of safety had a target for the assessment by the section 12 approved doctor and the approved mental health professional to commence within four hours of the person's arrival. Most assessments took place within the trust target of four hours. When this target had not been met the service had documented the reasons for the delay.
- Staff contacted the approved mental health professional service as soon as possible rather than waiting for the outcome of the healthcare screening.
- We saw evidence of staff effectively managing difficult and challenging behaviour.

Track record on safety

- Information provided by the trust recorded 110 incidents taking place for the previous 12 months at the Abraham Cowley Unit. Three of these incidents met the trust threshold for serious incidents. Two incidents related to absconsion and the other incident involved delay in treatment. Of the remaining 107 incidents, 26 related to patient allegations of abuse by staff and 17 concerned self-harm during 24 hour care. There were 32 reported incidents for the place of safety at Farnham Road Hospital which had opened in November 2015. Nine of these incidents concerned appointment, admission, transfer and discharge.

Reporting incidents and learning from when things go wrong

- Staff were able to give examples of what incidents should be reported. All staff had access to the datix incident reporting tool to record incidents. When an incident was reported using the datix tool, the information was cascaded to relevant members of staff including the manager, service line manager and members of the senior management team.

Requires improvement

Are services safe?

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

- We saw evidence that 110 incidents had been reported at Abraham Cowley Unit and 32 at Farnham Road Hospital between 31 March 2015 and 29 February 2016.
- The trust had made improvements in the places of safety following incidents. For example, CCTV coverage had been extended and the protocol to ensure patients received 1:1 staff supervision, whilst accessing fresh air had been amended. Also, staff now completed the 'Respect' programme which provided guidance regarding escalating concerns following abuse or assault. Prevention and management of violence and aggression training which included de-escalation and holding techniques, was available for staff. However, only 70% of Blake ward staff, which included staff from the place of safety at the Abraham Cowley Unit, had completed this training.

Crisis Resolution and Crisis Line

Safe and clean environment

- The Crisis House was a safe and clean environment. Efforts had been made to create a welcoming and homely environment.
- The Crisis House was a six bedded unit providing respite care for those in crisis. Three beds were for females and three for males. The accommodation was separated into male and female accommodation. There was a bathroom with shower and toilet in both the male and female accommodation. There was an additional bed for patients funded by the risk panel. One of the bedrooms had disabled access with an en-suite shower room.
- Residents had access to the kitchen 24 hours a day seven days a week. Residents were encouraged to take part in healthy eating menu planning and cooking meals.
- There was a laundry room for residents which was unlocked by staff when required. Staff monitored the use of the laundry room and dispensed washing powders and detergents to residents.
- Each resident could lock the door to their own room which staff were able to override if necessary. Each bedroom had a lockable wall safe to use for valuables and as required medicines. Staff kept the key to these safes and residents could ask for the safe to be unlocked when necessary.
- There was a shared lounge and a separate female lounge had opened a few weeks prior to our inspection.

Safe staffing

- The establishment levels for whole time equivalent (WTE) staff were: One WTE band six, Five WTE at band five, four WTE at band four and six WTE at band two.
- There were five vacancies at Crisis House.
- Staffing for Crisis House was adequate and consisted of one qualified member of staff, one non-qualified member of staff during the day and one member of staff out of hours. Regular safe staffing audits were carried out.
- There were staff vacancies for the crisis line. Staffing of the crisis line consisted of two full time members of staff and one part time member of staff working 22 hours per week over two shifts. Regular agency staff were used for the crisis line. Two new members of staff had been recruited and were due to start in March and April.
- The absence rate between March 2015 and February 2016 was 7%. The absence rate between October 2015 and February 2016 was between 12% and 19%. We were told that data had been affected by the long term sickness of a member of staff.
- Information provided by the trust showed that there had been a reduction in staff turnover between March 2015 and February 2016.
- Staff from Crisis House had not met the trust's training target in the following: Information governance 89%; Equality & diversity 89%; Immediate life support 80%; Safeguarding Children 89%; Clinical risk assessment 89%; Mental Health Act 89%; Medicines management 40%
- The older adult and children and adolescent mental health service (CAMHS) teams had delivered training to staff at Crisis House and were due to deliver further training in April when new staff were due to be in post. Additional training had been arranged during February and March for crisis line training, carer support training, system one (the electronic patient record system) training, older adult crisis helpline, fire training and adolescent training.
- Crisis House had a link person and main point of contact for the older adult and CAMHS team.
- Staff from Crisis House often had to answer the crisis line using a second line in the Crisis House office. This affected the staff resources available for service users staying in Crisis House.

Requires improvement

Are services safe?

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

Assessing and managing risk to patients and staff

- Risk assessments were completed by the referring crisis resolution home treatment team which staff from Crisis House updated where appropriate. Staff at Crisis House completed a risk screening tool and liaised with the referring crisis resolution home treatment team to assess risk. Referrals had to include a risk assessment, care plan, purpose of admission/ respite, planned length of stay and review date prior to patients being admitted to the Crisis House.
- Staff completed mandatory safeguarding training. There had been two safeguarding queries in the last 12 months. We were told that following discussions between the patients and community mental health recovery service, it had been agreed that these did not warrant safeguarding investigations.
- Staff were knowledgeable and followed the trust health and safety lone working policy.

Track record on safety

Staff had not reported any serious incidents within the last 12 months.

Reporting incidents and learning from when things go wrong

- All staff recorded incidents on the datix incident reporting tool. Staff had expressed concern during team meetings about the lack of feedback from reported incidents. The team leader attended quality assurance group meetings and was responsible for sharing learning with the team. The team leader acknowledged that this did not routinely happen and told us that reviews were taking place to introduce a more robust system.
- Serious incidents were shared using risk alert emails. Staff had to sign to say that these had been read and a copy was kept in the risk folder. The team leader sent key messages of learning in a team email.
- Crisis line staff had a daily debrief with the nurse in charge of Crisis House. Crisis line staff received monthly clinical supervision.
- Information provided by the trust stated that there were no incidents for Crisis House for the previous 12 months.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Crisis resolution and home treatment teams

Assessment of needs and planning of care

- We saw evidence that twelve of 18 patients at South West crisis resolution home treatment team and four of 28 patients at the North East Hampshire and Surrey Heath crisis resolution and home treatment team were inpatients.
- All patient records were stored on the electronic recording system which could be accessed by all staff. Paper records that had been uploaded onto the system were difficult to find during our inspection. Staff told us that the new system was slow and kept freezing. This meant that staff had to spend more time trying to update records, rather than on direct patient contact.
- We looked at 40 care records which demonstrated care plans had been shared with patients. The assessment form captured information including employment, housing and benefits. Staff told us this information should then be included in the patient's care plan. The electronic progress notes were more comprehensive than care plans and demonstrated a good assessment of needs which included assessing capacity. However, there was little evidence that care plans were holistic or personalised. The electronic assessment care plan proforma was more a 'management plan' listing actions. There was no evidence of patient involvement, goals or needs in the 12 care records we reviewed in the North East Hampshire and Surrey Heath crisis resolution home treatment team. However, at the Epsom crisis resolution home treatment team, all care records were up to date, personalised with actions for both patients and staff, and gave details of frequency of visits and capacity. All records had health assessments, signed care plans, consent to share information and Mental Health Act documentation attached.
- Staff from different services who worked with patients completed their own care plan rather than sharing one overarching care plan.
- We were given an example of an interpreter being used to support a patient and ensure that their needs were being met.
- The crisis resolution home treatment teams were involved in section 136 assessments and advised whether the team had the capacity to provide treatment at home and whether it was appropriate. The crisis resolution home treatment teams only accepted telephone referrals.

Best practice in treatment and care

- Staff had attended training on giving information about the side effects of medicines. For example, they were able to use effective analogies to describe incidence of side effects. Patients were given information leaflets about their medicines.
- The manager at the North East Hampshire and Surrey Heath crisis resolution home treatment team had completed audits in record keeping and care plans, medication, peer service review and health and safety. However, this was not standardised across all home treatment teams.
- Staff completed an initial physical healthcare screening for patients. However, on-going physical healthcare was recorded in the progress notes and was difficult to find. The level of detail regarding physical healthcare was inconsistent across teams.
- We reviewed four care records at Redhill crisis resolution home treatment team. All four had evidence of a physical health examination and two of the four records showed evidence of on-going physical health care.
- Routine auditing was unable to take place due to the implementation of a new electronic recording system which was unable to generate reports.
- Access to psychology was limited with no dedicated input. However, staff could make a referral to the psychology team.
- Three crisis resolution home treatment teams had taken part in a University of London crisis resolution team optimisation and relapse study. The north west and east crisis resolution home treatment teams had been in the active group and the mid crisis resolution home treatment team had been in the control group. The study involved staff spending time in another team to improve working relationships and gain a greater understanding of the work of each team. The north east crisis resolution home treatment team had taken part in a CORE project to employ peer support workers.
- The north west and east crisis resolution home treatment teams were involved in a CORE study which included improving the physical health care needs of patients. Plans to achieve this goal included: patients to

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be offered a health check within 72 hours of assessment and for all physical health checks to be documented. The trust was waiting for the results and final publication of the CORE study.
- Data from the Meridian 'Your Views Matter' survey had been used to identify patient concerns. We were shown an example of the introduction of a medicines questionnaire for patients following such an audit.

Skilled staff to deliver care

- Staff in the crisis resolution home treatment teams were experienced and highly qualified and consultant cover was sufficient for all teams. However there was no dedicated psychology or occupational therapist within the teams.
- The trust had a robust induction programme which consisted of five days for all staff.
- Staff told us they felt supported in applying for specialist training and felt encouraged to improve their skills. Some staff members told us they had applied for non-medical prescriber training, personality disorder training and master's degree training.
- Staff performance was monitored and addressed with improvement action plans.
- A monthly spread sheet was sent to crisis resolution home treatment team manager's which contained information regarding outstanding appraisals. Appraisals and supervision levels were inconsistent within the teams. All appraisals had been completed and were up to date at the Redhill team. However, the North East Hampshire and Surrey Heath crisis resolution home treatment team had four appraisals outstanding, North West Surrey crisis resolution home treatment team had three appraisals outstanding and South West Surrey crisis resolution home treatment team had five appraisals outstanding.
- Supervision was inconsistent across the teams. Some teams had devised local processes and structures for supervision responsibilities. Some staff told us that they received regular supervision and felt supported. Supervision records at Redhill crisis resolution home treatment team demonstrated regular staff supervision only since November 2015, following the recruitment of a band seven nurse. Staff at Redhill also referred to reflective supervision led by psychology.

Multi-disciplinary and inter-agency team work

- We observed two daily multidisciplinary (MDT) meetings which involved the crisis resolution home treatment teams, ward doctors, ward nurses and CMRHS. These meetings took place via a telephone conference meeting to allow different disciplines to participate in the meeting. One of the telephone meetings we attended involved staff who were upstairs from the crisis resolution home treatment team. The crisis resolution home treatment teams discussed their caseloads on a 'first come, first served' basis during the meeting. This meant that staff could spend a significant amount of time listening to conversations between other teams that were not relevant. However, we observed effective use of resources at MDT meetings in Epsom, where one member of the team attended the MDT teleconference and then fed back to the team. The handover meeting at Epsom crisis resolution home treatment team was comprehensive and thorough with regular discussion regarding risk, capacity, safeguarding and discharge planning.
- Regular multi-agency meetings were held with the police liaison officer. Staff had the opportunity to ask questions and concerns directly to the police via a dedicated email address called Tardis police box.

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

- Mental Health Act e-learning training was part of the trust's statutory and mandatory training. Staff from the East, South West and North West crisis resolution home treatment teams had met the trust target of completing the Mental Health Act training. However, 83% of staff from Mid Surrey crisis resolution home treatment team, 64% of staff from North East Hampshire and Surrey Heath crisis resolution home treatment team and 71% of staff from Blake ward, which included place of safety staff, had completed this training, which did not meet the trust target of 95%.
- There were no patients under a community treatment order during our inspection.
- The East and West approved mental health professional (AMHP) teams both had five whole time equivalent approved mental health professionals who undertook

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Mental Health Act assessments. There were also three back up approved mental health professionals on duty every day that were based in the community mental health recovery service.
- We saw evidence of a good working relationship between the crisis resolution home treatment teams and approved mental health professionals.
- Staff demonstrated a good understanding of the Mental Health Act.
- The trust had a Mental Health Act lead that staff could go to for advice.
- We observed a mental health assessment which was conducted professionally. Professionals involved in the meeting demonstrated respect and ensured the patient's understanding and needs were met.
- We saw evidence that least restrictive options had been used which demonstrated good practice.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act and Deprivation of Liberty Safeguards e-learning training was part of the statutory and mandatory training. We found that 86% staff from North West crisis resolution home treatment team and 87% of staff from South West crisis resolution home treatment team had completed this training. The trust target was 95%.
- Staff demonstrated knowledge and understanding the Mental Capacity Act during our inspection.
- Assessments of capacity were recorded in the progress notes. However, the electronic recording system did not have a specific place to record capacity assessments which made them difficult to find.
- Staff knew how to seek advice within the trust regarding mental capacity questions.
- Initial consent forms were scanned onto the electronic recording system.
- Local guides had been produced regarding assessing capacity. However, these had not been shared with other teams.

Health-based places of safety

Assessment of needs and planning of care

- Electronic records for patients in health based places of safety were of a good quality. We reviewed eight care records at each place of safety which contained comprehensive and relevant information.
- Approved mental health professionals told us that health based place of safety staff did everything possible to facilitate a good quality assessment with them and doctors. Physical health checks were completed quickly during early triage for health based place of safety patients.
- The places of safety were coordinated centrally at Farnham Road Hospital. The recent introduction of a rota for section 12 doctors had improved the process for health based place of safety.
- Approved mental health professionals' working hours were 9am-5pm, with screening available from 8am. The emergency duty team was available between 5pm to 9am weekdays and 24 hours a day for weekends and public holidays. Approved mental health professionals who worked 11pm to 9am also covered adult social care, emergency response plans and child protection. We were told the approved mental health professionals routinely telephoned the place of safety each morning between 8am and 8.30am to check if support was required. The services had plans to improve assessment times. For example, profiling the daytime approved mental health professionals to start at 8am; initiatives to increase doctor availability; the development of a crisis care single point of access and consideration to explore the suitability of assessment areas in other places such as acute hospitals and safe haven projects.
- The service had plans to introduce a waiting room specifically for those people who were waiting for an assessment to take place.

Best practice in treatment and care

- Assessments of children and young people and of people with a learning disability took longer to achieve due to the availability of section 12 approved doctors from a learning disability or CAMHS specialism.
- Two people had been discharged from the place of safety following an assessment by the duty doctor. Duty doctors were not section 12 approved doctors. In both these cases the person was discharged because the duty doctor had recorded that they did not have an acute mental disorder. In one case there was a significant history of obsessive compulsive disorder with recent stressors and in the other the person was advised to see their GP for treatment for depression.
- Regular audits took place on the use of sections 135 and 136, the use of the places of safety, outcomes for section 136 and information regarding minors.

Are services effective?

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- We saw audits from Surrey police regarding the volume of section 136 detentions, the use of custody as a place of safety, transport used for place of safety and the distribution of the use of section 136 across the days of the week.
- On 28 January 2016, the trust had started to record how often ambulances had been used to convey people to a place of safety. Data provided from the trust showed that ambulances had been used on 50 occasions to convey people to a place of safety since 28 January 2016. There was seven incidents recorded where ambulances had not been used during this period.
- Police data also showed that between April 2015 to January 2016, 35% of uses of section 136 related to individuals who had been detained under this section on two or more occasions. Therefore 75 people accounted for 231 of the total of 662 detentions during that period. The approved mental health practitioner informed us that they had been involved in highlighting cases where people were repeatedly detained under section 136. The approved mental health practitioners arranged professionals meetings to address such cases.
- Local audits captured reasons for the non-allocation of a place of safety. However, staff could not explain how the information from these audits was being used to develop and improve services.
- Farnham Road Hospital home treatment team place of safety co-ordinated all police calls for any place of safety across the Surrey area. The Farnham Road Hospital team directed the police to the most local or available place of safety in their organisation. East Surrey residents were taken to Langley Green Hospital which was provided by Sussex Partnership NHS Foundation Trust.
- There were records showing delays in accessing the place of safety. However, we saw no evidence that delays to patients accessing beds had been recorded. There had been 15 cases since November 2015 where there had been delays in accessing the place of safety due to availability. One person had been detained in excess of 72 hours due to inaccurate recording of the start time of the detention. Patients had to wait in the accident and emergency department of the local hospitals when there were delays in accessing the place of safety during peak times.
- A call screening sheet was completed by Farnham Road Hospital staff following contact by police requesting allocation of place of safety.
- The service had an operational policy which was specific to assessment suites.
- There was an emergency duty team available at night. Approved mental health practitioners routinely telephoned the place of safety between 8am to 9am in order to check if support was required.
- Staff could put forward questions to be asked at police liaison meetings using an email address known as the 'Tardis Police Box'.
- The health based place of safety at Farnham Road Hospital had an interactive communication window, which included activities, television and communication with staff.

Skilled staff to deliver care

- Staff at Farnham Road hospital had access to nursing support from the South West crisis resolution home treatment team.
- Staff told us that they received regular supervision and felt able to approach managers for support and advice.
- Most staff appraisals were up to date and we saw planned dates to complete any that were outstanding.

Multi-disciplinary and inter-agency team work

- There was good interagency working between the health based place of safety and external agencies including approved mental health practitioners and the police.
- Systems were in place to support access to places of safety. This included a call screening tool and an assessment suite monitoring form.
- Documents from the crisis care concordat delivery group showed that the group had discussed information on the safe haven project and plans for a single point of access.
- Regular multidisciplinary police liaison meetings took place. This group was also responsible for monitoring compliance with the interagency policy. However, it was noted that members of ambulance staff had not attended for some time.
- A Surrey declaration and action plan was in place as part of the mental health crisis care concordat. Members of the mental health crisis care concordat included Surrey police, health and wellbeing Surrey, Surrey county council and other stakeholders and partners.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Goals with allocated actions included a request for service commissioners to allow earlier intervention and responsive crisis services, access to support before crisis point and urgent and emergency access to crisis care.

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

- The organisational policy concerning the health based place of safety was updated in February 2016 to reflect the changes to the Mental Health Act 1983 Code of Practice 2015.
- The time of arrival at the place of safety was documented on 15 of the 16 care records reviewed. The time that the police had left the place of safety was recorded in 14 of the 16 care records reviewed. This had not been documented on the remaining two care records.
- Staff recorded the time of arrival of the approved mental health practitioner and doctor. There was consistent recording of the joint assessment and the outcome of assessment with reasons given. The time of discharge from the place of safety was consistently recorded. It was recorded in 15 of the 16 care records reviewed that staff had explained of the patients' rights to them.
- Assessments took place within four hours of arrival at the place of safety.
- Training figures for the health based places of safety were included in the Blake ward and South West crisis resolution home treatment team data. 71% of staff from Blake ward and 90% of staff from the South West crisis resolution home treatment team and had completed mandatory training concerning the Mental Health Act.

Good practice in applying the Mental Capacity Act

- Training figures for the health based places of safety were included in the Blake ward and South West crisis resolution home treatment team data. 91% of staff from Blake ward and 87% of staff from the South West crisis resolution home treatment team had completed the mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards.
- There was evidence of consent of use of the Mental Capacity Act for medical treatment in two of the sixteen care records reviewed. The remaining fourteen records showed that this was not applicable.

Crisis House and crisis line

Assessment of needs and planning of care

- All information was stored on the trust electronic recording system which could be accessed by all staff. Patients were referred by the crisis resolution home treatment team who remained the coordinator and liaised with Crisis House regarding risks and planned length of stay.
- There were two telephone lines for the crisis line. The average length of time per call to the crisis line during February 2016 was between five and nine minutes.

Best practice in treatment and care

- Medical reviews and support was provided by the patient's crisis resolution home treatment team. Daily liaison took place and a respite plan was formulated. Patients were seen by the crisis resolution home treatment teams on alternate days and CMHRS patients were reviewed a minimum of twice weekly.
- Patients had access to psychological interventions from the local community mental health recovery service team. A psychologist attended the service to provide interventions when appropriate.
- The responsibility regarding support concerning employment, housing and benefits remained with the referring crisis resolution home treatment team whilst patients stayed at Crisis House.
- We saw a crisis line action plan dated May 2015 which included actions to formalise the local induction process so that it resembled a preceptorship system. This meant that staff received a structured period of transition into their new role. The plan included a review of the operational policy to provide clarity to staff and avoid advice being given that could cause unnecessary additional distress for those seeking support. It also included specific training to be funded for staff to attend the skills and competency framework training level three for a telephone helpline.
- Staff provided interventions to callers which included examples of mindfulness and coping strategies to help 'in the now'.
- A service review of the crisis line took place in May 2015. The information from this report was used to develop the service including acknowledging the increased use of text messaging to contact the service and how further exploration to improve the service would be beneficial. The team leader monitored calls to the crisis line.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Skilled staff to deliver care

- All staff completed the trust induction programme.
- Information provided by the trust showed that all staff except one met the required compliance for mandatory and statutory training. Dedicated training for crisis line staff included customer care skills, brief telephone counselling skills and management of personality disorders. Psychologists delivered personality disorder training to crisis line staff. Additional training had been arranged for February and March 2016 for crisis line training, carer support training, and system one training, older adult crisis helpline, fire training in house and adolescent training. The older adult service and child and adolescent mental health service teams had delivered training to staff at crisis House. Arrangements had been made for this training to be delivered to new staff.
- Psychologists delivered clinical supervision for crisis line staff. The purpose of the supervision was to enable staff to reflect on their practice, feel supported and ensure a better service was offered to those contacting the crisis line.
- Staff at crisis house and the crisis line attended peer support meetings.

Multi-disciplinary and inter-agency team work

- There were regular team meetings between Crisis House, crisis line staff and members of the crisis resolution home treatment teams.
- Crisis line staff had a daily debrief with the nurse in charge of Crisis House.
- The referring crisis resolution home treatment team sent information to Crisis House which included the planned length of stay and review dates, before patients were accepted for respite support.

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

- Data provided by the trust showed that 89% of staff from Crisis House had completed the trust's mandatory Mental Health Act training.
- All patients at Crisis House were informal. Patients would be assessed under the Mental Health Act if considered appropriate. Patients were transferred to acute services following a Mental Health Act assessment if necessary.

Good practice in applying the Mental Capacity Act

- All staff had completed the trust's mandatory Mental Capacity Act and Deprivation of Liberty Safeguards training.

Good

Are services caring?

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

Our findings

Crisis Resolution and Home Treatment Teams

Kindness, dignity, respect and support

- All interactions we observed between staff and patients were caring and respectful. All three shadowed visits were thorough, supportive and patient centred. Staff demonstrated a good knowledge of the service user and a warm rapport had been established.
- We witnessed phone calls between staff and patients in crisis which were dealt with in a caring, compassionate and supportive way.
- We viewed 'Your Views Matter' boards where patients reported being grateful, satisfied and that it was a 'brilliant' service.
- We spoke with nine service users who all spoke positively about their care and treatment. We spoke with four families and carers who all spoke positively about their involvement and the care and treatment received by their relative.
- All patients were given a patient information pack at initial assessment. Information included Patient Advice and Liaison Service complaints and compliments leaflet, medicines leaflet, advocacy information, sharing information leaflet, care programme approach information, crisis helpline and contact details for patient and carer support.
- Staff gave carers a carer support information pack.

The involvement of people in the care that they receive

- We saw that staff involved service users in their care and aspects such as medication during meetings. However, there was little evidence of patient involvement in the 40 care plans reviewed. Most care plans were written more as a management plan rather than being holistic or including patient views.
- The crisis resolution home treatment teams used an interactive 'Your Views Matter' tool to capture patient feedback. Questions included: 'Do you feel you were treated with dignity and respect', 'Were you given (or offered) a copy of your care plan?', 'Do you think your views were taken into account in deciding which medications to take' and 'Were you told about possible side effects of the medication (either verbally or in writing?'). Data generated from this tool was used to develop and improve services. We were given an example where feedback had led to a medicines questionnaire being developed for patients in order to improve this process.

Health-based places of safety

Kindness, dignity, respect and support

- We observed staff being attentive and responding to the needs of patients in the places of safety. We observed staff proactively using activities to engage with a patient under the age of 18.
- Approved mental health professionals reported that staff in both places of safety were caring and responsive to patients.
- Ambulances were used to convey patients to places of safety wherever possible.
- However, privacy and dignity for patients accessing both places of safety could be compromised because they were overlooked by public areas.

The involvement of people in the care that they receive

- We saw evidence of good record keeping concerning patients' stay and access to treatment within the places of safety.
- Staff gave patients a guide which included a request to complete the 'Your Views Matter' survey.
- We saw no evidence of least restrictive options being considered in any of the sixteen care records reviewed.

Crisis House and crisis line

Kindness, dignity, respect and support

- We saw positive interactions between staff and service users at Crisis House.
- Crisis House patients told us that they found staff responsive, caring and helpful.
- We saw a 'Religious box' in the quiet room containing a range of resources to cater for a range of cultural and religious needs.

The involvement of people in the care that they receive

- Information recorded on the 'Your Views Matter' tool for January 2016 recorded that nine questionnaires were completed for Crisis House. Approximately 80% of people who responded said they were satisfied or

Good

Are services caring?

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

extremely satisfied with their experience of the service. Crisis House scored 100% on the 'Your Views Matter' tool concerning staff speaking to them with dignity and respect.

- The service had responded to patient feedback. For example, there were plans for patient involvement using an ex patient. Also the service had introduced a daily planning meeting and explored the possibility of having WIFI. Members of a community mental health recovery service supported patients and staff to create a recreational garden at Crisis House.

Are services responsive to people's needs?

Good

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

Our findings

Crisis Resolution and Home Treatment Teams

Access and discharge

- The trust had a target for the crisis resolution home treatment teams to see all requests for an assessment or referrals for acute services within four hours of receipt of the referral. The trust target for routine referrals was up to 24 hours. There was no data available to evidence that targets had been met since the implementation of the new electronic recording system and breaches could not be identified.
- The database captured timed information when entries were recorded by staff. However, we were told that a report could not be generated with this information and that in order to see waiting times each patient record had to be looked at individually.
- Referrals were only accepted from secondary mental health services, learning disability services, child and adolescent mental health services, the crisis line and from the health based places of safety. Patients and carers could not make referrals. All referrals received from the crisis line received a face to face assessment with the crisis resolution home treatment team. Skilled staff were available in all teams to assess patients.
- The first point of contact for GPs out of hours was the crisis line.
- We saw evidence that the Epsom crisis resolution home treatment team were trying to engage the travelling community.
- The introduction of the safe haven service provided immediate face to face out of hours support.
- We observed inconsistent discharge planning across teams. However, patients and carers told us that they had felt involved and prepared for discharge.
- We observed some multidisciplinary (MDT) meetings, where discharge planning was not discussed, despite bed pressures being evident and the involvement of the crisis resolution home treatment team was the least restrictive option. We observed some MDT meetings to be reactive rather than proactive regarding discharge planning. We saw evidence that a patient had been discharged from a ward to a home treatment team in another area but the local team had not liaised with the new team. However, at Epsom crisis resolution home treatment team, patients were discharged from the caseload as soon as they were admitted to hospital. There was a clear criteria for referrals and admission onto caseloads.
- Access to private beds for patients required authorisation from the manager on call and the director on call. Significant resources were used trying to find beds for patients. Staff told us that access to beds would benefit from a dedicated bed manager. We were told that there were significant concerns regarding bed occupancy. Data from the trust reported bed occupancy was 78%. However staff told us that it was over 100% within the trust.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff mainly saw patients in their own homes. The number of visits made to patients was flexible and determined upon risk and need. Families and carers told us that staff from the home treatment teams had been to their house several times.
- Patients were able to access inpatient groups including mindfulness and coping skills. Staff were able to arrange appointments to tie in with attendance at groups and see patients at the hospital. The trust paid for a taxi to and from the hospital to encourage attendance at groups and appointments.

Meeting the needs of all people who use the service

- Staff saw patients at home where possible. Staff made arrangements to ensure that disabled access needs could be met to see patients who attended groups.
- We saw evidence of access to interpreters.
- Staff gave all patients an information pack at initial assessment, which included information about medication, sharing information, advocacy services and the patients advice and liaison service (PALs).
- The trust had developed a families and carers pack which included information concerning the triangle of care, a carer registration and emergency card, consent form and advocacy information.

Are services responsive to people's needs?

Good

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

Listening to and learning from concerns and complaints

- One complaint had been received for the home treatment teams for the previous 12 months. This complaint had been investigated and was partially upheld.
- Patients were given an information pack which included how to make a complaint. Two patients we spoke to said that they knew how to complain and would feel confident in doing so. Another two patients we spoke to said that they did not know how to complain but felt able to do so if needed.
- The Meridian 'Your Views Matter' tool was used to capture feedback from patients regarding their experience of treatment. We saw evidence of this feedback being used to improve services by the introduction of a medicines questionnaire and a case record audit tool in the crisis resolution home treatment team East (Redhill).
- Managers told us that the patient advice and liaison service emailed complaints to them to action.
- A root cause analysis had been completed by senior managers and sent to a manager to share learning with staff regarding a complaint.

Health-based places of safety

Access and discharge

- Assessments took place within the trust target of four hours. We saw a copy of an action plan concerning the Surrey mental health crisis care concordat, to reduce the length of time from arrival to the place of safety to having an approved mental health professsional assessment to three hours and to record reasons for any breach. The Mental Health Act 1983: Code of Practice 2015 recommends 'Assessment by the doctor and approved mental health practitioner should begin as soon as possible after the arrival of the individual at the place of safety. In cases where there are no clinical grounds to delay assessment, it is good practice for the doctor and approved mental health practitioner to attend within three hours'.
- We saw a copy of the operational policy which was up to date and thorough. There was a clear protocol for referrals and clear guidelines about staffing and interagency working.
- We saw evidence that staff called the duty doctor when a person had been received into the place of safety. Staff completed a healthcare screening within one hour of the person's arrival to the place of safety. The member of staff on duty in the place of safety contacted the approved mental health practitioner as soon as possible rather than waiting for the outcome of the healthcare screening.
- The trust has implemented a section 12 doctor rota and the approved mental health professionals' service had made changes to prioritise assessments in places of safety. The availability of approved mental health professional's had been increased to improve response times for assessments.
- We saw evidence of data being collected regarding frequent users of the places of safety. The approved mental health professionals' had been involved in highlighting cases where people were repeatedly detained under section 136 and calling professionals meetings to address such cases.
- We saw evidence that assessments of children and young people and those with a learning disability had taken longer to achieve due to the availability of section 12 doctors from learning disability and child and adolescent (CAMHs) specialisms. We observed that an assessment for a young person had started over 12 hours after they arrived. We were informed that this was in part due to the delay in securing the attendance of a CAMHS section 12 doctors with the AMHP having to contact five doctors before being successful.
- We saw evidence of two cases where people were discharged from the place of safety without having been assessed by a section 12 doctors or AMHP. The patients had been seen by the duty doctor who had assessed them as not having a mental disorder. However, in one case there was a significant history of obsessive compulsive disorder with recent stressors and in the other, the person was advised to see their GP for treatment for depression.
- Delays in accessing the place of safety were clearly recorded. However, we saw no evidence of how this information was used to develop and improve services.

The facilities promote recovery, comfort, dignity and confidentiality

- Both places of safety were discreet, quiet and secure and rooms contained ensuite facilities.
- Both places of safety had safe, heavy and comfortable furniture. Bed linen was available but was removed if risks presented.

Are services responsive to people's needs?

Good

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

- There was access to a shower room for patients at Farnham Road Hospital. However, there were no shower facilities available within the assessment suite at the Abraham Cowley Unit.
- Food and drink was available for patients at all times.
- The assessment suites at Farnham Road Hospital contained communication windows which patients used to watch television, draw, play interactive activities and communicate with staff.
- There were privacy and dignity issues for patients accessing the places of safety due to the places of safety being overlooked by public areas.

Meeting the needs of all people who use the service

- The health based places of safety had no exclusion criteria and was available 24 hours a day, seven days a week.
- We observed staff managing difficult and challenging behaviour well. We observed staff engaging with one young person detained under section 136 through the use of games and drawing.
- The operational policy stated that all persons under the age of 18 should be taken to the assessment suite at Farnham Road Hospital. However, during our inspection a young person was taken to the Abraham Cowley Unit. Staff told us that they had judged that this was more appropriate for the young person to avoid the transfer a person from the place of safety at Farnham Road Hospital in the middle of the night to free up a place for the young person.
- All patients who accessed the assessment suites were given a brief guide which provided information about what to expect during their stay.
- Carer packs were available for families and carers.

Listening to and learning from concerns and complaints

- Patients told us that they knew how to complain.
- All patients who used the assessment suites were given a give a brief guide at initial assessment or when appropriate, dependent upon the level of distress being experienced. The pack included information concerning how to complain and information about the 'Your Views Matter' feedback tool.
- Complaints were discussed during team meetings.

Crisis house and crisis line

Access and discharge

- Staff at Crisis house received a risk assessment, care plan, purpose of admission / respite, planned length of stay and review date from the referring crisis resolution home treatment team prior to admission.
- Day respite care was available for patients between the hours of 9am-5pm, although this could be negotiated. The local policy was that the care coordinator for a day patient should complete a care plan and that a review would take place after three days. The nurse in charge could refuse day respite if patients were not settled enough or if there was an increase in activity.
- The manager of Crisis House told us that research was being completed regarding best practice for a single point of access which had included visiting a 111 service.

The facilities promote recovery, comfort, dignity and confidentiality

- Crisis house was divided into male and female accommodation. Patients were able to lock their bedroom doors and staff were able to override this lock. There were separate bathrooms with shower facilities for male and female service users. There was a shared lounge and a separate female lounge. There was a shared kitchen that patients could use 24 hours a day, seven days a week. Staff encouraged healthy eating and patient involvement in menu planning and cooking. Patients accessed a garden area through the lounge. We were told that discussions with the Richmond Fellowship had taken place to develop the garden.

Meeting the needs of all people who use the service

- There was a large bedroom on the ground floor with a large shower room to accommodate disabled patients.
- There was a quiet area with a 'religious box' which included the Bible, the Quran and beads. Staff received training in equality and diversity as part of their mandatory training. We reviewed training records and found that 89% of staff had completed this training.
- Patients told us that they had been given crisis resolution home treatment team out of hours and crisis line contact details.
- A protocol was being developed to help manage text conversations via the crisis line.

Are services responsive to people's needs?

Good

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

- We received mixed feedback concerning the effectiveness and helpfulness of the crisis line with some patients telling us that they found the Samaritans more helpful. Patients wishing to contact the team out of hours had to use the crisis line. Of 1529 calls made to the crisis line between 1-29 February 2016, 943 were connected. Reasons for this included limited staff availability to answer calls and crisis line staff talking to another caller. However, further information provided from the trust showed that there was an 80% response rate of calls and audible voice mails between December 2015 and February 2016.

Listening to and learning from concerns and complaints

- Patients were encouraged to complete the 'Your Views Matter' survey on discharge from the service.
- One patients told us that they knew how to complain, felt confident in doing so and felt confident that staff would listen to them. Another patient told us that they did not know how to complain but that they had nothing to complain about as they were happy with the services received.
- Patients were asked to provide feedback on the service. A 'you said we did' board was displayed to demonstrate to patients how feedback was being used to develop and improve the service. A suggestion box was available for patients.
- Learning from local complaints and incidents was discussed in team meetings. There was a complaints folder containing complaints received, the outcome and actions or learning from each complaint.
- One complaint had been received for crisis house and three complaints had been received regarding the crisis line. Two concerned the attitude of staff and two concerned poor communication to patients. All four complaints had been partially upheld.
- One patient told us that their experience of crisis line had been 'hit and miss dependent upon who answered the phone. However, they were complimentary concerning the out of hour's crisis resolution home treatment team support that they had received.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Crisis Resolution and Home Treatment Teams

Vision and values

- The trust vision and values were evidently displayed throughout the trust.
- Staff told us that the service manager's were approachable, supportive and knowledgeable.

Good governance

- There was no risk assessment tool to identify the level of risk for a patient and recording and discussing risk was inconsistent across teams. The lack of staff knowledge concerning the new database meant that comprehensive risk assessments were not always completed. There were inconsistencies concerning the completion of contingency plans and discharge planning.
- Staff did not regularly review medicines despite the availability of non-medical prescribers in some teams and training rates for medicines management was low.
- Team managers had access to a training spreadsheet to see when training was due and this was discussed within staff supervision. However, staff compliance with mandatory and statutory training was inconsistent across teams.
- A spread sheet was sent to the team manager's monthly meeting which contained information regarding outstanding appraisals. The completion of appraisals was inconsistent between teams.
- Supervision was inconsistent across the teams and good practice was not shared. Some, but not all, teams had devised local systems and structures for supervision responsibilities. Not all teams had access to psychology led reflective supervision.
- We saw ineffective use of time and resources through the amount of time spent in meetings. We observed staff spending a significant amount of time on admin tasks due to difficulties being experienced with system one.
- Due to the implementation of a new electronic recording system it was not possible to capture data or measure performance at the time of our inspection.
- We saw actions plans as part of the Surrey mental health crisis care concordat to improve assessment times and access to support prior to times of crisis. Safe haven steering groups took place in order to provide interagency support to develop this project within each locality.
- All staff had access to the incident reporting system, and were accountable for their own reporting. Staff knew when to report an incident and managers shared learning from incidents with the team.
- There was an operational policy which covered the acute care pathway. Staff were knowledgeable regarding the lone working policy.
- Managers felt they had appropriate authority to do their job with reasonable admin support in place.

Leadership, morale and staff engagement

- Staff sickness rate between 1st February 2015 to 31st January 2016 was between 1% and 8%. Manager's monitored absence and were able to contact HR for advice.
- Team managers attended monthly 'brief encounter' meetings with senior management where topics discussed included staffing, training, appraisals and use of bank staff.
- There was a rolling recruitment programme for staff. A band seven staff member attended the interview panel and had the authority to offer and appointment staff.
- All teams we inspected displayed clear evidence of team working and mutual support. Staff said they were proud to work for their teams.
- Staff told us of opportunities for specialist training and leadership development including taking a master's degree.
- Staff said they could raise concerns with their manager without fear of victimisation. Staff knew the whistleblowing process.
- Some staff told us of a history of bullying which had been managed appropriately.
- Staff told us of little opportunity to develop services or involvement in trust decisions.
- Staff reported frustration at difficulties experienced with the new electronic recording system.

Commitment to quality improvement and innovation

- We saw evidence of involvement in the home treatment team CORE study which was a five year study commissioned by the Department of Health and University College London. The study was to identify the

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

national picture of crisis resolution home treatment team and to develop a model of good practice and a tool to test this model nationally. The final phase of the study was to test selected crisis resolution home treatment team pre and post intervention to see if practice could be improved through the support of an online tool. The study involved 14 crisis resolution home treatment teams throughout England. Publication of findings is awaited.
- Data from 'Your Views Matter' had been used to develop and improve services.

Health-based places of safety

Vision and values

- The trust vision and values were evidently displayed throughout the places of safety.
- Staff told us that managers were approachable and supportive.

Good governance

- The organisational policy concerning the health based place of safety had been updated in February 2016 to reflect the changes to the Mental Health Act 1983 Code of Practice 2015.
- The places of safety had a clear and comprehensive standard operational procedure which was based on the multi-agency agreement. There were good working relationships with the police and ambulance service at the senior level.
- There was a commitment and clear leadership at all levels to improve access to places of safety. The trust had signed up to the multi-agency agreement with Surrey police and was involved in the Surrey Mental Health Crisis Care Concordat. Ambulances were used to convey patients to a place of safety in a majority of cases.
- Staff told us that they received regular supervision and felt able to approach managers for support.
- Most staff appraisals were up to date and we saw planned dates to complete any that were outstanding.
- There was a coordinator for the suites who was located at Farnham Road Hospital. We saw evidence of good coordination of the suites with processes in place to promote effective access for patients.
- All staff had access to the incident reporting system, and were accountable for their own reporting. Incidents were discussed during team meetings. Learning was shared and information displayed on some staff notice boards.
- The trust did not track delays in accessing the health based place of safety or keep records of what happened to a person whilst waiting for a place of safety. There was no evidence that the trust tracked delays in accessing a bed once an assessment in a place of safety had been completed.
- Due to the implementation of a new electronic recording system we were told that it was difficult or not possible to capture data or measure performance at the time of our inspection.

Leadership, morale and staff engagement

- Staff told us that they enjoyed their work and found their manager supportive within their role. Staff told us that they felt able to approach their immediate manager and the lead service manager.
- Staff told us that they were aware of the whistleblowing process and felt confident to use.
- Staff at Farnham Road Hospital told us that they felt able to contribute towards the development of the service.

Commitment to quality improvement and innovation

- Staff showed us how auditing the use of the assessment suites had been improved.
- Staff told us about the introduction of the safe haven project in Surrey. The aim of the project was to offer accessible, patient centred support in a crisis and avoid and reduce the use of 136 assessments and attendance at the accident and emergency department.

Crisis house and crisis line

Vision and values

- The trust vision and values were evidently displayed in Crisis House.
- Staff told us that they felt comfortable discussing concerns with their manager.
- We saw evidence of visits to crisis house by members of the senior management team.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Good governance

- Staff followed the local policy concerning referrals to Crisis House.
- The team leader had access to a training spreadsheet to see when training was due. We saw evidence of specialised training for staff which included carer support training, system one training, older adult crisis helpline, fire training in house and adolescent training.
- There were plans to formalise the local induction process to resemble a preceptorship system.
- There were plans to review the operational policy for the crisis line and for specific funding for staff to attend the skills and competency framework training level three.
- We received mixed feedback concerning the effectiveness and helpfulness of the crisis line with some patients telling us that they found the Samaritans more helpful. People calling the crisis line were sometimes not called back. The crisis line received 1,529 calls between 1 and 29 February 2016 but only 62% were connected. The number of calls to the crisis line diverted to voicemail during February 2016 ranged from two to sixty.
- Staff from Crisis House often had to answer the second crisis line due to staff vacancies within the crisis line team, which affected staff availability for patients at Crisis House.

Leadership, morale and staff engagement

- The team had a sickness rate of 5.28%, compared to 3.55% trust wide. The team leader told us that this had been affected by the long term sickness absence of a member of staff which was being managed appropriately.
- Staff told us that they were aware of the whistleblowing process and felt able to raise concerns without fear of victimisation.
- Staff told us that they enjoyed their job. One member of staff had returned to work for crisis house on a part time basis following their retirement. The other member of staff told us that they had recently joined crisis house and had no concerns to date.
- Regular team meetings took place. However, staff expressed concern at the lack of feedback received concerning incidents.

Commitment to quality improvement and innovation

- The team leader had recently visited a local 111 service to develop and improve the crisis line service.
- Audits had identified an increase in calls to the crisis line during certain periods which supported the recruitment of additional staff.
- The team leader monitored calls to the crisis line and used the information to reflect with staff and improve standards.
- There were plans to introduce a single point of contact which will involve the manager of crisis house.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance The trust had not protected service users against the risk of inappropriate or unsafe care by means of the effective operation of systems designed to identify, assess and manage risks relating to the health, welfare and safety of service users. This was in breach of Regulation 17 (1), 2(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment The trust had not protected service users against the risk of inappropriate or unsafe care by means of the effective operation of systems designed to identify, assess and manage risks relating to the health, welfare and safety of service users.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014** Staffing The provider had not ensured that staff had received appropriate training to enable them to deliver care and treatment to service users safely and to an appropriate standard. This was in breach of Regulation 18 (2) (a)
	The trust had not protected service users against the risk of inappropriate or unsafe care by ensuring that allergies were appropriately recorded. The trust had not protected service users from risk of harm by not responding to all calls made to the crisis line. This was in breach of Regulation 12 (2) (a) (b)