

Surrey and Borders Partnership NHS Foundation Trust

Quality Report

18 Mole Business
Park Randalls Road
Leatherhead
Surrey
KT22 7AD
Tel: 0300 555 5222
Website: www.sabp.nhs.uk

Date of inspection visit: 7-11 July
Date of publication: 24/10/2014

Core services inspected	CQC registered location	CQC location ID
Acute admission wards	Mid Surrey Assessment & Treatment ServiceRidgewood CentreSt Peters Site	RXX87 RXX20 RXXW1
Psychiatric intensive care units and health-based places of safety	Mid Surrey Assessment & Treatment ServiceSt Peters SiteRidgewood Centre	RXX87 RXXW1 RXX20
Long stay/rehabilitation services	Margaret Laurie House Inpatient Rehabilitation Unit	RXXHE
Child and adolescent mental health services	Trust Headquarters	RXXHQ
Services for older people	Trust HeadquartersFarnham Road HospitalSt Peters SiteWest ParkWoking Community Hospital	RXXHQ RXX22 RXXW1 RXX2T RXXXX
Services for people with learning disabilities or autism	Trust HeadquartersBramdeanApril Cottage	RXXHQ RXXX1 RXXHK

Summary of findings

Adult community-based services	Trust HeadquartersSt Peters Site	RXXHQ RXXW1
Community-based crisis services	Trust Headquarters Crisis House	RXXHQ RXX90
Specialist eating disorder services	Trust Headquarters	RXXHQ

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the services and what we found	5
Our inspection team	8
Why we carried out this inspection	8
How we carried out this inspection	8
Information about the provider	9
What people who use the provider's services say	10
Good practice	11
Areas for improvement	12

Detailed findings from this inspection

Findings by main service	16
Findings by our five questions	16
Action we have told the provider to take	36

Summary of findings

Overall summary

The trust was led by a committed board, executive team and senior managers. People who use the services, staff and external stakeholders told us that senior staff were generally open, accessible and willing to learn. We heard of many new initiatives and the trust was constantly looking for ways to improve its services.

Before and during our inspection, people told us that most staff treated them with kindness, dignity and respect.

Many of the staff we spoke to enjoyed working for the trust and felt they had opportunities to professionally develop and to engage with the future direction of the work of the trust.

We also found good collaborative working relationships with partner agencies such as social services.

The main challenge for the trust is that the governance processes are not yet fully supported by robust quality assurance systems. Many of these systems are new and may not always identify poorly performing services in a timely manner so that the focus could be given to ensuring the necessary improvements were made. This meant that although the trust understood its broad areas of risk it did not always know all of its service “hot spots”.

This has meant that in each domain there are areas of very positive work such as the safe staffing initiative which has improved the assurance around staffing levels for inpatient services and yet there are variations between divisions and also between services in the same divisions. This has led to variations in the quality of care and the need for different areas of improvement across the services.

We inspected 10 adult social care services provided by the trust as part of this comprehensive inspection and found that four of them were now compliant. The remaining six had all improved since our last inspection and separate draft reports were being sent to the trust.

As a consequence there are a number of compliance actions relating to different services and it is our view that the trust needs to take steps to improve the quality and safety of their services. We will be working with them to agree an action plan to help improve the standards of care and treatment.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

The trust had systems in place to report and monitor incidents. In most services these systems were understood and were being used appropriately by staff. The trust was investigating serious incidents appropriately. They were working with commissioners towards meeting agreed timescales for these investigations to be completed and this was improving. Learning from incidents was mainly taking place although in a couple of areas such as the inpatient services for older people lessons were not being shared across services or recommendations from investigations were not fully implemented.

Inpatient services for older people were not consistently managing the risk of falls and of people developing a pressure ulcer. Whilst the trust had developed action plans these had not been fully implemented and people using the service had not all been assessed to identify risks so that care plans could be put into place.

Staff were generally well informed in the use of safeguarding processes but the numbers of staff who had completed training at different levels was not clear due to issues of data accuracy.

The trust was maintaining safe staffing levels in inpatient services and where needed was using temporary staff. The trust was actively recruiting staff to vacant posts.

Physical interventions were not always safely managed. Staff did not always recognise when a patient was being secluded so that the appropriate systems and safeguards could be put into place. Some temporary staff working in the psychiatric intensive care unit were helping to restrain patients without having the appropriate training.

In two areas at the Mid Surrey assessment and treatment centre we found that emergency equipment used for resuscitation had not been checked regularly to ensure it was always in good working order.

The trust was working to provide a safe environment for people using their services. A ligature minimisation programme was in place where the trust had identified services as being in scope. There were some specific concerns about the safety of some environments such as call bells not working on Victoria ward in the division for older people.

Summary of findings

Are services effective?

People were mainly supported to have a comprehensive assessment of their needs. There were many good examples of multi-disciplinary and multi-agency working which contributed to services being effective and innovative.

The trust recognised the need to improve the physical health assessments for people using their services but in the division for older people we found that health monitoring checks such as blood pressure were not always being recorded which meant we could not be certain that those checks were taking place.

Staff training on the Mental Capacity Act was progressing and staff demonstrated a knowledge of this legislation. In a few areas recording of decision specific capacity assessments were not taking place. The Mental Health Act was operating well across the trust, although recording that people had been told their rights needed to improve in a couple of areas.

Staff were well supported by the pharmacy team and medication was generally well managed.

The trust used external accreditation and internal audits to evaluate many aspects of the services it provides.

Many staff spoke positively about opportunities for continuing professional development but the poor data quality of figures for statutory and mandatory training meant it was not possible to accurately know where training was required.

Are services caring?

Before and during our inspection, people told us that most staff treated them with kindness, dignity and respect. The exception to this was on Fenby ward the psychiatric intensive care unit where interactions between staff and people using the service were brief and task focused.

We heard about people having opportunities to be involved in the development of their care plans such as in the learning disability services. However we also found that in other services people had more mixed experiences and the care plan records did not always show how people had been involved.

People were given information so they could access independent advocacy services when they wished to do so.

Carers also told us they had mixed experiences of being involved and being able to provide support to people using services, although the trust is engaged in an initiative to improve this.

Summary of findings

Are services responsive to people's needs?

Many of the services provided by the trust were responsive although accessing inpatient beds can be difficult.

We heard from people using the service and staff in the trust that the crisis line was not meeting the needs of some of the people who needed this input. The trust must ensure the review of the crisis line is completed with clear recommendations for change in place so it meets the needs of people using the service.

We saw many positive examples of how the trust respects peoples diversity and human rights.

The trust provided people using the service with information about how to complain and where complaints were received these were generally addressed to a high standard. The trust needs to ensure the responses are more consistently timely.

Are services well-led?

The trust had a clear vision and shared values. Staff and patients said that senior staff were accessible and open.

Staff were generally very positive about working for the trust and felt they had opportunities to be involved in how services were developing. Staff also valued the opportunities to access programmes for leadership development.

The trust offers a range of opportunities for people who use the service to give feedback and we found that senior staff were listening.

The main challenge for the trust is that the quality assurance processes, many of which are new, are not always identifying poorly performing services in a timely manner so that the focus could be given to ensuring the necessary improvements were made.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Sheena Cumiskey Chief Executive Officer at Cheshire & Wirral Partnership NHS Foundation Trust

Team Leader: Jane Ray, Care Quality Commission

The team of 50 people included CQC Inspectors, Mental Health Act Reviewers, and an analyst. We also had a variety of specialist advisors which included a consultant psychiatrist, nurses, junior doctors and social workers.

We were additionally supported by five Experts by Experience who have personal experience of using or caring for someone who uses the type of services we were inspecting.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme. This trust was selected to enable the Care Quality Commission to test and evaluate its methodology across a range of different trusts.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, we always ask the following five questions of every service and provider:

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

The inspection team inspected the following core services, which are inspected at each trust:

- Acute admission wards
- Health-based places of safety
- Psychiatric intensive care unit
- Services for older people
- Adult community-based services
- Community-based crisis services
- Child and adolescent mental health services
- Services for people with learning disabilities or autism
- Long stay/rehabilitation services

We also inspected the specialist eating disorder services provided by the trust.

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

Before the inspection visit took place, we met with five different groups of people who use the services provided by the trust. We also met with the trust's council of governors. They shared their views and experiences of receiving services from the provider.

Before and during the week of the inspection we undertook separate inspections at 10 social care services provided by the trust: Ashmount, Beeches Bungalow, Court Hill House, Derby House, Ethel Bailey & Oak Glade, Hillcroft, Larkfield, Redstone House, Rosewood and The Shielling. These inspections are reported on separately, although their findings are included in the 'well-led' section of this report.

We inspected all the acute inpatient services and crisis teams for adults of working age. We visited the psychiatric intensive care unit on Langley wing at Epsom hospital. We went to the three places of safety located in Langley Wing, Epsom General Hospital, Wingfield ward, Ridgewood Centre, Frimley and St Peter's.

Summary of findings

We also inspected the inpatient and some community services for older people. We visited a sample of community teams across a range of services, including services for adults, services for people with learning disabilities, and services for people with eating disorders.

During our visit the team:

Held focus groups with different staff members such as nurses, student nurses and healthcare assistants, senior and junior doctors, allied health professionals and governance staff.

- Talked with patients, carers, family members and staff.

- Looked at the personal care or treatment records of a sample of patients.
- Observed how staff were caring for people.
- Interviewed staff members.
- Reviewed information we had asked the trust to provide.
- Attended multi-disciplinary team meetings.
- Collected feedback using comment cards.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Information about the provider

Surrey and Borders Partnership NHS Foundation Trust provides health and social care services for people with mental health problems, drug and alcohol problems and learning disabilities in Surrey and North East Hampshire.

Services are provided to children and young people, adults of working age, adults with learning disabilities, and to older people.

The trust has 24 locations registered with CQC. Thirteen locations are registered to provide social care for children and adults with learning disabilities. The remaining locations are registered to provide a range of healthcare services. Acute and older people's inpatient beds are provided at a number of locations: Farnham Road Hospital, West Park Epsom, Mid Surrey Assessment & Treatment Service, Ridgewood Centre, St Peters site, and Willows, Woking Community Hospital. Services for people with learning disabilities are provided at Bramdean and April Cottage. Margaret Laurie House provides inpatient rehabilitation services. Community based services are registered to the trust headquarters in Leatherhead.

The trust was formed in 2005 and became a foundation trust in May 2008. It employs 2,300 staff across 56 sites, including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. The trust is currently undertaking a programme of work costing £64m to replace, modernize or maintain its building stock which is a significant programme of change for the trust.

The trust serves a population of 1.3 million people. Deprivation in the population is lower than the national average, although some areas of deprivation do exist. Life expectancy is 6.3 years lower for men and 4.0 years lower for women in the most deprived areas of Surrey than in the least deprived areas. In Surrey, 9.7% of the population is non-White.

The trust works with partner agencies and the voluntary sector to provide a range of services. The services are delivered through four divisions:

- Mental Health Services for Adults of Working Age
- Mental Health Services for Older People and Specialist Services
- Services for People with Learning Disabilities
- Services for Children and Young People

Surrey and Borders Partnership Foundation NHS Trust's locations have been inspected on 51 occasions since registration across 29 of its locations. Reports of these inspections were published between April 2011 and March 2014. At the time the comprehensive inspection was undertaken the trust was non-compliant for at least one regulation at 20 of its locations. Of these locations 12 were non-compliant for the safety and suitability of their premises and 10 for the care and welfare of people who use services. Two locations were compliant for all regulations. Seven locations were no longer registered to provide services. This non-compliance was followed up across the relevant locations as part of this comprehensive inspection.

Summary of findings

What people who use the provider's services say

Prior to the inspection we met with people who use services provided by the trust through five different groups. We met a group of Surrey child and adolescent mental health service (CAMHS) youth advisors, attended a MIND drop in session in Woking, and attended a Speak Out event organised in association with Surrey coalition of disabled people in Guildford. Twenty nine people attended two open focus group events organised by Richmond Fellowship held in Guildford and Redhill. We also reviewed information shared with the CQC directly by people using the service through our website and by calling our phoneline. During the inspection we also received feedback through people completing the CQC comment cards.

We received mixed feedback from people about the quality of service provided by the trust. Some people told us they felt the staff were supportive and that they had received a good service. Other people told us they felt the trust needed to improve and become more person centred.

Some services received positive feedback. An example of this was when we met with people who had experience of accessing the CAMHS service they told us they appreciated the support the 'Hope' service, which works with young people in the early stages of emotional and mental health difficulties/distress, had offered them. Many people who had used community mental health recovery services (CMHRS) also told us the trust had provided a good service. For example, several people told us they had received good support from the Tandridge CMHRS.

We received mixed feedback about the quality of the staff. Many people told us they had felt well supported by staff and that they were helpful. Some people told us they felt staff in inpatient areas should spend more time interacting with them. Some of the people we spoke with

told us they felt their support in the community would be improved if there was more consistency in the person supporting them. They told us they felt there was a high turnover of staff and lots of agency staff being used.

People who had used the crisis line told us they had found it difficult to get a response when they called the line. Many of the people who had accessed the line also told us they had found the responses from it to be unhelpful. They also told us that they felt the home treatment teams were under-resourced. When they were visited by staff the visits were often short.

Some people we spoke with told us they felt their care could be planned better to suit their particular needs. They felt there was often a focus on medication, with little other therapy available.

Many people we met with told us they were concerned about the quality of the environment in some of the trust's locations. For example, people we met with told us they felt the environments on Elgar ward and in Bridgewell House were not appropriate. Many people also told us they were concerned that planned redevelopments of the trust's inpatient facilities may take a long time to be completed. People we met who were caring for people with Aspergers syndrome told us they felt the inpatient facilities at the trust were not suitable for people with Aspergers as they were too noisy and over stimulating.

When we met with people who had experience of accessing the CAMHS service we received mixed feedback. Most people told us they felt the staff were supportive and kind. They also told us they felt the service had communicated well with other services, such as their school. However, some people told us they felt the service had been poor at organising appointments and that these were often cancelled. They also told us they were concerned that the trust was not able to provide tier 4 inpatient beds near to where they lived.

Summary of findings

Good practice

Trust wide:

- The “value conversations” held by the chief executive with groups of staff were felt by many staff to be a way of genuinely hearing about the challenges staff were facing.
- The clinical strategy was very comprehensive and highly valued by staff and set a strategic framework for the services provided by the trust and the contribution they can make to the health of the communities.
- The work of the leadership faculty was acknowledged by staff as offering opportunities for leadership development in the trust.

Acute admission wards:

- All but one of the wards had been accredited by the Royal College of Psychiatrist's Accreditation for Inpatient Mental Health Services (AIMS) scheme.
- People using the service were positive about the therapeutic input in each of the units.
- Health-based places of safety:
- The trust places of safety did not exclude people due to intoxication and there were policies in place to ensure they could meet the needs of these patients. There were also specific procedures in place for the care of people under the age of 18 years.

Community-based crisis services:

- Crisis house provided a positive alternative to support people and reduce their need for a hospital admission.
- Good use of local knowledge to signpost people to community agencies.

Long stay/rehabilitation services:

- A community development worker was employed at the service to support people and promote social inclusion through accessing community facilities as part of moving from hospital to live in the community.

Adult community-based services:

- The criminal justice liaison and diversion service was an innovative service and had provided specialist mental health awareness training to police custody officers.

Services for older people:

- Albert Ward and Hayworth House had developed dementia friendly environments including reminiscence rooms.
- Spenser and Albert wards had regular meetings for the carers of people who used the service to encourage participation and engagement.

Services for people with learning disabilities or autism:

- People were supported by the behaviour specialists at the community team East, to make a ‘how to book’ of their recovery plan to help them and others understand the strategies they needed to cope with living in the community.
- Risk assessments were detailed and care plans were person centred and people were involved in decisions taken about their care and information was discussed with, and provided to, people in an accessible way. This included the use of pictures and easy to read materials.

Specialist eating disorder services:

- There were clear children and young people (CYP) transition protocols in place and there was evidence of joint, flexible working between CAMHS and adult eating disorder services to ensure a smooth transition
- Service led audits which have led to improvements in service provision, for example, looking at the transition from CAMHS to adult services and the management of patients with anorexia nervosa when they were admitted to acute medical wards.
- The CAMHS eating disorder service was actively involved in collaborative research

Child and adolescent mental health services:

- The CAMHS youth advisors (CYA) is an innovative user-led service run by young people who use/ have recently used the service. The CYA are a support network for young people experiencing emotional distress and mental health issues for the first time. They actively encourage young people to get involved in their work through workshops, trips out and groups.
- The CAMHS service ran the targeted mental health in schools (TaMHS) approach that worked to support

Summary of findings

school staff to recognise young people with emerging mental health and emotional needs, and provide access to early advice and consultation from a mental health professional.

- The CAMHS social work service worked jointly with the Surrey youth support Service under the 'No Labels'

approach. This was to try and connect with young people using a youth work model rather than traditional CAMHS interventions, to reduce the stigma relating to mental health and involve young people who were known to services, but not actively engaged in treatment.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action the provider **MUST** take to improve trust wide services

- The existing quality assurance processes used by the trust must be completed accurately so they reflect the service being reviewed. The trust must ensure it has the most appropriate quality assurance systems available so it can identify where services are not performing well so that measures can be put into place to improve these services to ensure consistently high standards of care.

Action the provider **MUST** take to improve acute admission wards:

- Staff must have a clear understanding of the definition and use of seclusion at the Mid Surrey assessment and treatment centre, how it should be practiced, and documented in line with the Mental Health Act code of practice.
- The resuscitation equipment must be monitored on Delius Ward at the Mid Surrey assessment and treatment centre to ensure it is properly maintained.

Action the provider **MUST** take to improve the psychiatric intensive care unit:

- Staff working in the service must respond promptly to people's requests for help and engage proactively with them.
- The resuscitation equipment must be maintained and monitored. Staff must be able to identify the equipment accurately.
- Staff must be clear about when the use of interventions constituted seclusion and ensure the necessary safeguards are in place.
- Patients detained under Section 2 of the Mental Health Act must have their rights explained to them on a

weekly basis and recorded. The documentation given to patients must include details of how to access advocacy services and how to contact the Care Quality Commission.

- Agency staff must be trained to an appropriate standard in the use of restraint before using this physical intervention.
- The quality assurance process used by the trust must be completed correctly so it accurately reflects the service being reviewed.

Action the provider **MUST** take to improve places of Safety

- Whilst the physical environment of the place of safety on Blake Ward at St Peters had been improved the other two places of safety used by the trust must have their physical environments reviewed to ensure they safely meet the needs of the patients.

Action the provider **MUST** take to improve community-based crisis services:

- Staff in the crisis team and crisis house must be supported to undertake outstanding training in supporting people with challenging behaviours and basic life support.
- The trust must ensure the review of the crisis line is completed with clear recommendations for change in place to ensure the service has a clear sense of direction.
- Action the provider **MUST** take to improve services for older people:
- The trust must ensure that all the people using the inpatient services for older people have their regular physical health monitoring checks such as weight and blood pressure especially on Victoria ward.

Summary of findings

- The trust must ensure that all the people using the inpatient services for older people have assessments in place for risks of falls and tissue viability so that appropriate risk assessments and care plans can be put into place if needed.
- The trust must ensure in the division for older people that governance processes are working effectively so that services which are not performing well are identified and improvements made to ensure consistently high standards of care.

Action the provider MUST take to improve child and adolescent mental health services

- The trust must ensure that all staff know how to report incidents and are made aware of the findings.

Action the provider SHOULD take to improve trust wide services:

- The trust should ensure the new electronic staff record provides an accurate record of the training the staff have completed so it is possible to know what training staff need to receive or have refreshed to work in different services in the trust so this can be provided in a timely manner.
- The trust should continue its work to ensure that serious incidents are investigated in a timely manner in line with the agreed timeframes to ensure learning is shared promptly.
- The trust should continue its work to ensure all the people using services have their physical health assessed and have a health action plan.
- The trust should continue its work to ensure people who make a complaint receive a thorough response in a timely manner.

Action the provider SHOULD take to improve acute admission wards:

- The trust should review the use of blanket restrictive policies at the Mid Surrey assessment and treatment service, and where these are considered necessary they should be consistently applied.
- Staff at the Ridgewood Centre should receive their refresher training on the management of challenging behaviours in a timely manner.
- Risk assessments on Delius Ward at the Mid Surrey assessment and treatment service should be updated before patients go on leave.

- Assessments of capacity should be consistently carried out where appropriate and recorded in the care records.
- People detained under the Mental Health Act on Delius ward should be given a record of their section 17 leave form and their views should be recorded when their care is being reviewed.
- People detained under the Mental Health Act on Elgar ward at the Mid Surrey assessment and treatment centre should have a record to confirm that their rights have been regularly explained to them.
- At the Ridgewood Centre the care plans must record if people have been involved in the planning of their care.

Action the provider SHOULD take to improve psychiatric intensive care services:

- Staff should be able to explain what actions they would take in response to allegations of abuse.
- There should be a clear record of people entering and leaving the ward.
- The accuracy and detail of documentation should improve – especially incident forms, restraint forms, documentation of rapid tranquilisation and people's involvement in their care plans.
- Agency staff should complete a ward induction before caring for patients on the unit.
- Activities provided on the ward should be reviewed to ensure they reflect the interests of people using the service.
- Recruitment should continue to provide more permanent staff on the ward and improve consistency of care.
- Leadership should improve to provide a consistently high quality service.

Action the provider SHOULD take to improve places of safety:

- The Ridgewood centre place of safety should ensure that where recommendations are made following serious incidents, the recommendations are fully implemented.
- The trust should work with other stakeholders to reduce the time spent by some patients in the places of safety waiting for a Mental Health Act assessment or where needed a bed, especially out of hours.

Summary of findings

- The provider should ensure that all documentation relating to the use of the places of safety is accurate and fully completed

Action the provider SHOULD take to improve community-based crisis services:

- The trust should review if there is any further work needed to make the crisis house a safe environment in terms of ligature points.
- The trust should complete the recruitment of staff to fill vacant posts in the home treatment teams and the crisis house and crisis line to ensure they can work effectively.
- The trust should ensure the staff in the crisis house feel confident to use the Mental Capacity Act where needed.

Action the provider SHOULD take to improve long stay/rehabilitation services:

- The trust should ensure that each person has a complete record of their annual physical health check so that it is clear this has been undertaken and any health care needs that need to be followed up.
- The trust should ensure that people have their risk of self-harm thoroughly assessed especially as the decision has been made not to reduce ligature points in this service.

Action the provider SHOULD take to improve adult community-based services:

- The trust should ensure that staff working in the Criminal Justice Liaison and Diversion Service have received training on how to work with people who have challenging behaviours.
- The trust should ensure that accurate records are maintained for medications stored at community team bases.
- The trust should continue to work towards people who are supported by community teams having a record of their involvement in the development of their care plan and being offered a copy of their care plan.

Action the provider SHOULD take to improve services for older people:

- The trust should ensure that learning from incidents occurs consistently across all the services in the division for older people.

- The trust should ensure that health and safety audits are completed thoroughly to identify environmental repairs that are needed to maintain the safety of people using the service such as the call bell system in Victoria Ward. Where these risks are identified they must be addressed in a timely manner.
- The trust should ensure that across the older peoples inpatient wards that people using the service and carers are given an opportunity to be involved in the development of their care plan.
- The trust should ensure that across the older peoples inpatient wards that Mental Capacity assessments are completed and recorded correctly.
- The trust should ensure that staff on Victoria ward have access to regular supervision and team meetings so they are supported to undertake their roles.
- The trust should ensure that on Victoria ward regular meetings are held so people using the service can be involved in decisions about the service provision.

Action the provider SHOULD take to improve services for people with learning disabilities or autism:

- The trust should ensure that locally held training records are updated on the trusts electronic staff records to ensure staff working in learning disability services undertake all the required statutory and mandatory training.
- The trust should ensure that where capacity assessments have been completed that this is recorded.
- The trust should ensure that staff have up to date training on the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The trust should ensure regular fire drills take place in their community team bases.
- People using inpatient services should have access to sufficient activities in the evening and weekend.
- The trust should make sure that actions arising from the trust Periodic Service Reviews (PSR's) are fed back to the staff working in the learning disability service in a timely way to ensure that where changes and improvements are needed they are made as soon as possible.

Summary of findings

Action the provider SHOULD take to improve specialist eating disorder services:

- The trust should ensure that people's assessments and care plans are updated to reflect their changing needs and circumstances.
- The trust should ensure that where a person's capacity to consent is assessed that this is recorded.
- The trust should look at whether there are options available to support people to access outpatient services more easily while the plan to have a more accessible single site was completed in 18 months.

Action the provider SHOULD take to improve child and adolescent mental health services:

- The trust must ensure that there is a clear record of the training completed by staff so that refresher training can take place and training needs can be identified and addressed.
- The trust should ensure that all staff have a clear working knowledge of their responsibilities in relation to consent and Gillick Competencies, so this can be used in their work with young people.
- The trust should ensure that staff are appropriately supported about changes that affect them during the ongoing reconfiguration of the community services.
- The trust should ensure that the results of feedback received from young people and their parents are readily available and clear improvements made as a result.

Surrey and Borders Partnership NHS Foundation Trust

Detailed findings

Are services safe?

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

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

Summary of findings

The trust had systems in place to report and monitor incidents. In most services these systems were understood and were being used appropriately by staff. The trust was investigating serious incidents appropriately. They were still not meeting agreed timescales for these investigations to be completed although this was improving. Learning from incidents was mainly taking place although in a couple of areas such as the inpatient services for older people lessons were not being shared across services or recommendations from investigations were not fully implemented.

Inpatient services for older people were not consistently managing the risk of falls and of people developing a pressure ulcer. Whilst the trust had developed action plans these had not been fully implemented and people using the service had not all been assessed to identify risks so that care plans could be put into place.

Staff were generally well informed in the use of safeguarding processes but the numbers of staff who had completed training at different levels was not clear due to issues of data accuracy.

The trust was maintaining safe staffing levels in inpatient services and where needed was using temporary staff. The trust was actively recruiting staff to vacant posts.

Detailed findings

Physical interventions were not always safely managed. Staff did not always recognise when a patient was being secluded so that the appropriate systems and safeguards could be put into place. Some temporary staff working in the psychiatric intensive care unit were helping to restrain patients without having the appropriate training.

In two areas at the Mid Surrey assessment and treatment centre we found that emergency equipment used for resuscitation had not been checked regularly to ensure it was always in good working order.

The trust was working to provide a safe environment for people using their services. A ligature minimisation programme was in place where the trust had identified services as being in scope. There were some specific concerns about the safety of some environments such as call bells not working on Victoria ward in the division for older people.

The Strategic Executive Information System records serious incidents and never events. A total of 86 serious incidents were reported by the trust as having occurred between April 2013 and the end of March 2014. Of these 41% happened in the patient's own home and 24% happened in ward areas. The most common incident type for the trust was the "unexpected death of a community patient" (in receipt of a service from the trust) which accounted for 40% of the incidents.

The NHS Safety Thermometer is designed to measure a monthly snapshot of four areas of harm, including the number of falls. Falls are a particular risk for the trust particularly for inpatients on wards for older people. In the period April 2013 – March 2014 the trust's reporting of falls had fluctuated widely by month, with no falls reported in five of the months. Between August and November 2013 the number of falls were well above the England average, reaching peaks of 2.8% in September 2013 and 3.42% in November.

We inspected the older people's inpatient wards and found patients who were at risk of falls and pressure ulcers were not having their needs met. The trust had developed a falls action plan. However this was not yet implemented across all the wards. For example, on Victoria ward we found that some patients did not have a completed assessment in place to identify if they needed a care plan to manage their risk of falls. We also saw that while there was a plan to ensure that people had an assessment of their skin integrity on admission to the inpatient services, this was not happening consistently. On Victoria ward some people who were potentially at risk of developing or who had developed pressure ulcers, did not have assessments or care plans in place to ensure these needs were being managed.

Every six months the Ministry of Justice publishes a summary of Schedule 5 recommendations (previously rule 43) which had been made by coroners with the intention of learning lessons from the cause of death and preventing further deaths. In the latest report covering the period from October 2012 – March 2013 no concerns regarding the trust were raised.

The trust has an electronic system to report incidents. The trust has identified on its own risk register the need to ensure staff continue to report incidents. Most staff we spoke to were aware of the system and how to report incidents. Although in the community CAMHS services, we

Our findings

Track record on safety

The Care Quality Commission when preparing for an inspection looks at 51 different indicators that may reflect potential risks for a trust. For Surrey and Borders Partnership NHS Foundation Trust there were no elevated tier one risks identified relating to safety.

The trust was identified as being a potential risk for the rate of incidents of self-harm amongst informal patients. Between April 2012 and March 2013 the trust reported a rate of 33.6%, against an expected rate of 8.2%. External stakeholders explained that this triggered a focused review by the lead Clinical Commissioning Group. This led to two pieces of work and the second one concluded in September 2013. This noted that the number of serious incidents appeared to be higher but it was recognised that Surrey and Borders were accurate reporters and other trusts may under report.

All trusts are required to submit notifications of incidents to the National Reporting and Learning System and between April 2013 and March 2014, 326 incidents were reported. The proportion of reported incidents that were categorised as harmful was within the expected range. There was a total of 63 deaths reported during the period, of which 44 were reported as 'suspected suicide (actual)'.

Detailed findings

found not all staff were aware of how to do this. We also found some variation in the detail being included in incident reports, with some services not providing enough detail in their reports.

Learning from incidents and Improving safety standards

The trust had recently reorganised its reporting structure relating to quality and risk. This had led to the establishment shortly before the inspection of the quality management board reporting to the trust and executive boards. This group received information relating to quality and risk from each of the divisions. The trust was also developing an integrated quality and performance report. This report covered a range of indicators, including service user feedback, complaints and key indicators. At the time of the inspection the quality management board had only met twice. Senior staff told us they felt this was a positive development that will enable a more detailed discussion of risks.

In the previous year the trust had not been able to investigate all serious incidents within the expected timescales. The trust had identified this as a concern and a plan had been developed to reduce the backlog in collaboration with external stakeholders. As of 31 March 2014 there were 139 serious incidents recorded on the National database STEIS as reported by Surrey and Borders. Of these 42 were open and overdue and the trust was working collaboratively with commissioners to secure their closure. External stakeholders have said that the trust was moving in the right direction in terms of developing a team of experts to address the serious incidents. They also said the quality of investigation reports had improved and that the trust was open to external scrutiny.

We heard about the work the trust was doing to improve safety. This included a trial of the “safe wards” initiative, some focused work looking at incidents of people being absent without leave and also a multi-agency group that was looking at suicide prevention. They are also developing a safety and experience hub which is an on-line facility available to staff to share guidance and good practice.

Each division had a quality action group, which was responsible for ensuring learning was shared with staff across that division. We found variations in how each division was implementing this learning. For example some divisions relied on managers attending the quality action

group and cascading the feedback to their teams. The learning disabilities division had recently introduced the ‘SharePoint’ on-line system for ensuring that each team was aware of actions in response to incidents.

In many areas staff told us of examples where learning from incidents had been fed back to them and that the lessons learnt had been put into practice. However, we found variation in learning being implemented across the trust robustly. For example in the division for older people learning from incidents on one ward were not shared with staff working on wards for older people across different sites. At the Wingfield Place of Safety some recommendations from a previous incident from March 2013 had not been followed through. External stakeholders told us they were concerned that learning from incidents is not always embedded across the trust.

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

We found the trust had a reliable system in place to safeguard people from abuse, although we were not able to gather clear information on the training levels of staff. Most staff we spoke with understood the importance of safeguarding vulnerable adults and protecting children. The trust policy was up to date and clearly advised staff how to raise an alert and who to contact. An audit conducted of the trust’s safeguarding by their external auditors recorded ‘significant assurance’ that the trust’s arrangements for fulfilling its safeguarding adults responsibilities were effective. The trust had clear policies for each local authority covered by the trust, including contact details available for staff on their website.

The trust has a safeguarding lead for both adult and children’s safeguarding

The trust data for adult safeguarding training indicated that in April 2014 64.7% of staff had completed training on safeguarding children and 72.6% on safeguarding vulnerable adults. Feedback from the trust and staff suggested that the actual figures were higher than this but the data collection could not robustly confirm this.

Safeguarding was discussed at divisional quality action groups and learning identified. Most teams we visited explained they would discuss safeguarding during multi-

Detailed findings

disciplinary discussions and team meetings. Feedback we received from the local authority was that safeguarding arrangements were working well and information was being shared appropriately.

The trust had a lone working policy. Staff we spoke with were aware of the lone working policy and were clear on the procedures they needed to follow.

Assessing and monitoring safety and risk

Risk register:

The trust has a high level risk register, which is reported to the Board. This register is constructed by the collation of divisional risk registers. In April 2014 the trust had 27 active risks identified on its high level risk register. We were told that staff across the organisation regardless of grade, speciality or post can choose to put risks on the register and these were very variable. The responsibility for the development and maintenance of the risk register rests with the director of risk and safety and the high level risk register is reviewed by the trust executive board and trust board. The director of risk and safety uses a matrix to determine the risk levels. We found that at the time of the inspection the identified high risks were very mixed and may not reflect the greatest risks for the trust.

Safe staffing levels:

We looked at whether the trust provided safe staffing. We found that in most areas staffing was safe.

The trust had developed a managing capacity tool, which was completed daily on each ward at 10am. This recorded whether the ward had sufficient staffing and bed capacity. If staffing shortages were identified these would be escalated and addressed.

The trust reported on safe staffing to each Board meeting. The report for the month of June for the wards which operated 24 hours a day showed that out of the 12,054 planned registered nurse day hours, 12,134 were worked representing a 101% fill rate overall and night registered nurse hours had a 98% fill rate, which is slightly lower than expected. This report also monitored each division and ward to look at local variation. This tool highlighted that there were some wards that did not cover all planned day and night shifts. For example, Spenser ward recorded an average fill rate for registered nurses of only 71.3%.

Staff vacancies are monitored by ward and team on an ongoing basis. In May 2014 the trust vacancy rate was

14.3% the turnover rate was 16.9% and absence rates were 3.8%. This was below the national average. We heard that where turnover was raised exit interviews would be analysed to look for any specific issues.

In April 2014 staff vacancies for the trust were 13.4%. In some community based services we found examples where staffing was stretched. For example, there were difficulties safely and effectively staffing the crisis house and the crisis line. The acting manager told us that there were five vacancies for staff, these included qualified and support staff. These were mostly filled using regular staff and NHS Professionals temporary staff. We saw several other wards and teams such as the East and Mid Surrey home treatment team, where there were greater numbers of staff vacancies but these had also arranged cover where possible with temporary staff and were actively recruiting.

Use of physical interventions:

The trust had recorded 116 incidents of restraint in the six months until May 2014. Thirty one people had been restrained in the prone position (face down) and in most of these cases rapid tranquilisation had been administered.

We found that incidents of restraint were not always being recorded appropriately. On Fenby ward the trusts psychiatric intensive care unit (PICU) the recording of the use of restraint was incomplete and not easy to understand. For example, we read a document for a patient, which stated that a staff member had restrained the person's legs but did not say where the patient had been held.

We found the trust could not provide evidence that staff had received the training or had refresher training in how to support people with challenging behaviours and safely use physical interventions where needed. In April 2014 the trust data recorded that only 36.9% of staff were up to date with receiving this training (the trust use MAYBO training). We were told that all temporary staff working in mental health services have to have completed training on how to use physical interventions before they can work in the services. On the PICU temporary staff told us that they had not been trained in how use physical interventions and were being asked to help with restraining patients. The trust was aware that they had to provide more MAYBO training and were facilitating an increase in the number of MAYBO trainers. The trust must ensure that where temporary staff need to support permanent staff with physical interventions that this only happens once they have been trained.

Detailed findings

New guidance published by the Department of Health in April 2014 called “Positive and Safe” included new guidance on the use of face down restraint which aims to ensure it is only used as a last resort. The trust was in the process of reviewing its procedures to reflect the new guidance and just prior to the inspection had issued a clinical risk alert instructing staff about restrictive practices including safe restraint positions.

We found that when seclusion was used it was not always recognised correctly so the procedures were not followed. For example on Fenby ward (the PICU) we were informed by staff that they had not used seclusion. However we found records which showed that seclusion had been used three times this year. Documentation was not completed fully and there was no record of the patients having a medical assessment. Staff we spoke to had different understandings of what they called the de-escalation space and seclusion.

When we visited Mid Surrey assessment and treatment centre staff were not clear about the use of seclusion and how it should be documented. The staff we spoke did not all have the same understanding of what “seclusion” was. As such, they were not always clear if a person who used the service had been “secluded” or not, and this was reflected in the documentation. The trust must ensure that seclusion is recognised by staff and carried out in line with the correct procedures so that appropriate safeguards are in place.

Use of blanket restrictions:

When we inspected with acute wards we found that some rules were in place about patients not having access to phone chargers or cigarette lighters for their own safety. We found that within wards these rules were not being applied consistently and across the acute wards there were variations.

Risk to individuals:

Individual risk assessments were looked at across all the areas inspected. The quality of the risk assessments were variable. In older people’s services we found that risk assessments for falls and pressure ulcers were not always being completed appropriately. On some acute wards it was noted that risk assessments were not always being completed for people going on leave – which could mean that potential risks to people when they were outside the hospital may not always have been considered.

In most inpatient teams we found that risk was being reviewed on an ongoing basis and discussed at daily handover. For example, at Ridgewood records showed that risk assessments were reviewed daily, and changes were made to the traffic light or ‘RAG’ (red / amber/ green) rating system. However, changes in the level of risk were not always reflected in the individual care plans.

Understanding and management of foreseeable risks

The trust has governance processes to oversee and manage risk. These are considered by the Quality Management Board and feed into the board.

Medical devices and resuscitation equipment

The trust has a register of medical devices and a programme of maintenance for them.

During the inspection we checked the resuscitation equipment which was available to staff. In a couple of areas we found this was not being checked on a regular basis. On Delius ward the resuscitation equipment was not checked regularly in accordance with the trust’s policy. On Fenby ward (the PICU) we were told that the resuscitation emergency bag was checked every week. We found from looking at the records that checks were only being carried out approximately once a month and staff were not able to clearly identify all the equipment. The trust must ensure that all resuscitation equipment is checked regularly to ensure it is in full working order.

Management of ligature points

The trust had a ligature minimisation programme, which was monitored by a ligature minimisation group. In the last six years the trust had invested more than £3 million directly into ligature minimisation. Recent work had focussed on assessing areas to identify whether they were in or out of scope for ongoing ligature minimisation. A ligature audit tool was in place and being used across the trust. We saw many environments where ligature points had been removed or work was being undertaken to do this. At Mid Surrey assessment & treatment service ligature-free vanity units and wet rooms were in the process of being installed. Where potential ligature points remained in this service, these had been assessed and a means of managing the risk had been implemented.

At the Crisis House their ligature audit reflected that there were multiple high risk points that remained in the house and yet we were told the work on the environment was

Detailed findings

complete and that as this was a community based service they were deemed as not being in scope of the ligature minimisation programme. This should be reviewed to ensure it safely meets the needs of the people using this service.

Are services effective?

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

Summary of findings

People were mainly supported to have a comprehensive assessment of their needs. There were many good examples of multi-disciplinary and multi-agency working which contributed to services being effective and innovative.

The trust recognised the need to improve the physical health assessments for people using their services but in the division for older people we found that health monitoring checks such as blood pressure were not always being recorded which meant we could not be certain that those checks were taking place.

Staff training on the Mental Capacity Act was progressing and staff demonstrated a knowledge of this legislation. In a few areas recording of decision specific capacity assessments were not taking place. The Mental Health Act was operating well across the trust, although recording that people had been told their rights needed to improve in a couple of areas.

Staff were well supported by the pharmacy team and medication was generally well managed.

The trust used external accreditation and internal audits to evaluate many aspects of the services it provides.

Many staff spoke positively about opportunities for continuing professional development but the poor data quality of figures for statutory and mandatory training meant it was not possible to accurately know where training was required.

inpatient areas for older people. For example at Mid Surrey assessment and treatment service we found care plans were person centred and recovery focused. In the adult community services we found that staff were aiming to undertake "holistic" assessments considering people's mental health and social circumstances.

Management of medications

Throughout the inspection staff fed back that they felt supported by the trust's pharmacy service. In most services we visited we found medications were being managed appropriately. We just found that in one community mental health recovery service that there were not accurate records of medication stored at the team base.

The trust had undertaken audits on the use of benzodiazepines and other hypnotic medications to ensure prescribing practice was appropriate.

Use of the Mental Capacity Act

The trust had provided training for staff on the Mental Capacity Act. In April 2014 over 60% of staff had completed this training. Most members of staff were aware of the need to assess capacity and the need to conduct best interest meetings where appropriate. However, we found recording of decision specific capacity assessments were not always taking place.

In the older people's inpatient wards we found that some members of staff had received specific training regarding the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) and we found that appropriate applications had been made for DoLS. However, we saw that there were poor mental capacity assessments in the clinical documentation. For example, on Victoria Ward we saw that assessments were completed in the case notes which did not specify which decisions a person lacked the capacity to make which is contrary to the Mental Capacity Act (2005) and the Mental Capacity Act Code of Practice which states that assessments are decision-specific.

In the CAMHS a majority of staff we spoke with demonstrated a working knowledge of the Mental Capacity Act 2005 and their responsibilities within this for young people over the age of 16 years.

Our findings

Assessment and delivery of care and treatment

Comprehensive assessments

The trust used the electronic patient record system called RiO to record assessment and care plans. In most of the areas we visited we found comprehensive assessments had taken place with the exceptions being some of the

Are services effective?

Consent

We found that staff generally had a good understanding of when they needed to seek the consent of people using the services. The exception to this was in relation to staff awareness of Gillick Competencies, in deciding whether a young person under 16 years is able to consent to treatment without the need for parental permission or knowledge, which was not consistent across the teams. In most CAMHS teams we found that there was a general assumption that the parents could give consent where the young person was under 16 years. Whilst there were appropriate procedures in place to address this, there was a need to improve staff awareness.

Promoting good health

The trust had identified physical healthcare as a priority area for improvement as part of its clinical strategy. As a result it had developed a key performance indicator relating to the number of people who have had a physical health check and have a health action plan. In May 2014 only 57% of people using the service had a physical health check and a health action plan. In the older people's service this was 47%. This was below the trust's own target.

Recent work in the trust had seen the establishment of a physical healthcare group to oversee improvements. The trust was also implementing the use of the modified early warning score to monitor physical health in people using the service and identify where additional interventions are needed.

We found variations between wards in the monitoring of the physical health of people using the service. The older people's service had a target that people's physical health would be monitored regularly. We checked records and saw that people had an initial physical health check by doctors when they were admitted to the ward. When we looked at the records of patients on Victoria ward some people who had been admitted to the ward did not have a record of receiving regular checks of their weight, blood pressure and nutrition. This meant that there was a risk that physical health concerns may not have been picked up and could lead to deterioration in people's physical health outcomes.

During the inspection medical staff told us they did not always have the necessary equipment to monitor physical health. Management told us they had ordered the equipment and were awaiting its arrival.

Outcomes for people using services

The trust had recently introduced and was developing further a new performance dashboard to monitor performance across divisions. This had a number of indicators to monitor outcome performance. At the time of the inspection it was in the process of developing its information system to provide more robust data on individual team performance.

The trust also carried out a large number of ongoing audits as well as one off audits where they want to look at a specific issue. In the last financial year it had conducted 12 clinical audits and five non-financial audits.

The trust also participated in some national clinical audits including the National Audit of Schizophrenia in 2011 and the Prescribing Observatory for Mental Health (PROM).

As part of their quality assurance system the trust participated in the Royal College of Psychiatrists quality improvement programmes. Five adult wards were accredited (Anderson, Blake, Delius, Elgar and Wingfield) with their adult inpatient accreditation service. The learning disability unit April Cottage and the older people's Spenser ward were also accredited. The trust has three accredited memory clinics at West Elmbridge, Guildford and East Surrey. The CAMHS teams were members of the Quality Network for Community CAMHS, which meant they were subject to peer review checks as well as conducting self-audits of specific areas.

The trust was monitoring whether its policies and procedures reflected current published NICE guidelines. Overall the trust had reported full compliance with all mental health related guidelines. It assessed itself as showing partial compliance against NICE guidance relating to falls, tissue viability and infection control. Each divisional quality action group was responsible for ensuring NICE guidance was implemented.

We heard about how the trust's research and development team were increasing the trust's participation in research. We were also told about how the early intervention clinical academic group had been admitted into the Surrey Health Partnership in June 2014.

Staff, equipment and facilities

Staff training and development:

The trust's draft five year education and development plan provided details of current and future training programmes. These included training programmes the trust was legally

Are services effective?

obliged to offer staff such as fire safety, manual handling and infection control. Referred to by the trust as 'statutory training', these programmes aimed to ensure a safe working environment. Staff were also provided with training on how to protect children and adults from harm neglect or abuse, mental health law and life saving techniques. Referred to by the trust as 'mandatory training', these programmes aimed to support staff to provide safe, effective and responsive care to people who used services.

The trust had set a target of 95% of staff to have completed up to date statutory training and 85% for mandatory training between April 2014 and March 2015. However, trust records showed that in April 2014 statutory training compliance stood at 59.7% and mandatory training compliance 52.9%. In July 2014, statutory training compliance stood at 66.2% and mandatory training 62.4%. Whilst numbers of staff completing training had improved, the trust had not achieved its own targets.

We also looked at the training figures for each of the statutory and mandatory training subjects and noted that these had improved in most areas between April and July 2014. However, training figures had fallen in some areas. An example of this was training in the 'Care Planning Approach' which is used by staff to support them assess, plan, deliver and review care provided to people accessing trust services. In July 2014 the numbers of staff who had up to date training in care planning had fallen by 14.6%.

Senior staff and staff working in the services told us they felt the number of staff who had completed the statutory and mandatory training was higher, but the data quality needed to be improved. The trust was implementing an electronic staff record to address this issue. We were also given assurances that action was being taken to improve statutory and mandatory training. An action plan provided details of how targets were going to be monitored and achieved. For example, implementation of an annual statutory and mandatory review cycle was planned for June 2014.

We found that there were some areas we visited where we were able to confirm from speaking to staff and looking at local records that essential training had not taken place. An example of this is the crisis house where some staff had not received training in life saving techniques or supporting people with challenging behaviours. The trust must ensure this training takes place in this service and in other services where needed.

Many of the staff we spoke to throughout the inspection were positive about the opportunities offered to them for continuing professional development. The trust has a self-booking system in place enabling staff and managers to book a range of training online. The trust had established partnerships with a number of universities and trainee doctors, nurses and clinical psychologists were given placements within the trust. Staff without a health or social care qualification are given opportunities to access vocational or academic programmes. Leadership forums facilitated by the chief executive formed part of education and development modules offered to trust leaders and managers.

We heard positive accounts of how staff felt well supported by their immediate line managers and had access to team meetings and managerial and clinical supervision. Again there were areas where this did not occur consistently such as Victoria ward in the division for older people. In the March 2014, 91% of staff across the trust had completed an appraisal although in older people's services only 79% staff had done so.

Access to meaningful activities:

During the inspection we found there was variation in the therapeutic activities available to people. Some people told us they felt there should be more activities. The trust's 'your views matter' survey 27% of people responded that they did not think there were sufficient activities to take part in at weekend and 31% responded that they thought there were sufficient activities.

In some wards we found good access to therapeutic activities. For example Albert ward in the division for older people there were specific activities co-ordinators and volunteers who visited in the evening and weekends to provide additional activities. We saw that people on Albert ward had access to a reminiscence room and memory boxes. On Spenser Ward we saw that activities had a strong therapeutic, recovery focus and people on the ward could access therapeutic activities on site for working age adults as well as activities specifically based within older people's services.

In the adult inpatient wards at St Peter's Hospital people we spoke with were very positive about the therapy service. People told us they had asked for the service to be provided later into the evening but had been told there weren't the resources available to do this. However, the

Are services effective?

service supplied “activity boxes” for people to use in the evenings instead. These were rotated around the wards, so each ward received a number of different activity boxes each evening.

In the learning disability services at April Cottage and Bramdean we found the evening activities programme was limited.

Multi-agency and multi-disciplinary working

Most of the teams we visited demonstrated good multi-disciplinary working, with staff from a range of professional backgrounds supporting the assessment and care of people. We also found good links between teams in a number of services. For example in older people’s services we found there were good links between the community and inpatient services.

The eating disorder service had developed links with third sector partners to help support people, including local self-help and carers groups such as BEAT (Beating Eating Disorders).

We found some good examples of the trust working with local groups to help support people. For example, in some older people’s community teams the teams had links with such as the Alzheimer’s Society, and a ‘dementia navigator’ helped people using the service to be aware of other additional support services.

In CAMHS the team was working with local schools to identify ways of enhancing referral and behaviour pathways. This included agreements around more joined up working for young people with complex needs. There was also CAMHS community nurses who worked with schools to provide support to teachers and young people.

Feedback from Surrey County Council was that the trust was a positive partner and that there was good partnership working.

Mental Health Act (MHA)

The Mental Health Act reviewers checked that all the appropriate documentation was in place to reflect what was required in the Mental Health Act and Code of Practice and in most cases this was correct. The trust could demonstrate that there is a trust wide process in place to ensure that the operation of the Mental Health Act met legal requirements.

We found that thorough conditions of leave were being recorded and reviews of risk carried out prior to leave with the exception of Delius acute ward at the Mid Surrey assessment and treatment centre. Patients’ capacity and consent was usually being recorded, but not all paperwork was up to date or included the views of the patient. We found that while patients told us that their rights were being explained to them regularly on the psychiatric intensive care unit and Elgar ward at the Mid Surrey assessment and treatment service they did not have a consistent record of this taking place in line with the trust policy.

Care plans did not show involvement of the patient in all cases. There was little evidence found on care plans or within the notes regarding statements being made by detained patients with regard to their preferences for what they would or would not like to happen. This included legally binding advance decisions to refuse treatment in line with the Code of Practice – Chapter 17

The reviewers noted good use of community treatment orders in place in the assertive outreach teams.

Good information was available for patients and carers including information on how to access independent mental health advocacy services.

Are services caring?

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

Summary of findings

Before and during our inspection, people told us that most staff treated them with kindness, dignity and respect. The exception to this was on Fenby ward the psychiatric intensive care unit where interactions between staff and people using the service were brief and task focused.

We heard about people having opportunities to be involved in the development of their care plans such as in the learning disability services. However we also found that in other services people had more mixed experiences and the care plan records did not always show how people had been involved.

People were given information so they could access independent advocacy services when they wished to do so.

Carers also told us they had mixed experiences of being involved and being able to provide support to people using services, although the trust is engaged in an initiative to improve this.

Our findings

Kindness, dignity and respect

Both prior to and during the inspection most people we spoke with felt staff treated them with kindness, dignity and respect. We also received 37 comment cards, left in boxes around the trust in the week of our inspection. Most people who completed these were positive about the care they had received. Twenty seven people had recorded they felt their care had been good and one person felt their care had not been good.

We observed many examples of positive interactions between staff and people who use the service throughout the inspection visits. For example, in the older people's community teams we witnessed warm, sensitive and professional approaches to users of the service. In the learning disability inpatient services we saw that staff interacted well with people and supported people well

when needed to ensure their dignity. At lunchtime we saw that staff sat with people who used the service to eat. In most of the wards we visited people told us they felt staff were respectful towards them and the atmosphere on the wards was relaxed and friendly. The exception to this was on Fenby ward, the psychiatric intensive care unit, where interactions tended to be brief and task-focused. We did not observe any one to one time occurring. Staff appeared to be watching the patients without positively and actively engaging with them.

People who had used the crisis line gave us mixed reviews about the responses they received when they contacted the line. While some people reported that they had good experiences, others reported an inconsistent and sometimes unhelpful response when they contacted the crisis line.

The CQC Community Mental Health Patient Experience Survey 2013 the trust scored 9 out of 10 for being treated with respect and dignity by the health or social care worker seen most recently. This was similar to other trusts.

The trust monitors the views of people using the service through its ongoing inpatient and community surveys. In June 2014, 89% of inpatients who responded to this survey confirmed the staff spoke to them with respect and dignity. In the previous six months there was only one month, April, where the trust missed its target of 75%. In June 2014, 94% of people receiving support in the community felt they were treated with dignity and respect. In the previous six months the trust had scored 89% or higher for every month.

Involvement of people using services

The inspection looked at whether people were being involved in decisions about their own care. Most people we spoke with told us they felt involved in their care and were involved in decisions. However, in some of the services we visited we did not see the person's involvement being recorded in the records we reviewed. For example, in older people's services on Victoria ward some people told us that they were aware of their care plans but told us that they had not been discussed with them. We saw little evidence in the care plans that we looked at that they had been discussed with people on the ward. On Fenby ward,

Are services caring?

the psychiatric intensive care unit, the care records we looked at showed an inconsistency in the recording of the involvement of patients in the care planning process. On the adult inpatient services we visited people were not routinely involved in their care planning on all the wards. In the community mental health and recovery teams the care plans had sections for recording 'client's views' however these were not consistently completed. The trust should ensure that care planning involves the views of people using the service and that this is recorded across all the services.

In the CQC community mental health patient experience survey 2013 the trust scored 7 out of 10 for having their views taken into account when deciding what was in their NHS care plan (those that had a care plan). This was similar to other trusts. The trust scored 5 out of 10 for having chance to talk to their care co-ordinator or lead professional before the meeting about what would happen (those that had a care review). This was below average. In the trust's internal survey April 2014, 41% said staff spend one-to-one time with them each day. This meant people may not have the chance to share their views with staff.

The trust worked with four different advocacy groups to support people. In our visit we found that in most areas there was information available about the advocacy service and they visited the ward regularly.

In many of the services we visited information packs were available to support people to access services. For example, in the eating disorder service we saw that information packs given to people who use the service and their carers.

In some of the services we visited we saw good examples of people being supported to engage with decisions about how the service was delivered. For example, the adult inpatient wards at St Peter's hospital each had a weekly community meeting led by the patient advice and liaison service (PALS) team. Records of these meetings were on display and showed the actions that had been taken in response to the concerns, complaints and requests for changes that had been made.

Emotional support for care and treatment

The carers we spoke to prior to and during the inspection gave mixed feedback on the support they had received. Some told us they felt the trust did not involve them enough in the care of the person they were caring for. The

trust monitors the views of carers as part of its ongoing 'your views matter' survey. From January to the end of March 2014 the trust had 32 carers surveys submitted. Seventy seven per cent of those responded they had a named person they could contact when they needed to. Another question asked if the person had been offered a carer's needs assessment and 44% of carers responded they had not. The trust has identified a need to increase offering carer's assessments as part of their clinical quality priorities for 2014/15.

The trust was in the process of implementing the 'triangle of care' within its services. As part of this carers' trust programme the trust will be assessing each of its community and hospital mental health services against 39 criteria to identify where it needs to support working with carers more closely. The trust should ensure this work is completed to ensure support to carers is improved. The trust have also introduced 13 new Carers Liaison Workers across some of the integrated teams.

The CAMHS team had recently introduced the Social Care Institute for Excellence initiative 'Think child, think parent, think family' to ensure the mental health needs of all immediate family members and carers were assessed, to find out if parents were also in receipt of services, and carry out joint assessments with the adult team where necessary.

The trust has the FOCUS group which is the Forum of Carers and People Who Use Services. This is geographically based and provides support for people and carers using the service. The group also provides a forum for people to raise concerns and contribute to decision making within the trust.

We saw examples of people receiving good emotional support in some of the services we visited. In older people's inpatient services saw that some activities, particularly on Spenser ward had a strong recovery focus. We saw that groups took place which were led by psychologists and occupational therapists which were aimed at people working towards discharge. People told us that they found these activities useful. At the crisis house staff had recently completed a ten week course in cognitive behavioural therapy and mindfulness. We saw a small room which they had recently designated for relaxation and guided mindfulness sessions.

Are services caring?

Throughout the inspection we heard about the work done by the trust to support people with their recovery. The trust has a clear clinical strategy, which it is working towards, which details its recovery focus. As part of the recovery pathway at Margaret Laurie House we saw that staff were supporting people who had left the service to

live in the community as part of their rehabilitation and recovery. This ranged from holding their medication or monies and giving them to people as identified or inviting them back to house open days for socialising and giving them opportunities to talk to people about their lives outside of hospital.

Are services responsive to people's needs?

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

Summary of findings

Many of the services provided by the trust were responsive although accessing inpatient beds can be difficult.

We heard from people using the service and staff in the trust that the crisis line was not meeting the needs of some of the people who needed this input. The trust must ensure the review of the crisis line is completed with clear recommendations for change in place so it meets the needs of people using the service.

We saw many positive examples of how the trust respects people's diversity and human rights.

The trust provided people using the service with information about how to complain and where complaints were received these were generally addressed to a high standard. The trust needs to ensure the responses are more consistently timely.

Our findings

Planning and delivering services

The trust worked closely with commissioners, local authorities, people who use services, primary care services and other local providers to understand the needs of the people it serves and to plan and design services to meet their needs. We saw many examples of services being designed to support people to receive services close to their homes. For example, the CAMHS teams were spread throughout Surrey so that young people could receive support close to where they lived. The trust home treatment teams worked twenty four hours a day to support people in the community. In the east of the county a crisis house had been commissioned to provide respite and support to people without requiring an inpatient admission.

The CAMHS was undergoing a significant service re-design to provide a trust-wide, single access, specialist service. Many staff and people using the service had expressed concerns about access to tier 4 inpatient beds and young

people having to travel a long way from Surrey. The trust was not responsible for sourcing tier 4 CAMHS inpatient beds, but had raised this as a concern and was trying to ensure this did not continue to happen.

The trust has undertaken deep dive reviews at its services. Part of this process is to look at the delivery of each service to ensure it is meeting the needs of people.

The crisis line was a trust-wide service. During the inspection we found that it was expected to perform a number of functions including signposting people to other services, triaging urgent mental health presentations from professionals, carers or service users, talking to people who may be experiencing distress and directing people who were enquiring about a routine aspect of their care. We found that the service was struggling to deliver all these functions with unqualified staff. Some people had complained to the trust that they did not always get a timely or effective response to their contacts with the crisis line. The trust monitors response times to calls and is speaking to callers within 30 minutes for 99.6% of people who phone the crisis line. The trust must ensure the review of the crisis line is completed with clear recommendations for change in place to ensure it meets the needs of people using the service.

Right care at the right time

Access in a crisis

The trust had a crisis line available to people from 5pm to 9am, Monday to Friday and 24 hours a day at weekends and on bank holidays. The service offered telephone and text support to people experiencing a mental health crisis. If indicated, the staff would liaise with the home treatment team or other emergency services to respond.

In the last five months the home treatment team during the day has undertaken assessments within four hours of referral for 90% of people. However, at night only 67% of people were seen within these timescales. Some people told us they felt the teams were under resourced and that visits were often short.

Speed of assessment for patients being supported in a place of safety

In the places of safety, section 136 facilities we visited we found there were variations in the speed in which people

Are services responsive to people's needs?

were assessed to see if they needed to be detained under the Mental Health Act. We looked at the records kept for the service across the trust and noted the delays in waiting for an approved mental health professional (AMHP) and Section 12 Approved Doctors to attend, particularly out of hours. We found some people were staying in the place of safety suite for up to 29 hours waiting for an assessment or a bed to be available if they needed an acute admission.

The place of safety protocols did not exclude people on the grounds of intoxication. This meant that if someone was intoxicated they could still access the service. This also meant that the assessment times could be longer.

Ongoing support in the community

The adult community mental health recovery teams had assessed 94% of urgent referrals within five days in the previous five months. Ninety nine per cent of routine assessments were undertaken in four weeks. Most of the CMHRS provided a service to people between 9am to 5pm with flexibility for offering people assessment appointments outside these times. We saw Epsom and Ewell and Mole Valley CMHRS had piloted on behalf of the CMHRS an extended service until 7pm across the working week in response to people's feedback.

Access to CAMHS

The CAMHS service has a 65 day referral to assessment target. We found there were large variations between teams in meeting this target. In the north east the average time was 90 days, in the south west it was 41 days.

Young people aged 17 had been admitted to adult inpatient acute wards within Surrey. During the past year there were 23 admissions to adult inpatient wards for up to three days whilst waiting for a CAMHS inpatient bed. The young person would be supported by the CAMHS team during this time. When this happened it was raised as an incident.

Access to eating disorder services

People told us that once they had been referred to the services, assessment and treatment was prompt. The service locations of the adult and CAMHS eating disorder services were difficult for some people to access, due to distance and accessibility by public transport. Where people were entitled to it, the services supported people with reimbursement of travel cost or provision of transport. The trust does not have any specialist in-patient beds for

adults or children and young people with eating disorders. This meant that when adults and children and young people needed an inpatient admission they were having to use services away from their home.

Access for older people

We were told that when people were admitted to inpatient beds in the older adults' services they might have to go to a trust location wherever the beds were available, which meant that sometimes people had to travel long distances. This also meant that it was harder for the staff from the community teams to keep in contact. Staff on the wards told us that usually beds were available when they were needed. The trust had separate wards for people with dementia and mental health conditions which was in line with recommendations from the Royal College of Psychiatrists. Older people were not commissioned to receive support from the trust's home treatment teams. We were told that the older adults' community mental health teams provided support when people needed additional levels of care which would usually be directed through the home treatment teams. However, this service was not available out of hours.

Access to Psychological services

We found that when psychological therapies were available these were appreciated by people using the service and that they felt they were a good service. However, the capacity of the service has not matched the number of referrals. At the time of the inspection people had to wait up to six months to access the service. Stakeholders told us that the trust has a remedial action plan in place to address this that is being monitored.

Care Pathway

We looked at the care pathways across the services we visited. We found that some services within the trust were under pressure due to high bed occupancy levels.

- In adult services we were told by patients and staff that there was often a problem finding beds for people who needed an admission due to high bed occupancy levels during the current period. The bed occupancy on the wards was often at capacity, or above when leave beds were used. Bed occupancy (excluding leave) over the previous three months had averaged over 95% on all of the adult inpatient wards. It had been 100% on Blake ward, 98.1% on Wingfield ward and 96.4% on Elgar

Are services responsive to people's needs?

ward. For a small number of people an acute bed would need to be found outside the trust in the independent sector but within a reasonable distance from easy their homes.

- Staff told us there could be delays if people needed to be transferred to more appropriate care facilities, such as the psychiatric intensive care unit (PICU) if there were no beds available there.
- During the inspection we saw people in the PICU waiting for a bed to be available in a specialist service such as the learning disability inpatient service so they could move to a more appropriate service.
- There was a discharge coordinator who attended multi-disciplinary team meetings to aid planning for people's discharge. Some staff told us that there was a lack of less supported accommodation and this could lead to a delay in discharging a person with some staying for long periods.
- Community teams were supporting people when they were discharged from inpatient services. Information from the 2013 CQC community mental health survey showed that the trust performance had been above the England average for nine of the twelve months for ensuring that people were followed up within seven days after discharge from hospital. However performance had dipped to below the national average (93.3%) from January to March 2014.

Equality, diversity and human rights:

People's diversity and human rights were respected. Attempts were made to meet people's individual needs including cultural, language and religious needs. Contact details for representatives from different faiths were on display in the wards. Local faith representatives visited people on the ward and could be contacted to request a visit

Staff within the trust had access to training in equality, diversity and human rights. The trust also had a BME (black and minority ethnic) network to support staff from these groups. It had launched a zero tolerance policy towards abuse to try and reduce the number of incidences of staff being abused.

The trust has an equality and human rights strategy. Each division had produced a targeted plan to improve access to services for people who were significantly under-represented which was leading to some innovative pilot projects.

Interpreters were available to staff and were used to assist in assessing people's needs and explaining people's rights as well as their care and treatment. Letters and communication to people could also be provided in a person's own language or in large print for people with a visual impairment or easy read versions. Induction loops were available for people using a hearing aid.

A choice of meals was available on the wards. A varied menu enabled people with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to access appropriate meals.

Learning from concerns and complaints

In the services we visited during the inspection we saw that information was made available on how to complain. The trust website has clear information on the process and how to complain. Prior to the inspection we had received mixed feedback on the complaints system. Some people told us they felt they were not responded to appropriately and that they were not confident their concerns would be followed up.

People we spoke with during the inspection mostly told us they knew how to complain and felt their concerns would be taken seriously.

The trust monitored complaints. During the period 1 April 2013 – 31 March 2014 the trust received 130 complaints. The trust had been benchmarking the number of complaints it received against other mental health trusts. In the last year it had received 71 complaints per 100,000 bed days putting it in the lower percentile of the number of complaints reported when benchmarked against other mental health trusts.

Of the 130 complaints received during the year, 101 responses were completed by the end of the year. A total of 26 were upheld and 22 partially upheld. When people are not satisfied with a trust's response to a complaint they can refer this to the parliamentary and health services ombudsman (PHSO) for second stage investigation. The PHSO have received 38 contacts relating to the Surrey & Borders Partnership NHS Foundation Trust. Of these 7 were accepted for investigation. At the time of writing 1 had been upheld, 2 not upheld and the remaining investigations were ongoing.

In the last year the trust had responded to 14% of complaints in fewer than 25 days, 48% between 25 and 49

Are services responsive to people's needs?

days, and 39% in over 50 days. This result had fluctuated throughout the year and achieving a consistent response time is an ongoing area of work for the trust. The amount of time taken to respond to complaints had been identified by the trust's quality committee.

During the inspection we undertook a review of a selection of complaints. The examples we looked at showed that themes identified were mostly responded to appropriately and that the written responses were appropriate and respectful to the complainant.

The complaints were analysed by division and by category of complaint. Senior staff explained that complaints are discussed at divisional quality action groups so that trends can be monitored and lessons learnt. Most staff we spoke with told us they had received feedback from complaints. However, we found that lessons learnt from complaints were not shared robustly across all the services to ensure lessons learnt in one area were shared in all areas.

Are services well-led?

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

Summary of findings

The trust had a clear vision and shared values. Staff and patients said that senior staff were accessible and open.

Staff were generally very positive about working for the trust and felt they had opportunities to be involved in how services were developing.

The trust offers a range of opportunities for people who use the service to give feedback and we found that senior staff were listening.

The main challenge for the trust is that the quality assurance processes, many of which are new, are not always identifying poorly performing services in a timely manner so that the focus could be given to ensuring the necessary improvements were made.

We asked staff about the clinical strategy at our focus groups for consultants and for junior doctors. Most of the feedback we received was very positive. Staff members told us they felt the strategy was strong. Many also told us they felt their views had been listened to and they had been engaged in the development of the strategy.

The trust had also recently introduced the word CARE (representing communicate, aspire, respond and engage) to engage staff and help them to ensure they do the right thing every time.

Responsible governance

The trust had a board of directors who are accountable for the running of the trust. The board had participated in a quality development programme with peers from other trusts.

There was a clear governance structure that consists of committees that review areas of the trusts work that feed into the board. These committees had clear terms of reference, membership and decision making powers. The Board had three sub-committees: the quality committee, the audit committee, and the remuneration and terms of service committee. The quality committee met on a quarterly basis and reviewed a wide range of information and reports. To support this work they also received feedback from regular walk-about undertaken by the board members and senior executive staff.

The trust had adopted a new board assurance framework in January 2014 which had started to be used. The framework adopted a heat map approach and aimed to provide a high level summary of key risk areas to focus the Board's attention, underpinned by a more detailed presentation of the higher risks.

The trust has also recently restructured some of its reporting for governance. This had led to the establishment of the quality management board (QMB) to monitor quality and performance. Previously the areas covered by this board had been included as part of the Executive Board, to

Our findings

Vision and strategy

The trust had a clear set of vision and values. This was created as a result of conversations in 2005 with over 600 participants including people who use services, staff, carers and stakeholders. As part of this work the trust had developed a 'values wheel'. We saw these displayed around the trust and many staff made reference to them. At the centre of this was the aim, "for a better life", which was surrounded by four high level values: involve not ignore; creating respectful places; open, inclusive and accountable; and treat people well.

In 2014 the trust had developed a three year quality improvement plan identifying their priorities for improvement and key performance indicators.

The trust had also produced a clinical strategy. This set out the vision that the trust's core purpose was, "to work with people and lead communities in improving their mental and physical wellbeing for a better life; through delivering excellent and responsive prevention, diagnosis, early intervention, treatment and care."

Are services well-led?

which the QMB now presents a report. At the time of the inspection this group had only met twice. Staff we spoke with were positive about the change and felt that the longer time afforded to discuss information was important.

Each division within the trust had a Quality Action Group, which was responsible for identifying concerns and implementing learning at a local level.

The trust had a number of quality assurance tools to identify poor performing services. The trust had a system of periodic service reviews. This was a peer review process where a staff member from elsewhere in the trust would visit a ward or team and using the check sheet conduct a review. We were told that if a service scored less than 85% in any domain it would be flagged as a concern. However, for one service where we found poor practice when we looked at the review it did not identify concerns. In June 2014 Fenby ward the psychiatric intensive care unit had scored 97.5% in their review.

The trust also conducted deep dives to look at performance across a division on an approximately yearly basis. These sought to bring together all the information on a service and look for areas for development.

The trust had also recently introduced an early warning system data dashboard. This had the intention of bringing together up to date performance information on services within the trust. At the time of the inspection this was still new. It is important this work is developed to ensure the trust has accurate up to date information on the performance of its services.

In other services in the trust we found examples of poor practice not being identified by local audits. For example, on Victoria ward we found that recent environmental audits had failed to identify that out of twenty calls bells, 18 were not working at the time of our inspection.

We concluded in this inspection that the trust despite all these tools was not always identifying poorly performing services in a timely manner so that the focus could be given to ensuring the necessary improvements were made.

Leadership and culture

In most teams we visited we found that staff felt generally positive about working for the trust, that staff spoke openly about the challenges they faced and were keen to improve

the quality of the service. In the focus groups we undertook with staff most of the people who attended were very positive about the culture of the trust and of the leadership by senior staff.

In the 2013 NHS staff survey the trust scored within the best 20% of mental health trusts nationally on indicators relating to fairness and effectiveness of incident reporting procedures, staff experiencing harassment and bullying from staff, and staff feeling pressure to attend work when feeling unwell. The trust did not score in the worst 20% of mental health trusts in England against any indicators. The trust's staff sickness rate has been continuously well below the national average for mental health and learning disability trusts since January 2012.

The trust has a serious incident support team (SIST). This psychology led team provides support to staff following a traumatic incident. SIST were highly commended in the national positive practice in mental health awards in 2013.

The inspection did find that there were variations in the quality of care provided by divisions within the trust and also within divisions. This was sometimes reflected in the quality of the leadership of those services and we found that there had been a number of changes in management in different parts of the organisation, which was generally very positive.

Engagement

Service user engagement

The trust has a forum of carers and people who use services, FOCUS, which is arranged geographically. The central forum is chaired by the chief executive and provides an opportunity for people using the service to input their views.

The trust also engages with a number of service user involvement groups. In total it engages with 34 groups, four of which look at the service as a whole and the rest relate to specific services.

In April 2013 the trust revamped the way it collects feedback from people using the service. The people experience trackers have been replaced by the "your views matter" surveys, which are accessed via the website and tablets. The views from this are collected and key indicators are presented as part of the integrated quality and

Are services well-led?

performance report. In addition the trust collates a quarterly 'expert report' which collates feedback from a range of sources to give an overview of the feedback received.

Throughout our inspection we saw examples of user involvement through ward and group meetings that provided opportunities for people to discuss what was happening in the service.

The trust had just established a new council of governors. To support the council to do its role a programme, including meetings with the Chair, had been established. An induction programme for the Council had been launched and the Board and Council had their first joint away day in July 2014. When we met with the council they told us they felt their role could be developed.

Staff engagement

Many staff we spoke with told us they had opportunities to become involved in the development of services provided by the trust.

In the 2013 NHS staff survey the trust scored within the best 20% of mental health trusts nationally for staff reporting good communication between senior management and staff and for staff feeling satisfied with their quality of work and patient care.

The trust had the 'synergy' monthly newsletter which was mailed to all staff to keep them up to date. People told us that they thought this had a very accessible style.

The chief executive holds regular 'values conversations', where members of staff were chosen at random to meet with her and feedback information about their working environment. These have been running since 2009 and at the time of the inspection nearly 60 conversations had taken place.

The trust had procedures in place for staff to raise 'whistleblowing' concerns outside of their line management and we saw that these had been addressed.

The trust has a "respect" programme that encourages staff to report any incidents of discrimination and underpins a zero tolerance towards the abuse of staff.

Performance Improvement

The trust developed a leadership faculty in 2012. This has led to a clear definition of good leadership and leadership competencies to assess and support leadership within the service. It had a clear programme to improve leadership across the organisation with a leadership forum for leaders at level 3 and above for senior clinical and managerial leaders in existence since 2005. In June 2014 the trust launched their level 4 leadership forum to connect clinical and managerial leaders as part of their wider leadership faculty work.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010

Safeguarding service users from abuse

How the regulation was not being met:

On the acute wards and psychiatric intensive care unit seclusion is being used without suitable arrangements in place to protect service users against the risk of physical interventions being excessive, as the use of seclusion is not being recognised as such so its use can be correctly recorded and monitored to ensure the appropriate safeguards are in place.

Regulation 11(2)(b)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 16 HSCA 2008 (Regulated activities) Regulations 2010

Safety, availability and suitability of equipment

How the regulation was not being met:

The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of

unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is properly maintained and suitable for its purpose

The resuscitation equipment at the Mid Surrey assessment and treatment service and the psychiatric intensive care unit was not regularly monitored in line with trust policy and documentation demonstrated staff appeared unable to identify the equipment accurately.

Regulation 16(1)(a)

This section is primarily information for the provider

Compliance actions

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA 2008 (Regulated activities)

Regulations 2010

Respecting and involving people who use the service

The registered person must so far as reasonably practicable make suitable arrangements to treat service users with consideration and respect.

The psychiatric intensive care unit must treat people with respect and engage proactively. Patients told us their needs were not attended to in a timely fashion and were consistently told to wait, with their request not always being attended to. Our observations found poor engagement levels between staff and patients.

Regulation 17(2)(a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA 2008 (Regulated activities)

Regulations 2010

Respecting and involving people who use the service

How the regulation was not being met:

The trust is not making arrangements to enable patients to be involved in decisions about their care and treatment by ensuring that patients detained on section 2 of the Mental Health Act are regularly informed of their rights in relation to the treatment they are receiving.

This was a breach of Regulation 17 (1)(f)

Regulated activity

Accommodation and nursing or personal care in the further education sector

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated activities)

Regulations 2010

Assessing and monitoring the quality of service

How the regulation was not being met:

This section is primarily information for the provider

Compliance actions

The registered person must protect service users against the risk of inappropriate or unsafe care by means of an effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of services provided.

The current governance processes are not clearly highlighting services in the division for older people which are not performing well such as Victoria Ward, so that improvements can take place and be closely monitored.

The trusts internal quality assurance system (periodic service review) had not been completed in a way that identified the areas for improvement in the psychiatric intensive care unit to ensure timely improvements were put into place.

This was in breach of Regulation 10(2)(c)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated activities)

Regulations 2010

Staffing

How the regulation was not being met:

In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Agency staff working on the psychiatric intensive care unit informed us they were regularly involved in restraining patients and had little or no training.

This was a breach of regulation 22

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Regulation

Regulation 15 HSCA 2008 (Regulated activities)

Regulations 2010

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury

Staffing

How the regulation was not being met:

The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of—

(a) suitable design and layout;

The Wingfield place of safety was housed within a converted day room. There were no ensuite facilities in the suite. The entrance is via the main reception and ward area. People are able to view inside the area from the garden. There was an unlocked door through to a small corridor with 2 locked rooms from it posing a risk to staff undertaking 1-1 observations.

At the Fenby place of safety the window in the bedroom door was high up and in a position which was not easy for staff to observe through for long periods. There was no communication system in place to allow people to communicate with staff whilst in the bedroom area. To facilitate people using the toilet, staff had to enter the toilet via a door from the main area and unlock the interconnecting door. This placed the staff at risk. The doors to the bedroom, interconnecting door and toilet to main area were old and showed damage and repair. We noted the hand push plate had a sharp corner which a person could potentially injure themselves on.

This was a breach of regulation 15(1)(a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated activities)

Regulations 2010

Supporting workers

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 section is primarily information for the provider

Compliance actions

Some staff in the crisis house and crisis line had not completed or refreshed their training on supporting people with challenging behaviours or basic life support.

This is in breach of Regulation 23 (1) (a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated activities)

Regulations 2010

Assessing and monitoring the quality of service

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.

The crisis line was still being reviewed and did not have clear recommendations in place to ensure it operated to meet the needs of people who use the service.

This was in breach of Regulation 10(1)(b)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated activities)

Regulations 2010

Care and welfare of services users

How the regulation was not being met:

The registered person had not ensured that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of carrying out of an assessment of the needs of the service user and the planning and delivery of care and, where appropriate, the treatment in such a way as to have met the service users' individual needs.

They had not ensured the welfare and safety of the service user because there were not records

This section is primarily information for the provider

Compliance actions

demonstrating that skin integrity and falls risks were monitored and assessed on admission and were not identified in the management of care of people on Victoria ward.

Service users on Victoria Ward had not had regular physical health monitoring checks such as weight and blood pressure checks.

Regulation 9 (1) (a) (b) (i) (ii)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated activities)

Regulations 2010

Assessing and Monitoring the Quality of Service

How the regulation was not being met:

The registered provider had not protected people at risk of inappropriate or unsafe care. There was not an effective system to ensure that changes were made to treatment or care provided, by the analysis of incidents.

Not all staff knew how to report incidents and were not made aware of the findings.

This was a breach of Regulation 10(2)(c)(i)