Surrey and Borders Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Farnham Road Hospital (Mental Health Unit) St Peter's Site Mid Surrey Assessment and Treatment Service	RXX22 RXXW1 RXX87
Long stay/rehabilitation mental health wards for working age adults	Margaret Laurie House Inpatient Rehabilitation Unit	RXXHE
Wards for older people with mental health problems	Farnham Road Hospital (Mental Health Unit) St Peter's Site West Park Epsom	RXX22 RXXW1 RXX2T
Wards for people with learning disabilities	April Cottage	RXXHK
Community-based mental health services for adults of working age.	Trust Headquarters	RXXHQ
Mental health crisis services and health-based places of safety.	Trust Headquarters Crisis House St Peter's Site Farnham Road Hospital (Mental Health Unit)	RXXHQ RXX90 RXXW1 RXX22

Summary of findings

Specialist community mental health services for children and young people.	Trust Headquarters	RXXHQ
Community-based mental health services for older people	Trust Headquarters	RXXHQ
Community mental health services for people with learning disabilities	Trust Headquarters	RXXHQ

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Requires improvement 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Good** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Good** 
Are Mental Health Services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Surrey and Borders Partnership NHS Foundation Trust as requires improvement because:

- The board did not have a thorough oversight of incidents and complaints. Whilst the board discussed individual, high profile cases and received annual reports of incidents and complaints, there was no detailed regular report to the board which examined and analysed all incidents and complaints. This meant that board members were not aware of all trends or hot spots and could not adequately challenge each other on what needed to change or the lessons that should be learned from serious incidents and complaints.
- The trust had weaknesses in their systems for reporting and learning from incidents. Some incidents logged by staff were not signed off by managers which resulted in a backlog. This means that the initial actions and learning from some incidents were not captured and documented.
- The trust's seclusion policy did not reflect the updates to the changes to the Mental Health Act Code of Practice.
- There was no consistent use of a recognised risk assessment tool or consistent recording of patient risk across all core services. In the community child and adolescent mental health service and the mental health crisis and place of safety teams there were poor risk assessments.
- Medicines management practice was inconsistent across the trust. Issues included controlled drugs discrepancies on two wards and out of date drugs on three wards. Fridge temperatures were not recorded correctly at three sites.
- There were weaknesses in the trust's oversight of its social care homes for people with a learning disability. Six of the trust's social care homes have been rated as requires improvement by separate CQC inspections in the past year. Prior to our inspections, the trust's quality assurance systems had highlighted some concerns at these services but had not identified all of the concerns or the severity of some of the issues.

However:

- The trust had carried out a comprehensive review of its inpatient services and health based places of safety since our last inspection. The trust had closed wards and units that were not safe or no longer suitable for inpatient mental health services and had opened a new purpose built unit for adult acute services, the psychiatric intensive care unit and a health based place of safety.
- Access to physical healthcare and monitoring of physical health had improved in the trust since our last inspection.
- There were good waiting times and response times particularly for community services.
- The trust had good leadership, with strong and effective leaders and managers. They presented as passionate and engaging and were open and transparent.

We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement for the following reasons:

- The trust did not fully comply with same sex accommodation guidance in Margaret Laurie House, on Primrose ward at West Park Epsom and on Delius ward at the Mid Surrey Assessment and Treatment Service.
- Ward ligature risk assessments did not always include full information on the action taken to mitigate risks.
- There was no consistent use of a recognised risk assessment tool or consistent recording of patient risk across all core services. In the community child and adolescent mental health service and the mental health crisis and place of safety teams there were poor risk assessments.
- The trust had weaknesses in their systems for reporting and learning from incidents. We found that some incidents logged by staff were not signed off by managers which resulted in a backlog. This means that the initial actions and learning from some incidents were not captured and documented.
- There was inconsistent medicines management practice across the trust. There were controlled drugs discrepancies on two wards and out of date drugs on three wards. On three wards, liquid medicines and creams did not have opened dates recorded. Fridge temperatures were not recorded correctly at three sites.

However:

- The trust had carried out a comprehensive review of its inpatient services and health based places of safety since our last inspection. The trust had closed wards and units that were not safe or no longer suitable for inpatient mental health services and had opened a new purpose built unit for adult acute services, the psychiatric intensive care unit and a health based place of safety.
- The trust had fully equipped clinic rooms in all inpatient services and at most community services.
- Most staff had received appropriate mandatory training.
- Staff were trained in, and understood, the trust safeguarding policy and procedures and knew how to make safeguarding referrals.

Summary of findings

Are services effective?

Good

We rated effective as good for the following reasons:

- Access to physical healthcare and monitoring of physical health had improved in the trust since our last inspection.
- The quality of care planning and record keeping was generally high across the trust's services.
- The trust used a range of nationally recognised rating scales to monitor patient outcomes.
- There were strong multidisciplinary teams across the services.
- Mental Health Act documentation was generally in order and complied with the Code of Practice across the trust.
- Clinicians across the trust demonstrated they understood, and adhered to, the principles of the Mental Capacity Act. Capacity assessments were recorded for patients appropriately and best interests decision making was documented properly.

However:

- The trust had recently introduced a new electronic patient records system and it was difficult for staff to access all relevant information needed to deliver care. Some historic care and treatment information had not transferred across to the new system.
- The trust's seclusion policy had not been updated in line with the new Mental Health Act Code of Practice.
- The trust achieved an overall appraisal rate of 81% (January 2015 data) however there were inconsistencies across the core services which ranged from 100% to 58.3%.

Are services caring?

Good

We rated caring as good for the following reasons:

- Across all core services we rated the trust as good for caring and found that people were treated with dignity, respect and kindness.
- We observed excellent interactions between staff and patients across the trust. Staff were largely approachable and engaged readily with patients. Staff demonstrated they had good working relationships with the patients and understood their individual care needs.
- With few exceptions the patients we met spoke positively about the support they received from the staff.

Summary of findings

- There were initiatives across the trust to involve patients in decisions about their services.

Are services responsive to people's needs?

Good

We rated responsive as good for the following reasons:

- The adult community mental health team had no waiting lists for assessment.
- Most of the community mental health teams met the trust's target to assess patients within 28 days of referral.
- The average bed occupancy in the trust in the last six months was 78%. This meant that generally beds were available to patients when they were needed.
- The new and refurbished wards that had opened in the trust in the previous 12 months had ensured that the inpatient facilities were more suitable for patient care and treatment.

However:

- The Spelthorne adult community team was based in a portacabin and the facilities were not suitable for delivering appropriate patient care or for ensuring confidentiality.
- The trust's complaints team did not meet its target response time for complaints.

Are services well-led?

Requires improvement

We rated well-led as requires improvement for the following reasons:

- The trust's governance processes did not ensure that all incidents were reported or that staff learnt from all incidents, complaints or patient feedback. Whilst the board discussed individual, high profile cases and received annual reports of incidents and complaints, there was no detailed regular report to the board which examined and analysed all incidents and complaints. The board did not have a thorough oversight of all incidents and complaints. This meant that board members were not aware of all trends or hot spots and could not adequately challenge each other on what needed to change or the lessons that should be learned from serious incidents and complaints.
- The trust's governance systems did not ensure there was consistency across the trust's services in rates of staff mandatory training, staff appraisal and staff supervision.

Summary of findings

- The trust's seclusion policy had not been updated to reflect the updated Mental Health Act Code of Practice. The trust had a system to ensure policies were regularly reviewed and updated to reflect changes in guidance but this system had not identified that the seclusion policy had not been updated following the change in the Code of Practice effective 1st April 2015.
- There were weaknesses in the trust's oversight of its care homes for people with a learning disability. Five of the trust's care homes have been rated as requires improvement by separate CQC inspections in the past year. Prior to our inspections, the trust's quality assurance systems had not highlighted concerns at these services.

However:

- The trust had good leadership, with strong and effective leaders and managers. They presented as passionate and engaging and were open and transparent. Executive directors and non-executive directors understood their roles and responsibilities. Non-executive directors felt they were involved and that the organisation was open and transparent. We found a trust that was able to be honest and reflect on where services needed to improve and worked hard to put things right.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Jonathan Warren, Director of Nursing and Quality, East London NHS Foundation Trust

Co-chair: Leeanne McGee, Director of High Secure and Forensic Services, West London Mental Health NHS Trust

Team Leader: Natasha Sloman, Head of Hospital Inspection, South East region, Care Quality Commission

The team included CQC inspectors and a variety of specialists:

Three CQC inspection managers

Ten CQC inspectors

Two CQC assistant inspectors

Three medicines inspectors (pharmacist specialists)

Two analysts

Six Mental Health Act reviewers

One inspection planner

12 specialist mental health nurses

Six consultant psychiatrists

Five psychologists

Three occupational therapists

Four mental health social workers

Two specialist advisors with governance experience

Why we carried out this inspection

We inspected this provider as part of our ongoing comprehensive mental health inspection programme

How we carried out this inspection

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

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

Before the inspection visit we:

- Asked other organisations for information, including Monitor, NHS England, clinical commissioning groups, Healthwatch and other professional bodies and user and carer groups.
- Sought feedback from patients and carers through attending three user and carer groups.
- Received information from patients, carers and other groups through our website.
- Requested information from the trust and reviewed the information we received.
- Our adult social care inspections team inspected eleven care homes for people with a learning disability run by the trust.

During the inspection visit we:

- Visited 14 hospital inpatient wards.
- Visited 32 community health services.
- Held focus groups with a range of staff who worked in the trust, such as nurses, doctors and therapists.
- We talked with 105 people who use services who shared their views and experiences of the service.
- We observed how people were being cared for.
- We talked with 54 carers and/or family members.
- We reviewed 236 care or treatment records of people who use services.
- We reviewed 97 medication charts.

Summary of findings

We reviewed 93 comment cards from people who use services

Information about the provider

Surrey and Borders Partnership NHS Foundation Trust provides services across the area of Surrey and North East Hampshire to a population of 1.3 million. Surrey and Borders Partnership NHS Foundation 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 organisation now provides services from more than 47 sites and employs more than 2,000 staff and 200 social worker staff assigned to the trust by local authorities.

It provides the following core services:

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

Long stay/rehabilitation mental health wards for working age adults

Wards for older people with mental health problems

Wards for people with learning disabilities

Community-based mental health services for adults of working age

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

Specialist community mental health services for children and young people

Community-based mental health services for older people

Community mental health services for people with learning disabilities

Surrey and Borders Partnership NHS Foundation Trust has a total of eight registered locations serving mental health and learning disability needs, including four hospital sites: Farnham Road Hospital (Mental Health Unit) in Guildford, the Abraham Cowley Unit at St Peter's Hospital in Chertsey, the Mid Surrey Assessment and Treatment Service at Epsom General Hospital and the Meadows at West Park in Epsom. The trust provides community mental health and learning disability services from a range of community sites across Surrey and North East Hampshire all of which are registered under the Trust Headquarters location.

Surrey and Borders Partnership NHS Foundation Trust also provides adult social care services. The trust has 12 care homes registered which provide residential services to adults with a learning disability. Eleven of these care homes were inspected by our adult social care inspection teams prior to our comprehensive inspection. The trust also provides a registered domiciliary care service for adults and older people in North East Hampshire and North West Surrey.

Surrey and Borders Partnership NHS Foundation Trust provides a specialist hospital drug and alcohol service in Surrey and community drug and alcohol services in Surrey, Hounslow and Brighton and Hove.

We carried out a previous comprehensive inspection of the trust's specialist mental health and learning disabilities services in July 2014. We issued 11 compliance actions against five core services. The trust provided us with an action plan and regular updates of action taken following the inspection.

The adult social care services were inspected across a nine month period prior to our comprehensive inspection. Separate inspection reports were produced for these inspections. Five care homes were rated as good, five care homes were rated as requires improvement and one care home, Ashmount, was rated as inadequate. Ashmount care home was placed in special measures because we found that people were not kept safe, were not well cared for and that the service was not well led. The trust responded positively to this action. We re-inspected Ashmount in March 2016 and rated the service as requires improvement.

Summary of findings

What people who use the provider's services say

We received 93 comment cards from people who used the services. Eighty-four of the comments (90%) were positive about the care they received. Seven comments were negative and two were neutral.

With few exceptions the patients we met spoke positively about the support they received from the staff and the treatment they received. Patients and their carers told us that staff treated them with respect and dignity.

We received mixed feedback concerning the crisis line. Some patients told us that advice received had included to make a cup of coffee or to go for a walk. Some patients told us that comments could often feel 'scripted' and that they preferred to contact the Samaritans for support.

One carer was extremely complimentary about the older people's inpatient service. Their relative had early onset dementia and this had been the first time they had felt supported in many years. They told us that staff were patient and compassionate towards the patients. The carer had a better understanding of their relative's condition and treatment plan and had seen improvements in their quality of life.

Good practice

The specialist community child and adolescent mental health service (CAMHS) had developed a very effective partnership with an independent patient-led organisation, the CAMHS Youth Advisors (CYA). This organisation provided induction training for staff on the patient experience of using services. They also provided patient representation for interview panels and were consulted on building designs for the new restructured children's and young people's services. They had been consulted on the design of waiting areas for existing buildings.

The recent introduction of 'Safe Haven' services in Aldershot and Woking provided an innovative alternative to traditional out of hours crisis services. The services were set up as cafes and provided walk in support between 6pm and 11pm for those wishing face to face contact with qualified staff.

The trust's research and development team was the winner of the Health Service Journal award 2015 for clinical research impact.

The trust was selected as one of the seven NHS test beds for their "internet of things" in partnership with the Universities of Surrey and Royal Holloway, and the Alzheimer's Association.

The trust's early intervention in psychosis team had developed a "my journey" app with young people for young people. The trust was working with the University College London Hospital to develop the app further.

The trust created a Mental Capacity Act app supported by the Nursing Technology Fund. The app creates a platform to improve the quality of Mental Capacity Act assessments and to make the process easier.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

Provider:

- The trust must ensure that it has effective systems for reporting and learning from incidents.
- The trust must ensure that the board has a thorough oversight of incidents and complaints.
- The trust must ensure that its medicine management practice is safe trustwide.
- The trust must ensure it complies with same sex accommodation guidance.
- The trust must ensure the seclusion policy is updated to reflect the current Mental Health Act Code of Practice guidance.

Summary of findings

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

- The trust must ensure incident reports are reviewed, escalated and investigated, to ensure adequate measures are taken to protect patient safety, allow learning from incidents and prevent reoccurrence.
- The trust must ensure risk assessments are regularly reviewed and updated following incidents.
- The trust must ensure medicines are stored, recorded, administered and disposed of safely.
- The trust must ensure staff attend appropriate training to enable them to carry out the duties they are employed to perform.

Wards for older people with mental health problems:

- The trust must ensure that all sites meet same-sex accommodation guidance at all times.
- The trust must take action to ensure all call alarms are appropriately positioned to allow them to be activated.

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

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

Community-based mental health services for adults of working age:

- The trust must improve measures to protect confidentiality within the premises used by Spelthorne CMHRS.

Specialist community mental health services for children and young people:

- The trust must ensure that risk assessments are completed and easy to access.
- The trust must ensure that staff follow the lone workers policy. The policy was not enforced or reviewed by team managers.
- The trust must ensure that staff supervision and appraisals for all staff are conducted regularly.

Action the provider SHOULD take to improve

Provider:

- The trust should ensure that there is consistent use of risk assessment tools across inpatient and community services.
- The trust should ensure that its system for assessing ligature risks includes full information on the action taken to mitigate risks.
- The trust should ensure that all care and treatment information is easily accessible to staff.
- The trust should ensure that staff annual appraisals take place consistently across the core services.
- The trust should ensure that there is a more consistent rate of mandatory training for staff across the core services.
- The trust should ensure that staff supervision is managed consistently across the core services.
- The trust should ensure it has a system in place to ensure policies are reviewed and updated in response to updated national guidance.
- The trust should review the facilities at the Spelthorne adult community team to ensure they are suitable for delivering treatment and care and for ensuring patient confidentiality.
- The trust should ensure that responses to complaints meet trust target response times.

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

- The trust should ensure recovery focused care plans are implemented consistently.
- The trust should ensure all patients able to make telephone calls in private.
- The trust should ensure that performance data is available and regularly reviewed.

Wards for older people with mental health problems:

- The trust should ensure staff have clear lines of sight and take action to minimise the risk of blind spots.
- The trust should deliver a consistent approach towards maintaining their environments. This should include addressing the cleaning provision on Victoria ward and ensuring patients have access to a lockable space in their rooms on Primrose ward.

Summary of findings

- The trust should ensure that all patients have their continence managed in a way that promotes independence.
- The trust should ensure that patients routinely have crisis and contingency plans in place.
- The trust should take action to ensure that patients' future preference for care and treatment is recorded
- The trust should ensure that patients' records and care plans fully reflect the patients' assessed needs and plans.
- The trust should review its training for staff in SystmOne and ensure the system's tools are suitable to meet the service's needs.
- The trust should ensure that the status of all Deprivation of Liberty Safeguards applications is followed up and recorded regularly.
- Victoria ward should ensure all patients are familiar with how to use their viewing screens so their privacy is maintained to their preference.

Long stay/rehabilitation mental health wards for working age adults:

- The trust should review the lack of an alarm/call system in the unit.
- The trust should continue to closely monitor the potential risk to safety of patients due to mixed sex corridors, especially at night when the corridors are not continuously observed by staff.
- The trust should review the need to provide individual vocational rehabilitation plans for patients.

Wards for people with learning disabilities:

- The trust should ensure that a comprehensive risk assessment framework is in place so that all staff can assess, record and report risks in the same way. This will enable staff to see and understand what risks currently exist and how these are to be effectively managed.
- The trust should ensure that an agreed assessment framework for physical care is introduced so that all staff can assess, record and report physical health monitoring in the same way. This will enable staff to see and understand what health risks currently exist and how these are to be effectively managed.
- The trust should ensure electronic patient records are organised in a way that promotes safety and wellbeing for people who use services and assists in the effective delivery of care and treatment.
- The trust should review the staff workforce to ensure that staff and patients have ready access to a speech and language therapist and an occupational therapist.
- The trust should improve the current level of activities provided and ensure that activities are based upon an occupational therapist's assessment of need.
- The trust should review the current arrangements for the recording and monitoring of requests for assessments under the deprivation of liberty safeguards, to protect people's rights under the Mental Health Act and Mental Capacity Act.

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

- The trust should ensure that the electronic patient records system meets the needs of the trust and staff.
- The trust should provide adequate training for staff to ensure effective and comprehensive use of the electronic recording system to manage risk and ensure safe care and treatment for patients.
- The trust should ensure that holistic and comprehensive care plans are completed for all patients which demonstrate patient involvement.
- The trust should ensure that there are consistent processes between crisis resolution home treatment teams and that good practice is shared between teams.
- The trust should review processes to ensure effective use of time and resources for crisis resolution home treatment team staff. The trust should ensure that there are clear guidelines in place regarding content and time spent in meetings.
- The trust should review the criteria for case load management to ensure a true reflection of patients being worked with in the community. Discharge planning should be clear and consistent.
- The trust should review the skill mix of crisis resolution home treatment teams and ensure patient access to occupational therapy and psychological interventions is consistent.
- The trust should continue to actively recruit into vacant posts to reduce the use of bank and agency staff.

Summary of findings

- The trust should ensure that regular checks of resuscitation equipment are recorded.
- The trust should track delays for accessing places of safety in order to develop and improve services.
- The trust should develop processes to reduce delays in assessments for children and young people and those with a learning disability at the places of safety.
- The trust should review staffing at the crisis line in order to reduce the number of unconnected calls and waiting times.

Community-based mental health services for adults of working age:

- The trust should increase the number of rooms available for interviewing and treating service users within the premises used by Reigate, Spelthorne and Woking CMHRS teams.
- The trust should address the issue of the unpleasant odour within the premises used by Spelthorne CMHRS team.
- The trust should improve the layout of the building used as the premises for Spelthorne CMHRS team.
- The trust should make improvements to disabled access at the premises used by Spelthorne, Reigate and Woking CMHRS teams.
- The trust should improve the level of sound-proofing within the premises used by Reigate and Woking CMHRS teams.
- The trust should consider the current provision of alarms within interview rooms.
- The trust should ensure that all refrigerators used for storing medicines operate within an appropriate temperature range.

Specialist community mental health services for children and young people:

- The trust should ensure that they are committed to service improvement through internal and external clinical audits to monitor the effectiveness of their work.
- The trust should ensure that children and adult patients have separate waiting areas. This was not available at the Redhill Children with Learning Disabilities team.

Community-based mental health services for older people:

- The service should continue to review team and individual practitioner caseloads to ensure these do not become unmanageable and unsafe for people using the service and staff.
- The service should review waiting times at the Oxted team where these were longer than the trust operational policy target.
- The service should review why staff within some teams felt they were not connected and engaged with the wider trust organisation.

Community mental health services for people with learning disabilities:

- The trust should take action to ensure the community teams are involved in the change process and implementation of the intensive support team model.
- The trust should review the environment at the service in Aldershot to ensure it meets all current legislation regarding supporting patients with a learning disability with particular regard to signage and visible information.
- The trust should conduct a regular ligature audit of all environments where patients access the services premises.
- The trust should ensure that the Kingsfield Centre and Cassia House have a daily fire record of all staff on duty for the entire building.
- The trust should ensure that autism awareness training is included within general equality and diversity training programmes for all staff working in health and care.

Surrey and Borders Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The director of quality oversaw the operation of the Mental Health Act (MHA). The Mental Health Act committee met quarterly and reported MHA outcomes quarterly to the quality committee. The trust's MHA team carried out the day to day work relating to the MHA 1983. The MHA team provided training to trust staff, carried out regular reviews of MHA documentation, did spot check ward reviews and co-ordinated tribunal and managers' review hearings. The team also carried out audits of compliance with the MHA and MHA Code of Practice. Recent audits included checks on the use of section 136 and the health-based places of safety, a review of absence without leave processes and checks on the requirements for treatment of young people under the age of 18. Feedback from these audits was shared with the Quality Committee and the ward teams.

All staff received MHA training as part of their mandatory induction training. Refresher MHA training was provided every two years. The trust reported in February 2016 that 81% of staff were compliant with MHA mandatory training. Some actions had been taken to implement the new Code of Practice, including updating the MHA training and providing guidance on the new Code for trust staff. Some policies had been updated, for example, the section 136 policy, the leave policy, the community treatment order policy and the policy regarding the use of doctor or nurse holding powers. However, not all policies had been updated. For example, the seclusion policy had not been updated since February 2014. The new Code of Practice was introduced on 1 April 2015.

During the inspection we carried out a full Mental Health Act review on five wards in a range of core services and visited the trust's two section 136 suites.

Overall, we saw good evidence that MHA documentation was properly completed. There were robust systems in place to scrutinise documents. Patients across all wards were informed of their rights regularly and advocacy services visited all inpatient units. The formal consent to treatment documentation was generally in good order across the inpatient services. The trust had a standardised system for authorising section 17 leave. Risks were assessed before patients went on leave and patients were given a copy of the leave authorisation. The involvement of patients in their care was well recorded but it was not clearly recorded on the the newly introduced electronic records system whether patients had received copies of their care plans. Staff in all services told us that the trust's MHA administration team was supportive, provided prompt advice and guidance and delivered a good service to the ward teams.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of their mandatory induction training. Refresher training was provided every two years. The trust reported that 85% of staff were compliant with MCA and DoLS training.

Overall, clinicians across the trust demonstrated they understood, and adhered to, the principles of the MCA. Capacity assessments were recorded for patients appropriately and best interests decision making was documented properly. In the community child and adolescent mental health service, however, staff did not fully understand the legal principles of the Mental Capacity Act for over 16s or Gillick competence for under 16s.

Applications for DoLS assessments had been made in services where patients were subject to restrictions on their liberty, such as wards with a locked door, and where clinicians had judged that patients did not have capacity to consent to treatment or to stay on the ward. Where there had been delays in the assessments taking place by the local authority, the trust had escalated these delays formally to the local authority. Trust senior staff had discussed the possibility that people were deprived of their liberty at their safety huddle meeting, MCA/DoLs steering group and recorded on the high level board risk register/ risk register report. However, at a local level, the inpatient service for people with a learning disability had no formal process to consider the risks of patients continuing to be treated on a locked ward without the capacity to consent to their care and treatment. Therefore, whilst the service waited for two DoLS assessments, they risked the possibility that patients were deprived of their liberty without formal authorisation.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated safe as requires improvement for the following reasons:

- The trust did not fully comply with same sex accommodation guidance in Margaret Laurie House, on Primrose ward at West Park Epsom and on Delius ward at the Mid Surrey Assessment and Treatment Service.
- Ward ligature risk assessments did not always include full information on the action taken to mitigate risks.
- There was no consistent use of a recognised risk assessment tool or consistent recording of patient risk across all core services. In the community child and adolescent mental health service and the mental health crisis and place of safety teams there were poor risk assessments.
- The trust had weaknesses in their systems for reporting and learning from incidents. We found that some incidents logged by staff were not signed off by managers which resulted in a backlog. This means that the initial actions and learning from some incidents were not captured and documented.

Detailed findings

- There was inconsistent medicines management practice across the trust. There were controlled drugs discrepancies on two wards and out of date drugs on three wards. On three wards, liquid medicines and creams did not have opened dates recorded. Fridge temperatures were not recorded correctly at three sites.

However:

- The trust had carried out a comprehensive review of its inpatient services and health based places of safety since our last inspection. The trust had closed wards and units that were not safe or no longer suitable for inpatient mental health services and had opened a new purpose built unit for adult acute services, the psychiatric intensive care unit and a health based place of safety.
- The trust had fully equipped clinic rooms in all inpatient services and at most community services.
- Most staff had received appropriate mandatory training.
- Staff were trained in, and understood, the trust safeguarding policy and procedures and knew how to make safeguarding referrals.

Our findings

Safe and clean environments

- At our last inspection in July 2014 we had issued a compliance action regarding the unsafe and unsuitable premises for the places of safety at the Ridgewood Centre and at the Mid Surrey Assessment and Treatment Service. The trust has closed both of these places of safety and opened a new place of safety at Farnham Road Hospital, Guildford. This compliance action has been met.
- The trust had carried out a comprehensive review of its inpatient facilities since our last inspection in July 2014. The number of inpatient sites has been reduced. Many of the older acute wards have been closed and the previous psychiatric intensive care unit has closed. A new unit for adult acute and psychiatric intensive care services opened in November 2015 in Guildford. The inpatient wards for older people have been refurbished at the Meadows, West Park site in Epsom. Two wards for older people have closed at the Abraham Cowley Unit at St Peter's Hospital and at Farnham Road Hospital at Guildford and have moved to the refurbished wards in Epsom. One inpatient service for people with a learning disability has closed and a new unit in Epsom was being built. The current ward for people with a learning disability, April Cottage, was due to transfer to the new site in the summer of 2016.
- The inpatient and community services were mainly clean and well-maintained. Many of the inpatient wards were new or newly refurbished. Delius ward at Mid Surrey Assessment and Treatment Service however was in poor decorative order. Some of the sites used for community services showed signs of wear and tear. For example the walls and carpet in the Elmbridge and Woking community adult service were stained and scuffed. The Spelthorne community adult service, which was based in a portacabin in Staines, had recently had a problem with vermin. The trust had ensured that an appropriate pest removal service had been used but the service was left with an unusable office due to a very unpleasant odour.
- The trust had different arrangements in place for managing the cleaning and maintenance of their estate across Surrey and North East Hampshire. Some services had trust cleaners and maintenance staff whilst others had external contractors providing cleaning and maintenance services. The trust Facilities and Estates department had reviewed all of their cleaning services and was in the process of rationalising the number of contractors and service providers they used. The department was also carrying out a similar review of the maintenance contracts across the trust estate. The trust planned to have new arrangements in place by 1 April 2016.
- All wards were mixed sex across the trust and not all services complied with same sex accommodation guidance. The new unit at Farnham Road Hospital was purpose-built, had only single bedrooms and all bedrooms had en suite shower rooms. The wards at Mid Surrey Assessment and Treatment Service and at St Peter's Site had a mixture of single sex dormitory bedrooms and single rooms. Margaret Laurie House had single bedrooms and shared single sex bathrooms. Patients on Primrose ward at West Park Epsom had to

walk through areas of the ward occupied by the opposite sex in order to reach their bathroom and toilet facilities. The dormitory bedrooms at Mid Surrey Assessment and Treatment Service could not be locked and Delius ward had experienced an incident where a female patient had entered the male dormitory and assaulted a male patient. The trust's "your views matter" surveys showed that patients had fedback concerns relating to people of the opposite sex sharing the same bathroom, toilet or shower facilities.

- The trust had a policy and system in place to ensure that environmental risk assessments were carried out. All wards had ligature risk assessments in place. Ward ligature risk assessments did not always include information on action taken to mitigate risks, dates for work completion or the responsible person. For example, the ligature risk assessments for Delius and Elgar wards at the Mid Surrey Assessment and Treatment Service and Blake ward at St Peter's Site did not contain full information on the action taken to mitigate risks.
- At our previous inspection in July 2014 we had issued a compliance action regarding the safety, availability and suitability of equipment. The resuscitation equipment at the Mid Surrey Assessment and Treatment Service and at the psychiatric intensive care unit had not been regularly monitored in line with trust policy and documentation. Since our inspection the previous psychiatric intensive care unit in Epsom had closed. The trust has ensured this compliance action has been met. All services had full records of checks of the resuscitation equipment and emergency drugs.
- The 2015 patient-led assessments of the care environment (PLACE) score for Surrey and Borders Partnership NHS Foundation Trust was 99.8%. This figure is 2% higher than the national average.

Safe staffing

- The trust had set safe staffing levels for all services and used bank and agency staff to cover shifts that were unfilled by permanent staff due to sickness and vacancies. Managers across the trust were able to use additional staff to manage particular pressures such as increased observation levels and escorted patient leave. In August to October 2015 the trust filled over 110% of all planned registered nurse day shifts and 97% of all registered nurse night shifts. In the same period over 115% of all planned nursing assistant/care support worker day shifts were filled and 128% of planned nursing assistant/care support worker night shifts were filled.
- The trust had experienced difficulties in recruiting and retaining qualified nurses and nursing assistants. The trust had an overall vacancy rate of 14%. However, nurse vacancies across the trust were far higher across most services. In February 2016 the trust had 116 vacancies for qualified nurses and 80 vacancies for nursing assistants. Between 1 August and 31 October 2015 the trust had filled 5,809 shifts using bank or agency staff. The trust had a continual rolling programme of recruitment for nurses and nursing assistants.
- The adult acute and psychiatric intensive care unit (PICU) service had the highest vacancy rate of qualified nurses with a rate of 32% and a vacancy rate of 25% for nursing assistants. The older people's inpatient service had a vacancy rate of 27% for qualified nurses and 16% for nursing assistants. April Cottage had the highest rate of nursing assistant vacancies with a rate of 46%. The specialist community services for children and young people had the highest vacancy rate of nursing assistants amongst the trust's community services. Its vacancy rate was 38%.
- The trust was carrying out a detailed review of its human resources strategies. The review included the recruitment process, pay in relation to other local trusts, retention strategies, sickness policies, management and supervision policies and training and development opportunities. The human resources directorate produced a monthly workforce report which included detailed information regarding workforce numbers, turnover, sickness absence and disciplinary issues. The human resources director reported to the Quality Committee on workforce issues.
- At our previous inspection in July 2014 we issued a compliance action to the trust regarding staffing. Agency staff who had worked in the PICU had informed us that they were regularly involved in restraining patients but had little or no training. The trust increased the staffing establishment for the PICU and recruited additional staff. The trust also has put in place a process to ensure bank or agency staff are trained to an acceptable level in physical restraint. Additionally, since our last inspection

the trust has closed the previous PICU in Epsom and opened a new PICU at Farnham Road Hospital in Guildford. At this inspection we found that staff involved in restraining patients were suitably trained. This compliance action has been met.

- At our previous inspection in July 2014 we issued a compliance action to the trust regarding supporting workers. The trust had not ensured that staff in the crisis line service had completed their basic life support training or had completed training in supporting people with challenging behaviour. The trust responded to this compliance action by providing additional training. At this inspection we found that only one member of the crisis line staff team was not fully up to date with mandatory training. This compliance action has been met.
- Throughout the trust, staff generally had received and were up to date with appropriate mandatory training. The average mandatory training rate for staff was 87% in February 2016. The lowest mandatory training rate was for medicines management courses which was 74%. However, there was a difference between the mandatory training rates across the core services. The inpatient ward for people with a learning disability had an overall mandatory training rate of 70%. Both the community child and adolescent mental health service and the adult acute and PICU service had an overall mandatory training rate of 71%. Wards for older people had a mandatory training rate of 72%. However, the community learning disability service had a mandatory training rate of 88% and the mental health crisis and place of safety service had a mandatory training rate of 84%.
- In January 2016 the trust had an overall sickness rate of 3.8%. The core services with the highest sickness rate were the older people's inpatient service and the acute and PICU service which both had a sickness rate of 6%. The staff rolling turnover rate for the trust was 21% in January 2016.

Assessing and managing risk to patients and staff

- At our last inspection in July 2014 we issued a compliance action to the trust regarding safeguarding service users from abuse. On the acute wards and PICU seclusion had been used without suitable arrangements in place to protect service users against the risk of physical interventions being excessive. The use of seclusion had not been recognised and correctly recorded and monitored. The trust had produced an action plan to improve awareness and guidance on the use of seclusion in response to our compliance action. The trust reported to us prior to this inspection that seclusion had been used six times in the six month period May to October 2015. Seclusion had only been used by the acute and PICU service and had been correctly recorded and monitored. The trust had only one seclusion room which was in the new Farnham Road Hospital. Seclusion was not carried out in any other location. This compliance action has been met.
- The trust had two safeguarding leads and two safeguarding advisors who report to the Director of Risk and Safety. The trust had a standard safeguarding process to ensure all safeguarding referrals were made appropriately through the electronic incident management system. The trust's risk and quality team reviewed all incidents and safeguarding referrals to ensure that safeguarding issues and incidents were correctly referred to the local authority.
- The trust had high rates of compliance with the mandatory safeguarding training, 94% of staff had completed the safeguarding adults training and 95% of staff had completed the safeguarding children training. The staff we spoke with across the core services were able to tell us how they would make a safeguarding alert and that they had done so, where applicable. On most wards and in most community services we saw posters in the staff offices which detailed how to make safeguarding referrals and to whom they should be sent.
- We reviewed 236 care records across all core services. Most of these records contained updated risk assessments. However, there was no consistent use of a recognised risk assessment tool or consistent recording of risk across all core services. In the adult acute and PICU service there was no use of a recognised risk assessment tool on three of the seven wards. In the inpatient service for people with a learning disability and in the home treatment teams, each patient's risk had been reviewed but a recognised risk assessment tool had not been completed. In the inpatient service for people with a learning disability and in the community services for older people the initial risk assessments were recorded on the risk assessment forms but updates to the risks were recorded either in the individual patient's progress notes or on an updated

form. Staff across most of the core services told us that the risk assessment tool on the trust's new electronic patient records system did not provide staff with sufficient prompts to assess risks as fully as the previous system they had used. Many of the more experienced staff continued to complete risk assessments fully but newer or more inexperienced staff relied on the system prompts to assist them when carrying out risk assessments.

- The trust had not used long-term segregation in the six month period May to October 2015. Rapid tranquilisation had been used 14 times in the same six month period. Thirteen of these occasions had been in the adult acute and PICU service. We saw examples of post-rapid tranquilisation questionnaires which had been completed to ensure each episode was reviewed effectively. The staff we spoke with demonstrated that they understood the need to monitor patients' physical health following rapid tranquilisation. However, stock emergency medicines in the adult acute and PICU service did not meet the National Institute for Health and Care Excellence (NICE) guidance NG10 and resuscitation council guidelines for providers of health and social care in settings where restrictive interventions might be used.
- Across the trust there were inconsistencies in the medicines management practice. Medicines were stored securely, audits regularly took place of missed doses and staff across all inpatient and community services told us that the trust's pharmacists were responsive to requests for medicines supply or advice. However, the management of controlled drugs was not adequate on some wards. Elgar and Delius wards at Mid Surrey Assessment and Treatment Service had controlled drug discrepancies. Also on Elgar ward the administration of controlled drugs was not always recorded accurately in the ward controlled drugs register. Our pharmacy inspectors found out of date drugs in three locations. Out of date medicines were in the clinic room cupboards on Elgar and Delius wards and out of date medicines were in the emergency drug cupboard for the Epsom West Park site located on Primrose ward. Liquid medicines and creams did not have opened dates recorded on Elgar ward, Delius ward and on Spenser ward at the Abraham Cowley Unit at St Peter's Hospital. Also, medicine fridge temperatures were not correctly recorded on Elgar ward, Victoria ward at Farnham Road Hospital, and at the crisis home treatment team at Ramsay House, Epsom.
- Across the trust there were 142 incidents of restraint in the six month period May to October 2015. Of these incidents of restraint, 20 were in the prone position and 14 had resulted in rapid tranquilisation. The adult acute and PICU service used the most restraint with 114 incidents in the six month period. The trust's prevention and management of violence and aggression training emphasised the importance of de-escalation techniques and all staff we spoke with who had used restraint told us that it was only used as a last resort.

Track record on safety

- In the period 27 May 2014 to 20 October 2015 the trust reported 78 serious incidents through its incident reporting system. Twenty-six (33%) of the 78 serious incidents were unexpected deaths, of which 20 were patients receiving community services. A further 26 serious incidents concerned serious self-inflicted harm by patients. Two serious incidents were admissions of a patient under the age of 18 to an adult inpatient ward. There were no reported never events.
- A total of six prevention of future death reports had been sent to Surrey and Borders Partnership NHS Foundation Trust since July 2014. These reports highlight concerns found by coroners (at inquests) in the systems or processes of organisations which, if they are not improved, could lead to future deaths. The trust had responded with an action plan to all six reports.

Reporting incidents and learning from when things go wrong

- The trust had weaknesses in their systems for reporting and learning from incidents. There were incidents on the trust's incident reporting system awaiting review or with actions overdue. At 3 March 2016 the trust's incident reporting system showed there were 368 incidents awaiting review by the local manager, of which 290 (79%) were overdue. The number of incidents being reviewed was 31, of which 29 (94%) were reported as overdue. A further 124 incidents were awaiting final approval, of which 99 (80%) were overdue. Therefore not

all incidents were being reviewed promptly to ensure that learning could be identified and shared across the trust in order to prevent similar incidents from reoccurring.

- The incident reporting guidance for staff lead to few incidents being escalated. The trust escalated incidents to serious incidents in accordance with the serious incident reporting framework 2015 definitions. Incidents that did not reach the national reporting criteria were investigated locally and centrally as high level incidents. Not all near misses were recorded as serious incidents in accordance with the serious incident reporting framework. Some incidents of serious self-harm were not reported as serious incidents and incidents of repeated serious self-harm were not highlighted. For example, an incident where a patient on an acute ward had self-harmed and needed 18 stitches at the local accident and emergency department was not reported as a serious incident. The patient repeated self-harm two days later. Another patient on an acute ward had five repeated incidents of self-harm reported in one month which required the patient to attend the local accident and emergency department. None of the individual incidents had been considered to be serious incidents. The patient seriously self-harmed on the ward using a razor blade on the same day as the ward had reduced the patient's observation levels following five days without self-harming.
- Incidents where detained patients had absconded from hospital were recorded in accordance with the trust's Incident Management Policy and missing person agreement. Some lessons were not promptly identified in the acute mental health wards at Epsom to prevent future incidents involving patients absconding from hospital because reviews of incidents and the closure of incident reports were overdue.
- The quality of some of the learning identified on the incident reporting system was limited. However we recognise that the datix incident recording system is not the only means used to record and report learning from incidents. We saw one incident had taken place in February 2016 where a female patient had alleged sexual abuse by a male patient. The police had been called and the local authority safeguarding team had been informed. The incident had not been identified as a serious incident. The learning recorded on the incident reporting system was "male patients can access female areas". The allegation had been later withdrawn by the female patient but there were no actions recorded regarding how to mitigate the risks of male patients accessing female areas of the ward. Another incident had been recorded where a patient on Blake ward at the Abraham Cowley Unit at St Peter's Site had admitted taking a legal high whilst on section 17 leave. The patient had died that night. A serious incident review was outstanding but the initial learning recorded on the trust's incident reporting system was that "drug use is an ongoing problem at ACU [Abraham Cowley Unit]". A further serious incident was recorded in December 2015 where the adult community service was informed by the Department for Work and Pensions that a community patient had spoken to them of suicide. It was recorded that the adult community service had called the patient the same day and the patient said they were despondent and they were not taking their medication. The service and a rapid access worker called the patient the next day but could not get a response. The decision had been taken not to do an urgent physical welfare check because it was decided there was insufficient risk. Three days later the service had carried out a welfare check but the patient had been found dead. The trust's incident reporting system did not identify any learning or actions to be taken following this incident. However, good practice was recorded in the incident report because the incident review had found the service's response was "timely and appropriate".
- The trust had not identified all of the issues with their incident reporting system before we brought the issues to the trust's attention during our inspection. However, the trust called an urgent extraordinary board meeting in the week following our inspection to address the adequate monitoring, reporting and scrutiny of serious untoward incidents at board level. The trust set up an urgent review of the incident reporting systems and policies. The trust put in place additional immediate requirements for the scrutiny of incidents and for the reporting of incidents to the trust board. The trust increased the size of the dedicated team in place to lead its serious incident investigations. In particular the trust increased the senior medical input to the team. The trust accelerated the work they were already doing to ensure that the acute mental health inpatient wards were supported to review their incidents.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The trust had a duty of candour policy and had produced guidance for staff on meeting the requirements of the duty. The trust was meeting the requirements of the duty of candour and was open and transparent when it was identified that something had gone wrong. We saw examples of letters sent to patients and carers informing them of the issue concerned and offering them the opportunity to meet with trust staff to discuss the issue.

Anticipation and planning of risk

The trust had a major incident emergency policy which detailed the processes and procedures that would be put into place in the event of an emergency or major incident

Good

Are services effective?

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

Summary of findings

We rated effective as good for the following reasons:

- Access to physical healthcare and monitoring of physical health had improved in the trust since our last inspection.
- The quality of care planning and record keeping was generally high across the trust's services.
- The trust used a range of nationally recognised rating scales to monitor patient outcomes.
- There were strong multidisciplinary teams across the services.
- Mental Health Act documentation was generally in order and complied with the Code of Practice across the trust.
- Clinicians across the trust demonstrated they understood, and adhered to, the principles of the Mental Capacity Act. Capacity assessments were recorded for patients appropriately and best interests decision making was documented properly.

However:

- The trust had recently introduced a new electronic patient records system and it was difficult for staff to access all relevant information needed to deliver care. Some historic care and treatment information had not transferred across to the new system.
- The trust's seclusion policy had not been updated in line with the new Mental Health Act Code of Practice.
- The trust achieved an overall appraisal rate of 81% (January 2015 data) however there were inconsistencies across the core services which ranged from 100% to 58.3%.

Our findings

Assessment of needs and planning of care

- At our last inspection in July 2014 we issued a compliance action to the trust regarding the care and welfare of people who used trust services. The trust had not ensured that skin integrity and falls risks were monitored and assessed on admission and identified in the management of care for patients on Victoria ward. The trust had also not ensured that regular physical health monitoring checks such as weight and blood pressure checks had been carried out for patients on Victoria ward. Since our last inspection the trust had produced an action plan to ensure that physical health checks and tissue viability and falls risks assessments were carried out by staff in the older people's inpatient service. We did not find these issues at this inspection. This compliance action has been met.
- The quality of care planning and record keeping was generally high across the trust's services. Care plans in most services were holistic and recovery focused. However, the care plans for patients in the adult acute and PICU services at Farnham Road Hospital were not personalised and were not all up to date. The care plans for patients in the crisis resolution and home treatment teams were not personalised or holistic.
- Many of the services were struggling to access all relevant information needed to deliver care because the trust had recently introduced a new electronic patient records system. Staff in the older people's community services, in the inpatient rehabilitation service and in the adult acute and PICU services reported that not all records had migrated to the new system from the old system and there were gaps in the care and treatment history in some patient records. There was a lack of consistency regarding where in the system information was recorded which meant that staff had to check different parts of the electronic system to locate care and treatment information.

Best practice in treatment and care

- There was good access to a range of psychological therapies in most of the core services. However, on Spenser and Victoria wards in the older people's inpatient service there was a lack of access to psychological therapies because the trust had struggled

to recruit psychologists to these wards. In the crisis resolution and home treatment teams there was little access to psychological therapies because there was no dedicated psychology input to the service.

- The trust used a range of nationally recognised rating scales to monitor patient outcomes. The health of the nation outcome scales (HONOS) were used widely across the trust to assess and rate severity and outcomes. Occupational therapists used the recognised model of human occupation (MOHO) for assessments. The Glasgow antipsychotic side effect scale (GASS) was used across the trust.
- Many clinical audits were undertaken by the trust to guide best practice and care. For example, the trust carried out a trustwide audit of the use of the medication, sodium valproate, in women of child bearing age. This audit was in response to a national safety alert and checked that the recommendations for this treatment were being followed. The older people's inpatient service carried out two audits of their treatment and care of venous thromboembolism (a condition where a blood clot forms in a vein) in response to updated NICE guidance. One audit checked that all patients on admission received an assessment of venous thromboembolism and the second audit reviewed the service's management of venous thromboembolism in people taking antipsychotic medication.
- Access to physical healthcare and monitoring of physical health had improved in the trust since our last inspection. The trust had appointed a lead physical healthcare nurse to oversee the physical healthcare of patients. The older people's inpatient service had made a range of improvements to their service to ensure patients received comprehensive physical healthcare. The physical health of patients was routinely assessed and monitored in all services. Community services liaised with patients' GPs to provide physical healthcare.
- The national audit of schizophrenia (an audit of community treatment for people with schizophrenia) found that availability and uptake of cognitive behavioural therapy was above average in the trust. The audit found that the monitoring of physical health risk factors was average. The national audit also found that a higher than average proportion of patients received more than one antipsychotic medication at the same time.

Skilled staff to deliver care

- There were strong multidisciplinary teams across the services. In addition to medical and nursing staff there were psychologists, occupational therapists, pharmacists, art therapists and music therapists. Social work leads were assigned to each service. Most services could access specialist support such as physiotherapy, speech and language therapy and dietitians when required. However, the community child and adolescent mental health service had difficulties with the arrangements for accessing occupational therapy, physiotherapy and speech and language therapy. These services were provided through schools so teams had little access to them, for example the children and young people's learning disability (CYPLD) service had access to occupational therapy for two hours per month. Also, because they were term time services, they were not available in school holidays, which were peak periods for the community teams, particularly the CYPLD teams, as parents required more support.
- Staff in some services told us that pharmacy support had been an issue, particularly in the inpatient older people's service. However, staff told us this issue had improved recently and inpatient services received scheduled weekly pharmacist input.
- All new staff received a comprehensive trust induction and local induction to their service. Mandatory and specialist training was provided to staff. Staff and their managers received automated reminders when they were due for refresher or updated training.
- The trust's education and development service provided regular reports on the trust's performance in training and development. The team had set up initiatives to provide training for new staff and newly qualified staff to help attract them to join the trust and to provide them with additional training and support opportunities. For example they had set up apprenticeships for healthcare support workers. The trust was a host employer for trainee clinical psychologists. The education and development team worked with the operational teams to provide placements for pre-registration nursing students. The team had set up a new leadership and management programme which was being rolled out to all supervisory staff. Across the trust the staff we spoke with were positive about the training and development opportunities open to them.

Good

Are services effective?

- The percentage of non-medical staff across the trust that have had an appraisal was 77%. There were inconsistencies in annual appraisal rates for staff across the core services. The crisis resolution and home treatment team had 100% appraisal rate for their staff. However, five core services had an annual appraisal rate of below 75%. The community team for patients with a learning disability had an appraisal rate of 74%. The specialist community team for child and adolescent mental health had an appraisal rate of 71%. The inpatient adult acute and PICU service had an appraisal rate of 70%. The inpatient service for older people had an appraisal rate of 63% and the community service for older people had an appraisal rate of 63%.
- Most services ensured that staff received regular supervision. However, only 50% of the community child and adolescent mental health team's staff had received supervision in the three month period prior to our inspection.

Multidisciplinary and inter-agency team work

- Across the trust multidisciplinary team working across the whole range of mental health professions was normal practice. In all services there were regular multidisciplinary team meetings.
- We observed handover meetings and multidisciplinary meetings in many of the core services during our inspection and heard respectful, patient-centred, detailed discussions and saw effective working relationships in practice. A carer of a patient in the inpatient older people's service told us that she had felt supported when she attended a review meeting and was impressed how information was projected on a screen so everyone felt involved. Telephone conference facilities were often used across the trust to ensure that members of external teams and agencies could attend meetings where necessary.

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

- The director of quality oversaw the operation of the Mental Health Act (MHA). The Mental Health Act committee met quarterly and reported MHA outcomes quarterly to the quality committee. The trust's MHA team carried out the day to day work relating to the MHA 1983. The MHA team provided training to trust staff, carried out regular reviews of MHA documentation, did spot check ward reviews and co-ordinated tribunal and managers' review hearings. The team also carried out audits of compliance with the MHA and MHA Code of Practice. Recent audits included checks on the use of section 136 and the health-based places of safety, a review of absence without leave processes and checks on the requirements for treatment of young people under the age of 18. Feedback from these audits was shared with the Quality Committee and the ward teams.
- All staff received MHA training as part of their mandatory induction training. Refresher MHA training was provided every two years. The trust reported in February 2016 that 81% of staff were compliant with MHA mandatory training. Some actions had been taken to implement the new Code of Practice, including updating the MHA training and providing guidance on the new Code for trust staff. Some policies had been updated, for example, the section 136 policy, the leave policy, the community treatment order policy and the policy regarding the use of doctor or nurse holding powers. However, not all policies had been updated. For example, the seclusion policy had not been updated since February 2014. The new Code of Practice was introduced on 1 April 2015.
- Overall, we saw good evidence that MHA documentation was properly completed. There were robust systems in place to scrutinise documents. Patients across all wards were informed of their rights regularly and advocacy services visited all inpatient units. The formal consent to treatment documentation was generally in good order across the inpatient services. The trust had a standardised system for authorising section 17 leave. Risks were assessed before patients went on leave and patients were given a copy of the leave authorisation. The involvement of patients in their care was well recorded but it was not clearly recorded on the newly introduced electronic records system whether patients had received copies of their care plans. Staff in all services told us that the trust's MHA administration team was supportive, provided prompt advice and guidance and delivered a good service to the ward teams.

Good practice in applying the Mental Capacity Act

- All staff received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as

part of their mandatory induction training. Refresher training was provided every two years. The trust reported that 85% of staff were compliant with MCA and DoLS training.

- Overall, clinicians across the trust demonstrated they understood, and adhered to, the principles of the MCA. Capacity assessments were recorded for patients appropriately and best interests decision making was documented properly. In the community child and adolescent mental health service, however, staff did not fully understand the legal principles of the Mental Capacity Act for over 16s or Gillick competence for under 16s.
- Applications for DoLS assessments had been made in services where patients were subject to restrictions on their liberty, such as wards with a locked door, and where clinicians had judged that patients did not have capacity to consent to treatment or to stay on the ward. Where there had been delays in the assessments taking place by the local authority, the trust did not have a system in place to ensure that there was regular follow up of the applications. The inpatient service for people with a learning disability had no formal process to consider the risks of patients continuing to be treated on a locked ward without the capacity to consent to their care and treatment. Therefore, whilst the service waited for two DoLS assessments, they risked the possibility that patients were deprived of their liberty without formal authorisation.

Good

Are services caring?

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

Summary of findings

We rated caring as good for the following reasons:

- Across all core services we rated the trust as good for caring and found that people were treated with dignity, respect and kindness.
- We observed excellent interactions between staff and patients across the trust. Staff were largely approachable and engaged readily with patients. Staff demonstrated they had good working relationships with the patients and understood their individual care needs.
- With few exceptions the patients we met spoke positively about the support they received from the staff.
- There were initiatives across the trust to involve patients in decisions about their services.

Our findings

Dignity, respect and support

- At our last inspection in July 2014 we issued a compliance action to the trust regarding respecting and involving people who use the service. The trust had not ensured that suitable arrangements were in place to treat patients with consideration and respect. Patients on the psychiatric intensive care unit did not have their needs met in a timely fashion and were consistently told to wait, with their request not always attended to by staff. After the inspection the trust took some immediate action and closed the ward to admissions. The trust recruited new senior staff for the ward and introduced a new handover and multidisciplinary team process. The ward had a phased re-opening programme. We did not find these issues at this inspection. This compliance action has been met.
- Across all core services we rated the trust as good for caring and found that people were treated with dignity, respect and kindness.
- We observed excellent interactions between staff and patients across the trust. Staff were largely approachable and engaged readily with patients. Staff demonstrated they had good working relationships with the patients and understood their individual care needs.
- With few exceptions the patients we met spoke positively about the support they received from the staff.
- The trust scored 93% on the latest patient-led assessments of the care environment (PLACE) scores. This is 6% higher than the national average.
- The trust scored 88% in the friends and family test completed by service users and their carers, which is lower than the England average of 96%.
- The trust scored 76% in the friends and family test completed by staff members, which is lower than the England average of 79%. Of the staff members who completed the friends and family survey, 57% said they would recommend the trust as a place to work which is lower than the national average of 62%.

The involvement of people in the care they receive

- At our last inspection in July 2014 we issued a compliance action to the trust regarding respecting and involving people who use the service. The trust had not enabled patients to be involved in decisions about their care and treatment. Patients detained under section 2 of the Mental Health Act were not regularly informed of their rights in relation to the treatment they were receiving. Following the inspection the trust took action to revise information given to patients and to review the ward admission packs to ensure there was sufficient information about the rights of people detained under section 2 of the Mental Health Act. We did not find this was an issue at this inspection. This compliance action has been met.
- Inpatient services across the trust provided patients with an information pack, or welcome pack, when they were first admitted to the wards. The inpatient service for people with a learning disability provided their information pack in an easy read format.
- Across most core services we found that patients were involved in their care planning. However, the care plans we reviewed in the crisis resolution and home treatment teams did not demonstrate that patients were involved

in their care planning. Multidisciplinary meetings were patient centred and often used projectors so everyone could see the notes. In the older people's inpatient service carers regularly received feedback and minutes of meetings concerning their relatives.

- Advocacy services visited all inpatient wards and information regarding advocacy services was provided in the community services.
- Patients were able to feedback on the service they received. Each service had a tablet computer available for patients and carers to record their views and give feedback. Staff assisted patients who were unsure of how to use the tablet computer, for example, on the inpatient older people's wards staff enabled patients to complete the survey on paper which allowed them to take their time answering the questions and not to feel rushed to complete the survey in one go. Feedback from the surveys was discussed at team meetings and patient community meetings.
- There were initiatives across the trust to involve patients in decisions about their services. Patients helped with the PLACE inspections across most services. Patients had been involved in the recruitment process for new staff in the adult community services. Patients were involved in the induction programme for new members of staff. Patients and carers had been very involved in the planning of the new Farnham Road Hospital. The specialist community child and adolescent mental health service (CAMHS) had developed a very effective partnership with an independent patient-led organisation, the CAMHS Youth Advisors (CYA). This organisation provided induction training for staff on the patient experience of using services. They also provided patient representation for interview panels and were consulted on building designs for the new restructured children's and young people's services. They had been consulted on the design of waiting areas for existing buildings.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as good for the following reasons:

- The adult community mental health team had no waiting lists for assessment.
- Most of the community mental health teams met the trust's target to assess patients within 28 days of referral.
- The average bed occupancy in the trust in the last six months was 78%. This meant that generally beds were available to patients when they were needed.
- The new and refurbished wards that had opened in the trust in the previous 12 months had ensured that the inpatient facilities were more suitable for patient care and treatment.

However:

- The Spelthorne adult community team was based in a portacabin and the facilities were not suitable for delivering appropriate patient care or for ensuring confidentiality.
- The trust's complaints team did not meet its target response time for complaints.

Our findings

Service planning

- Commissioners of services had different levels of involvement in planning services across the trust. The community CAMHS service was due to start a new contract on 1 April 2016 which involved some significant changes to the service. We met with the commissioners for community CAMHS prior to our inspection and they told us about their plans for the service in the future and how positively and proactively they had worked with the trust to plan for the changes. The CAMHS commissioners described the trust as "open, transparent and responsive". The older people's inpatient services had made changes to their service in the twelve months prior to our inspection. Two inpatient wards had been closed and newly refurbished wards opened on a different site. The trust's director of older people's services told us that some of the trust's decisions had needed to be made quickly and the trust had informed the commissioners of the changes. The commissioners had agreed to the changes but they had not been significantly involved in the planning of these changes.

Access and discharge

- There were considerable differences in the experiences of patients who accessed community services across the core services. The trust target for routine referrals to assessment was 28 days. The adult community service did not have any waiting lists for assessment and all adult community teams met or exceeded the target. Eight of the nine teams in the older people's community service met the trust's target. Most of the teams in the community services for people with a learning disability were able to meet the trust target. The East Surrey team had an average wait of 31 days from referral to assessment which was just outside the trust target. However, none of the CAMHS teams met the trust target of referral to assessment within 28 days. One team, CAMHS East, had an average waiting time of 75 days.
- The community services were able to offer some flexibility in their appointment times. The Elmbridge and Reigate adult community teams were able to facilitate later appointments one day a week for those who could not attend during the day. The Frimley older people's community service operated from 8am to 8pm Monday to Friday so was able to take later appointments every day. Staff within the crisis service provided cover for adults and older people's community services outside of normal working hours. A large proportion of people using the older people's community services lived in nursing homes. The services had set up clinics at these nursing homes for patients' convenience.
- The average bed occupancy in the trust in the last six months was 78%. This meant that generally beds were available to patients when they were needed. The adult acute inpatient service had the highest bed occupancy rate at 93%. The two individual wards with the highest

Good

Are services responsive to people's needs?

bed occupancy rate were Delius ward (96%) and Elgar ward (95%) which were both at the Mid Surrey Assessment and Treatment Service in Epsom. The average bed occupancy figures for the trust in 2015/16 were affected considerably by the closure of wards and opening of new wards. Some wards had periods when they did not accept new admissions because they were due to close. This had put pressure on the other inpatient wards which had remained open throughout the year, including Delius and Elgar wards. The inpatient service for people with a learning disability had a very low bed occupancy rate of 44%. However, this service was based in April Cottage which was due to close within a few weeks of our inspection.

- The trust had twelve patients whose discharge from inpatient services was delayed in the last six months. Six of these patients were in the older people's inpatient service and three were in the adult acute inpatient service. Eleven of the twelve patients were delayed because they were waiting for a residential or nursing home placement and/or a care package in their own home. The twelve patients whose discharge was delayed remained in hospital for a total of 461 days beyond their planned discharge date. The average delay was 38 days.
- The proportion of patients on the care programme approach followed up within seven days of discharge from psychiatric inpatient care was 96.3% compared to the England average of 96.8%. Historically the trust was usually above or level with the national average.

The facilities promote recovery, comfort, dignity and confidentiality

- The new and refurbished wards that had opened in the trust in the previous 12 months had ensured that the inpatient facilities were more suitable for patient care and treatment. Most inpatient services were able to offer a full range of rooms and equipment to support patient treatment and care. However, April Cottage, the inpatient service for people with a learning disability, had insufficient rooms and space which compromised patient care. This service was due to close within a few weeks of our inspection. A new site with additional facilities for patients and access to a local community was due to open.
- Across the inpatient services, wards had quiet areas, access to outside space and female only lounges. Patients could access hot drinks and snacks when they wanted. Patients could bring in personal items to personalise their bedrooms if they wished.
- Information leaflets were available in all inpatient services and in the waiting areas of most community services which provided information to patients and their carers regarding treatment, local services, patients' rights and how to complain.
- Most of the community services had good facilities. There were confidentiality issues caused by insufficient sound proofed interview rooms at some services. The Woking and Reigate adult community teams had concerns about some of their interview rooms. The community service for people with a learning disability at the Kingsfield Centre had issues with soundproofed interview rooms but was planning a move to more suitable premises. The Spelthorne adult community team, however, was based in a portacabin and the facilities were not suitable for delivering appropriate patient care or for ensuring confidentiality. The walls that divided the interview room and the group room were very thin and staff told us that conversations could be overheard in the rooms. Also, patients had to walk through the team office in order to reach the interview and group room. Staff had to cover their screens every time patients walked through the office in order to ensure that confidential information was not seen by patients as they walked through.

Meeting the needs of people who use the service

- The trust had access to interpreting services and staff who had used the service told us it was relatively simple to use although there could be delays in receiving translated written material. The adult and children's learning disability services were able to provide literature in an easy read format. The community CAMHS service had carried out an extensive project to engage with a large local gypsy/Roma/traveller community.
- Nearly all of the trust's services had disabled access. The Spelthorne community adults service had limited access and Margaret Laurie House, the inpatient rehabilitation service, was not suitable for disabled access.

Good

Are services responsive to people's needs?

- A choice of food was available in the inpatient services to meet the dietary requirements of religious and ethnic groups.

Listening to and learning from concerns and complaints

- The trust had a very low number of formal complaints. From November 2014 to October 2015 the trust received 82 complaints. Seven complaints were upheld and none were referred to the Ombudsman. The vast majority of complaints were categorised by the trust as complaints about clinical treatment. At the time of our inspection the ombudsman had under review six complaints about the trust.
- Despite the low number of formal complaints the trust's complaints team did not meet its target response time. The trust's target was to respond to 50% of complaints within 49 days which is a very low target. At the time of our inspection the trust responded to 48% of complaints within 49 days. The trust had lowered its target response time from 75% of complaints answered within 49 days to 50% in the last year. The trust's complaints and PALS team was very small and included one complaints officer and two coordinators. The trust had trained all band seven staff on how to investigate complaints and trained staff were contacted to carry out investigations when necessary. The trust's complaints manager acknowledged there were delays in all areas of the complaints process.
- Across all services we saw information provided to patients and carers on how to complain. The complaints and patient advice and liaison service (PALs) visited most inpatient services every week to meet patients and staff and to discuss any concerns. Many low level concerns were managed informally. Informal concerns and complaints were recorded in the Trust's "Expert report" which was sent to the executive board.
- Learning from complaints was shared across the trust. The complaints team produced a quarterly report which included data about complaints and learning. Where applicable, lessons learnt were also shared through clinical risk alerts, quality assurance groups, lessons learnt papers issued by the clinical risk and safety team and service improvement programme sessions. The staff we spoke with across the core services were able to give examples of lessons learnt from complaints that had been discussed in team meetings.

Requires improvement

Are services well-led?

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

Summary of findings

We rated well-led as requires improvement for the following reasons:

- The trust's governance processes did not ensure that all incidents were reported or that staff learnt from all incidents, complaints or patient feedback. Whilst the board discussed individual, high profile cases and received annual reports of incidents and complaints, there was no detailed regular report to the board which examined and analysed all incidents and complaints. The board did not have a thorough oversight of all incidents and complaints. This meant that board members were not aware of all trends or hot spots and could not adequately challenge each other on what needed to change or the lessons that should be learned from serious incidents and complaints.
- The trust's governance systems did not ensure there was consistency across the trust's services in rates of staff mandatory training, staff appraisal and staff supervision.
- The trust's seclusion policy had not been updated to reflect the updated Mental Health Act Code of Practice. The trust had a system to ensure policies were regularly reviewed and updated to reflect changes in guidance but this system had not identified that the seclusion policy had not been updated following the change in the Code of Practice effective 1st April 2015.
- There were weaknesses in the trust's oversight of its care homes for people with a learning disability. Five of the trust's care homes have been rated as requires improvement by separate CQC inspections in the past year. Prior to our inspections, the trust's quality assurance systems had not highlighted concerns at these services.

However:

- The trust had good leadership, with strong and effective leaders and managers. They presented as passionate and engaging and were open and transparent. Executive directors and non-executive directors understood their roles and responsibilities. Non-executive directors felt they were involved and that the organisation was open and transparent. We found a trust that was able to be honest and reflect on where services needed to improve and worked hard to put things right.

Our findings

Vision, values and strategy

- The trust had a clear set of values and a vision. Staff from across all the core services and in the central teams recognised the trust values and CARE (communicate, aspire, respond and engage) initiatives. Their strapline was, "helping us to remain ambitious, passionate and do the right thing every time". This set of values sat underneath four pillars of a house, called the quality house. The pillars were described as, experience, effectiveness, safety and value for money. The roof of the quality house referred to 'governance and assurance'.
- The CARE values statement was visible across the organisation on trust posters and information leaflets. Staff from across all the core services recognised the CARE values.
- The trust had an overarching clinical strategy, which was aligned to the financial plan and estates strategy. The action plan associated with the strategy was monitored by the annual plan. This was reviewed annually.

Good governance

- At our last inspection in July 2014 we issued a compliance action to the trust regarding assessing and monitoring the quality of service. The governance systems did not clearly highlight services in the division

of older people which were not performing well such as Victoria ward, so that improvements could take place and be closely monitored. Following our inspection the trust appointed a new ward manager to lead Victoria ward. The trust's quality team further developed the quality framework for older people's services. The trust also introduced the weekly safety huddle meeting to focus on risks and proactive responses. We did not find these issues at this inspection. This compliance action has been met.

- At our last inspection in July 2014 we issued a compliance action to the trust regarding assessing and monitoring the quality of service. The trust had not protected patients against the risk of inappropriate or unsafe care by means of the effective operation of systems designed to identify, assess and manage risks. The crisis line was still being reviewed and did not have clear recommendations in place to ensure it operated to meet the needs of the service. Following the inspection the trust created an action plan to improve the crisis line service. Additional support from senior managers was provided to the service and staff received additional training and support. We did not find this issue at this inspection. This compliance action has been met.
- At our last inspection in July 2014 we issued a compliance action to the trust regarding assessing and monitoring the quality of service. There was not an effective system to ensure that changes were made to treatment or care provided by the analysis of incidents. Not all staff in the CAMHS service knew how to report incidents and were not made aware of the findings of incident investigations. Following the inspection the trust set up a workshop for community CAMHS teams to increase knowledge and understanding of risk and incident reporting. The trust also improved the communication of lessons learnt from incidents within the CAMHS teams. We did not find this specific issue in the community CAMHS teams at this inspection. This compliance action has been met. However, we did find further issues with the incident reporting systems and processes across the trust.
- The board had a board framework and a corporate risk register. Risks were routinely discussed at board meetings and the trust also operated a safety huddle every week on a Tuesday. This meeting was led by the chief executive and reviewed all new risk areas. Directors were given immediate actions to address and improve any areas of concern. The safety huddle also considered safe staffing levels through surge and escalation reports.
- The trust had all the statutory committees in place, which reported directly to the board. Below these committees were four divisional quality assurance groups.
- There were weaknesses in the trust's oversight of its care homes for people with a learning disability. Six of the trust's care homes have been rated as requires improvement by separate CQC inspections in the past year. Prior to our inspections, the trust's quality assurance systems had not highlighted concerns at these services. At our first inspection of Ashmount care home in August 2015 we had major concerns about the quality of care and treatment provided. We rated the service as inadequate at that time. The trust has responded to the concerns we raised about the care homes. The trust had made improvements in the quality of care and treatment provided at Ashmount by the time of our second inspection in March 2016. However, there were still improvements required and the service was rated as requires improvement.
- Whilst the trust had ensured that the overall mandatory training rate for staff was good, the trust's systems had not ensured there was consistency across the trust's services. Mandatory training rates in individual core services varied from 70% on the inpatient ward for people with a learning disability to 88% in the community learning disability service.
- The trust achieved an overall appraisal rate of 81% (January 2015 data) however there were inconsistencies across the core services. Appraisal rates varied from 100% in the crisis services and place of safety team to 63% in both the inpatient service for older people and the community service for older people.
- The trust's governance systems did not ensure that staff were supervised to a consistent standard across the trust's services. Most services ensured that staff received regular supervision. However, only 50% of the community child and adolescent mental health team's staff had received supervision in the three month period prior to our inspection.

Requires improvement

Are services well-led?

- The trust ensured that services were covered by a sufficient number of staff of the right grades and experience. This was despite the fact the trust struggled to fill nursing vacancies. Bank and agency staff were used to cover vacancies.
- The trust submitted data that showed participation in a range of clinical audits across a number of services. These included: clinical risk assessment audit, audit of restraint and seclusion practices against policy, Mental Health Act audit, lithium monitoring in community mental health services, audit of psychology clinical activity, audit of use of sodium valproate in women of child bearing age.
- The trust's governance processes did not ensure that incidents were reported or that staff learnt from incidents, complaints or patient feedback. During our observations and interviews with the trust board plus a review of the trust board minutes, it was clear that the board did not have a thorough current oversight of all incidents and complaints. Whilst the board discussed individual, high profile cases and received annual reports there was no regular detailed report to the board which examined and analysed all incidents and complaints. This meant that board members were not aware of all trends or hot spots and could not adequately challenge each other on what needed to change or the lessons that should be learned from serious incidents and complaints. The quality committee received an annual serious incident report, an annual complaints report, reports on health and safety issues, a report on never events and a suicide prevention report in the twelve months prior to our inspection. The board received quarterly complaints information at the Council of Governors' meetings. However, there was no formal record of regular board meeting discussions of the quarterly complaints information.
- The trust did not have a system in place to ensure policies were regularly reviewed and updated to reflect changes in guidance. The trust's seclusion policy had not been updated to reflect the updated Mental Health Act Code of Practice.
- There was good financial management at the trust and it had a Monitor rating of green. The trust was committed to collaborating in order to achieve its transformation plans. The finance director described how mental health trusts had much to offer acute NHS trusts in this sense, particularly around integration. The current financial position of the trust was to break even; there will be no surplus in 2016/17. This had been discussed with Monitor and the trust had stated that it was possible that additional funds might be saved. The trust had £12million in cash reserves.
- The trust had plans to upgrade more inpatient services at Mid Surrey Assessment and Treatment Service and at the St Peter's Site. The trust had set aside £3million for this work.
- The trust had a systematic programme of clinical and internal audit which was used to monitor quality and systems to identify where action should be taken.
- The systems for identifying, recording and managing risks did not ensure that mitigating actions were fully recorded for all risks.
- The trust had reasonably good relationships with the six local clinical commissioning groups. The financial director had started a programme of working closer with the clinical commissioning groups.

Leadership and culture

- The trust had good leadership, with strong and effective leaders and managers. They presented as passionate and engaging and were open and transparent with us. Executive directors and non-executive directors understood their roles and responsibilities. Non-executive directors felt they were involved and that the organisation was open and transparent. We found a trust that was able to be honest and reflect on where services needed to improve and worked hard to put things right.
- In the latest NHS staff survey 36% of staff who responded said they had suffered work-related stress in the last 12 months, below the national average for mental health and learning disability trusts. Also, 16% who responded had experienced harassment, bullying or abuse from other staff in the last 12 months. This figure is 5% below the national average for mental health and learning disability trusts. None of the trust's results were in the bottom 20% of mental health and learning disability trusts. The trust's results were in the top 20% of all mental health and learning disability trusts in the following areas:

Requires improvement

Are services well-led?

- Agreeing that their role makes a difference to patients
- Effective team working
- Receiving job-relevant training, learning or development in the last 12 months
- Having well-structured appraisals in the last 12 months
- Support from immediate managers
- Reporting errors, near misses or incidents witnessed in the last month
- Fairness and effectiveness of incident reporting procedures
- Agreeing that they would feel secure raising concerns about unsafe clinical practice
- Reporting good communication between senior management and staff
- Able to contribute towards improvements at work

- The trust had invested £1million in leadership training. In the last 12 months 110 staff members had attended the leadership programme.

- The trust met the requirements of the fit and proper persons regulation. The trust had a fit and proper persons policy and had used best practice in the employment, reference, identity and disclosure and barring service checks they had carried out. We reviewed the files for all the current executive and non-executive directors. The trust had ensured that all checks had been carried out for existing directors as well as for new directors.

- The provider met the requirements of the duty of candour regulation. We reviewed the trust policy and spoke to staff who were able to articulate how they met the duty of candour. We were given examples of letters sent to families and evidence that this information was logged and monitored. We heard examples of how the families were involved in investigations and the psychological support provided to staff who were working with bereaved families.

Engagement with the public and with people who use services

- The trust had a forum of carers and people who use services (FoCUS) committee. This committee was made up of elected representatives of four area groups and board and divisional directors. It met bi-monthly and was co-chaired by the chief executive and a FoCUS representative. The FoCUS committee had developed the trust's standards for involving people which showed good practice in the involvement of people who use services, carers and families.

- The CAMHS youth advisors (CYA) were an integral part of the trust's services for children and young people. CYA had been involved in the recruitment and selection for team members and senior appointments and had co-designed the new models of care that were due to launch in April 2016.

- The trust carers action group met regularly with the trust's carers' leads.

- The trust delivered a diverse range of membership engagement and recruitment events including community events such as hospital community open days, partner events such as the Surrey independent living fayre and member events such as members' day and supporting carers events.

- The trust used twitter, facebook and other social media outlets to promote their services

Quality improvement, innovation and sustainability

- The trust's research and development team was the winner of the Health Service Journal award 2015 for clinical research impact.

- The trust was selected as one of the seven NHS test beds for their "internet of things" in partnership with the Universities of Surrey and Royal Holloway, and the Alzheimer's Association.

- The trust's early intervention in psychosis team had developed a "my journey" app with young people for young people. The trust was working with the University College London Hospital to develop the app further.

- The trust created a Mental Capacity Act app supported by the Nursing Technology Fund. The app creates a platform to improve the quality of Mental Capacity Act assessments and to make the process easier.

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 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good governance The trust did not have systems or processes established and operated effectively to assess, monitor and improve the quality and safety of the services provided. The trust board did not have a thorough oversight of incidents and complaints. This is a breach of regulation 17 (1), (2) (a).

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 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good governance The trust does not have systems or processes established and operated effectively to assess, monitor and improve the quality and safety of the services provided.

This section is primarily information for the provider

Requirement notices

The trust had weaknesses in their systems for reporting and learning from incidents. Incidents logged by staff were not signed off by some managers which resulted in a backlog.

This is a breach of regulation 17 (1), (2) (a).

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment The trust does not ensure that care and treatment is provided in a safe way for service users by the proper and safe management of medicines. There was inconsistent medicines management practice across the trust. There were controlled drugs discrepancies on two wards and out of date drugs on three wards. On three wards, liquid medicines and creams did not have opened dates recorded. Medicines fridge temperatures were not recorded correctly at three sites. This is a breach of regulation 12 (1), (2) (g).

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 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good governance

This section is primarily information for the provider

Requirement notices

The trust does not ensure that all policies have been reviewed and updated in line with changes in national guidance and guidelines.

The trust's seclusion policy had not been updated to reflect the revised Mental Health Act Code of Practice dated 1 April 2015.

This is a breach of regulation 17 (2)(a).

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 12 Safe care and treatment

The provider had not ensured the proper and safe management of medicines in the adult acute mental health wards and psychiatric intensive care unit.

Staff did not follow policies and procedures about managing medicines, including those related to administration, disposal and recording in the adult acute mental health wards and psychiatric intensive care unit.

This was a breach of regulation 12(2)(g).

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 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	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. In the adult acute mental health wards and psychiatric intensive care unit, staff compliance with mandatory training was below acceptable targets. Some staff had not received an appraisal. In the child and adolescent community mental health services, compliance with staff supervision and appraisal was below acceptable targets. This was a breach of regulation 18 (1)(2)(a)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 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 in the adult acute mental health wards and psychiatric intensive care unit 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

This section is primarily information for the provider

Requirement notices

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)

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 10 HSCA (RA) Regulations 2014 Dignity and respect Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 10 Dignity and respect

The provider had not ensured that patients on Primrose ward at West Park had access to toilet and bathroom facilities without having to pass bedrooms occupied by patients of the opposite sex.

This is a breach of regulation 10 (1) (2) (a)

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 15 Premises and equipment

This section is primarily information for the provider

Requirement notices

The provider had not ensured that nurse call alarms in shower areas on Spenser ward were appropriately located to be used by patients.

This is a breach of regulation 15(1)(f).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 17 Good Governance

The trust had not protected service users against the risk of inappropriate or unsafe care by means of the effective operation of systems designed to identify, assess and manage risks relating to the health, welfare and safety of service users.

Risk assessments and risk assessment tools in the home treatment teams were not consistent or always updated in response to changes in risk.

This is a breach of regulation 17 (1), 2(c).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 12 Safe care and treatment

This section is primarily information for the provider

Requirement notices

The trust had not protected service users against the risk of inappropriate or unsafe care by means of the effective operation of systems designed to identify, assess and manage risks relating to the health, welfare and safety of service users.

The trust had not protected service users in the home treatment teams against the risk of inappropriate or unsafe care by ensuring that allergies were appropriately recorded.

The trust had not protected service users from risk of harm because the trust had not responded to all calls made to the crisis line.

This is a breach of regulation 12 (2) (a) (b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 18 Staffing

The provider had not ensured that staff in the crisis resolution and home treatment teams had received appropriate training to enable them to deliver care and treatment to service users safely and to an appropriate standard.

This is a breach of regulation 18 (2) (a).

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

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 10 Dignity and respect The trust did not ensure the privacy of service users at the Spelthorne CMHRS service. Service users were required to walk through the staff office in order to access interview rooms. There was a risk that members of the public could access confidential material within the office (by overhearing telephone conversations; reading and/or taking written material, in electronic or in paper form). There was an inadequate level of sound proofing in the interview and meeting rooms. There was a risk of members of the public overhearing confidential discussions in adjoining rooms. This is a breach of regulation 10(1) and (2)(a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment The provider did not always assess the risks to the health and safety of service users of the child and adolescent community mental health services and did not always do all that was reasonably practicable to mitigate such risks. This is a breach of regulation 12 (2) (a) (b).