Surrey and Borders Partnership NHS Foundation Trust

Long stay / rehabilitation ward

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Margaret Laurie House	RXXHE	Margaret Laurie House	RH2 8HY

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

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

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

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

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

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

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

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

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

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

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

We last inspected Margaret Laurie House in August 2013 and asked the provider to take actions regarding the safety and suitability of the premises and regarding assessing and monitoring the quality of service provision. At this inspection we found that the actions had been completed and the previous compliance actions were now met but there were still some actions the provider should take to ensure the service is safe.

Margaret Laurie House is the trust's only inpatient community-based rehabilitation unit. It provides a "recovery based" service for men and women aged from 18 to 65 years although most of the patients are male. The people using the service have mental health difficulties. The service is able to admit people detained under the Mental Health Act 1983 (MHA) as required but most people who use the service are informal.

Margaret Laurie House was built in the 19th century and therefore not purpose built. It is set in a residential area of the community. There are 12 bedrooms over three floors. It has been a rehabilitation unit since 2004. It is staffed on a 24 hour basis by nurses and support time recovery workers and has a multi-disciplinary team (MDT) of professionals.

Summary of findings

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

Are services safe?

There were systems for reporting incidents and learning lessons from these to reduce the risk of reoccurrence.

Risks to people were identified through assessments, as well as the ongoing monitoring and review of people and risk management plans. Staff reviewing people's risk of self-harm were only considering their recent history.

Staff understood the need to assess and report safeguarding concerns and ensure people were safe.

Environmental improvements had taken place to make the building safer but records of health and safety checks were not all available to confirm the building was safe.

Are services effective?

There was effective multi-disciplinary team working within the service to meet people's needs.

Staff told us they undertook training and had regular supervision, team meetings and appraisals to ensure they were supported in their role and keep skills up to date.

People were supported to access services for their physical health but records showed that some people may not be having their annual health check.

People were actively supported with their rehabilitation.

Are services caring?

People told us that staff were caring treated them with respect and that staff gave them support they needed to be independent as possible.

There were systems in place to ensure the privacy and dignity of people such as gender specific areas of the unit. People had their own keys to their rooms and the unit provided a domestic atmosphere to assist people with the transition from hospital to home.

People were encouraged to make choices and decisions relating to their care and treatment, and they were encouraged to give their views.

There were systems in place to keep people informed about the services provided. Advocacy services supported people to communicate their needs.

Summary of findings

Are services responsive to people's needs?

People reported their individual needs were being met by staff.

People were supported through their care pathway. There was evidence of planning and developing services to meet people's needs and encourage social inclusion.

Systems were in place for people to give feedback on the service and raise any complaints. There were systems for reviewing complaints within the unit and also across the trust's services, considering if actions were required to make improvements.

Are services well-led?

Staff were aware of the trusts visions and values.

Staff had an understanding of the governance framework function to review the performance of the service and make improvements where needed.

Staff told us they felt well led and supported by their direct and senior managers.

People who use the service and staff felt able to contribute to the future development of the service.

Summary of findings

Background to the service

Margaret Laurie House had systems in place to monitor and assess safety. We saw that safeguarding and incident reporting mechanisms were well established. There were effective ways for staff to learn from incidents relating to the service and in the wider trust. We saw that risk assessments were in place for people.

Improvements were required to ensure effective records were being consistently maintained and to reduce risk to people's health and safety. We saw that professionals worked together to ensure that the needs of people who used services were met. People received a service that was supported by evidence and research. The provision of induction, training, supervision and for staff was established.

People told us that staff were caring and supportive. There were opportunities for people to be involved in their care and treatment and we found evidence of person centred care planning.

The service was responsive. We saw that there were systems for responding to people's feedback on the service to plan and deliver services such as to ensure social inclusion opportunities. Support was available to people during their care pathway.

Staff reported a well-led service. Staff were dedicated and reported effective management and leadership. We saw a supportive culture within the team. There were systems for people using the service, staff and other to give feedback on the service. Staff were aware of the values and visions of the trust. There were systems for governance and teams to monitor and improve their performance.

Our inspection team

Our inspection team was led by:

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

Team Leader: Jane Ray, Care Quality Commission

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

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

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Summary of findings

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

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

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

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

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

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

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

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

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

During our visit the team:

- Held focus groups with different staff members such as nurses, student nurses and healthcare assistants, senior and junior doctors, allied health professionals and governance staff.
- Talked with patients, carers, family members and staff.
- Looked at the personal care or treatment records of a sample of patients.
- Observed how staff were caring for people.
- Interviewed staff members.
- Reviewed information we had asked the trust to provide.
- Attended multi-disciplinary team meetings.
- Collected feedback using comment cards.

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

What people who use the provider's services say

Results from the trust, 'your views matter' inpatient survey for April 2014 had 35 responses. Most people (71%) indicated they were satisfied with the service and 69% would likely recommend the ward/unit to the friends and family if they needed care or similar treatment.

Summary of findings

Good practice

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

Areas for improvement

Action the provider MUST or SHOULD take to improve

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

Detailed findings

Surrey and Borders Partnership NHS Foundation Trust

Long stay / rehabilitation ward

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Margaret Laurie House	RXXHE

Mental Health Act responsibilities

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

We did not monitor responsibilities under the MHA at this location. The ward contacted the MHA administrative team if they needed any specific guidance about people detained under the MHA.

Where required staff could contact the Approved Mental Health Professionals (AMHP) service to coordinate assessments under the MHA.

Most people were not detained under the MHA. Where people were, we saw evidence of people being informed of their legal rights.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff reported receiving Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

We only saw records of mental capacity assessments completed by staff in relation to people's ability to consent to medication. Staff told us that people's mental capacity was assessed on an ongoing basis.

We could not find MCA assessments for people where it was identified that they lacked capacity to manage their finances and the trust held 'appointeeship' for them. One person told us that they did not know what happened with

their money although they could explain systems for receiving it from staff. The community mental health recovery service manager told us that the local authority staff undertook these and reviews and held records.

On both the days we visited the front door was unlocked and people had free access to outside space. There were no people present subject to DoLS applications.

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

There were systems for reporting incidents and learning lessons from these to reduce the risk of reoccurrence.

Risks to people were identified through assessments, as well as the ongoing monitoring and review of people and risk management plans. Staff reviewing people's risk of self-harm were only considering their recent history.

Staff understood the need to assess and report safeguarding concerns and ensure people were safe.

Environmental improvements had taken place to make the building safer but records of health and safety checks were not all available to confirm the building was safe.

Our findings

Track record on safety

Staff said there had been no reported serious incidents (SI) or accidents on the unit within the last year. Staff were able to describe how they report incidents and accidents. The system ensured senior managers within the trust were alerted to them promptly and could monitor the investigation and response to these.

Incidents in the trust were shared with the manager of the unit when they attended governance meetings. They then cascaded the learning, or actions to be taken, via team meetings. There was a process in place for staff to receive information around incidents via email as well as central risk and medical device alerts.

Learning from incidents and improving safety standards

We saw the the multi-disciplinary team reviewed incidents and looked at what steps needed to take place. For example people using the service could have mobile phones and computers but alcohol and non-prescribed medication was not allowed. We learnt that a recent incident had taken place when some people reported consuming alcohol and non-prescribed medication in the house. Staff conducted room searches, items were removed and staff reviewed people's risk assessments.

Where incidents of people leaving the premises without informing staff had occurred, actions included ensuring people's mental health and leave access was re-assessed. Risk assessments and care plans were also updated. Staff could, if needed, implement the 'locked door' policy.

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

Staff had received safeguarding training and had a clear understanding of safeguarding and their responsibilities in relation to identifying and reporting allegations of abuse. All the staff we spoke with knew who the safeguarding lead was for their area and felt able to contact them for advice when needed.

Assessing and monitoring safety and risk

The service was staffed on a 24 hour basis by nurses and support workers. Staff reported working 13 hour shifts, with breaks. The multi-disciplinary team also included a manager and deputy, doctors, occupational therapy staff, a community development worker and a cleaner. We found there were sufficient numbers of staff working in the service and where required regular bank staff were used (not permanently employed staff but contracted to work for the trust), who were familiar with people's needs and the service procedures. Staff told us that on occasion agency staff were used.

Within care records we saw that risks people presented to themselves and others had been assessed and reviewed regularly to ensure people received appropriate support. Risk management plans detailed the actions that were required to minimise the risk to the individual and included any triggers/risk behaviours that people needed to be aware of, and strategies for coping with these. Additionally people had crisis contingency plans identifying relapse indicators and management plans.

Weekly multi-disciplinary team meetings took place and people were formally reviewed on a three weekly basis unless there were concerns, when they were then reviewed that week.

Are services safe?

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

Understanding and management of foreseeable risks

Staff had undertaken control and conflict resolution (Maybo) de-escalation training to help them manage any challenging behaviour. In an emergency crisis situation staff would call '999' for emergency services.

As there was reduced staffing at night, staff carried personal alarms in the event they needed assistance. Rooms, such as the activity room, had alarms staff could use in the event a worker needing help.

We saw that some restrictions had been put into place to manage risks to people using the service. Household cleaning products had been risk assessed as part of the Control of Substances Hazardous to Health (COSHH) and were securely stored. The laundry area was kept locked but people had access under staff supervision to wash and dry their clothes. Sharp kitchen and gardening equipment was available for people to use under supervision.

Staff had locked the kitchens when a person's physical health was at risk due to them excessively drinking liquids. Some people using the service told us they were unhappy about this as it restricted their ability to make drinks and snacks and had raised this in the community meeting. Staff told us they opened the kitchen when people requested it and and kept it unlocked when the person was not on site. Staff told us that they had considered this as the least restrictive option for people.

At our last inspection we identified actions that the provider was asked to take to keep the building safe. We saw that live electrical hazards had been repaired and were no longer exposed. Door smoke strips had been replaced. We noted that working locks were available in the clinic and laundry room. This meant the previous compliance action had been met. At this inspection we noted that not all the portable electrical equipment had stickers to confirm they were in safe working order. This included a kettle in a communal kitchen which was cracked and leaking water. Staff said that they were not keeping records of all the checks and this would be addressed.

Some records we requested to see were not accessible when we visited both days. This included the latest legionella assessment. This meant we could not be assured this health and safety check had taken place.

We saw that fire safety was however being implemented. There was a system for staff to record when maintenance issues were reported and completed and staff told us that maintenance staff visited each week to carry out fire safety checks and we saw records for this. We saw that an annual fire conformity test and risk assessment had taken place.

We found examples of food not being safely managed. We found a piece of chicken and ham on a plastic wrapped plate that was left on a windowsill to defrost in sunlight. Staff removed this. It is important that meat is defrosted as per manufacturer's instructions and kept separately as when defrosting, the liquid which comes out can contain harmful bacteria. This could spread to other foods. We saw that staff had received food hygiene training as part of their role in supporting people with cooking. Records for fridge temperatures indicated that for one fridge, temperatures had exceeded five degrees Celsius nine times in a week but did not detail what action staff had taken as detailed in the trusts' policy to address this and ensure food was kept safe.

We identified from our last inspection that that there were no effective systems in place to monitor quality, and assess and manage risks to health safety and welfare, because risks were not identified and managed. We referenced in our report that there was no 'effective ligature audit' and systems for identifying priorities for maintenance work. The provider sent us an action plan which explained that the review of the ligature audit would be reported to the trusts 'ligature minimisation group' to agree the approach being taken. The manager advised us that since then the group had determined that Margaret Laurie house "was out of scope" as the service was considered as having, 'a low risk patient group'.

The manager told us there had not been any incidents of a person self-harming using a ligature point. As part of rehabilitation it was not possible to have a ligature free environment as they were supporting people towards living in the community. We found that some changes had taken place to reduce ligature points in bathroom areas.

We found effective records were not always maintained to confirm that people using the service had been assessed to ensure their risk of self-harm had been considered. We found that some people with self-harming histories were referred to the service and assessed by staff. For one person assessed, staff had not asked them about their self-harm beyond a month prior to their admission. We considered that by not having effective guidance for staff to refer to in their assessing of people, this could mean that assessments were not comprehensive.

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

There was effective multi-disciplinary team working within the service to meet people's needs.

Staff told us they undertook training and had regular supervision, team meetings and appraisals to ensure they were supported in their role and keep skills up to date.

People were supported to access services for their physical health but records showed that some people may not be having their annual health check.

People were actively supported with their rehabilitation.

Our findings

Assessment and delivery of care and treatment

There were safe systems for the storage and administration of medication.

People using the service usually had an identified care coordinator from one of the trust's community teams. Each person was allocated a named nurse who was responsible for ensuring they had an up-to-date assessment and care plan. Care plans were developed based on each person's individual needs using the care programme approach (CPA).

We found that people's care plans contained information from community teams. We saw that people had 'health action plans' detailing support needed for their physical health needs. Staff understood the importance of giving people support to reduce risks to their physical health. For example they referred to encouraging healthy eating and for people to regularly exercise. Blood tests were arranged for people as required. People were registered with community GPs and the focus was on people accessing community based care where possible.

Some information had not been updated, such as records of annual physical health checks. For example three out of five people's records we looked at had no record of the last physical health assessment taking place within the last year. For one record completed in 2012 the deputy manager acknowledged it was, "not very detailed."

Outcomes for people using services

We saw staff used nationally recognised assessment, and assessment tools, as part of their work with people, to measure improvements made. For example, staff carried out the Camberwell assessment of needs short appraisal schedule (CANSAS) during the initial assessment of the person and before discharge. It covers 22 domains of an individual's life, such as accommodation, food, self-care, daytime activities, psychotic symptoms, childcare, money, psychological distress, physical health and relationships.

The health of the nation outcome scale (HoNOS) problem rating tool was used to measure the health and social functioning of people with severe mental illness as part of the 'mental health clustering' and the reviewing of people's care pathway.

Occupational therapy staff reported using assessment tools to measure people's progress such as occupational self-assessment (OSA) and the model of human occupation screening tool (MOHOST).

Staff, equipment and facilities

Systems were in place for new or temporary staff to receive inductions to the trust and the service. Specific staff took lead responsibilities for ensuring staff had both refresher statutory and mandatory training. Staff said that opportunities for training were excellent. The service promoted a learning culture with student nurses on placement receiving support from onsite mentors and a trust practice placement facilitator.

There were facilities for people to develop their daily living skills and prepare for moving out of hospital to living in a less supported community environment. People had keys to their rooms unless there were risks identifying that they should not. People had access to an area to make private telephone calls.

Multi-disciplinary working

Staff spoke positively about working as part of a multi-disciplinary team. Staff spoke about cross team working, such as with community mental health recovery services and the community forensic mental health team, when people had specialist needs. People's community care coordinators were invited to attend multi-disciplinary meetings to contribute to care planning and as part of ensuring ongoing communication about people's needs.

The community development worker reported liaising with the 'enabling independence service' a county-wide service

Are services effective?

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

promoting recovery, independence and social inclusion to support people. Staff liaised with charity/voluntary agencies, such as the Mary Frances Trust and Richmond Fellowship, as part of supporting people with socialising, getting them back into employment or help with accommodation.

Mental Health Act (MHA)

We did not monitor responsibilities under the MHA at this location. The ward contacted the MHA administrative team if they needed any specific guidance about people detained under the MHA.

Where required staff could contact the Approved Mental Health Professionals (AMHP) service to coordinate assessments under the MHA.

We saw that most people were not detained under MHA. Where people were, we saw evidence of people being informed of their legal rights.

Are services caring?

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

Summary of findings

People told us that staff were caring treated them with respect and that staff gave them support they needed to be independent as possible.

There were systems in place to ensure the privacy and dignity of people such as gender specific areas of the unit. People had their own keys to their rooms and the unit provided a domestic atmosphere to assist people with the transition from hospital to home.

People were encouraged to make choices and decisions relating to their care and treatment, and they were encouraged to give their views.

There were systems in place to keep people informed about the services provided. Advocacy services supported people to communicate their needs.

Our findings

Kindness, dignity and respect

People told us that most staff were caring and treated them with respect. We observed, and heard staff speaking with people, in a kind, compassionate manner. People told us, "They're very good to me here. I try and push myself to move on." Another person told us, "I like it here."

There were gender specific areas of the service to ensure people's privacy. We observed staff knocking on people's doors and checking with people before entering their rooms showing people's privacy was being considered.

In the event a person was admitted, and they did not have any basic possessions, a stock of staff donated clothing was available. Also there were funds available to buy essential toiletries.

People using services involvement

People told us they felt involved in their care plans and reviews. Most said they had seen their care plan and had the opportunity to sign it. A person told us, "I am shown my care plan and this is discussed with me". We found evidence of person centred planning detailing people's views of their care and any disagreements.

Weekly community meetings and planning meetings included agenda items such as the menu and activities so people could give feedback on the service and things they would like to do. One person told us they were encouraged to "do things" themselves. One person told us that they could raise issues at community meetings such as ensuring healthy eating options but that, "they [staff] don't do anything about them."

We saw that family, friends and carers were encouraged to attend multi-disciplinary team reviews and other events. One carer told us that they were not able to attend the multi-disciplinary meeting due to their work and staff had talked about how this might be addressed.

Emotional support for care and treatment

People told us that staff supported them and listened to them. Comments included, "I feel I can talk to staff", and "my named nurse is really helpful". Another person said, "I am supported to make decisions". A carer told us that staff were supportive and, "always available".

People also told us they had opportunities for contact with their community care coordinator. Most people were aware of the advocacy service and how this could be accessed. One person told us this was very helpful to them.

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

People reported their individual needs were being met by staff.

People were supported through their care pathway. There was evidence of planning and developing services to meet people's needs and encourage social inclusion.

Systems were in place for people to give feedback on the service and raise any complaints. There were systems for reviewing complaints within the unit and also across the trust's services, considering if actions were required to make improvements.

Our findings

Planning and delivering services

A pastoral advisor visited fortnightly to support people with their religious and spiritual needs. The service was next to a church and we saw there were strong links as the vicar provided Easter and Christmas services and had supported the OT garden project. The project had involved people, staff and carers. The OT had planned and delivered changes to the garden to make a more usable space and during our visit several people were using it. The garden now included a pagoda, vegetable patch, sensory and decking areas.

The OT reported carrying out activities according to people's level of functioning and interest. They also obtained feedback from people as to what activities were meaningful to them. The OT referred to attending the, 'rehabilitation best practice forum' to learn about other initiatives and practice taking place across services as part of developing their service.

One person told us that they would like an opportunity to undertake training to gain a qualification. The service had employed a specialist community development worker whose role was to support people to link in with community facilities as part of promoting social inclusion. They told us that they had been developing working links with a range of services including charities to support people with education and vocational opportunities. People told us they were encouraged to access community facilities such as social groups.

The service had a vehicle to help with community access for people. However the local town centre was a 20 minute walk away. Staff reported that as part of a transition back to more independent living most people would leave the service during the day and go to the local town.

Right care at the right time

Following admission a review took place after two weeks with people, staff and others involved in their care to give feedback on whether the placement was suitable.

There were opportunities for people to learn, or maintain their skills and independence, to the level they felt they were able to manage. For example, people could carry out laundry, cooking, money management and travel by public transport. In addition to looking after themselves and their room there was a rota for people to take turns to cook for others. Staff supported people as required with shopping and budgeting. If people were unable to do any activities of daily living staff supported them.

We saw that staff were supporting people who had left the service to live in the community as part of their rehabilitation and recovery. This ranged from holding their medication or monies and giving them to people as identified or inviting them back to house open days for socialising and giving them opportunities to talk to people about their lives outside of hospital.

Care Pathway

Margaret Laurie house was part of the care pathway for people with complex mental health needs, who could not be discharged directly from hospital to an independent or supported community placement due to their ongoing high levels of need.

There was an identified referrals process, with most made by community care coordinators for people usually coming out of acute hospitals. Occasionally people came from community placements or from low secure units (out of area). Staff told us there was a waiting list of approximately one month to come into the house.

We asked staff what the average length of stay was and were told five months or less. However the service operational policy inaccurately stated 'four to six weeks'. Most people were then able to move on from hospital to local authority housing, family, residential or supported accommodation with community service support. If people's mental health deteriorated at Margaret Laurie house and the person needed a more specialist service

Are services responsive to people's needs?

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

then staff would liaise with other services in the trust. This demonstrated staff awareness of a care pathway and services being considered for the level of support a person needed as they recovered.

There was a discharge coordinator that attended MDT meetings to aid planning for people's discharge. Some staff told us that there was a lack of less supported accommodation and this could lead to a delay in discharging a person with some staying for up to a year. People using the service, and staff, referred to the community development worker helping them with accommodation and moving on. Prior to discharge a CPA review took place and following it staff sent documentation to the person, their GP and care coordinator.

Learning from concerns and complaints

Systems were in place such as suggestion boxes for people using the service, staff and others to make complaints and give feedback on the quality of care. The service information pack gave information about how to make a complaint. Patient Advisory Liaison Service (PALS) and advocacy services information was displayed for people in the service. The trust website gave additional information for people.

Most people we spoke with were aware of how they could give feedback on the service or make a complaint. The manager reported there had not been any recent complaints. The manager told us that a bathroom and toilet had been refurbished in response to a person making a past complaint. During our visit a person raised a complaint with us and staff. We saw that action was taken to report and allocate a member of staff to investigate the matter.

After our inspection we received some feedback from a person regarding waiting a long time for support and counselling. Staff had told us that their previous psychologist had left five months ago and the post was vacant but the manager told us recruitment was underway.

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

Staff were aware of the trusts visions and values.

Staff had an understanding of the governance framework function to review the performance of the service and make improvements where needed.

Staff told us they felt well led and supported by their direct and senior managers.

People who use the service and staff felt able to contribute to the future development of the service.

Our findings

Vision and strategy

Information was available for staff, people who use the service and others regarding the trust's vision and strategy and future plans to improve the service. We saw that the trust's four key values: treat people well, involve not ignore, create respectful places, open, inclusive and accountable were also measured through trust 'periodic service reviews'. Staff spoke of using a recovery approach in their work in line with the service operational policy.

Responsible governance

Staff described various ways in which they received information from the board and other governance meetings. For example they referred to their manager attending a monthly Quality Action Group meeting and giving feedback to the team about key information within the organisation. For example we saw that key issues such as serious incidents, complaints and safeguarding issues were discussed in team meeting minutes. Staff reported information and developments were publicised on the trust intranet and through the weekly email.

We saw there were a range of audit and governance systems at service level and trust level to monitor and review the service provided, such as auditsd of electronic patient records and periodic service reviews which were undertaken by staff from other services.

Leadership and culture

Staff felt they were well led at local and senior levels. Staff said there was good team working and good support in their work. All staff said their manager/supervisor was accessible for advice and guidance as required.

There were opportunities for staff to undertake training such as leadership, supervision and mentorship as appropriate to support them in their roles. From the NHS staff survey 2013 the trust rated in the top 20% of staff feeling satisfied with their work and care given.

Staff talked about the chief executive and board members undertaking 'walkabouts' at services and the chief executives 'conversation' with staff. They felt able to give feedback on the service.

Staff told us that the pressures in their work and service were acknowledged and known and actions were taken to make improvements.

The trust operated a staff achievement and recognition scheme where people using the service, staff or others could nominate individual staff or a team who deserved special recognition for their work. Categories included, 'team of the year' and the Margaret Laurie House staff team had won the silver award.

Engagement

Margaret Laurie House had a visitor's information board near the main entrance. This gave information about the service and trust such as the Forum of Carers and people who Use Services groups (FoCUS) giving opportunities for people to get involved in the trusts work and meet others using services. We saw information encouraging people to become 'a member' to help influence how the trusts services were run.

Additionally the trust had developed a system for gaining more real time feedback from people through use of the, 'your view matters' website where staff gave tablet devices to people or cards with website details following meetings to get feedback on the service provided. We saw that feedback from this was discussed in community meetings.

The trust website described the 'connecting for a better life' project focusing on talking to people, both within and outside the Trust, to find out how to work together for a better life for people in the community.

Staff told us about a communication bulletin from senior managers with updates on issues relevant for their work. Staff told us there were opportunities to give feedback on issues via supervision, appraisal and team meetings or they could email feedback to the trust. They were aware of whistleblowing procedures and knew how to use these should the need arise.

Are services well-led?

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Performance improvement

There were regular performance meetings attended by senior staff from the team, where issues such as performance, incidents, and plans for improvement were discussed.

Any specific highlighted risks for the service were communicated from the trust to the manager through key performance indicators, which was then communicated to staff. There were systems for monitoring and tracking the team's performance for example capturing staff's attendance at training and sickness.