Surrey and Borders Partnership NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

The Evidence appendix appears under the Reports tab on our website here: www.cqc.org.uk/provider/RXX/reports. A detailed Use of Resources report is available under the Inspection summary tab (www.cqc.org.uk/provider/RXX/inspection-summary).

Background to the trust

Surrey and Borders Partnership NHS Foundation Trust provides mental health services for people with a learning disability and community drug and alcohol services across Surrey and North-East Hampshire. It serves a population of 1.3 million.

The trust was formed on 1 April 2005 following the merger of Surrey Hampshire Borders NHS Trust, Surrey Oaklands NHS Trust and North-West Surrey Partnership NHS Trust. The trust achieved Foundation Trust status on 1 May 2008.

The trust employs 2,300 staff across 39 sites and has 194 inpatient beds across 12 wards.

Guildford and Waverley Clinical Commissioning Group is the lead commissioner for mental health services.

The trust is actively working with health and social care across two integrated care systems covering all of Surrey and North East Hampshire – Frimley Health and Care and Surrey Heartlands. The trust chief executive officer leads the Frimley ICS.

Our last well-led inspection of the trust was 11 December 2018- 17 January 2019. We inspected four core services delivered by the trust and completed a well-led inspection. We rated the trust as Good overall, and Good overall for the four core services.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good 

What this trust does

The trust provides the following services:

- Community and hospital mental health services for adults and older adults with severe and/or complex illnesses.
- Community mental health services for children and adolescents.
- Community drug and alcohol services for adults.
- Community and hospital learning disability health care services in Surrey for people of all ages.
- Residential learning disability social care services for people in Surrey.
- Acute wards for adults of working age and psychiatric intensive care units
- Long-stay/rehabilitation wards for working age adults

Summary of findings

- Wards for older people with mental health problems
- Talking therapies services for adults with mild to moderate mental ill-health.
- Community eating disorder services for young people and adults in Surrey.
- Community forensic mental health services in Surrey.
- Fetal Alcohol Spectrum Disorder clinic, national referral service.

The trust provides a range of mental health services including acute and rehabilitation in-patient services, crisis and home treatment teams and health-based places of safety for working age and older adults.

The trust has 11 residential care homes for adults with a learning disability. These are all currently rated Good and have either been inspected recently by the CQC adult social care inspections team, or have a scheduled date for inspection. We did not inspect the care homes during this inspection.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. In addition, we used our information to identify which core services to inspect on this inspection.

Between 7-9 January 2020 we inspected four mental health core services:

- Acute wards for adults of working age and psychiatric intensive care units (PICUs)
- Long stay or rehabilitation mental health wards for working age adults
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety

These core services were either selected due to their previous inspection ratings or our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

We also looked at how well-led the trust was between 11-12 February 2020. In order to ensure we have appropriate expertise to make a robust judgement about how well-led the trust is our inspection team comprised an executive reviewer (a board level leader from another organisation rated good or outstanding), two specialist advisors with expertise in governance and financial expertise. as well as CQC inspection team members.

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

What we found

Summary of findings

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- Staff in the trust had worked hard to maintain the improvements that we found in our last inspection. The four core services that we inspected maintained their rating of good which means that all ten of the trust's core services have a rating of good.
- During this inspection we inspected four core services and carried out a well-led review. In rating the trust we have taken into account the previous ratings of the six mental health services not inspected this time.
- We found that the trust was led by a highly skilled and experienced senior team, including the chair and non-executive directors. There was a strong patient-focussed, learning culture within the trust and staff showed caring, compassionate attitudes, were passionate and proud to work for the trust and were involved in the development and improvements within the trust.
- We found that the trust leaders had the skills, knowledge, integrity and experience to perform their roles and had a good understanding of the services they were delivering. Senior leaders were open and honest, presented and spoke with passion, compassion and authenticity.
- There was a clear vision, underpinned by a set of values that were well understood by staff across the trust. The trust values were embedded in a real commitment to people, both staff and patients, and in creating a value-driven organisation.
- Effective leadership from senior trust leaders and leaders in the community-based mental health services for working age adults was enabling staff to manage the separation of health and social care teams following the local authority taking back management of social care staff (this happened shortly before the inspection). The trust was supporting team leaders effectively and monitoring the impact on patients.
- The trust had made improvements to the therapeutic programmes offered to patients within its inpatient wards since our last inspection. Both the variety of activities and their availability to patients across seven days per week had improved.
- The trust was developing a digital strategy which supported the overall clinical strategy. This ensured that both strategies were aligned and focused on improving patient care and supporting staff to deliver care.
- Generally, staff completed comprehensive risk assessments and managed risks well. Physical and mental health needs were assessed and monitored, and care plans were holistic and recovery orientated. Staff followed good practice with respect to safeguarding.
- Patient safety incidents were managed well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons with their teams and the wider organisation.
- Staff provided a range of care and treatment interventions suitable for the patient groups and these were consistent with national guidance on best practice.
- Staff across all the services we inspected were kind, compassionate, supportive and respected the dignity of patients. Feedback from people using services and their relatives and carers was positive. Staff ensured that the emotional and spiritual needs of people who used services were addressed, along with their mental and physical healthcare needs.
- Since the last inspection, the trust had appointed a Director of Workforce and was working to attract recruits to the organisation with a newly launched workforce strategy.

Summary of findings

- Staff across the trust were confident and willing to develop their services, using quality improvement methods. Staff were proud of the areas in which they worked. They felt encouraged and supported by the trust leaders to try out new ideas and improve the experience of people using their services.
- The trust had positive and collaborative relationships with external partners and was actively engaged with the local health economy in shaping services, including patients, staff, equality groups and local organisations.

However

- The wards at the Abraham Cowley Unit remained unfit for the purpose of delivering modern mental healthcare. The patient experience remained poor due to the dormitory accommodation, communal bathroom areas, drab and dreary environment experienced by most patients. The staff had worked hard and implemented many procedures to manage the overall environmental risks however, the physical design of the building and the wards meant that staff found it difficult to maintain patients' dignity and privacy. We saw that the trust was continuing to consider options to replace the hospital and the board was moving forward with a longer-term plan. However current patient experience continued to be affected by the poor environment at the Abraham Cowley Unit.
- We noted that there were areas in governance and assurance that would benefit from a full review. The last formal governance review had taken place in 2016 and the trust informed us that they were working on commissioning such a review within the timescale set for NHS trusts.

Are services safe?

Our rating of safe stayed the same. We rated it as good because:

- The trust delivered safe services as nine of the ten trust core services were rated as good for safe. We took in to account the previous ratings of the six services not inspected this time.
- The trust was working creatively to increase the recruitment and retention of staff to ensure it always had enough, suitably qualified and competent staff in all its services. A new workforce strategy had been developed. Although there were still vacancies across services, local ward managers were able to adjust staffing levels to account for acuity of patients on the ward. The wards always worked to safe staffing levels.
- Staff understood how to protect people who used services from abuse. Staff knew how to make a safeguarding referral.
- Staff across all services managed patient safety incidents well. Staff knew what to report and reported incidents when they needed to. Serious incidents were thoroughly investigated at a senior level and lessons were learned and shared across teams.
- The majority of staff had an annual appraisal, had completed mandatory training and could access specialist courses to enhance their knowledge and skills.

However

- The key question of safe in mental health crisis services and health-based places of safety moved from good to requires improvement as medicines management needed to be improved to ensure that medicines were safely stored and administered. Post inspection the trust informed us they had taken immediate action to address these issues.
- The health-care assistants based at the health-based places of safety were not receiving supervision regularly with only 49% being completed.

Are services effective?

Our rating of effective stayed the same. We rated it as good because:

Summary of findings

- All of the ten trust core services were rated as good for effective prior to inspection. We took in to account the previous ratings of the six services not inspected this time.
- Staff provided a range of treatment and care for patients based on national guidance. The range and availability of therapeutic interventions offered to inpatients were particularly good.
- The quality of care planning was generally good. This was particularly clear in the acute wards for adults of working age where the staff had developed holistic, recovery-focused care plans informed by a comprehensive assessment.
- Staff in all services were experienced and had the right skills and knowledge to meet the needs of the patient group.
- Staff from different disciplines worked together as a team to benefit patients. The teams consisted of a range of health care professionals including doctors, nurses, healthcare assistants, therapy staff and psychologists.
- Patients could access specialist independent mental health advocates and mental capacity advocates. There was information displayed within each service on how to contact an advocacy service.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Clinical staff were well supported by a pro-active Mental Health Act administration team.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- All of the ten trust core services were rated as good for caring prior to the inspection. We took in to account the previous ratings of the six services not inspected this time.
- Staff across the trust treated patients with compassion and kindness. The privacy and dignity of patients was respected and embedded in the work of staff. Staff understood the individual needs of patients. Patients were supported by staff to understand and manage their care, treatment or condition. Staff put patients at the centre of everything they did.
- Staff involved patients in decisions about their care and treatment. Patients were involved in care planning and risk assessment. Managers and staff sought patient feedback on the quality of care received. Patients had access to advocates.
- Staff kept families and carers appropriately and involved in the care their family members received.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- Nine of the trust's core services were rated as good for responsive prior to the inspection. We took in to account the previous ratings of the six services not inspected this time.
- People could access services closest to their home if they needed it. For most services waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Patients were not moved between wards during an admission unless it was justified on clinical grounds and was in the interests of the patient.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shred these with staff.
- Staff could access interpreters and could produce easy-read leaflets when needed.

Summary of findings

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Nine of the trust's core services were rated as good, and one rated outstanding, for well-led prior to the inspection. We took in to account the previous ratings of the six services not inspected this time.
- Since our last inspection the trust had appointed a director for workforce which had resulted in increased focus at board level on a strategy for the recruitment and retention of staff.
- The pharmacy service had a clear vision and strategy focussing on delivering person centred care and developing the team.
- The trust digital strategy supported the overall clinical strategy. This ensured that both strategies were aligned and focused on improving patient care and supporting staff to deliver care.
- The trust had responded to emerging issues, such as the ending of the section 75 agreement with the local authority (were the social workers moved from the integrated teams to being managed by the local authority), with considered and well-executed plans for improvement.
- Senior leaders and managers at all levels had the right skills and abilities to run services providing high-quality sustainable care.
- Leaders and managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust had maintained its own comprehensive internal service accreditation programme which rated each team against key performance standards. The number of teams achieving accreditation had increased to 12.
- There was significant commitment to quality improvement at a local level and within the senior leadership team. The trust was committed to improving services by learning when things went wrong, promoting training, research and innovation.
- The trust continued to build on innovation and make improvements in their use of technology. There was good practice and innovation around IT that was patient focussed such as the Technology Integrated Health Management (TIHM) for dementia and the app My Journey.

However

- We noted that there were areas in governance and assurance that would benefit from a full review. The last formal governance review had taken place in 2016 and the trust informed us that they were working on commissioning such a review within the timescale set for NHS trusts.
- The long-term plans to replace the Abraham Cowley Unit remained in discussion, and the overall plan was yet to be signed off by the trust Board. The trust did not have a short-term plan to improve the hospital environment.
- Although local managers held a record of staff supervisions, there was no trust-level assurance that all staff had received supervision.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Summary of findings

Outstanding practice

We found examples of outstanding practice in acute wards for adults of working age and psychiatric intensive care units (PICUs).

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including two breaches of legal requirements that the trust must put right. We found 13 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

- We issued three requirement notices to the trust. Our action related to a breach of the legal requirements of Regulation 12 safe care and treatment in the mental health crisis services and health-based places of safety. We told the trust it must make improvements to the medicines management in the home treatment teams. And to a breach of Regulation 17 good governance in acute wards for adults of working age and psychiatric intensive care units (PICUs). We told the trust it must make improvements to the environment of the Abraham Cowley Unity to improve patient experience. One related to a breach of Regulation 10 in mental health crisis services and health-based places of safety. We told the trust the staff working in the service must understand how to provide care to patients with a leaning disability and autism.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Acute wards for adults of working age and psychiatric intensive care units (PICUs)

The core service acute wards for adults of working age and psychiatric intensive care units (PICUs) was implementing a new strategy to improve the effectiveness of admissions to the acute wards for patients with an emotionally unstable personality disorder (EUPD). They had also developed effective physical healthcare clinics on the wards to support and maintain patient's physical wellbeing. These ensured that patients' physical health was prioritised as part of their treatment whilst they were a patient on the acute wards.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services. We told the trust that it must take action to bring services into line with one legal requirement. This action was related to one service.

Action the organisation MUST take to improve:

Summary of findings

Acute wards for adults of working age and psychiatric intensive care units (PICUs)

- The trust must improve the environment at the Abraham Cowley Unit to better the experience of patients whilst longer term plans to replace the unit are finalised.

Mental health crisis services and health-based places of safety

- The trust must ensure that the administering, recording, storage and management of medicines at the home treatment teams is safe and follows trust policies.
- The trust must ensure that all staff understand how to provide care to patients with a leaning difficulty and autism.

Action the organisation SHOULD take to improve:

Mental health crisis services and health-based places of safety

- The service should ensure medical equipment in the clinic rooms at the home treatment teams is always fit for use.
- The trust should ensure that all staff working at the home treatment teams complete training in basic and immediate life support.
- The service should ensure that health care assistants at the health-based places of safety have regular access to supervision in line with trust policy.
- The service should ensure that patient crisis and contingency plans are created in a timely way with patients, consistently across all the home treatment teams.

Acute wards for adults of working age and psychiatric intensive care units (PICUs)

- The trust should ensure there is a process for documenting gaps in medication administration using the incident reporting system,
- The trust should ensure that there is a process for overseeing that supervision is regularly happening on the wards.
- The trust should ensure that female patients have freer access to the female lounges and make them better resourced with televisions and / or activities for patients.

Community-based mental health services for adults of working age

- The trust should ensure that risk assessments at Epsom community mental health recovery service are up-to-date, reviewed regularly and reflect current risks.
- The trust should ensure that staff follow the trust lone working policy in maintaining personal safety by using personal alarms when meeting patients on their own.
- The trust should ensure that staff at Epsom community mental health recovery service have access to Community Treatment Order paperwork for patients.

Long stay or rehabilitation mental health wards for working age adults

- The service should ensure that adequate staff are available after five o'clock to meet the needs of the patients.
- The service should ensure that its rehabilitation and recovery philosophy is effectively integrated into how patients' recovery goals are described and recorded in its care planning system.
- The service should use a recognised outcome measure for patients that can demonstrate patient's overall recovery progress during their admission.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We found that the trust had a highly skilled, strong, stable and experienced senior team, including the chair and non-executive directors.

Leaders had the skills, knowledge, integrity and experience to perform their roles and had a good understanding of the services they were responsible for delivering. They were visible in the service and approachable to patients and staff.

Senior leaders were open and honest, presented and spoke with passion, compassion and authenticity.

There was a clear vision, underpinned by a set of values that were well understood by staff across the trust. The trust values were embedded in a real commitment to people, both staff and patients, and in creating a value-driven organisation.

The trust was working to further nurse and allied health professional leadership development within the organisation.

The trust digital strategy supported the overall clinical strategy. This ensured that both strategies were aligned and focused on improving patient care and supporting staff to deliver care.

The trust was embracing a strategy about being a system leader and embracing partnership working. The trust chief executive was leading the Frimley ICS.

The trust managed incidents and complaints well. A core team of people were now dealing with the process and demonstrated robust systems and processes for investing and responding. We saw a positive focus on improvement. The responses were individualised, and incident investigation reports were geared toward patients and families and there was shared learning across the services and support for staff.

We saw real improvement in assurance for Mental Health Act and the Mental Capacity Act. The oversight of Mental Health Act responsibilities had been strengthened since our last inspection with reports directly to the trust Board.

However:

At the time of inspection, the trust board was considering options for the re-provision of the Abraham Cowley Unit (ACU) to provide a better hospital environment without dormitory accommodation. At the previous inspection the trust had a strategy to address the environment and dormitory issues at this hospital with a completion date in late 2022. The trust target for completion of the new proposals had moved to 2023/4 for the new services to be operational. In the interim, the trust had no short-term strategy to improve the patient experience at the Abraham Cowley Unit.

We had concerns over elements of the governance structure particularly the governors' attendance at some committees such as the Quality Assurance Committee. They appeared to be contributing to the development of policy, agenda and decision making process which could interfere with their role in holding the non-executive directors to account. The trust explained that governors were involved in this way to enhance the ability of governors to raise issues of concern, and to better understand the role of the non-executive directors and hold them to account, and that this was kept under review.

Summary of findings

We noted that there were areas in governance and assurance that would benefit from a full review. The last formal governance review had taken place in 2016 and the trust informed us that they were working on commissioning such a review within the timescale set for NHS trusts.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020
Long-stay or rehabilitation mental health wards for working age adults	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020
Wards for older people with mental health problems	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
Wards for people with a learning disability or autism	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Outstanding Apr 2018	Good Apr 2018
Community-based mental health services for adults of working age	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ↑ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020
Mental health crisis services and health-based places of safety	Requires improvement ↓ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020	Good ➔➔ Jan 2020
Specialist community mental health services for children and young people	Good Dec 2018	Good Dec 2018	Good Dec 2018	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018
Community-based mental health services for older people	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Community mental health services for people with a learning disability or autism	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Substance misuse services	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community-based mental health services of adults of working age

Good

Key facts and figures

Surrey and Borders Partnership NHS Foundation Trust provides community-based mental health services across the county of Surrey, and the North East of Hampshire.

The service is organised in 12 locality bases, one in each of Surrey's 11 boroughs and one serving North East Hampshire. The locations of the 12 teams are: Epsom, Dorking, Godalming, Guildford, Chertsey, Woking, Oxted, Reigate, Frimley, Aldershot, West Molesey and Staines.

Each one of the 12 community mental health recovery services (CMHRSs) provide specialist support and treatment to people aged 18-65 and for functional mental health illness for people over 65 experiencing more complex, severe and enduring conditions such as depression, schizophrenia and bi-polar disorder. Their services are accessed via the Single Point of Access. The CMHRS teams included doctors, nurses, psychologists, occupational therapists, support workers, administrators and mental health practitioners.

This core service was last inspected by the Care Quality Commission in February 2016 when we rated the service good overall

Until November 2019 CMHRS were delivered in partnership with the Surrey County Council. Local authority social workers were integrated into the teams. However, this arrangement came to an end in November 2019 and now social care and mental health care are provided separately.

During this inspection we visited:

- Elmbridge CMHRS
- Epsom CMHRS
- Guildford CMHRS
- North East Hampshire CMHRS
- Runnymede and Spelthorne CMHRS
- Surrey Heath CMHRS.

We inspected this service as part of our routine inspection schedule.

Our inspection was announced (staff knew we were coming) with 48-hours notice given to ensure that everyone we needed to talk to was available.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection the team:

- Spoke with 16 patients who were using the service and seven carers
- Spoke with team managers and team leaders of each of the teams
- Spoke with 18 other staff members, including doctors, nurses, psychologists and occupational therapists

Community-based mental health services of adults of working age

- Observed three meetings discussing patient care, two post assessment meetings and one multidisciplinary team meeting
- Observed one medical review appointment.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

We rated safe, effective, caring, responsive and well-led as good.

- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff at five of the six services assessed and managed risk well.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was easy to access. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The criteria for referral to the service did not exclude patients who would have benefitted from care.
- The service was well-led and the governance processes ensured that that procedures relating to the work of the service ran smoothly.

However:

- Staff at Epsom CMHRS were not regularly reviewing all patient risk assessments or updating them to reflect changes in risk.
- Staff did not always follow good personal safety protocols when lone working. Team records showed that staff were attending patient meetings without collecting a personal alarm.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- All clinical premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Community-based mental health services of adults of working age

- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support

However,

- Staff at Epsom CMHRS were not regularly reviewing all patient risk assessments or updating them to reflect changes in risk.
- Staff did not always follow good personal safety protocols when lone working. Team records showed that staff were attending patient meetings without collecting a personal alarm.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Community-based mental health services of adults of working age

- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However,

- The Mental Health Act paperwork for Community Treatment Order patients at Epsom CMHRS was not easily accessible.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Patients told us that staff treated them well and behaved kindly. We spoke to 23 patients and carers, they all said were respectful and kind.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

Community-based mental health services of adults of working age

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Areas for improvement

The provider SHOULD ensure:

- That risk assessments at Epsom community mental health recovery service are up-to-date, reviewed regularly and reflect current risks.
- That staff follow the trust lone working policy in maintaining personal safety by using personal alarms when meeting patients on their own.
- That staff at Epsom community mental health recovery service have access to Community Treatment Order paperwork for patients.

Long stay or rehabilitation mental health wards for working age adults

Good 

Key facts and figures

Surrey and Borders Partnership NHS Foundation Trust provide long stay or rehabilitation mental health services for working ages adults at Margaret Laurie House based in Reigate, Surrey. The unit has 12 beds for a mixed-sex patient group between the ages of 18-65 years. Four beds are for female patients and eight beds for male patients. The core group of patients for the service are people with long-term severe psychosis and enduring disabilities who need longer term support.

The unit provides therapeutic rehabilitation in a structured and supportive environment with 24-hour nursing input and other multi-professional intervention. The length of stay is approximately four to six months but is sometimes longer depending on the needs of the individual. Margaret Laurie House also offers support to an established group of day patients who attend the unit for occupational therapy activities, or to collect or have medication administered.

During the inspection visit the inspection team:

- visited the unit and looked at the quality of the environment and observed how staff were caring for patients
- spoke with five nurses and a ward manager, allied health professionals, and one doctor.
- observed one community meeting, attended by patients and staff
- observed two therapeutic groups
- spoke with two patients and two relatives
- reviewed six sets of inpatient records.
- reviewed staff meeting minutes and management records and,
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The environment was well-maintained, clean and well-equipped. The service had enough nurses and doctors to support patients safely during the day. Staff assessed and managed risks well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- All patients had care plans based on their assessed needs which were regularly reviewed. Patients were offered a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation unit. This included access to psychological therapies, to support patients to care for themselves, develop and relearn everyday living skills, and to them take up meaningful occupation.
- The service had access to the full range of specialists required to meet the needs of patients on the unit. Managers ensured that these staff received training, supervision and appraisal. The unit staff worked well together as a multidisciplinary team and with those outside the unit who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Long stay or rehabilitation mental health wards for working age adults

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. Carers we spoke to confirmed this.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well led and the governance processes ensured that unit procedures ran smoothly.

However:

- The service had lower staffing numbers after five o'clock and this made it difficult to safely manage the environment and support patients when the service was busy.
- The service did not fully reflect its philosophy of rehabilitation and recovery in the care planning system. There was inconsistency in how patient recovery goals were described and recorded within the care planning system.
- At the time of inspection staff were not regularly using a recognised outcome tool, such as health of the nation outcome scales (HoNOS), during admission to reflect the patients' progress. Post-inspection the trust informed us that the service has introduced an evidence-based outcome measure at Margaret Laurie House.

Is the service safe?

Good ➔➔

Our rating of safe stayed the same. We rated it as good because:

- The unit was clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff on the unit knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Staff understood how to protect patients from harm and abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records, which were stored in the trust's online electronic patient record system.
- The service used systems and processes to safely prescribe, administer, record and store medicines, with support from the trust's pharmacy team. Staff regularly reviewed the effects of medications on each patient's physical health.
- The unit had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service via staff meetings and email. When things went wrong, staff apologised directly and via the community meeting. They gave patients honest information and suitable support.

However:

- Staff were concerned about working after five o'clock when there were only two staff on shift and they were not always able to manage the environment or support patients easily.

Long stay or rehabilitation mental health wards for working age adults

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, however were not always personalised, holistic and recovery-oriented.
- Patients could access a range of care and treatment interventions suitable for their needs and consistent with national guidance on best practice. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation. Staff helped patients to access to physical healthcare and supported them to live healthier lives.
- The unit team included or had access to the full range of specialists required to meet the needs of patients on the unit. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The unit team had effective working relationships with other staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Staff explained patients' rights to them and regularly documented this in clinical records.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However

- Staff were not using a relevant overall outcome measure during a patient's admission. The Camberwell Assessment of Need was used once as an assessment tool on admission, but staff were not regularly using this or any other outcome tools, such as health of the nation outcome scales (HoNOS) during admission to reflect the patients' progress. Post-inspection the trust informed us that the service has introduced an evidence-based outcome measure at Margaret Laurie House.
- The service did not fully reflect its philosophy of rehabilitation and recovery in the care planning system. There was inconsistency in how patient recovery goals were described and recorded within the care planning system.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

Long stay or rehabilitation mental health wards for working age adults

- Patients said staff treated them with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided through community groups and discussion with staff. They ensured that patients had easy access to independent advocates when they needed them.
- Family members felt informed and involved with care of patients and told us they were happy with the service.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the unit supported patients' treatment, privacy and dignity. Each patient had their own bedroom with access to a nearby communal bathroom and could keep their personal belongings safe. There were quiet areas for privacy, including a female-only lounge.
- The food was of good quality and patients could make their own meals as part of their recovery process. Hot drinks and snacks were available at any time.
- The unit met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. Staff could access interpreters through the trust if needed.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew the trust's vision and values.
- Staff felt respected, supported and valued. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at unit level and that performance and risk were managed well.

Long stay or rehabilitation mental health wards for working age adults

- The unit team had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in trust quality improvement activities, such as the Your Views Matter surveys, integrating results from these into patient community meetings.

Outstanding practice

Areas for improvement

- The service should ensure that adequate staff are available after five o'clock to meet the needs of the patients.
- The service should ensure that its rehabilitation and recovery philosophy is effectively integrated into how patients' recovery goals are described and recorded in its care planning system.

Acute wards for adults of working age and psychiatric intensive care units

Good 

Key facts and figures

Surrey and Borders Partnership NHS Foundation Trust provides acute wards for adults of working age and a psychiatric intensive care unit. Some patients are detained under the Mental Health Act 1983.

The trust provides up to 115 beds for adults who require a hospital admission due to their mental health needs, either for assessment or treatment, or under the Mental Health Act.

These beds are located across two sites:

Abraham Cowley Unit, Chertsey

- Clare Ward is a 20-bed male ward for patients from Elmbridge, Epsom and Ewell.
- Anderson Ward is a 13-bed female ward for patients from Elmbridge, Epsom and Ewell.
- Blake Ward is a 20-bed mixed gender ward for patients from Surrey Heath, Runnymede and Spelthorne.

Farnham Road Hospital, Guilford

- Juniper Ward is an 18-bed mixed gender ward for patients from Waverley and Woking.
- Magnolia Ward is a 15-bed mixed gender ward for patients from Guildford.
- Mulberry Ward is a 15-bed mixed gender ward for patients from Hart and Rushmoor.
- Rowan Ward is a 10-bed mixed gender psychiatric intensive care unit (PICU) with capacity to increase to 12. Rowan ward provides intensive care services for both men and women who present more risks and require increased levels of observation and support.

We inspected this core service as part of our next phase mental health inspection programme.

At the last inspection, December 2018, we rated the wards as good overall and for all five key lines of enquiry (safe, effective, caring, responsive, and well led).

We inspected this core service as part of our ongoing comprehensive mental health inspection programme. Our inspection was unannounced. Our inspection was completed between 7 and 9 January 2020.

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust. These included NHS Improvement, local Health Watch organisations, local clinical commissioning groups and local authorities.

During the inspection visit, the team:

- visited all seven inpatient wards. We looked at the quality of the environments and observed staff caring for patients
- spoke with 28 patients who were using the service
- spoke with seven carers of people using the service
- spoke with 39 members of staff, including ward managers, medical staff (including consultant psychiatrists), psychologists, physiotherapists, nurses, nursing assistants and occupational therapists

Acute wards for adults of working age and psychiatric intensive care units

- attended and observed three multidisciplinary team review meetings and two patient group meetings
- reviewed 48 patient medicine administration charts and carried out a specific check of the medicine management on the wards
- reviewed 28 care and treatment records including the Mental Health Act documentation of detained patients and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- All the ward environments were clean, furnished and most were well equipped. The wards at Farnham Road Hospital were purpose built for modern mental health care. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in local clinical audit of care plans and the environment to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

However:

- The wards at the Abraham Cowley Unit were not fit for purpose. The physical construction of the building was outdated and there were lots of blind spots which were difficult to observe. There were multiple comers across all the wards which meant that it was difficult for staff to easily maintain visibility across the wards. However, staff had implemented many procedures to try to manage patients safely.
- The layout of the Abraham Cowley Unit did not support the maintenance of dignity and privacy due to the dormitory bedrooms and communal bathrooms. On Blake ward there were gender separate sleeping areas however it remained non-compliant with the Mental Health Act Code of Practice due to the access to bathrooms/shared corridors. Patients across all wards at The Abraham Cowley Unit told us they did not feel like it was a relaxing environment and they had little privacy on the wards.
- The female lounges at the Farnham Road hospital did not have any televisions or any activities for patients, they were underused by the female patients as they were locked so not freely accessible.

Acute wards for adults of working age and psychiatric intensive care units

- The wards were not regularly documenting gaps in medication administration using the incident reporting system, this was dealt with at a local level by ward managers but there was no overall view of medication gaps which might pick out themes and trends.
- At ward level supervision was happening but the wards had no overall system of reporting supervision levels back to the board so there was no way of the organisation ensuring itself that supervision was happening regularly across the wards.

Is the service safe?

Good  

Our rating of safe stayed the same. We rated it as good because:

- All wards were clean, furnished and most were well equipped.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Every day the wards had two safety escalation conference calls where the ward managers would discuss any incidents related to the running of the ward, review ward safety and discuss how to support each other. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme and we saw all wards had recorded what restrictive practices were in use and kept these practices under review.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Despite recent changes in the structure of local social work teams the wards all had an updated flow chart indicating who to contact in the event of a safeguarding alert. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. The wards were visited on a daily basis by the trust pharmacy teams who worked closely with the medical teams to provide medicine guidance.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- The wards at the Abraham Cowley Unit were not fit for purpose. The staff had implemented many procedures to mitigate this however the physical construction of the building meant there were lots of blind spots which were difficult to observe easily.
- The wards were not regularly documenting gaps in medication administration using the incident reporting system, this was dealt with at a local level by ward managers but there was no overall view of medication gaps which might pick out themes and trends.

Acute wards for adults of working age and psychiatric intensive care units

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills need to provide high quality care. Each ward manager had access to a dashboard which showed them staff sickness, training and appraisal levels. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff and a local induction for agency staff when they first came on to the wards.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Wards had excellent support from therapies teams who offered relevant and inclusive occupational and psychological therapies throughout the working week and also in the evenings and at weekends.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Every ward had "you said – we did " boards which were reviewed in a weekly patient meeting. This was empowering for the patients and we saw lots of ideas which were being put into place by the staff and patients with good outcomes.

Acute wards for adults of working age and psychiatric intensive care units

- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.
- Patients told us permanent staff were caring and did their best to meet their needs. When they consented, their families were included in their care planning and were invited to multidisciplinary meetings or care plan review meetings.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons. All wards had a structured daily phone conference where bed availability was reviewed across all inpatient beds, this meant that there was close oversight of where patients would be most suitably placed.
- The design, layout, and furnishings of the Farnham Road Hospital supported patients' treatment, privacy and dignity, each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. Both hospitals had quiet areas on the ward for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

However:

- The female lounges at the Farnham Road hospital were poorly resourced with no televisions or activities for patients, they were underused by the patient group. They were also locked so were not freely accessible by female patients wishing to have a private lounge, away from male patients.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- The acute and PICU services had well supported ward managers on post on all wards who had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

Acute wards for adults of working age and psychiatric intensive care units

- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Groups of staff across all wards were engaged actively in local and national quality improvement activities. These were having a direct impact and improving patient care.

However:

- The Abraham Cowley Unit was not fit for purpose. Its layout did not fully promote dignity and privacy due to the dormitory bedrooms and communal bathrooms. Little had been done to make the environment more conducive to providing a good experience for patients.
- Although at ward level we could see that supervision was happening, the organisation had no overall system of reporting supervision levels back to the board so there was no way of the organisation ensuring itself that supervision was happening regularly across the wards.

Outstanding practice

- The core service was implementing a strategy on supporting patients with emotionally unstable personality disorder (EUPD) ,to effectively manage their contact with inpatient services.
- The services had effective physical healthcare clinics which were implemented in 2018 and have a focussed approach to supporting and maintain patient's physical healthcare, to ensure physical healthcare is prioritised as part of the patient's treatment whilst they are in the acute wards.

Areas for improvement

The trust must

- The trust must improve the environment at the Abraham Cowley Unit to better the experience of patients whilst longer term plans to replace the unit are finalised. Regulation 17 (1)(a)

The trust should

- The trust should ensure there is a process for documenting gaps in medication administration using the incident reporting system,
- The trust should ensure that there is a process for overseeing that supervision is regularly happening on the wards.
- The trust should ensure that female patients have freer access to the female lounges and make them better resourced with televisions and / or activities for patients.

Mental health crisis services and health-based places of safety

Good

Key facts and figures

Surrey and Borders Partnership NHS Foundation Trust provides mental health crisis services and health-based places of safety for people across Surrey. Crisis services are specialist teams that provide short term support to people experiencing mental health crisis. The trust refer to their mental health crisis teams as home treatment teams (HTT). A health-based place of safety is a place where patients experiencing a significant deterioration in their mental health are taken, usually by the police, for an assessment by a team of mental health professionals. The trust has four home treatment teams:

- East Surrey – based in Redhill at Gatton Place
- South West Surrey – based in Guildford at Farnham Road Hospital
- North West Surrey – based in Chertsey at the Abraham Cowley Unit
- Surrey Heath and North East Hampshire – based in Frimley

The trust has a single point of access, which incorporates the crisis line, based at Gatton Place.

The trust has two health-based places of safety:

- Guildford – based in Farnham Road Hospital
- Chertsey – Based at the Abraham Cowley Unit

The Guildford health-based place of safety is also designed for children and young people.

We visited three of the four teams that form part of the trust's mental health crisis services and both health-based places of safety.

In addition, we visited two safe havens in Guildford and Aldershot. There are five safe havens for adults operating across Surrey to support people during the evenings and weekends when they are in crisis or to help prevent them reaching crisis. The services are run in partnership with voluntary sector organisations.

The crisis services and health-based places of safety were last inspected in December 2018, when the service was rated as good overall. At the time, we rated each of the five key questions, safe, effective caring, responsive and well-led as good.

Our inspection of mental health crisis services and health-based places of safety took place between 7 and 9 January 2020 and was unannounced (staff did not know we were coming), to enable us to observe routine activityWe inspected mental health crisis services and health-based places of safety as part of our comprehensive inspection programme.Before our inspection, we reviewed the information we held about the trust and asked other organisations to share what they knew about the trust.

During the inspection visit, the inspection team:

- spoke with managers of the three home treatment teams and the manager who had responsibility for the health-based places of safety, and a deputy assistant director
- spoke to 27 members of staff including nurses, consultant psychiatrists, support workers, approved mental health practitioners, a pharmacist and administrative staff

Mental health crisis services and health-based places of safety

- looked at the quality of the environment at each of the home treatment teams
- reviewed 12 patient care and treatment records
- spoke with five patients
- observed two handover meetings and
- visited the single point of access and listened in on the telephone crisis advice service.

Summary of this service

Our rating of this service stayed the same. We rated it as good because.

- Clinical premises where patients were seen were safe and clean. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff was no too high to prevent them from giving patient the time they needed. Staff assessed and managed risk well and followed good practice with respect to safeguarding. Staff knew how to report incidents, there was learning from when things went wrong, and lessons were shared with staff.
- Staff working for the mental health crisis teams worked with patients, families and carers to develop care and treatment plans. They provided a range of treatments that were informed by best practice guidance and suitable to the needs of the patients.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of the patients, such as consultant psychiatrist, nurses and psychologists Staff worked well together as a multidisciplinary team and with relevant services outside the organisation, such as local third sector partners that support patients' wellbeing and recovery.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The mental health crisis service and the health-based places of safety were easy to access. Those who required urgent care were taken onto the caseload of the crisis teams immediately. Staff and managers managed the caseloads of the mental health crisis teams well. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. The services did not exclude patients who would have benefitted from care. The service did not have any waiting lists. Patients who required urgent care were seen promptly.
- The service had a clear plans and priorities of how it aimed to improve the mental and physical wellbeing of people who use the service. Managers and staff worked hard to ensure the service ran smoothly. There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety.

However:

- Staff did not always ensure emergency equipment was fit for use. The emergency bag at Farnham Road hospital had expired items in it, and staff were unaware of this.

Mental health crisis services and health-based places of safety

- Mandatory training for basic life support and immediate life support was low at 69% and 67% respectively, which was below the trusts' target of 90%. This meant that staff may not be able to respond sufficiently in the event of a medical emergency.
- The service did not always store medicines safely. Staff did not always ensure patients who were prescribed antipsychotics were routinely monitored. Staff did not always document blood results for patients on clozapine. Medication keys were not always managed safely. Patient's allergy status was not always documented in patient's prescription charts. Post inspection the trust took immediate action to review and revise their medicines management processes across the service.
- Staff at home treatment teams did not always complete a crisis or contingency plan for patients who were or may be in crisis. Of the 12 care records we reviewed across the home treatment teams, half of them did not have a crisis plan.
- The healthcare assistants at the health-based places of safety did not always receive clinical supervision in line with trust policy. The average clinical supervision rate was 49% across both health-based places of safety.
- The service and the teams did not have a robust system for monitoring and reviewing risks. This meant that risks were not always identified, and actions taken to mitigate risks were not being recorded and reviewed in a systematic way.

Is the service safe?

Requires improvement 

Our rating of this service went down. We rated it as requires improvement because:

- Staff did not always ensure emergency equipment were fit for use. The emergency bag at Farnham road hospital had expired items in it, and staff were unaware of this.
- Mandatory training for basic life support and immediate life support was low at 69% and 67% respectively, which was below the trusts' target of 90%. This meant that staff may not be able to respond sufficiently in the event of a medical emergency.
- The home treatment teams overnight staffing was very low. Staff told us that one member of staff was sometimes covering for three teams at night.
- The service did not always store medicines safely. Staff did not always ensure patients who were prescribed antipsychotics were routinely monitored. Staff did not always document blood results for patients on clozapine in line with trust's policy. Medication keys were not always managed safely in line with trust policy. Patient's allergy status was not always documented in patient's prescription charts. We shared these issues with the trust and they took action at the time of inspection.

However:

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- Staff across the service had received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Mental health crisis services and health-based places of safety

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols, including for lone working.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good 

Our rating of this service stayed the same. We rated it as good because:

- Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients, families and carers to develop individual care plans and updated them when needed.
- Staff working for the mental health crisis teams provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group. For example, patients at the health-based places of safety and patients from the mental health crisis teams could access groups sessions on the ward. Staff ensured that patients had good access to physical healthcare.
- Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with opportunities to update and further develop their skills. Managers ensured all new staff who joined the service on a permanent basis had an induction.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005. For patients who were deemed to lack capacity or might have impaired mental capacity, the teams made decisions in their best interest.

However;

- The healthcare assistants at the health-based places of safety did not always receive clinical supervision in line with trust policy. The average clinical supervision rate was 49% across both health-based places of safety. Agency staff who worked at the North West home treatment team did not always receive an induction.

Mental health crisis services and health-based places of safety

- Staff did not always complete a crisis or contingency care plan for patients who were or may be in crisis. At the home treatment team in Redhill, one patient did not have a crisis plan and five patients with the North West home treatment team did not have a crisis plan, out of 12 records we reviewed.

Is the service caring?

Good 

Our rating of this service stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients we spoke with told us staff were caring, empathic and professional.
- Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately. Staff helped families to give feedback on the service.

However:

- Staff at the home treatment teams sometimes visited patients unannounced. Patients told us they would prefer for staff to always inform them prior to visits.

Is the service responsive?

Good 

Our rating of this service stayed the same. We rated it as good because:

- The mental health crisis service was available 24-hours a day and was easy to access, including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. The mental health crisis teams assessed and treated patients promptly. Staff followed up patients who missed appointments.
- The health-based places of safety were available when needed and there was an effective local arrangement for young people who were detained under Section 136 of the Mental Health Act. Section 12-approved doctors and approved mental health professionals attended promptly when required.
- The services met the needs of patients who use the service, including those with protected characteristics. The service ensured people were not discriminated against factors such as their age, gender reassignment, race or religion. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The service did not have a clear protocol of how they would support patients with autism or a learning disability. Staff we spoke to were not sure of how to support a patient with a learning disability.

Mental health crisis services and health-based places of safety

Is the service well-led?

Good 

Our rating of this service stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the trust's vision and values, and had clear plans and priorities to help the trust achieve its objective and strategy
- Most staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staff collected analysed data about outcomes and performance.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.

However:

- The service and the teams did not have a robust system for monitoring and reviewing risks. This meant that risks were not always identified, and actions taken to mitigate risks were not being recorded and reviewed in a systematic way.

Areas for improvement

Areas in which the service **must** make improvements.

- The service must ensure that the administering, recording, storage and management of medicines at the home treatment teams is safe and follows trust policies. Regulation 12(2)(g).

Areas in which the service **should** make improvements

- The service should ensure medical equipment in the clinic rooms at the home treatment teams is always fit for use.
- The trust should ensure that staff working at the home treatment teams are compliant with their mandatory training for basic and immediate life support. The service should ensure all staff receive supervision at the in line with trust policy and health care assistants at the health-based places of safety have regular access to support from qualified staff.
- The service should ensure that patient crisis and contingency plans are created in a timely way with patients, consistently across all the home treatment teams.
- The service should ensure that the teams have a robust system for monitoring and reviewing their risks.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Our inspection team

Karen Bennett-Wilson, Head of Hospital Inspection led this inspection. The inspection of trust wide leadership was supported by Jess Lievesley, Executive Reviewer.

The team included two inspection managers, 11 inspectors, two medicines inspectors, two assistant inspectors, two Mental Health Act reviewers, 14 specialist advisers and five experts by experience.

Specialist advisers are experts in their field who we do not directly employ.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.