Surrey and Borders Partnership NHS Foundation Trust

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

Quality Report

St Peters Site
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Follow up visit 27 April 2017
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXXZ4	St Peter's Site	Blake Ward	KT16 0QA
RXXZ4	St Peter's Site	Anderson Ward	KT16 0QA
RXXZ4	St Peter's Site	Clare Ward	KT16 0QA

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

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

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

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We found the following issues that the provider needed to improve:

- One of the wards contained dormitories. The dormitories were poorly lit during the day and had restricted space around the bed areas also we observed clinical conversations happening in bed spaces while patients were opposite, this meant the conversations were easily overheard
- The layout of all wards meant that observing patients was challenging for the staff. In particular the semi-circular layout of Blake ward and the position of the ward office at one end made it particularly difficult to ensure all areas of the ward were easily observed.
- When we looked at the care records we found 14 of the 23 sets reviewed did not have a care plan that was recovery orientated or highlighted the individual patient's full range of strengths and weaknesses. In addition five of the patient's on Clare ward did not have any care plans in place.
- The modified early warning score (MEWS) was being inconsistently applied to the patient's. Out of the 23 sets of care records reviewed none of the MEWS charts observed were being scored at the time of the inspection.

However we found the following areas of good practice:

- Safety was being considered on a regular basis when the ward managers had twice daily safety calls with the service line leads. This ensured that discussions around safe staffing levels and the skill mix of the staff on each ward was reviewed and addressed. It also reviewed how staff were managing keys and personal alarms safely.
- Wards used a reporting system for incidents called Datix and the staff on the wards had regular "Datix huddle" meetings to review the incidents for each of the wards over the previous seven days.
- On Blake ward there was a multi disciplinary conference call every day which was attended by the consultant, associate specialist, the ward doctor, representatives from the home treatment team, the community mental health teams and the ward nursing team.
- We could see that supervision was happening and ward managers had developed their own method to make sure supervisions were happening. Appraisal levels were at 100% across all three wards in March 2017.

Due to the issues described as concerns above, the CQC issued a letter of concern, highlighting these issues. The management team addressed these issues and created a plan and response by the 21 April 2017. We revisited the hospital on the 27 April 2017 and found that the issues that were not influenced by changing the environment of the hospital had been addressed. The care plans and risk assessments for patients had all been reviewed and updated and physical health monitoring was taking place and being recorded consistently.

However the dormitories and the physical layout of the ward remained as described in this report

Summary of findings

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

Are services safe?

We found the following issues that the provider needed to improve;

- the dormitories were poorly lit during the day and had restricted space around the bed areas
- clinical conversations were happening in bed spaces while patients were opposite, this meant the conversations were easily overheard
- the layout of all wards meant that observing patients was challenging for the staff. In particular the semi-circular layout of Blake ward and the position of the ward office at one end made it particularly difficult to ensure all areas of the ward were easily observed.

We found the following areas of good practice:

- there were systems in place to support staff to manage keys and personal alarms safely
- the ward managers had twice daily safety calls with the service line leads to ensure that discussions around safe staffing levels and the skill mix of the staff on each ward was reviewed and addressed
- the wards were having regular "Datix huddle" meetings to review the incidents for each of the wards over the previous seven days.

Are services effective?

We found the following areas of good practice:

- there was a system in place for ward managers to complete a weekly audit of care plans which was shared with the modern matron.
- on Blake ward there was a multidisciplinary conference call every day which was attended by the consultant, associate specialist, the ward doctor, representatives from the home treatment team, the community mental health teams and the ward nursing team.
- appraisal levels were at 100% across all three wards in March 2017.
- at a local level we could see that supervision was happening and ward managers had their own individual systems for tracking their team.

However we found the following issues that the provider needed to improve:

Summary of findings

- fourteen of the 23 sets of patient care records reviewed did not have a care plan that was recovery orientated or highlighted the individual patient's full range of strengths and weaknesses. Five of the patient's on Clare ward did not have any care plans in place.
- the physical health monitoring tool was being inconsistently applied to the patient's. Out of the 23 sets of care records reviewed none of the MEWS charts observed were being scored

Summary of findings

Information about the service

The Abraham Cowley Unit has three adult and psychiatric intensive care wards (PICU) wards:

• Clare Ward - 20 bed male ward for patients from Elmbridge, Epsom and Ewell

• Anderson Ward- 13 bed female ward for patients from Elmbridge, Epsom and Ewell

• Blake ward - a 20 bed mixed gender ward for patients from Surrey Heath, Runnymede and Spelthorne.

We last inspected the Abraham Cowley unit in March 2016 as part of the trust comprehensive inspection. During that inspection, we found the trust had breached three of the regulations of the Health and Social Care Act 2008 (2014). These were:

Regulation 12 Safe care and treatment:

The provider had not ensured the proper and safe management of medicines. Staff did not follow policies and procedures about managing medicines, including those related to administration, disposal and recording. This was a breach of regulation 12(2) (g).

Regulation 18 Staffing.

The provider did not ensure that staff received appropriate training and appraisal to enable them to carry out the duties they were employed to perform. Staff compliance with mandatory training was below acceptable targets. Some staff had not received an appraisal. This was a breach of regulation 18 (1) (2) (a).

Regulation 17 Good Governance

The provider did not ensure that there were systems or processes in place and operated effectively to ensure incidents and risks were assessed and monitored. There was a lack of governance and oversight of the incident reporting system. Incidents were reported by front line staff but they were not viewed by the ward managers on Delius and Elgar wards. This meant there was no assurance that potentially serious incidents were fully investigated or escalated to the attention of the service manager and matron. Risk assessments were not consistently reviewed and updated following incidents. This was a breach of regulation 17(1)(2)(a)(b)(c)

Our inspection team

The team responsible for inspecting the Abraham Cowley Unit was led by:

Team Leader: James Whittle, Inspector, Care Quality Commission (CQC).

The team that inspected acute wards for adults of working age and psychiatric intensive care unit comprised of 11 people; one pharmacist, four CQC inspectors, one Mental Health Act reviewer. It also included one CQC inspection manager and four specialist advisers who were mental health nurses and a psychiatric consultant with expertise in the care of adults with mental health problems.

Why we carried out this inspection

This inspection was an unannounced focused inspection triggered by information of concern raised to the Care Quality Commission regarding the safety of the patients at The Abraham Cowley Unit following the trust notifying CQC that a patient had died on one of the adult inpatient wards at the Unit. The information related to poor care planning and risk assessments across the inpatient wards, this meant that there was a concern that patients were not being safely cared for.

When we last inspected the trust in March 2016 we rated acute wards for adults of working age and psychiatric intensive care unit (PICU) as requires improvement

Summary of findings

overall. We rated the inspection areas as requires improvement for Safe, good for Effective, good for Caring, good for Responsive and requires improvement for Well-led.

On this inspection, as well as responding to the recent concerns, we assessed whether the trust had made improvements to the specific concerns we identified during our last inspection. We had issued requirement notices in relation to the safe management of medicines across the wards, the levels of appropriate training across the wards and monitoring of incidents and oversight of the incident reporting systems across the wards.

How we carried out this inspection

We asked the following questions of the service:

- ? Is it safe?
- ? Is it effective?

Before the inspection visit, we reviewed information that we held about this service and considered the action plan provided by the trust following our last comprehensive inspection.

During the unannounced inspection visit, the inspection team:

- Visited all three of the adult wards at the Abraham Cowley Unit and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service, parents of a patient and a patient liaison office
- spoke with the managers or deputy managers for each of the wards
- spoke with 12 other staff members; including doctors, nurses, health care assistants and pharmacists
- attended and observed three handovers and a ward round
- looked at 23 sets of care and treatment records of patients
- looked at 18 sets of prescription and administration cards and carried out a specific check of the medicine management on all wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

Due to the issues identified in this inspection, we revisited the hospital on the 27 April 2017 to ensure that the immediate issues in relation to safety had been addressed. The trust had taken immediate action to ensure the safety issues were addressed and this is described in the report.

What people who use the provider's services say

We spoke with nine patients during the inspection. Seven of the patients we spoke with told us they felt their property and possessions were not safe on their ward. Four of the patients did not like being in dormitory wards and stated they had little privacy from other patients. All patients felt daytime staff were caring and compassionate, however, two of the patients felt there was a difference at night when the night staff came in.

Five of the patients we spoke with told us they were not offered a copy of their care plan and did not feel involved in their care. One patient described how they felt their care plans were written based on their history before they came into hospital and not based on discussion and their involvement.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The Trust must ensure that the risks to patients accommodated in dormitories are mitigated by ensuring there are sufficient levels of light in the sleeping areas.

Summary of findings

- The Trust must ensure that clinical conversations do not happen in the dormitory areas.

Action the provider SHOULD take to improve

Action the provider Should take to improve:

- The trust should review their inpatient facilities for adults to remove dormitory bedrooms and replace these with single room accommodation for patients.

Surrey and Borders Partnership NHS Foundation Trust

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

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Clare ward	St Peters Site
Anderson ward	St Peters Site
Blake ward	St Peters Site

Are services safe?

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

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

Our findings

Safe and clean environment

- In the Abraham Cowley Unit all three wards had multiple areas throughout their ward environments where patients were not able to be seen easily by staff. This was due to the design of the building. This was partly mitigated by the use of convex mirrors and CCTV. However, staff were not assigned to watch it. The CCTV was used after an incident had occurred rather than a pro-active management strategy.
- A ligature point is something, which people can use to tie something to in order to strangle themselves. Staff told us that the risk of harm was minimised because they knew where the ligature point risks were and staff used an annual ligature audit to identify them. We reviewed all of these audits and found that they had been updated annually, as per trust policy on all four wards. This had last been completed in March 2017.
- All the shower rooms around the ward were kept locked at the time of the inspection and were opened by staff when requested by patients. This action had been implemented by the trust as a result of an incident on one of the wards. The toilets were unlocked to enable patients to access them freely.
- Clare and Anderson wards were single gender and complied with guidance on same sex accommodation.
- Blake ward was a mixed gender ward. Patients were accommodated in single sex dormitories. Single sex bathrooms were available opposite the dormitories. This meant that patients' privacy and dignity was compromised but not breached. A patient commented on how they found it difficult being on a mixed sex ward but they had no choice. There was a separate female lounge on Blake ward as well as the main shared lounge on all wards; this was accessible by female patients using their using their key fob. When we revisited the hospital on the 27 April we saw that all patients on Blake ward had a "mixed sex accommodation plan" and leaflets and posters were available for patients to help support them whilst they were an inpatient.
- Blake ward had separate male and female dormitory sleeping areas with four single rooms which could be used by either gender. The female dormitory on Blake ward had a fob operating system to allow the women patients to access the dormitory. During the first day of the inspection the female dormitory door had been propped open to stop it from closing. After discussion with the staff we were told the patients did this to stop the door from closing to make it easier and quicker to get in and out of the dormitory, but this also meant that males could access the female dormitory. This was addressed immediately by the ward staff and when we revisited on the 27 April 2017 this was no longer happening.
- The dormitories on Blake ward were poorly lit as there was only natural light at one end of the room. The natural light was blocked by the partitions making up the bed areas. This meant that patients sleeping nearest the door had dark and poorly lit bed spaces. There were bedside lights to support people to read but they were dim and patients told us they found the lack of natural light made them feel claustrophobic.
- During the inspection we observed nurses and doctors having clinical conversations with patients in their bed spaces, while other patients appeared to be asleep in bed opposite them with their curtain open. This meant that patient's privacy and dignity was compromised.
- The clinic rooms were clean and we could see that regular cleaning schedules were in place and being used. On Clare and Anderson wards there was medical equipment that was out of date for electrical testing and calibration. This was discussed with the ward managers who were not aware of any auditing system for calibrating the medical equipment other than the annual routine portable appliance testing (PAT). The routine PAT testing was being carried out the week of the unannounced inspection and we observed this occurring. The managers did not have a list of medical devices on the ward showing when they had last been calibrated and when they were next due, so did not know if the equipment was being used safely. When we questioned the managers about this they were able to contact the clinical medical devices team at trust headquarters who were able to provide the information from a central location.
- The wards all had up to date cleaning schedules and dedicated cleaning staff and the wards were regularly cleaned.

Are services safe?

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

- There was a system in place for ensuring keys and personal alarms were managed in a structured way. The bedrooms and bathrooms had nurse call buttons and we tested several of these and they were working effectively. Personal alarms were individually assigned to staff and on every shift there was a member of staff allocated to be a responder and these staff had up to date training in the trust recognised de-escalation and physical management training which is called MAYBO.

Safe staffing

- Staff rosters were checked with the ward manager or deputy manager on each of the four wards for the previous four weeks. In addition the trust supplied us information on bank staff and agency staff for the three months from December 2016 to January 2017. There were four nurse vacancies on Blake ward, four on Clare ward and five vacancies on Anderson ward. Health care assistant vacancies were one on Blake, two on Clare ward and one on Anderson ward. These high vacancies meant that the wards were using high numbers of bank and agency staff. On Blake ward the use of bank and agency staff on day duty had increased from 29% to 47% this meant that 47% of day shifts were covered by bank and agency staff. This was not the case on the other two wards who, although were using high numbers of agency staff, had seen an overall reduction over the three months. The ward managers told us that they reduced this impact by using regular bank and agency staff wherever possible. It was clear that the trust was committed to ensuring the wards were running up to their established numbers using bank and agency but this was having an impact on the consistency of care. Agency staff were unable to read and review care plans on the electronic care records system. This meant that regular staff had more responsibility to ensure information was handed over and care plans were updated as agency staff were unable to do this. This was raised with the trust at the end of the inspection. The trust already had a plan in place for upskilling the agency staff and this was significantly sped up with five of the regular agency staff trained in using the system when we revisited on the 27 April 2017.
- The hospital also had twice daily safety calls with the service line leads to ensure that discussions around safe staffing levels and the skill mix of the staff on each ward was reviewed and addressed so that the wards mix of regular and non-regular staff was managed.
- Four staff members and three patients told us that planned escorted leave could be postponed when there were not enough staff on the ward. However, this information was not collated at a ward level.
- MAYBO was the training the trust use to support staff to physically manage patients safely, we found that all wards had 80% or above completion rate. This meant that the majority of the staff on duty across the wards were available to support and de-escalate patients when required. Regular agency staff were trained to the same standard as the trust staff.
- Staff were up to date and have received appropriate mandatory training and the average training rate for the staff was 85%.

Assessing and managing risk to patients and staff

- During the course of the inspection, we reviewed 23 sets of care and treatment records. Out of the 23 sets of care records all patients had basic risk assessments in place, however 14 patients did not have a management plan associated with all of their individual risks. This meant that patients might be at risk, as staff were not reading and reviewing a document that clearly laid out the patient's individual risks and a plan showing how to manage those risks. This was escalated at the end of the inspection and the trust took immediate action to put management plans in place. When we re-inspected the hospital on the 27 April 2017 we could see that this had been addressed and all patients had individualised risk management plans.
- Risks were being recorded in the daily notes for patients' but there did not seem to be a consistently used risk assessment and management tool. Patients were being RAG (red, amber, green) rated which meant that there risks were being considered on a daily basis by the multi disciplinary team but there was little evidence as to how this decision was being made. On several occasions risk scores were being discussed in the ward round and changed with no description as to how the decision was being made. When we revisited the hospital on the 27 April 2017 we could see that discussions around how risk levels were being met was being in a more detailed way in the RAG rating documentation and in the patient care records.
- We observed three handovers between shifts during the inspection and saw a comprehensive system for handover called the SBAR (situation, background, assessment, recommendation) in use. This handover

structure meant that issues that were not addressed in the care plans were being highlighted and handed over between teams and this was recorded in the SBAR notes for each ward.

- The wards also used a documented traffic light system to identify individual patient risks and this was updated on a daily basis and was a dynamic view of the patient risks on each ward. However this information was not always the same as the information recorded in the patient's risk assessment. This meant that the risks were being handed over and recorded in the overall ward review document but not consistently in the patient's individual record. When we revisited the hospital on the 27 April 2017 we could see that this was now happening and the traffic light system was the same as the information recorded in the patient notes.
- The staff were trained in safeguarding and were aware of the local procedures for escalating a safeguarding issue if required. The wards also shared safeguarding information in the weekly multidisciplinary meetings and this was recorded in the minutes of the meeting.
- All patients were encouraged to attend the main dining hall for meals. The main dining hall was separate from the wards and the patients leave their wards to attend for meals. The health and safety risk assessment for the dining room identified that each of the patients should have been individually risk assessed to access this area but we did not see evidence of any of the patients having this risk assessment in place. When this was identified with the trust they took immediate action to review the health and safety risk assessment for this area and now link this to the traffic light system. It was also recorded in the SBAR handover to ensure staff were aware of the patient's access to this area. When we revisited on the 27 April 2017 we could see that this risk was being recorded in the traffic light risk document.
- We reviewed 18 sets of medicine charts across the wards and found 16 charts had multiple annotations written across the charts by the Trust pharmacist. These annotations indicated issues with prescribing. On Clare ward one of the annotations referred to medicine to be prescribed as per the trust detoxification guidelines. The pharmacist had highlighted that the prescription did not follow the Trust policy on the management of detoxification and the medicine regime had continued after the pharmacist had made this comment. The medical lead identified that this should have prompted the completion of an incident report by the pharmacist escalating the issue but this had not been done. We could find no DATIX entries completed by the pharmacist for the last three months. When this was identified with the Trust during the inspection immediate action was taken by the chief pharmacist on the 21 April 2017 with the junior doctors highlighting the trust alcohol detox guidelines. When we re-inspected the hospital on the 27 April 2017 the pharmacist we spoke to identified that this had happened. The Trust was also reviewing their pharmacy ward cover arrangements to try a more consistent approach to pharmacy cover across the wards.

Track record on safety

- There had been 15 moderate harm incidents over the past 3 months across the hospital site and one extreme incident.

o Clare ward had three moderate Incidents, (one absence without leave (AWOL), one patient on patient assault and one incident of self-harm.

o Anderson ward had seven moderate Incidents, (five incidents of self-harm, one substance misuse issue and one outbreak of diarrhoea and vomiting)

o Blake ward had five moderate Incidents, (one accidental staff injury, one patient on patient assault, one incident of self-harm, one incident of property damage and one incident of police involvement on the ward)

o Blake ward also had one extreme incident of a patient death.

- When reviewing the incident reports for all of the above incidents it was clear that there were lessons learnt recorded and actions taken by the trust and the local management to change practice to reduce risk.
- The Trust risk register had one moderate risk for the Abraham Cowley Unit which was that Blake ward had lost full time staff to support other wards. This had impacted on care delivery on Blake ward. The actions identified in the trust risk register to manage this included prioritising the recruitment of staff for Blake ward and this was mirrored in the quality improvement plan for the hospital.

Are services safe?

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

Reporting incidents and learning from when things go wrong

- All staff were aware of the incident reporting and management system (Datix). Staff recorded patient related incidents in patient's daily notes, and this information was extracted into the Datix system.
- All full time staff were able to access the system to record incidents.
- The incident management system facilitated feedback on the outcome of the incident investigation via the newly instigated "DATIX huddle meeting". This meant that on a weekly basis the ward would collectively and routinely review the last seven days incidents and discuss the actions taken at a local level. The minutes from this meeting were posted on the office walls on the wards so staff not able to attend the Datix huddle were able to review the discussion.
- All ward managers described how a debrief was available to staff post-incident. This was confirmed by staff who felt supported by their local and senior managers post incident.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- Fourteen of the 23 sets of patient care records reviewed did not have a care plan that was recovery orientated or highlighted the individual patient's full range of strengths and weaknesses. Five of the patient's on Clare ward out of 14 did not have any care plans in place. This meant that for those patients', the staff did not have a document that clearly informed them how to manage those patient's individual needs. On Anderson ward, a patient with a long history of a serious physical health condition had had this need identified regularly at ward round meetings. In-between September 2016 and April 2017 the person did not have a care plan or a falls risk assessment that identified how the ward staff should support issues relating to this physical health condition, including a plan of how to support the patient in the event of an fire evacuation from the ward. This was escalated immediately to the trust. When we revisited the hospital on the 27 April 2017 we could see that the trust and the local management had taken immediate action to ensure that all patients had care plans in place that were linked to the patients individual risk and strengths. This meant that there had been immediate action taken to ensure that the care plans were now available for staff to read and implement.
- Nine care plans of the 23 sets of care records reviewed had evidence that patients' views had been included in the completion of the care plans. We saw on Blake ward evidence that the trust was implementing a "yellow care plan file" for the patients to help more easily identify what constituted their care plan. When this issue was identified to the trust they took immediate action to address this issue and when we re-inspected on the 27 April 2017 we could see that care plans had evidence that the patients had expressed specific statements relating to their care which was now addressed in the care plans.
- The nine patients that had been involved in their care plan had some evidence of good practice in relation to physical healthcare. The practices of the nursing and multidisciplinary teams was not represented in the care plans because the way we saw staff interact and care for patients gave us re-assurance that the shift to shift care was being delivered safely.
- There was a system in place for ward managers to complete a weekly audit of care plans which was shared with the modern matron. However, at the time of the inspection this was not highlighting the gaps in the care planning process. This was immediately addressed by the trust who have now implemented an additional level of scrutiny of the audit from within the nursing directorate. When we revisited on the 27 April 2017 we could see that this was having an effect as care plans were in place.
- All care planning information was contained on the electronic notes system and as described previously in this report this was not easily accessed by the high numbers of agency staff that were staffing the wards.

Best practice in treatment and care

- We saw evidence across all wards the modified early warning score (MEWS) tool had been partially adopted. The MEWS was a simple, physiological score that may allow improvement in the quality and safety of management provided to primarily surgical ward patients. The primary purpose was to prevent delay in intervention or transfer of critically ill patients. It had been adopted across mental health services as a way of identifying the trigger points for staff to intervene and address issues around physical healthcare.
- The MEWS tool was being inconsistently applied to the patient's. Out of the 23 sets of care records reviewed none of the MEWS charts observed were being scored which means the purpose of the MEWS may not have been fully understood by the ward teams. There was inconsistency in the frequency of the recording of the MEWS scores with 17 patients identified as needing weekly scoring but not being completed on a weekly basis. This issue had been identified by the trust in March 2017 and a quality improvement plan had been put into place and the recording had improved. When we revisited the hospital on the 27 April 2017 we could see that this had improved and the full MEWS scoring was now being completed
- Psychological therapies across the wards was allocated on a referral basis and consisted of one to one solution focussed short term pieces of work.
- Health of the nation outcome scores (HoNOS) were being used across all wards as a way to measure behaviour, impairment, symptoms, and social functioning. This was being regularly completed at care programme approach (CPA) meetings.

Are services effective?

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

Skilled staff to deliver care

- We saw there was access to the full range of multidisciplinary workers across all wards in varying degrees. On Blake ward there was a multidisciplinary conference call every day which was attended by the consultant, associate specialist, the ward doctor, representatives from the home treatment team, the community mental health teams and the ward nursing team. In these conference calls the suitability of the treatment was discussed, any incidents on the ward, any actions required by the community teams and a discussion around changing the traffic light system. This discussion happened for all patients on the ward and the traffic light recording sheet was then briefly updated by the associate specialist or the nurse and circulated to the team. When we revisited the hospital on the 27 April 2017 we could see that this was now being done in more detail and there was a recording as the decision making process around changes in risk.
- Staff data for staff supervision was not collected at trust level so there was no overall capture of supervision figures across the hospital, however, at a local level we could see that supervision was happening and ward managers had their own individual systems for tracking their team.
- Appraisal levels were at 100% across all three wards in March 2017.
- All ward managers were able to track and identify their ward sickness figures and they completed a monthly form for the HR department to ensure that sickness management issues were positively managed. The average sickness levels for all wards over the previous 12 months was 5% which was slightly higher than the NHS national average recorded in September 2016 as 4%. However, sickness was being managed effectively at ward level.

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

- The form the trust was using across the wards to record the capacity assessment and consent to treatment of detained patients stated that a new form should be completed every time the patient's consultant changed or there was a change to the patient's treatment plan. This was not being completed consistently across the wards. We found on Anderson ward that five patients had medicine prescribed which had been authorised by their previous consultant. After discussion with the trust we agreed that they were attempting what was considered reasonably practicable to engage the new consultant in completing a new consent to treatment form. The trust has now changed their Mental Health Act process, to link the completion of the new form with an existing audit system. This will ensure that these forms are always completed within seven days of a change of consultant.
- We found training for staff in the implementation of the Mental Health Act was above 80% across all wards.
- The Mental Health Act (MHA) administrator sent out a regular MHA newsflash to all wards which was posted on the ward notice boards. This highlighted any recent changes in trust policy or legislation which had a direct impact on patient care.
- All patients had access to "advocacy in Surrey" which was a partnership of advocacy organisations who attend the hospital. We saw information leaflets on all wards explaining the role of general advocate and Independent Mental Health Advocate (IMHA) with the contact phone numbers and addresses of the organisation.

Good practice in applying the Mental Capacity Act

- We found training for staff in the implementation of the Mental Capacity Act was above 80% across all wards.
- There was one Deprivation of Liberty Safeguard (DoLS) application from the hospital in the previous 12 months.
- The staff had a good working knowledge of the five key principles of the Mental Capacity Act and its guiding principles and knew to get advice and guidance from the MHA administrator if they had questions or concerns.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The trust had not ensured that patients accommodated in dormitories had adequate levels of light and suitable levels of privacy.** **This is a breach of regulation 15(1)(c)**