

# Surrey and Borders Partnership NHS Foundation Trust

## Inspection report

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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.

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.

## Ratings

### Overall rating for this trust

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

## Background to the trust

Surrey and Borders Partnership NHS Foundation Trust provides mental health services, services for people with a learning disability and community drug and alcohol services across Surrey and North-East Hampshire. The trust also provides community drug and alcohol services in Brighton and Hove.

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 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 in Surrey and Brighton and Hove.
- 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.
- 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 has 19 registered locations:

- Trust HQ
- St Peter's Site
- West Park Epsom -The Meadows
- Farnham Road Hospital (Mental Health Unit)
- Margaret Laurie House Inpatient Rehabilitation Unit
- Crisis House
- Deacon Unit
- Ashmount (care home)
- Brook House (care home)
- Courthill House (care home)
- Derby House (care home)
- Hillcroft (care home)
- Jasmine at Primrose (care home)
- Kingscroft (care home)
- Larkfield (care home)

# Summary of findings

- Oakwood (care home)
- Redstone House (care home)
- Rosewood (care home)
- The Shieling (care home)

The trust has 196 inpatient beds across 12 wards.

The trust employs 2,300 staff across 39 sites, serving a population of 1.3 million. The trust has over 6,500 public members. The trust has a partnership agreement with Surrey County Council which allows it to offer integrated health and social care.

There are six clinical commissioning groups covering Surrey and North-East Hampshire:

- East Surrey Clinical Commissioning Group
- Guildford and Waverley Clinical Commissioning Group
- North East Hampshire and Farnham Clinical Commissioning Group
- North West Surrey Clinical Commissioning Group
- Surrey Downs Clinical Commissioning Group
- Surrey Heath Clinical Commissioning Group.

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 one sustainability and transformation plan area – Sussex and East Surrey – and two integrated care systems – Frimley Health and Care and Surrey Heartlands.

The trust delivers the following mental health core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Long stay/rehabilitation mental health wards for working age adults
- Wards for people with learning disabilities or autism
- Mental health crisis services and health-based places of safety
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Community mental health services for people with a learning disability or autism
- Specialist community mental health services for children and young people
- Substance misuse services.

We have carried out two previous comprehensive inspections of the trust in July 2014 and March 2016. In March 2016 the trust was rated as requires improvement overall. We carried out a well-led inspection in July 2017 which rated the well-led domain as good and the trust's overall rating improved to good.

# Summary of findings

## Overall summary

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

## What this trust does

Surrey and Borders Partnership NHS Foundation Trust provides mental health services, services for people with a learning disability and community drug and alcohol services across Surrey and North-East Hampshire. The trust also provides community drug and alcohol services in Brighton and Hove.

## 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.

We inspected four mental health core services provided by this trust between 11 and 13 December 2018 as part of our continual checks on the quality and safety of healthcare services:

- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people.

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 inspected the well-led key question for the trust overall between 15 and 17 January 2019. We summarise what we found in the section headed *Is this organisation well-led?*

## Overall trust

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

- We rated all five domains – safe, effective, caring, responsive and well-led – as good. Following this inspection all ten of the trust's core services were rated as good. In rating the trust, we took into account the previous ratings of the six mental health services not inspected this time.
- Eleven of the 12 care homes provided by the trust are rated good and one is rated requires improvement.
- Since the last well-led inspection in 2017 the trust has continued to make improvements.

# Summary of findings

- Staff at all levels and across all services had renewed pride and confidence in their work and spoke with energy and enthusiasm about the improvements that they were delivering.
- There was stronger leadership at executive, divisional and service delivery levels throughout the trust.
- The trust had more robust operational systems and processes. The trust had responded to emerging issues in service quality with considered, well-executed and in-depth supportive plans for improvement.
- The trust had introduced a culture of quality improvement.
- The trust had continued to modernise and improve the environments from which they delivered community and inpatient services.

However:

- The wards at the Abraham Cowley Unit in Chertsey were not suitable for modern mental health care. The staff had implemented many procedures to mitigate this but the physical construction of the building meant there were blind spots which were difficult to observe easily and its layout did not fully promote dignity and privacy due to the dormitory bedrooms.

## Are services safe?

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

- All ten of the trust's core services are now rated as good for safe. In rating the trust, we took into account the previous ratings of the six services not inspected this time.
- All the wards and community services we inspected appeared clean and well-maintained.
- The wards and patient-accessible areas had been risk-assessed and mitigating actions taken to reduce risks to patients.
- Staff completed comprehensive risk assessments for each patient and updated them following incidents.
- Medicines were stored securely and safely. An appropriate range of emergency medicines and oxygen were stocked in clinic rooms.

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- Staff completed comprehensive risk assessments for each patient and updated them following incidents.
- Medicines were stored securely and safely. An appropriate range of emergency medicines and oxygen were stocked in clinic rooms.
- Pharmacists carried out medicines safety audits and monitored medicines incidents that staff reported. Learnings from audits and incidents were shared through a pharmacy newsletter and quality report.
- The trust had made significant efforts to fill staff vacancies and had filled almost all registered nurse posts in the acute wards and psychiatric intensive care unit for working age adults and the community child and adolescent mental health service (CAMHS) teams.

# Summary of findings

- Staff received regular mandatory training.
- 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 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.

However:

- The wards for older people with mental health problems had a significant level of staffing vacancies. Staff working on these wards told us their primary concern was the impact of vacancies on the team and the running of the service.

## Are services effective?

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

- All ten of the trust's core services are now rated as good for effective. In rating the trust, we took into 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.
- Across the trust the quality of care planning had improved. This was particularly clear in the acute wards for adults of working age and psychiatric intensive care units where the staff had developed holistic, recovery-oriented care plans informed by a comprehensive assessment.
- Staff 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, social workers 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 the 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 an experienced and pro-active Mental Health Act administration team.
- Staff in most services received regular supervision and had opportunities to update and further develop their skills. Managers ensured they had staff with a range of skills needed to provide high quality care.

However:

- The frequency of supervision meetings for staff varied in the wards for older people with mental health problems. Some staff had supervision meetings only every three to four months.

## Are services caring?

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

- All ten of the trust's core services are now rated as good for caring. In rating the trust, we took into account the previous ratings of the six services not inspected this time.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity and supported their individual needs. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

# Summary of findings

- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.

## Are services responsive?

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

- Eight of the trust's ten core services are now rated as good for responsive. Two are rated as requires improvement. In rating the trust, we took into account the previous ratings of the six services not inspected this time.
- People could access the service closest to their home when 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 episode 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 shared these with all staff.
- Staff could access interpreters and could produce easy-read leaflets when needed.

However:

- The community child and adolescent mental health service was not reaching its target for waiting times to treatment. In many treatment pathways the trust was not matching the national standard of 18 weeks from referral to treatment.

## Are services well-led?

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

- Nine of the trust's ten core services are now rated as good for well-led and one core service is rated as outstanding for well-led.
- Eleven of the 12 care homes provided by the trust are rated good overall and one is rated requires improvement.
- Since our last inspection the trust had introduced the post of Chief Operating Officer. This post, and other senior leadership team changes, had resulted in increased operational focus at board level and had significantly improved the day-to-day management and support for services.
- The pharmacy service had a clear vision and strategy focusing on delivering person centred care and developing the team.
- The trust had responded to emerging issues in service quality with considered, well-executed and in-depth supportive plans for improvement.
- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.
- 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 was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
- There was a significant commitment to quality improvement in all of the services we inspected, across the trust's support services and in the senior leadership team.

# Summary of findings

- The trust has developed its own comprehensive internal service accreditation programme which rates each team in the organisation against key performance standards.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and service type, and for the whole trust. They also show the previous 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.

## Outstanding practice

We found examples of outstanding practice in the well-led inspection.

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

## Areas for improvement

We found 18 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

For more information on action we have taken, see the sections on Areas for improvement.

## What happens next

We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

We found the following outstanding practice:

Trust wide

- The trust has developed an outstanding internal accreditation programme called the CARE excellence accreditation programme. CARE stands for communicate, aspire, respond, engage. This programme carried out a robust annual review of the performance of every team in the organisation and rated each team. The review included adherence to trust vision and values, CQC fundamental standards and key lines of enquiry and health and safety standards. Only teams that scored 95% or higher in mandatory standards progressed from the foundation stage to the accreditation stage. Teams that scored below 85% were rated as requires significant improvement and received additional support to help them improve their performance. Success was celebrated at annual staff CARE awards and successful teams were awarded a CARE excellence accreditation plaque. So far 11 teams have gained CARE excellence accreditation.
- The trust, working in partnership with the Alzheimer's Society, the University of Surrey and Royal Holloway University of London has developed an innovative system called Technology Integrated Health Management (TIHM) for dementia. This system enables people with dementia to stay in their own homes for longer and avoid readmissions to hospital. A network of internet-enabled devices has been installed in people's own homes which remotely monitor the



# Summary of findings

health, wellbeing and environment of the person with dementia. If the technology identifies a problem, an alert is flagged and a clinical monitoring team of healthcare practitioners decides on the necessary follow-up support. The system is part of the NHS England Test Beds programme and won the Health Service Journal award 2018 for improving care through technology.

- The trust has developed a mobile app called My Journey. The app helps young people with psychosis make informed choices to help improve their mental health. The app enables young people to monitor their mood, keep track of their medication and gives advice on what to do and who to contact if they need help.

## Child and adolescent mental health services

- Following on from the success of the adult safe havens, the trust has opened four children and young people's safe havens in partnership with other agencies for children and young people aged 10-18. They provide an evening and weekend support and advice service for young people with mental health issues staffed by youth workers and a mental health nurse. Young people can drop in to the service without an appointment and receive mental health guidance and support.

## Areas for improvement

We told the trust that it should take action either because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall or to improve services.

### Action the trust SHOULD take to improve

#### Trust wide

- The trust should ensure that its plans to rebuild the Abraham Cowley Unit are implemented as soon as possible.
- The trust should ensure it continues to prioritise recruitment and takes the necessary action to fill staffing vacancies across all of its services.

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

- The trust should ensure its plans to redevelop the Abraham Cowley Unit include the elimination of dormitory bedrooms at the earliest opportunity.

#### Wards for older people with mental health problems

- The trust should ensure that staff meetings take place regularly on all wards.
- The trust should ensure that all staff receive regular supervision.
- The trust should include the removal of dormitories in their plans to redevelop Spenser ward.
- The trust should ensure that all patients are able to internally control the viewing panel in their bedroom door.
- The trust should ensure that staff adhere to trust policy in establishing a baseline for physical observations on all newly admitted patients.
- The trust should ensure that patients on all wards have easy access to a garden.

#### Mental health crisis services and health-based places of safety

- The trust should ensure that staff always record the medical rationale for the use of rapid tranquilisation.
- The trust should ensure that physical observations are recorded by staff.

# Summary of findings

- The trust should consider improving the care plans and ensuring consistency across all three home treatment teams.
- The trust should consider improving how learning from deaths, serious incidents and complaints is shared with all staff and between the different home treatment teams and health-based places of safety.
- The trust should consider a review of the staffing needs of the Safe Havens to avoid unplanned closures.

## Specialist community mental health services for children and young people

- The trust should ensure it implements the improvement plan to address the waiting times to treatment in the CAMHS teams to meet trust targets and national guidance.
- The trust should ensure that standards for the recording of clinical information on Systmone are clear and that staff follow these consistently.
- The trust should ensure that CAMHS staff appraisal rates meet the trust target.
- The trust should consider improving the team performance data so that it adequately reflects the current composition of the CAMHS service.

## 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.

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

- Nine of the trust's ten core services are now rated as good for well-led and one core service is rated as outstanding for well-led.
- Eleven of the 12 care homes provided by the trust are rated good and one is rated requires improvement.
- The board had been strengthened by the appointment of new executive and non-executive members. Board meetings had become more rigorous and the non-executive directors were able to challenge the executive directors and debate reports presented to the board in an informed and confident manner.
- Since our last inspection the trust had introduced the role of Chief Operating Officer. This post, and other senior leadership team changes, had resulted in increased operational focus at board level and had significantly improved the day-to-day management and support for services.
- The pharmacy service had a clear vision and strategy focusing on delivering person centred care and developing the team.
- The trust had responded to emerging issues in service quality with considered, well-executed and in-depth supportive plans for improvement. The trust had taken difficult decisions operationally in order to improve services. For example the project to improve the community child and adolescent mental health services had involved a slow-down on new referrals for 16 weeks in order to give the service time to re-structure, improve its staffing and review all outstanding cases waiting for assessment.

# Summary of findings

- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. Support and training for managers had improved and there was a greater focus on ensuring ward and service managers had the resources necessary to deliver improvements in patient care.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff at all levels throughout the trust had renewed positivity and pride in their work.
- The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. The trust had improved their serious incident investigation process and now produced more in-depth, considered and timely serious incident investigation reports which identified learning and made recommendations for improvement.
- The trust had a robust and effective complaints process led by qualified and experienced staff.
- There was a significant commitment to quality improvement in all of the services we inspected, across the trust's support services and in the senior leadership team. Staff we spoke with throughout the organisation were eager and enthusiastic to discuss with us the improvement projects they were working on.
- The trust has developed its own comprehensive internal service accreditation programme which rates each team in the organisation against key performance standards.

## 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
<b>Overall</b>	Good ↑ Dec 2018	Good ↔ Dec 2018	Good ↔ Dec 2018	Good ↔ Dec 2018	Good ↔ Dec 2018	Good ↔ Dec 2018

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.

# Mental health crisis services and health-based places of safety

Good  

## Key facts and figures

We visited all the teams that form part of the trust's crisis services. Crisis services are specialist teams which provide short term support to people experiencing a mental health crisis.

Surrey and Borders Partnership NHS Foundation Trust has three home treatment teams:

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

The new single point of access, which incorporates the crisis line, is based at Gatton Place.

Surrey and Borders Partnership NHS Foundation Trust has two health-based places of safety. 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.

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

At the time of our inspection one of the beds at the Guildford health-based place of safety was closed for refurbishment due to damage caused by a person using services. The Guildford health-based place of safety is also designated for children and young people.

In addition, we visited two of the five Safe Havens in Surrey, Guildford and Redhill. There are five Safe Havens 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.

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

The crisis services and health-based places of safety were last inspected in March 2016, when the overall rating for the service was requires improvement. At that time, we rated safe and well-led as requires improvement and we rated caring, effective and responsive as good.

We issued four requirement notices following the 2016 inspection, in relation to:

- regulation 12 Safe care and treatment - the trust had not protected service users against the risk of inappropriate or unsafe care by means of the effective operation of systems designed to identify, assess and manage risk relating to the health, welfare and safety of service users.
- regulation 17 Good governance - the trust had not protected service users against the risk of inappropriate or unsafe care by ensuring that allergies were properly recorded and that the trust had not protected service users from risk of harm by not responding to all calls made to the crisis team.
- regulation 18 Staffing - the provider had not ensured that staff had received appropriate training to enable them to deliver care and treatment to service users safely and to an appropriate standard.

During our inspection in December 2018 we saw that the trust had addressed these issues.

# Mental health crisis services and health-based places of safety

Our inspection of mental health crisis services and health-based places of safety took place between 11 and 13 December 2018 and was announced (staff knew we were coming). The trust received 48 hours' notice of our inspection in line with CQC guidance in relation to inspections of community-based services to ensure that staff were present during our inspection.

Before our inspection, we reviewed 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 the managers of each home treatment team and the managers who had responsibility for each of the health-based places of safety
- spoke with 19 members of staff including nurses, consultant psychiatrists, support workers, AMHPs and a director of property
- looked at the quality of the environment at each home treatment team and health-based places of safety
- reviewed 14 care and treatment records
- spoke with five patients
- observed three handover meetings
- observed two daily bed calls.

## Summary of this service

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

- The service was adequately staffed and all the environments were well maintained and had adequate, safe furnishings. The service provided mandatory training in key skills to all staff and the majority of the staff had completed it. Staff completed and updated comprehensive risk assessments for each patient and patients' allergies were clearly recorded.
- Staff from all disciplines worked well together to benefit patients and were supported by managers through regular supervision meetings and appraisals. Staff knew how to protect patients from abuse and the service worked effectively with other agencies such as the local authority and police in a joint effort to protect patients. The new single point of access, which incorporated the crisis line, ensured calls to the crisis line were dealt with appropriately.
- Staff understood their roles and responsibilities under the Mental Health Act and the Mental Capacity Act. Staff treated patients with compassion and kindness and supported their individual needs.
- Patients were assessed in a timely manner and the services were accessible to all who needed it. Patients who needed support in a crisis were referred to the home treatment teams and assessed in a timely manner.
- The service had a process to enable staff to implement recommendations from reviews of deaths, incidents, complaints, and safeguarding alerts. However, this did not always ensure that staff were aware of events that had occurred outside of their own team.

However:

# Mental health crisis services and health-based places of safety

- In the health-based places of safety we saw one occasion where the medical rationale for rapid tranquilisation for a patient was not recorded but the trust confirmed to us after our inspection that this was recorded. There were not complete records of observations of patients following the use of rapid tranquilisation.
- Staff and patients reported that the Safe havens were on occasion closed on short notice due to staffing issues.
- Despite action from the trust, there was still some uncertainty amongst staff as to who was responsible for storing and administering patients' own regular medication whilst in the health-based place of safety. Managers told us that a new policy was in the process of being written.

## Is the service safe?

**Good**  

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

- All the environments, including the health-based places of safety appeared clean and well-maintained and had adequate furnishings. There were sufficient meeting rooms for patients who attended the home treatment teams and staff had an understanding of the environmental risks. Staff were aware of and used the trust and local lone working procedures.
- The service had enough nursing and medical staff who knew the patients and received training to keep people safe from avoidable harm. The service provided mandatory training in key skills to all staff and the majority of the staff had completed it, although this fell short of the trust's target. This had improved since our last inspection.
- Staff completed and updated comprehensive risk assessments for each patient using the trust's risk assessment tool. This was an improvement from our last inspection. Staff in the health-based places of safety followed best practice and the Mental Health Act when restricting patients' freedoms to keep them and others safe.
- Staff understood how to protect patients from abuse and the service worked effectively with other agencies such as the local authority in a joint effort to protect patients. The trust trained staff in safeguarding vulnerable adults and children.
- None of the home treatment teams operated waiting lists and there was no maximum caseload number which ensured that patients who were referred in an emergency could be taken on by the team.
- Staff used electronic records to keep information updated about individual patients. Staff knew what incidents to report and how to report them and we saw improvements happened following learning from incidents, although learning was not always shared between the home treatment teams.

However:

- Staff and patients reported that the Safe havens were on occasion closed at short notice due to staffing issues. The trust had agreed a Safe Haven business continuity plan with all partners which planned how organisations would work together to keep services safe and open whenever possible.
- Despite action from the trust, there was still some uncertainty amongst staff as to who was responsible for storing and administering patients' own regular medication whilst in the health-based places of safety. However, the trust told us that a new policy was in the process of being written.
- The Chertsey health-based place of safety had some raised screw heads which could cause injury to a patient.



# Mental health crisis services and health-based places of safety

- In the health-based places of safety, we saw one occasion where the medical rationale for rapid tranquilisation for a patient was not recorded but the trust confirmed to us after our inspection that this was recorded. We also did not see staff recording their observations of patients following the use of rapid tranquilisation.

## Is the service effective?

Good   

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

- All patients had individual care plans and these were regularly updated by the team. All home treatment teams held effective and concise morning meetings to discuss the patients on their caseloads.
- Staff provided a range of treatment and care for patients based on national guidance. Patients in the home treatment teams had access to a range of treatments and support including psychological therapies and medication. Staff in the teams worked with local authorities and third sector organisations in the community to signpost patients where they were unable to provide direct support or advice, for example, relating to housing issues.
- In accordance with the Mental Health Act Code of Practice, both health-based places of safety recorded each person's time of arrival and times of assessment. We saw accurate recording of the start times of detention. This was an improvement from our last inspection. Very few patients were kept in the health-based place of safety for longer than 24 hours, in accordance with the recent change in the law.
- 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.
- 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 consisted of a range of health care professionals including doctors, nurses, healthcare assistants, social workers and psychologists.
- Staff understood their roles and responsibilities under the Mental Health Act and the Mental Capacity Act.

However:

- Whilst we saw improvements from our previous inspection, such as the plans being holistic, some care plans were not detailed nor representative of the work carried out by the home treatment teams.
- Staff had concerns that the shortfall in staff for the Single Point of Access would impact on the home treatment team staff. However, the trust had spoken to staff as part of the consultation process and explained that they would not be asked to work in two teams at the same time. To date no home treatment team staff have been required to cover the Single Point of Access.
- Staff had not ensured that patients in the health-based place of safety at the Abraham Cowley Unit had access to a suitable range of safe crockery for meal times.

## Is the service caring?

Good   

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

# Mental health crisis services and health-based places of safety

- Staff treated patients with compassion and kindness. They respected patients' dignity and supported them with their individual needs. The patient we spoke with was positive about the care and treatment they had received.
- Staff involved patients and those close to them in decisions about their care, treatment and changes to the services. Patients told us that they had been involved in making decisions about their care and treatment

## Is the service responsive?

Good  → ←

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

- People could access the services when they needed it. Patients who needed support in a crisis were referred to the home treatment teams and assessed in a timely manner. The health-based places of safety were open to all people who may need it, including children and young people under the age of 18 and people who presented as intoxicated.
- The services took into account patients' individual needs, interpreters were easily accessed where needed. Most patients were seen at home by the home treatment teams and the teams were able to be flexible with appointments. Health-based places of safety were accessible for patients who may have had mobility impairments.
- Staff had a good understanding of the complaints processes.

## Is the service well-led?

Good  ↑

Our rating of well-led improved. We rated it as good because:

- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.
- Staff knew and understood the provider's vision and values and how they were applied in the work of the team. Staff at all three home treatment teams were complimentary about their colleagues of all disciplines.
- Staff had implemented recommendations from reviews of deaths, incidents, complaints, and safeguarding alerts.
- Staff maintained and had access to the trust risk register at a service and team level

## 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 the quality of services.

### Action the trust **SHOULD** take to improve

- The trust should ensure that staff always record the medical rationale for the use of rapid tranquilisation.
- The trust should ensure that physical observations are recorded by staff.
- The trust should consider improving the care plans and ensuring consistency across all three home treatment teams.

# Mental health crisis services and health-based places of safety

- The trust should consider improving how learning from deaths, serious incidents and complaints is shared with all staff and between the different home treatment teams and health-based places of safety.
- The trust should consider a review of the staffing needs of the Safe Havens to avoid unplanned closures.

# Specialist community mental health services for children and young people

Good   

## Key facts and figures

Surrey and Borders Partnership NHS Foundation Trust provides specialist community mental health services for children and young people up to the age of 18 across Surrey.

The child and adolescent mental health service (CAMHS) provides assessment and treatments for children and young people with moderate to severe emotional, mental health, or behavioural difficulties.

The service forms part of a broader coalition of mental health services known as Mindsight Surrey CAMHS which includes other third sector and private providers delivering mental health and learning disability services to children and young people. The referrals for Mindsight Surrey CAMHS teams are received by a single point of access team known as One Stop.

In early 2018, the service was experiencing high numbers of patients waiting for assessment and the trust developed an interim plan to address this. This involved a slow-down of referrals to the CAMHS community teams for a period of 16 weeks June - October 2018. The trust developed a communication and risk plan for this initiative and communicated with commissioners, stakeholders and patients and carers. The service opened to all referrals again in October 2018. Crisis and urgent referrals were not affected by this plan.

The service was last inspected in March 2016 and was rated as good overall. We rated the Safe domain as requires improvement because staff did not always assess patient risks and do all that was necessary to mitigate these, and staff were not always receiving adequate supervision and appraisal. CQC issued two requirement notices in relation to these and at this inspection we found that the trust had made improvements and was compliant with patient risk assessment and provided adequate appraisal and supervision to staff.

The trust has four CAMHS community teams organised to cover four geographic divisions and these were provided from eight bases. The trust provides four CYP Havens in partnership with other agencies for children and young people aged 10-18. They provide an evening and weekend support and advice service for young people with mental health issues staffed by youth workers and a mental health nurse. Young people can drop in to the service without an appointment and receive mental health guidance and support.

On this inspection, we visited three CAMHS community teams at three locations. We also visited one children and young person's Haven in Guildford. The teams we inspected were:

CAMHS North East, Epsom

CAMHS South East, Redhill

CAMHS South West, Guildford

CYP Haven, Guildford.

Our inspection was a short-notice announced inspection (staff knew we were coming) to ensure that everyone we needed to talk to was available. However, the service was only given two working days' notice to enable us to observe routine activity.

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

During the inspection visit, the inspection team:

# Specialist community mental health services for children and young people

- spoke with five team managers
- spoke with 10 carers and five patients across the service
- spoke with five consultant psychiatrists across the service
- spoke with 16 other members of the multidisciplinary team including nurses, social workers, therapists, psychologists and primary mental health workers
- reviewed 17 care records relating to patient risk assessments, risk management plans and care plans
- observed two assessments and one patient therapy session
- carried out specific checks of the environment at three locations
- looked at a range of policies, procedures and other documentation 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:

- Patients were kept safe because staff assessed risks and worked with patients to make plans for times of crisis.
- There were low levels of staff vacancies. Staff caseload numbers had come down to levels which allowed them the time to carry out all their role and support patients on their caseload.
- Staff understood how to protect patients from abuse, and complaints and incidents were effectively investigated and learning shared with the team.
- Patients had care plans which were based on their assessed needs. Patients had access to a range of specific treatment pathways and therapeutic interventions for patients that were all evidence-based and aligned with the National Institute for Health and Care Excellence (NICE) guidelines.
- Managers made sure they had staff with a range of skills needed to provide high quality care. Staff were positive and supportive of each other's well-being, and received regular supervision.
- Patients and carers said that the service had a positive impact on their wellbeing. They spoke positively about the attitudes and the contacts they had with staff. The service delivered a variety of additional workshops and training to equip patients and carers with skills and tools to understand their mental health and better manage their conditions.
- The service worked with youth advisors to get feedback about the service and involved them in making improvements to the service.
- The trust had a vision for what it wanted to achieve in transforming the performance of the service. Staff, patients and other stakeholders were aware and included in the vision.
- There were robust governance processes in place with team forums to discuss clinical and business matters, and regular meetings with other stakeholders in the CAMHS pathway.

However:

- While the service had significantly improved its waiting time for assessments and could meet its target for generic assessments, it was not reaching its target for waiting times to treatment. In many treatment pathways, the trust was not matching the national standard of 18 weeks from referral to treatment.

# Specialist community mental health services for children and young people

- There was variance in where staff recorded clinical information on the trust's electronic information system which meant that, in some records, information was not easily located.
- The trust management information reporting did not accurately reflect the current configuration of the four teams.
- The CAMHS completion rates for appraisal, at 86%, was lower than the trust target of 93%.

## Is the service safe?

Good  

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

- At our last inspection CQC had concerns that patients' risks were not adequately assessed and that the service was not doing all it could to mitigate these risks. On this inspection, we found all patients had a risk assessment in their care records and risk was frequently discussed and considered by staff members in multiple multidisciplinary team meetings.
- There was a range of consultation rooms for patients to meet with staff which were clean and there was equipment to carry out basic physical health assessments.
- Patients with medium or high risks had detailed crisis and contingency plans. The format of the plans had been devised with consultation from young people using the service.
- Clinicians' caseloads had been reduced to manageable levels. Caseloads were monitored and discussed in each team. Risks to patients who were on treatment waiting lists were well monitored and staff maintained contact with waiting patients.
- 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.
- The teams had few vacant posts and recruitment activity was taking place for current vacancies.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons with the whole team and the wider service.

However:

- There was variance in where staff placed clinical information on the trust's electronic information system which meant that, in some records, information was not easily located.

## Is the service effective?

Good   

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

- At our last inspection CQC had concerns that staff were not receiving adequate supervision to carry out their roles. At this inspection we found staff were receiving regular supervision and had opportunities to update and further develop skills. Managers made sure they had staff with a range of skills needed to provide high quality care.
- The service ran a range of specific treatment pathways and therapeutic interventions for patients that were all evidence-based and aligned with the National Institute for Health and Care Excellence (NICE) guidelines.

# Specialist community mental health services for children and young people

- The service was developing a range of therapeutic group interventions that ensured that patients could be seen sooner by the service and staff managed the risks of patients on waiting lists well.
- Care records we reviewed contained a detailed care plan that was regularly updated and reviewed.
- The service monitored and managed patients' physical health needs appropriately. There were good working relationships with GPs to arrange further testing and provide support.
- Routine outcome measures were frequently recorded to provide feedback to clinicians on the effectiveness of treatments.
- Staff from different disciplines worked together as a team to benefit patients. Staff were positive and supportive of each other's well-being.
- Staff understood their roles under the Mental Health Act and staff recorded that they had explained patients' rights to them.

However:

- The CAMHS completion rate for appraisal, at 86%, was lower than the trust target of 93%.

## 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, and supported their individual needs.
- Patients and carers spoke positively about the attitudes and the contacts they had with staff. We witnessed staff speaking sensitively and respectfully in all interactions regarding patients.
- The service delivered a variety of additional workshops and training to equip patients and carers with skills and tools to understand their mental health and better manage their conditions.
- Staff could access signers, translators and could produce easy-read leaflets when needed. Each service we visited had a large selection of leaflets in various age appropriate formats.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The service worked with youth advisors to get feedback about the service and involved them in making improvements to the service.

## Is the service responsive?

**Requires improvement** ● ↓

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

- While the service had significantly improved its waiting time for assessment and could meet its target for generic assessments, it was not reaching its target for waiting times for treatment. There was broad variance in the waiting times on different treatment pathways and these also varied across the individual CAMHS teams. In many treatment

# Specialist community mental health services for children and young people

pathways the trust was not matching the national standard of 18 weeks from referral to treatment. An average waiting time for cognitive behavioural treatment was 26-30 weeks. For psychotherapy patients were waiting between 12-24 weeks dependent upon which team was providing the treatment. This was true also for cognitive assessment where in one team the waiting time was 24 weeks and in another it was 60 weeks.

However:

- Staff supported patients with activities outside the service such as education and family relationships.
- The service was accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support.
- Patients had access to a team duty system and could see a doctor urgently if they needed to.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with staff.

## Is the service well-led?

Good   

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

- There were managers in the teams with the right experience and abilities to lead the teams in delivering good standards of care.
- The trust had a vision for what it wanted to achieve in transforming the performance of the service. Staff, patients and other stakeholders were aware and included in the vision. There had been improvements to the waiting times to assessments and the trust had an improvement strategy to make improvements to the wait times to treatment.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There were robust governance processes in place with team forums to discuss clinical and business matters, and regular meetings with other stakeholders in the CAMHS pathway.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and the unexpected.

However:

- Managers at times required extra assistance to interpret data about their team performance as the trust management information did not accurately reflect the current configuration of the four teams.

## Outstanding practice

- Following on from the success of the adult safe havens, the trust has opened four children and young people's safe havens in partnership with other agencies for children and young people aged 10-18. They provide an evening and weekend support and advice service for young people with mental health issues staffed by youth workers and a mental health nurse. Young people can drop in to the service without an appointment and receive mental health guidance and support.



# Specialist community mental health services for children and young people

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust **should** take to improve

- The trust should ensure it implements the improvement plan to address the waiting times to treatment in the CAMHS teams to meet trust targets and national guidance.
- The trust should ensure that standards for the recording of clinical information on Systmone are clear and that staff follow these consistently.
- The trust should ensure that CAMHS staff appraisal rates meet the trust target.
- The trust should consider improving the team performance data so that it adequately reflects the current composition of the CAMHS service.

# 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 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, Guildford

- 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.

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

At the last inspection, the service had two key questions (safe and well led) rated as requires improvement so our re-inspection included looking at those key questions.

Our inspection took place on 11, 12 and 13 December 2018. It was unannounced, which means that staff did not know we were coming, to enable us to observe routine activity.

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 six out of seven inpatient wards, we did not inspect Mulberry ward. We looked at the quality of the environments and observed staff caring for patients
- spoke with 18 patients who were using the service
- spoke with three carers of people using the service
- spoke with 33 members of staff, including ward managers, medical staff (including consultant psychiatrists), psychologists, physiotherapists, nurses, nursing assistants and occupational therapists
- attended and observed three multidisciplinary team review meetings
- reviewed 45 patient medicine administration charts
- carried out a specific check of the medicine management on the wards
- reviewed 29 care and treatment records including the Mental Health Act documentation of detained patients

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

- looked at a range of policies, procedures and other documents relating to the running of the service.
- conducted three short observational framework for inspection (SOFI) sessions
- attended and observed four activity sessions, three handover meetings, one community meeting, one nursing staff meeting and one bed flow management meeting.

## Summary of this service

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

- The wards had enough nurses and doctors and were safe and clean. 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.
- Risk assessments were regularly reviewed and updated following incidents. Learning from incidents was happening and being shared across the core service.
- The wards minimised the use of restrictive practices and followed good practice with respect to safeguarding. Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- Staff understood and carried out their roles and responsibilities under the Mental Health Act and the Mental Capacity Act.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. Staff involved patients in care planning and risk assessment. They actively involved patients and families and carers in care decisions and actively sought their feedback on the quality of care provided.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- The wards at the Abraham Cowley Unit are not designed for modern mental health care. The staff had implemented many procedures to mitigate this but the physical construction of the building meant there were lots of blind spots which were difficult to observe easily and its layout did not fully promote dignity and privacy due to the dormitory bedrooms and communal bathrooms.

## Is the service safe?

**Good** ● ↑

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

- The ward environments were safe and clean.

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

- The service had enough nursing and medical staff who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risk well. Patients' risk assessments were regularly reviewed and updated following incidents. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. 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.
- Staff followed good practice with respect to safeguarding. They understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- 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 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 are not designed for modern mental healthcare. 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.

## 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 were 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 through good physical healthcare clinics 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 needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. The trust provided an induction programme for new staff and each ward had an adapted version for use when new starters first came onto the ward.

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

- 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.
- 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 to make specific decisions.

## 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 whenever possible. 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. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

## 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 and a clinical reason. Discharge was rarely delayed for other than clinical reasons.
- 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. This was not the case at the Abraham Cowley Unit. 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 wards met the needs of all people who used the service – 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 the whole team and the wider service.

However:

- The Abraham Cowley Unit was not designed for modern mental health care, its layout did not fully promote dignity and privacy due to the dormitory bedrooms and communal bathrooms. The trust had plans to redevelop the building so that the dormitory accommodation would be eliminated by the end of 2022.

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

## Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- The whole core service had significantly improved the quality of the care it was providing. This was due to the development of the leadership across the two hospital sites. The strength of leadership had motivated the old staff and developed the new staff by using quality improvement programmes to review their systems and processes and to affect a positive and safe change.
- 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 how they were applied in the work of their team.
- 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 ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local quality improvement activities.

## 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 the quality of services.

### Action the trust **SHOULD** take to improve

- The trust should ensure its plans to redevelop the Abraham Cowley Unit include the elimination of dormitory bedrooms at the earliest opportunity.

# Wards for older people with mental health problems

Good   

## Key facts and figures

Surrey and Borders Partnership NHS Foundation Trust provides inpatient services for older people with mental health problems. Some patients are detained under the Mental Health Act 1983. The trust provides 68 beds across three sites:

### **Abraham Cowley Unit, Chertsey**

- Spenser ward is a 20-bed acute assessment and treatment inpatient unit for females with functional mental health problems.

### **The Meadows, Epsom**

The Meadows operates as a single ward, comprising three smaller units:

- Bluebell 1 is an eight-bed unit for males with dementia
- Bluebell 2 is an eight-bed unit for females with dementia
- Primrose 1 is an eight-bed unit for females with functional mental health problems.

### **Farnham Road hospital, Guildford**

- Victoria ward is a 24-bed mixed-gender unit for people with functional mental health problems.

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

Our inspection took place on 11, 12 and 13 December 2018. It was unannounced, which means that staff did not know we were coming, to enable us to observe routine activity. We carried out a supplementary visit to The Meadows on 20 December 2018.

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 three inpatient wards, looked at the quality of the environments and observed staff caring for patients
- spoke with 10 patients who were using the service
- spoke with four carers of people using the service
- spoke with 28 members of staff, including matrons, ward managers, medical staff (including consultant psychiatrists), psychologists, physiotherapists, nurses, nursing assistants and occupational therapists
- attended and observed two multidisciplinary team review meetings
- reviewed 26 patient medicine administration charts
- carried out a specific check of the medicine management on the wards
- reviewed 23 care and treatment records including the Mental Health Act documentation of detained patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

# Wards for older people with mental health problems

- conducted two short observational framework for inspection (SOFI) sessions
- attended and observed two activity sessions, one therapy planning meeting and one weekly bed management meeting.

## Summary of this service

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

- Staff stored, dispensed, administered and recorded patient medicine appropriately. Staff received support from pharmacists, who visited each ward regularly. Clinic rooms on all wards were fully equipped with accessible resuscitation equipment and emergency drugs which staff checked regularly.
- Staff we spoke with knew what type of incidents they should report and knew how to report them. Staff attended a weekly meeting on their ward, that focused solely on sharing information and learning about recent incidents.
- Patients had good access to physical healthcare. Staff could obtain support from a range of health professionals, such as a physical health lead nurse, dietitians and physiotherapists.
- Managers from all three sites met once a week for a bed management meeting to discuss planned and potential patient admissions, discharges and transfers within the service. All wards held weekly multidisciplinary meetings to review the care and treatment for individual patients.
- Staff treated patients in a caring, respectful and responsive manner. Staff displayed a high level of understanding of the individual needs and abilities of patients. Patients and carers we spoke with told us they were happy with the care provided by staff.
- Staff involved patients and carers when formulating care plans and risk assessments. Staff invited carers to attend weekly multidisciplinary team meetings to discuss developments in the care of their relative.
- Staff could access interpreters as needed. Staff had attempted to support one patient who did not communicate in English by learning some basic phrases in their preferred language.
- The internal environment in each ward had level access and therefore was suitable for people with restricted mobility. Two of the three units within The Meadows (called Bluebell 1 and Bluebell 2) had been assigned to accommodate patients with dementia. The environment within the two Bluebell units had been adapted with dementia friendly colour schemes, fittings and signage.
- Ward managers and matrons in this core service had the skills, knowledge and experience to perform their roles. Staff told us they felt able to raise concerns and propose suggestions to improve the service without fear of being victimised.
- Staff on Spenser ward had secured funding for a pilot project to study the therapeutic benefits of dog therapy in an inpatient setting for older people. The aim was to examine the effects of dog therapy sessions on patients with an affective disorder, such as depression.

However:

- Staff had not adhered to trust policy in establishing a robust physical observations baseline for new patients. The trust's policy stated an expectation that all newly admitted patients should have physical observations carried out by staff at least twice daily during their first three days of admission. On Spenser ward, none of the eight records we reviewed had had a baseline established in line with trust policy.



# Wards for older people with mental health problems

- Team meetings and supervision sessions took place only sporadically on The Meadows and Victoria ward. Managers from both wards cited pressures caused by staffing vacancies and the high demands of their patient groups as reasons for their team meetings not taking place at the scheduled monthly intervals. This core service did not meet the trust's target rate for appraisal compliance.
- Patients on Victoria ward did not have easy access to a garden.
- This core service had a significant level of staffing vacancies. Staff we spoke with cited the impact of vacancies on the team and the running of the service as their primary concern. They spoke of the extra stress placed on substantive staff when the ward was operating with a high proportion of bank or agency workers.
- Staff appeared to have limited knowledge of specific learning from the review into a death within this core service in 2016.
- Most patients on Spenser ward were placed in one of three shared dormitories. Proposed plans to redevelop the Abraham Cowley Unit incorporated the removal of dormitories on Spenser ward.

## Is the service safe?

**Good**  

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

- Staff stored, dispensed, administered and recorded patient medicine appropriately. Staff received support from pharmacists, who visited each ward regularly.
- Clinic rooms on all wards were fully equipped with accessible resuscitation equipment and emergency drugs which staff checked regularly. All clinic rooms were well maintained, organised and clean.
- Staff we spoke with knew what type of incidents they should report and knew how to report them. Staff submitted incident reports using the 'Datix' electronic system. Staff on each ward attended a weekly meeting, that focused solely on sharing information and learning about recent incidents.
- Staff completed comprehensive risk assessments for each patient and updated them following incidents. Staff worked with colleagues from community teams to best ensure that risks were effectively managed when each patient was ready to leave the ward.
- Staff conducted a comprehensive annual audit of ligature anchor points for each ward. The Bluebell 1 and Bluebell 2 units at The Meadows operated as dementia-friendly environments and as such were equipped with appropriate fixtures and fittings for the patient group. Staff had appropriately risk assessed dementia-friendly taps, hand rails and other potential ligature risks within the two Bluebell units.
- There were no concerns in relation to the mixed-gender environment on Victoria ward. The other units operated as single-gender facilities.
- Staff we spoke with understood the trust's safeguarding policy and procedures on how to raise a safeguarding referral. Approximately 90% of staff had completed the elements of safeguarding training in relation to risks to adults and children.
- There was adequate medical cover across all wards day and night which meant that a doctor could attend quickly in the event of a medical emergency.

# Wards for older people with mental health problems

- No instances of prone restraint or seclusion were reported to have occurred during the 12-month period September 2017 to August 2018. Prone restraint is face down restraint where the individual cannot freely move from that position.
- Wherever possible, ward managers used bank or agency workers who were familiar with their ward and its patients. Wards block-booked some bank and agency staff, to maximise continuity of care.

However:

- This core service had a significant level of staffing vacancies. As of 31 August 2018, qualified nursing vacancies represented 27% of establishment staffing levels and nursing assistant vacancies represented 18% of establishment staffing levels. The ward with the highest level of vacancies was The Meadows, which had a qualified nursing vacancy level of 37% and a nursing assistant vacancy level of 26%. However, the wards had secured long-term agency placement staff to cover some staff vacancies.
- There were some blind corners within wards (particularly Victoria ward). Staff managed the risks with hourly checks.
- Patients at The Meadows and Spenser ward could not control their bedroom door viewing panel from inside their room. Staff had external control of the vision panels and kept them closed, to safeguard the privacy and dignity of the occupant.

## Is the service effective?

**Good**   

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

- Staff had completed up-to-date training in the Mental Capacity Act. Staff we spoke with had a good understanding of the Mental Capacity Act and its five statutory principles. The trust had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Patients could access specialist independent mental health and mental capacity advocacy. There was information displayed within each ward on how to contact the advocacy service.
- Most staff had completed up-to-date training in the Mental Health Act. Staff had access to trust policies and procedures on the application of the Mental Health Act and had access to appropriate administrative support and legal advice from a central team within the trust. Staff requested the input of a second opinion appointed doctor when necessary and carried out regular audits of Mental Health Act documentation. Staff explained patients' rights to them at the point of admission and at regular intervals thereafter.
- Patients had good access to physical healthcare. Staff could obtain support from a range of health professionals, such as a physical health lead nurse, dieticians and physiotherapists.
- Staff were experienced and had the right skills and knowledge to meet the needs of the patient group.
- The ward teams had access to a comprehensive range of specialists required to meet the needs of patients. As well as doctors and nurses, each ward team comprised occupational therapy and psychology staff. Pharmacists and social workers visited each ward regularly. Other health professionals, such as speech and language therapists, dieticians and physiotherapists were available as part of the substantive staffing compliment.
- Staff we spoke with felt that managers supported them to access training appropriate to their current role and to support their continual professional development.
- New members of staff received a corporate induction from the trust and a ward-based induction from the manager and team leaders.

# Wards for older people with mental health problems

However:

- In the majority of care records we reviewed, staff had not adhered to trust policy in establishing a robust physical observations baseline for new patients who had not been identified on admission as having a serious physical health problem. For example, on Spenser ward, none of the eight records we reviewed had had a baseline established in line with trust policy. The trust's policy stated an expectation that all newly admitted patients should have physical observations carried out on them by staff at least twice daily for during their first three days of admission. The tool used by the trust for physical observations was the modified early warning score (MEWS) for clinical deterioration.
- Staff supervision frequencies on The Meadows and Victoria ward were variable. Some members of staff received supervision every four to eight weeks, but other members of staff received supervision only every three to four months. Managers from both wards cited pressures caused by staffing vacancies and the high demands of their patient groups as reasons why staff did not consistently receive supervision more frequently.
- Team meetings on The Meadows and Victoria ward occurred only sporadically, every two to three months. Managers from both wards cited pressures caused by staffing vacancies and the high demands of their patient groups as reasons for their team meetings not taking place at the scheduled monthly intervals.

## Is the service caring?

Good   

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

- Staff treated patients in a caring, respectful and responsive manner. Staff displayed a high level of understanding of the individual needs and abilities of patients. Patients and carers we spoke with told us they were happy with the care provided by staff.
- Staff used the admission process to inform and orient patients to the ward and to the service.
- Staff involved patients when formulating care plans and risk assessments. Staff offered patients a copy of their individual care plan and risk assessment and recorded if the patient accepted a copy.
- Patients could provide feedback on the service during weekly community meetings.
- Staff invited carers to attend weekly multidisciplinary team meetings to discuss developments in the care of their relative. Staff sought input from carers when formulating individual risk assessments and care plans. Carers we spoke with said they felt involved in their relative's care.
- Staff organised events where patients and carers could jointly attend, such as regular musical performance and cream teas held at The Meadows.
- Patients could access general and specialist advocacy support from an advocacy service that visited each ward on a weekly basis. Posters were displayed on each ward informing patients of advocacy services available.

## Is the service responsive?

Good   

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

# Wards for older people with mental health problems

- Staff supported patients in planning ahead for their discharge by involving community mental health teams and carers from the point of admission. Managers participated in a weekly bed management meeting, where they discussed planned and potential patient admissions, discharges and transfers within the service.
- Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient.
- Staff at The Meadows had created an excellent reminiscence room, for use by patients.
- Patients had a lockable space in their bedroom, or bed space in the case of patients on dormitories on Spenser ward. Patients could also store valuable items in the ward safe.
- Every ward had a well-equipped clinic room that was large enough to enable staff to conduct physical examinations on patients.
- The internal environment in each ward was level access and therefore suitable for people with restricted mobility.
- Staff could access interpreters as needed. Staff had attempted to support one patient who did not communicate in English by learning some basic phrases in their preferred language.

Two of the three units within The Meadows (called Bluebell 1 and Bluebell 2) had been assigned to accommodate patients with dementia. The environment within the two Bluebell units had been adapted with dementia friendly colour schemes, fittings and signage.

- Information about the complaints process was displayed on ward notice boards and contained within the information pack issued to new patients. Staff received feedback on the outcome of complaints.

However:

- Patients on Victoria ward did not have easy access to a garden.

Staff were unable to offer patients dementia friendly food menus, due to a lack of cooperation from their food supplier.

Most patients on Spenser ward were placed in one of three shared dormitories. Proposed plans to redevelop the Abraham Cowley Unit incorporated the removal of dormitories on Spenser ward.

## Is the service well-led?

Good  ➡ ➡

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

- Ward managers and matrons in this core service had the skills, knowledge and experience to perform their roles. They maintained a visible presence in their wards to provide support to staff and patients.
- Staff we spoke with said they felt able to raise concerns and propose suggestions to improve the service without fear of being victimised. Staff were familiar with the trust's whistleblowing policy and the role of the freedom to speak up guardian. They told us that each of the ward managers and modern matrons were approachable and open to feedback.
- All staff we spoke with contributed their ideas towards the development of their wards and the core service.
- Staff on each ward met for a weekly meeting, specifically to discuss recent incidents.
- Staff took part in clinical audits, which were regularly reviewed to identify areas for improvement.

# Wards for older people with mental health problems

- Staff we spoke with had a good understanding of the arrangements in place for working with other services within the trust and with external agencies.
- One member of staff at The Meadows had visited Ireland, to complete training in the delivery of multi-sensory therapeutic activity sessions for people with dementia. The training was unavailable in England.
- Staff on Spenser ward had secured funding for a pilot project to study the therapeutic benefits of dog therapy in an inpatient setting for older people. The aim was to examine the effects of dog therapy sessions on patients with an affective disorder, such as depression.

However:

- Some staff on Spenser ward expressed concern at the lack of clear communication from senior managers within the trust. The concerns centred around the planned redevelopment of the Abraham Cowley Unit site and if Spenser ward was due to be included within the plans.
- Staff we spoke with cited the impact of high levels of staff vacancies on the team and the running of the service as their primary concern. They spoke of the extra stress placed on substantive staff when the ward was operating with a high proportion of bank or agency workers.
- Staff appeared to have limited knowledge of specific learning from the review into a death within this core service in 2016.

## 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 the quality of services.

### **Action the trust SHOULD take to improve**

- The trust should ensure that staff meetings take place regularly on all wards.
- The trust should ensure that all staff receive regular supervision.
- The trust should include the removal of dormitories in their plans to redevelop Spenser ward.
- The trust should ensure that all patients are able to internally control the viewing panel in their bedroom door.
- The trust should ensure that staff adhere to trust policy in establishing a baseline for physical observations on all newly admitted patients.
- The trust should ensure that patients on all wards have easy access to a garden.

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](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://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

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

# 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 and 14 specialist advisers.

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