Surrey and Borders Partnership NHS Foundation Trust

Services for older people

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)
Farnham Road Hospital (Mental Health Unit)	RXX22	Victoria Ward/Albert Ward	GU7 7LX
St Peter's Site	RXXW1	Spenser Ward/Hayworth House	KT16 0TA
West Park Epsom	RXX2T	Bluebells 1 Ward/Primrose 1 Ward	KT19 8PB
Woking Community Hospital	RXXXX	Willow Ward	GU22 7HS
Trust Headquarters	RXXHQ	Community Mental Health Teams for Older Adults in Woking, Guildford, East Surrey (Oxted), Runnymede and Waverley	KT22 7AD

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

Staff in the older people's services delivered services in a thoughtful and compassionate manner and people who used the service were positive about the service they received from staff.

We received positive feedback from people and families of people who used the service. We observed positive interactions and skilled dementia care being delivered in inpatient settings. We saw that staff who worked across the services showed commitment to people who used the service. In the community mental health teams for older people we saw that staff showed a sensitive and respectful approach which was reflected in comments by people who used the service. Staff from the community teams and inpatient services worked well together.

We found however that there were variations in the inpatient services, not only between sites but also between wards on the same site. Willow ward at Woking Community Hospital had made significant improvements and was now fully compliant. At Farnham Road Hospital, Albert ward was working well but Victoria ward needed to improve in a number of areas that could affect the care and welfare of people using that service. Quality assurance processes such as health and safety audits had not identified all the areas for improvement on Victoria ward including the fact that 18 out of the 20 call bells were not working.

Another area of concern in services for older people were that patients admitted to the inpatient services had not always had comprehensive assessments including tissue viability and falls, which meant that risk was not clearly identified at the Meadows and Victoria ward and so care plans were not always in place. This meant that there was a risk that patients would not have all their needs met. The introduction of "quality matrons" were supporting ward staff to address these issues but further work was needed.

Staff across the older people's services told us that they felt supported by the leadership locally. However, some staff in inpatient services told us that they felt there was a disconnect with higher level leadership across the trust.

Summary of findings

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

Are services safe?

Staff across inpatient and community services had a good understanding of safeguarding and how to respond to allegations of abuse.

Staff were aware of how to report incidents. However we saw that sometimes information about incidents was not fed down to all the inpatient staff teams so they knew about the learning.

The safe staffing initiative was helping to ensure there were enough staff on the wards to meet the needs of patients.

Emergency medication and resuscitation equipment was available and monitored in inpatient areas.

The quality of risk assessments was variable and this meant on some inpatient wards that risks associated with falls and the development of pressure ulcers had not been identified so appropriate care plans could be put into place.

Audits were available to identify environmental risks in inpatient wards but these were sometimes not completed thoroughly and risks were not being identified or addressed.

Are services effective?

Across the inpatient services, appropriate referrals had been made where people were deprived of their liberty and needed to be assessed for authorisations to be granted. However, we saw on Victoria ward that some mental capacity assessments were not completed according to the best practice guidance in the Mental Capacity Code of Practice as capacity had not been recorded on a decision specific basis.

Most people using inpatient services had their physical health assessed during their admission but on some wards ongoing physical health checks might not be taking place as they were not recorded regularly.

There were many positive examples of good multi-disciplinary working across the inpatient and community services. The trust services for older people were also working well with other partner statutory and voluntary agencies.

Some memory services and one inpatient ward had been accredited through the Royal College of Psychiatrists. This meant that they were able to benchmark against external services and staff in those services were members of a peer network which ensures that good practice could be shared.

Summary of findings

Staff in the community and inpatient teams were provided with support to carry out their jobs. However, on Victoria ward staff had not had access to regular supervision and appraisals.

Are services caring?

We observed and people told us that kind and compassionate care being delivered in the inpatient and community services.

Opportunities for people who use services or their carers to be involved in decisions about their care or service provision was mixed. We saw that in some of the dementia services such as Albert ward, family members had been involved in care planning and discussions around services. On Victoria ward and on Spenser ward we saw little evidence that people had been involved in care planning in the care plans that we checked.

Many of the carers we spoke to said they found the trust had been responsive to issues they had raised.

Are services responsive to people's needs?

Most people were offered access to community services in a timely manner and where this was not possible people were informed about this.

We were told that usually beds were available for older people but as people were admitted across the trust's geographic area some people were admitted to inpatient services which were not local to their community team.

Services were sensitive to peoples ethnic, cultural and religious needs.

We saw that there was information available in the community teams and on the inpatient wards about how to make complaints and staff were aware of how to respond to complaints. There had been a number of recent complaints in the service and most staff were aware of them.

Are services well-led?

Most staff across older people's services were positive about their teams and wards. Most staff told us that they felt supported by their manager.

However we saw that in inpatient services there was an inconsistency in how concerns and difficulties in the service had been managed and there was a lack of evidence that lessons learnt in one part of the service were shared across the division.

Summary of findings

The governance processes were not working well as we saw that there was a wide variation in the quality of care delivered across the services for older people.

Summary of findings

Background to the service

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 adults and children 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 as part of this comprehensive inspection. Willow ward where there had been previous enforcement action was now fully compliant. At Farnham Road Hospital, Albert ward was much improved since the last inspection but Victoria ward still needed further work. While most of the previous compliance actions at Farnham Road Hospital were now met the compliance action about assessing people and managing risks associated with falls and the development of pressure ulcers had not been fully completed and so this compliance action is restated.

Older people's services are based in the community and in a number of inpatient wards across Surrey.

There are a number of community mental health teams for older people based across the area covered by the Trust. We visited the teams in Woking, Guildford, East Surrey, Runnymede and Waverley.

There are two wards at Farnham Road Hospital, Victoria ward and Albert ward. There are two wards at St Peter's Site, Spenser ward and Hayworth House. There are two wards at West Park Epsom which are known collectively as "The Meadows" , Bluebell 1 ward and Primrose 1 ward and there is one ward at Woking Community Hospital, Willow ward. We inspected all the inpatient services.

The older people's services also have a specialist liaison service which is based in all general hospitals in Surrey. We did not inspect this service.

Summary of findings

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?
- 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.

Summary of findings

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 St Peter's Hospital.

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

We saw that the trust completed regular surveys which allowed people to feedback to the service about their experiences of the care which they had received. We saw that most of the feedback from these surveys was positive.

We spoke with people who used the service and also received primarily very positive feedback. We left comments cards in the locations we visited but did not receive any which related specifically to services provided by older adults services.

Prior to our inspection we met with service user groups in the local areas covered by the trust to ensure that people had the opportunity to provide feedback about their experiences of the services provided however there were not specific comments which related to older people's services.

Good practice

- Albert Ward and Hayworth House had developed dementia friendly environments including reminiscence rooms.
- Spenser and Albert wards had regular meetings for the carers of people who used the service to encourage participation and engagement.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that all the people using the inpatient services for older people have their regular physical health monitoring checks such as weight and blood pressure especially on Victoria ward.

Summary of findings

- The trust must ensure that all the people using the inpatient services for older people have assessments in place for falls and tissue viability so that appropriate risks assessments and care plans can be put into place if needed.
- The trust must ensure in the division for older people that governance processes are working effectively so that services which are not performing well are identified and improvements made to ensure consistently high standards of care.

Action the provider SHOULD take to improve

- The trust should ensure that learning from incidents occurs consistently across all the services in the division for older people.
- The trust should ensure that health and safety audits are completed thoroughly to identify environmental repairs that are needed to maintain the safety of people using the service such as the call bell system in Victoria Ward. Where these risks are identified they must be addressed in a timely manner.
- The trust should ensure that across the older peoples inpatient wards that people using the service and carers are given an opportunity to be involved in the development of their care plan.
- The trust should ensure that across the older peoples inpatient wards that Mental Capacity Assessments are completed and recorded correctly.
- The trust should ensure that staff on Victoria ward have access to regular supervision and team meetings so they are supported to undertake their roles.
- The trust should ensure that on Victoria ward regular meetings are held so people using the service can be involved in decisions about the service provision.

Detailed findings

Surrey and Borders Partnership NHS Foundation Trust

Services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Victoria Ward/Albert 1 Ward	Farnham Road Hospital
Willow Ward	Woking Community Hospital
Spenser Ward/Hayworth House	St Peter's Site
Primrose 1/Bluebell 1	West Park Epsom
Community Mental Health Teams for Older People Woking, Guildford, East Surrey (Oxted), Runnymede and Waverley	Trust Headquarters

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.

Generally we found that the services adhered to the Mental Health Act 1983 and were aware of the proper use of the Mental Health Act (1983) Code of Practice.

Most peoples' capacity to consent to care and treatment was recorded together with how this decision had been made by the responsible clinician.

We saw that discussions with people were held and their views were recorded. There were some isolated issues which were picked up on specific wards. For example on Victoria and Albert ward there were some discussions with statutory consultees which had not been documented.

On Victoria ward we saw that the sign which explained to patients that they had the right to leave the ward was on the outside rather than the inside of the door.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

People had been appropriately referred for assessments under the Deprivation of Liberty Safeguards on inpatient wards. Some staff displayed a good awareness and understanding of the Mental Capacity Act. However, we found that on some wards, for example Victoria and Spenser, documentation and assessments of capacity were not completed in accordance with the Mental Capacity Act Code of Practice by ensuring that when decisions were made about the capacity of people, this was done clearly on a decision-specific basis.

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

Staff across inpatient and community services had a good understanding of safeguarding and how to respond to allegations of abuse.

Staff were aware of how to report incidents. However we saw that sometimes information about incidents was not fed down to all the inpatient staff teams so they knew about the learning.

The safe staffing initiative was helping to ensure there were enough staff on the wards to meet the needs of patients.

Emergency medication and resuscitation equipment was available and monitored in inpatient areas.

The quality of risk assessments was variable and this meant on some inpatient wards that risks associated with falls and the development of pressure ulcers had not been identified so appropriate care plans could be put into place.

Audits were available to identify environmental risks in inpatient wards but these were sometimes not completed thoroughly and risks were not being identified or addressed.

Our findings

Track record on safety

Most staff we spoke with across services for older people were able to recognise incidents and were aware of the process to report incidents. All staff were aware of their responsibilities to complete initial incident forms and these were reviewed by managers to ensure that they were recorded appropriately.

Learning from incidents and improvingsafety standards

In the division for older people there was a monthly quality action group meeting. These looked at incidents that had occurred in the division and the learning from them. There was a ward managers' quality forum that met monthly. We were told that serious incidents were discussed at a risk panel and information about them, including a root cause analysis would feed down to the service manager and action plans were put into place.

We found that the learning from incidents at a ward level was very mixed. Some staff we spoke to had a good understanding of incidents which had occurred and were able to give us examples of how this had led to changes in practice which had improved safety. Some wards reported that they had good systems in place to ensure that information was shared and that incidents were discussed across the service regularly.

We saw on the divisional risk register for older peoples services that serious incidents relating to falls on Bluebell Ward had been highlighted as a risk. The learning from this did not appear to be shared across the division as we found on Victoria ward that people did not consistently have falls risk assessments and care plans.

On Victoria ward there were no records of any staff meetings. This meant that there was not a forum for the staff team to discuss together about their learning from incidents.

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

Staff we spoke with on all the wards displayed a good understanding of safeguarding vulnerable adults and knew how to identify safeguarding concerns and how to raise an alert. Most staff told us they had completed relevant mandatory safeguarding training although on Bluebell, Primrose, Victoria wards and on Willow ward there was not a clear record of the training staff had received.

We saw that issues relating to safeguarding were discussed in multidisciplinary team meetings when it was appropriate and this ensured that learning was embedded in the ward teams. We saw on the wards we visited that safeguarding concerns had been referred appropriately. People on the wards that we visited, and their family members told us that they felt safe. Safeguarding had been a previous area of non-compliance at Farnham Road hospital but was now compliant.

Are services safe?

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

Assessing and monitoring safety and risk

Across all inpatient services for older people, we saw that the trust had recently adopted a safer staffing initiative which had increased staffing levels on inpatient units. Wards had their current staffing levels on display and people were able to see how many qualified and unqualified staff were on duty during the day and night and this was monitored by the trust.

When we last inspected Farnham Road Hospital in October 2013 we were concerned there were not enough skilled and experienced staff and made a compliance action. At this inspection we found the service was now compliant.

When we inspected Willow ward in January 2014 we were concerned that there were insufficient numbers and skills of staff to ensure people's safety and welfare. We took enforcement action to ensure people's safety and welfare. When we returned to the service in July 2014 we found that people had care and support provided by staff who were both skilled and knowledgeable about their needs. Staff knew how to assess people using the service to ensure risks were identified and addressed such as the risk of pressure ulcers or poor nutrition. Willow ward was now compliant in this area.

There had been an appointment in the division for older people of 'quality matrons' who were starting to implement 'quality plans' in specific areas such as falls management and nutrition however this system was not yet embedded at the time of our inspection. For example the trust had developed a falls action plan however this was not yet implemented across all the wards. On Victoria ward we checked care plans and saw that some patients did not have a completed falls care plan, including people who were identified as being at risk of falls. We also saw that while there was a plan to ensure that people had an assessment of their skin integrity on admission to the inpatient services, this was not happening consistently on Victoria ward so people who were identified as being at risk of developing or who had developed pressure ulcers, did not have assessments or care plans which demonstrated how issues relating to tissue viability were being managed. The management of risks associated with falls and tissue viability was an area of non-compliance at the previous inspection of Farnham Road Hospital. Whilst some work has taken place there is more to do and so this compliance action is restated.

We checked individual risk assessments on all the wards we visited and found a variation in the quality of the assessments. On Albert ward, Spenser ward and Hayworth House we saw that risk assessments were completed comprehensively and that care plans were linked directly to risks which had been identified. On Victoria ward we saw that some risk assessments were not updated with the most recent incidents.

Understanding and management of foreseeable risks

We saw that services had contingency plans in place to ensure that foreseeable risks were mitigated. We checked the emergency equipment and medication in all the wards we visited and found that it was ready to be used. Sufficient staff across the service were trained in emergency life support.

Clinical areas carried out local health and safety audits quarterly. These audits ensured people were protected from risks in the physical environment of the wards. However, we saw that there were some issues which had not been identified in these audits on Victoria ward. For example, we checked the call bells that people used to call for members of staff. Out of twenty in place, eighteen were not working at the time of our inspection. This meant that there was a risk that people who needed to contact staff were not able to call them safely. This had not been identified in a local health and safety audit which had taken place the week before our inspection visit. This issue was addressed on the day of our inspection when it was identified. At the Meadows, one of the gardens was unsafe as the lock to the gate leading to a trust site access road was broken, as was a manhole cover. The trust made arrangements to have these repaired on the day of our visit.

One fire door on Victoria ward had a gap which meant it would not protect people from a fire or smoke were there to be a fire on the ward. Environmental issues which had an immediate impact on the safety of people on Victoria ward had not been identified and actioned by the trust.

Ligature risk assessments had been completed on the wards. The trust had a ligature action plan in place including a ligature minimization programme.

Are services safe?

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

When we inspected the Willows in January 2014 we were concerned that the premises were poorly maintained and unsafe. This time we found that the Willows was well maintained and safe for people using the service. This compliance action is met.

Each ward had an infection control lead. We saw that care was provided in clean and hygienic environments. Staff, people who used the service and visitors had access to sufficient hand washing facilities.

Community services for older people

Track record on safety/ Learning from incidents and Improving safety standards

The community mental health teams for older people had a good safety record. There had been a total of four serious incidents in the past year requiring investigation. The service was able to detail the circumstances surrounding these and able to identify where any learning had taken place.

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

The community mental health teams for older people had lone policy procedures in place, and staff were able to explain how these were put into practice.

Staff members were able to give examples of how people were kept safe and how safeguarding concerns were responded to and how other agencies were alerted as appropriate. Staff were able to detail the actions they would take if they had individual safeguarding concerns within the service.

Assessing and monitoring safety and risk/ Understanding and management of foreseeable risks

Caseloads for community mental health teams for older people were high, but staff told us they were manageable. Some staff told us they regularly worked over hours to complete documentation and felt more administrative support would enable this part of the work to be dealt with more effectively, allowing more time for 'face to face' work.

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

Across the inpatient services, appropriate referrals had been made where people were deprived of their liberty and needed to be assessed for authorisations to be granted. However, we saw on Victoria ward that some mental capacity assessments were not completed according to the best practice guidance in the Mental Capacity Code of Practice as capacity had not been recorded on a decision specific basis.

Most people using inpatient services had their physical health assessed during their admission but on some wards ongoing physical health checks might not be taking place as they were not recorded regularly.

There were many positive examples of good multi-disciplinary working across the inpatient and community services. The trust services for older people were also working well with other partner statutory and voluntary agencies.

Some memory services and one inpatient ward had received accreditation through the CCQI (College Centre for Quality Improvement) through the Royal College of Psychiatrists. This meant that they were able to benchmark against external services and staff in those services were members of a peer network which ensures that good practice could be shared.

Staff in the community and inpatient teams were provided with support to carry out their jobs. They had regular supervision and appraisal and staff were supported to attend training. Some teams had had access to continuous professional development days which had focussed on learning in specific, relevant areas. However, on Victoria ward staff had not had access to regular supervision and appraisals.

Our findings

Assessment and delivery of care and treatment

When we inspected Willow ward in January 2014 there were inconsistencies in people's assessments and care records and people were not provided with meaningful therapeutic activities. We took enforcement action to ensure people were protected from the risks associated with inadequate care planning. When we returned to check compliance with the warning notice we found that people's individual assessments and care plans were in place. Where risks were identified these were addressed in their care plans. We saw that families and advocates were involved in planning people's care, including end of life care plans. Relatives told us they had copies of the care plans. Willow ward is now compliant in this area.

We checked the management of medication across the wards for older people and found that there were appropriate systems in place to ensure that medication was managed.

While some area of the services, such as Hayworth House and Spenser ward were working with a strong recovery focus, we did not see this evidenced in the care planning documentation on Victoria ward.

Some members of staff had received specific training regarding the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) and we found that appropriate applications had been made for DoLS. However, we saw that there were poor mental capacity assessments in the clinical documentation. For example, on Victoria ward we saw that assessments were completed in the case notes which did not specify which decisions a person lacked the capacity to make which is contrary to the Mental Capacity Act (2005) and the Mental Capacity Act Code of Practice which states that assessments are decision-specific. We also saw that some assessments of mental capacity were written in very vague terms without it being clear how decisions were made by clinicians when people lacked the capacity to make specific decisions. This showed that there was not a consistently robust adherence to the Mental Capacity Act (2005) and the principles therein.

The service had a target that people's physical health would be monitored regularly. We checked records and saw that people had an initial physical health check by doctors when they were admitted to the wards. Most people had routine monitoring checks of their physical health although this was not the case in all the records we looked at. We saw that on Victoria ward some people who had been admitted to the ward had not had regular checks of their weight, blood pressure and nutrition recorded. This meant that there was a risk that physical health concerns may not have been picked up and could lead to a deterioration in people's physical health outcomes.

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.

We saw some good examples of physical health being promoted such as access to fruit and snacks through the day on Victoria ward. There was information available about smoking cessation in Spenser ward. We also saw people accessing services from the dietician where needed.

Outcomes for people using services

Willow ward used an observational tool designed to measure outcomes for people with dementia who may not be able to express their experiences verbally. We reviewed the most recent audit undertaken in June 2014 and saw how it was used to provide the trust with an understanding of how people experienced the service and how care was provided to them.

At the Meadows whilst staff had been trained to use this observational tool, it had not yet been implemented.

Spenser ward had been accredited as excellent by the Royal College of Psychiatrists.

Staff, equipment and facilities

We asked staff on the ward about their training and access to training. We also looked at training records. The trust was implementing a new electronic system for recording and monitoring staff training. In some wards, including the wards at the Meadows, (Bluebell and Primrose), Victoria ward and Willow ward, senior staff were unable to provide us with accurate information about staff training. We were told that most staff had completed statutory and mandatory training. Some staff across different wards told us that training had been cancelled and some training had not been update. We saw that across some sectors that there had been recent CPD (continuing professional development) days which had started and covered specific areas such as nutrition and speech and language therapy. An example of this was two workshops which had taken place on the Meadows. This ensured that staff were kept up to date with information about the services in which they worked so staff had access to some specialist training within the area in which they worked.

Most staff received inductions when they started with the service which included local and service specific induction. Most staff received regular supervision and appraisal however on some wards, including Victoria ward, some staff told us that they had not had supervision regularly for over a year.

On Willow ward staff told us they felt very well supported and described how senior staff supported them to reflect on the service they provided. The service provided daily reflective practice to staff on the unit.

People had access to therapeutic activities which were structured in different ways depending on the ward and hospital in which they were based. Some wards, for example, Albert ward had specific activities co-ordinators and volunteers who visited in the evening and weekends to augment staffing for activities. We saw that people on Albert ward had memory boxes and access to a reminiscence room. On Spenser Ward we saw that activities had a strong therapeutic, recovery focus and people on the ward could access activities on site for working age adults as well as activities specifically based within the older people's division. At the Meadows and on Victoria ward there was an unplanned reduction in occupational therapy input for people but we saw that people were provided with alternative group and individual activities.

We saw that some activities, particularly on Spenser ward had a strong recovery focus with groups led by psychologists and occupational therapists which were aimed at people working towards discharge. People told us that they found these activities useful.

Multi-disciplinary working

There were close working links between community mental health teams for older people and the inpatient wards. This meant that people had input from teams who were familiar to them in the community and there was access to different professionals. Most wards had access to occupational therapy input. Some wards had access to psychology input and we were told that there were plans to develop this further. There were positive working relationships between the local authorities in the area and the mental health trust. Information was shared between relevant organisations to ensure that people received appropriate care.

At the wards at the St Peter's site, Spenser Ward and Hayworth House, we were told that advice regarding pressure ulcer management could be obtained via community nurses via GPs. We were told that the trust was employing a nurse with experience in tissue viability however this was not in place at the time of our inspection.

At the Meadows, we observed an occupational therapist undertake a home visit in preparation for a person's

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.

discharge. From discussion with the therapist and the person, it was evident that there was a strong focus on ensuring the person's discharge from hospital was successful.

Mental Health Act (MHA)

We visited each ward with a Mental Health Act Reviewer who had specific expertise in reviewing and monitoring the use of the Mental Health Act. We found that most staff were aware of their responsibilities under the Mental Health Act and the trust had suitable systems in place to ensure that the Act was upheld. Most peoples' capacity to consent to care and treatment was recorded together with how this decision had been made by the responsible clinician. We saw that discussions with people were held and their views were recorded. There were some isolated issues which were picked up on specific wards. For example on Victoria and Albert ward there were some discussions with statutory consultees which had not been documented. On Victoria ward we saw that the sign which explained to patients that they had the right to leave the ward was on the outside rather than the inside of the door.

Community services for older people

Assessment and delivery of care and treatment

Referrals to the community mental health teams for older people were made through GPs. Every team we visited told us they had good relations with GPs and the system worked well.

Staff told us how medication arrangements, where necessary, worked. Staff had limited involvement in medication.

Staff in community mental health teams for older people told us of the arrangements they had in place to ensure basic physical health was maintained, and gave examples of where concerns about physical health had been acted upon.

We saw lots of clear informative leaflets and booklets available for people using the community service. One person who used the service told us; "I can get lots of information and help."

We spoke with managers of three care homes who received support from community team staff. They were all complimentary about the support offered by different teams. Staff at one of these homes told us of the promptness and effectiveness of responses.

Outcomes for people using services

We saw how community mental health teams for older people were arranged to ensure optimal outcomes for people using services.

Three community mental health teams for older people had their memory services accredited with the Royal College of Psychiatrists. Of these, two were accredited as excellent. Other services we visited told us they were in the process of applying for accreditation.

The teams ran time-limited 'lifestyles matters' courses. These are recommended by NICE . One person who used this course told us, "Great; really wonderful. It has helped me tremendously."

We saw a 'Memory Matters' group being run effectively and sensitively. People were clear on the aims of the group and comments to us afterwards by users of the service were all complimentary.

Staff, equipment and facilities

Some community mental health teams for older people had offices attached to hospital sites while others were attached to other community services. Some were less accessible, because of parking or geography. These teams tended to offer more home visits. Where an office was upstairs, there was a ground floor room available for appointments.

Staff in community mental health teams for older people were generally positive about their offices and working environments.

Staff in community mental health teams for older people told us they were well supported, had appraisals, clinical and management supervision, and had access to advice and support when they needed it. Staff saw this as the most important element of support. They told us they received relevant training in statutory and specific areas, such as dementia and specific areas of functional mental health. A manager acknowledged that the new electronic staff training record system was having 'teething problems' and was not fully showing training that had recently taken place.

We saw details of induction procedures at one team, and at another a new staff member told us of satisfactory induction processes they had undertaken.

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.

Multi-disciplinary working

We saw evidence of effective multi-agency working. In some cases, social workers and other health professionals worked within the teams. In some teams, social workers were regular attenders at multi-disciplinary team meetings. Teams had links with local voluntary sector providers such as The Alzheimer's Society.

The community mental health teams for older people also had physiotherapy, speech and language therapy and dietician input. Team members told us they worked together well to ensure people had the most appropriate input.

A community nurse in one team expressed discontent with the information flows from inpatient wards, saying the team had often not been informed when people using their service were admitted as inpatients, only when they were about to be discharged. They acknowledged this was improving following the creation of a hospital liaison service which had helped improve co-ordination and communication.

Mental Health Act (MHA)

Staff in the community mental health teams for older people told us they could contact an approved mental health act professional (AMHPs) if they thought a person needed to be assessed to decide if a detention under the Mental Health Act was appropriate.

Are services caring?

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

Summary of findings

We observed and people told us that kind and compassionate care being delivered.

Opportunities for people who use services or their carers to be involved in decisions about their care or service provision was mixed. We saw that in some of the dementia services such as Albert ward, family members had been involved in care planning and discussions around services. On Victoria ward and on Spenser ward we saw little evidence that people had been involved in care planning in the care plans that we checked.

Many of the carers we spoke to said they found the trust had been responsive to issues they had raised.

Our findings

Kindness, dignity and respect

At our inspection in January 2014 we found that on Willow ward some people were not always addressed in a respectful manner. We took enforcement action to ensure people were treated in a dignified and respectful manner. When we returned to check compliance with our warning notices we observed warm and respectful interaction from staff. Staff had supported many of the people for several years and their approach and engagement reflected this. Relatives spoke very highly about staff and their interaction with people on the ward. Willow ward is now fully compliant in this area.

We spoke with people on all the wards we visited and we spoke with some family members who were visiting the wards. We also used structured observations to understand how people who were not able to communicate with us experienced care on the ward.

People told us that they received care which was delivered with kindness and thoughtfulness. On Victoria ward people told us “staff are very good”, “I don’t think I would have got better without the support of doctors and staff” “My husband visits and is made very welcome”. Some people raised concerns about the number of temporary staff and told us that “staff are too busy”. People told us that things were explained to them and that they were treated with respect.

On Spenser ward people told us “I feel well looked after” and “the staff are very good”. At Hayworth House someone told us “I am pleased with all the support I receive from the staff which helps me retain my independence”.

Observations which we carried out on Albert ward, Hayworth House, the Meadows and Willow ward showed high levels of positive staff interactions with people using the service with some of these clearly enhancing mood and general wellbeing. Staff on the ward used eye contact and touch to aid communication and provide reassurance when people were upset. Staff we spoke with had a clear understanding of the importance of meaningful interactions and ensuring individual wellbeing.

In the Meadows we saw that family members were asked for information about people when they first came into the service and used a ‘this is me’ document which recorded preferences and social history. This information was used to make a profile for each person however these documents were kept in the office and were locked away. It was not clear how this information was incorporated into personal care plans.

People on Willow ward were dependent on staff to ensure their privacy. We observed staff knocking before they entered people’s rooms. On Willow ward bedroom observation panels could not be closed from the inside and this could affect people’s privacy and dignity.

At the Meadows (Bluebell and Primrose wards), people’s individual confidentiality was compromised by the location of the office adjacent to people’s communal living space. We were able to hear medical staff talking with one person who used the service while we were sitting on a sofa carrying out observations. We also observed staff speaking about people who used the service in the main communal area. These issues risked compromising people’s right to privacy.

People using services involvement

We checked a sample of care plans on the wards we visited. We found some examples of good care plans which had involved people and their families and where it was clear that people had been involved in the development of care plans. We found that most staff were aware of best practice and ensuring that this was embedded. For example, we saw that the quality plans in the older adults division referred to NICE guidance and that the ward consultants were aware of the relevant guidance.

Are services caring?

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

However, we found that there were some care plans, on Victoria ward and at the Meadows (Bluebell and Primrose wards), which did not evidence the involvement of people who used the service. People we spoke with on Victoria ward told us that they were not always aware of what was in their care plans. At the previous inspection of Farnham Road Hospital there was non-compliance for the involvement of people as there was limited information available for patients on the advocacy services and how to complain. This has now been addressed and this compliance action has been completed. On the wards at the Meadows people told us that they were not involved in care planning and no-one we spoke with had a copy of their care plan. The care plans we reviewed at the Meadows (Primrose and Bluebell wards) were up to date with additional plans entered early July 2014 around meaningful engagement with the individuals. On Spenser ward people told us that they understood and knew the care which they were being provided with but we did not find evidence of the user voice consistently in care plans.

We spoke with an advocate at the St Peter's Site (Hayworth House and Spenser ward) who told us they visited the wards weekly. There was information available in the wards about advocacy services. We were told that on Victoria ward, advocates visited on request but not as a matter of course.

Some wards had regular meetings to involve people who were on the wards in decisions about the service. For example, Spenser ward had a weekly meeting where there were minutes which were put on display and action points were noted beside the minutes so people could be updated about issues that were raised. In the Meadows, the modern matron had just started community meetings however minutes of these were not available for us to review. This showed that people were actively involved in the ward and were able to feedback. However, on Victoria ward there were no meetings or formal process for group feedback about the ward.

Emotional support for care and treatment

Most carers we spoke with on the wards we visited told us that they were involved in discussions about their family members. We saw that some wards, for example, Albert ward, had regular carers' support groups and that feedback from these groups had been very positive. On Willow ward relatives attended regular carers' meetings. We reviewed the minutes of these and saw how they were encouraged to advocate on behalf of their relatives. Relatives told us that the trust had been responsive to issues they had raised at previous meetings.

Community services for older people

Kindness, dignity and respect

On each of our visits we saw that staff in community teams were committed, motivated and enthusiastic about supporting people to maximise their independence and well-being. We witnessed warm, sensitive and professional approaches to users of the service in all the interactions we saw. These included individual and group environments. Staff we spoke with showed a good awareness of the individual needs and individual circumstances of people they supported. This meant they were able to meet their needs in a sensitive and respectful way.

People using services involvement

We saw evidence of carers and users of the community mental health teams for older people being involved in assessments and treatments**.** One relative told us "The community nurse always asks for our opinions and we both feel involved."

We saw completed surveys undertaken by the trust that showed positive responses from users of the service which focused on involvement, information, dignity and respect.

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

Most people were offered access to community services in a timely manner and where this was not possible people were informed about this.

We were told that usually beds were available for older people but as people were admitted across the trust's geographic area some people were admitted to inpatient services which were not local to their community team.

Services were sensitive to peoples ethnic, cultural and religious needs.

We saw that there was information available in the community teams and on the inpatient wards about how to make complaints and staff were aware of how to respond to complaints. There had been a number of recent complaints in the service and most staff were aware of them.

Our findings

Planning and delivering services

The trust had carried out a "deep dive" review of services for older people. This provided detailed information on how the service was being delivered.

Right care at the right time

We were told that people were admitted to inpatient beds in the older peoples services wherever the beds were available which meant that sometimes people had to travel long distances to access care services. Staff on the wards told us that usually beds were available when they were needed.

The trust had separate wards for functional and organic mental health needs for older people which was in line with recommendations from the Royal College of Psychiatrists.

Older people were not commissioned to receive support from the trust's home treatment teams. We were told that the older adults' community mental health teams provided support when people needed additional levels of care. However, this service was not available out of hours.

Care Pathway

People told us that services had been sensitive to their individual needs. We saw examples, in the services that we visited, that people's needs had been adjusted based on their religious and cultural needs. For example, we saw that there was access to a chaplain in the wards if it was required and information was available on wards about this. One person on Victoria ward told us that as a devout Christian, they had found this to be a great comfort to them. We saw on Victoria ward that there were staff who were able to speak in the same native language as a patient on the ward and had been able to provide culturally appropriate care. We found across the wards that staff were sensitive to the individual needs of patients.

Links had been developed between community mental health teams for older people and the relevant wards. Because people were sometimes admitted to wards across the county, people were not always close to home but people did have access to beds when they were needed. We saw that care coordinators from local teams were kept informed of people's progress on wards and invited to discharge planning meetings to ensure that people were followed up after discharge.

Learning from concerns and complaints

On all the wards we visited we saw that there was information displayed about the local complaints procedure and how people could make complaints. We looked at recent complaints which had been made across the service. We found that some staff were aware of complaints in their own services but there was not a consistent understanding of complaints across the service.

On some wards where there had not been regular meetings, we could not see a record to show that complaints had been discussed at a team level. We looked at the time scales for responses to complaints. We were told that sometimes investigations into complaints had taken longer due to the need for police investigations.

Community services for older people

Planning and delivering services

Community mental health teams for older people planned and delivered services to a wide number of people, co-ordinating well with other agencies to meet the needs of people using the service. We were told that when one team had experienced delays because of some long-term sickness to key staff, people using the service had been

Are services responsive to people's needs?

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

informed and support from a neighbouring team had been provided to return waiting times to within acceptable limits. Apart from the exceptional circumstances of this one team, we saw that teams were keeping within their target referral times.

Right care at the right time

We saw that the community teams tried to offer support to people that responded to their individual circumstances. For example they offered choices of home visits, clinic based appointments, or other venues, to meet individual needs.

We accompanied community psychiatric nurses on visits to people using the service. The manager of a care home told us, "The speedy response helps us feel supported and shows respect to us and to the person."

Care Pathway

We saw that people being supported by the community mental health teams for older people were generally being cared for by consistent staff with whom they were familiar and comfortable.

The community teams worked with inpatient services to ensure that admissions and discharges were coordinated.

Learning from concerns and complaint

We saw that staff from the community teams listened to and learned from concerns and complaints. For example, one team told us they had received a number of informal complaints regarding transport. Although they did not directly control this area, they made changes and offered alternatives in response to the concerns.

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

Most staff across older people's services were positive about their teams and wards. Most staff told us that they felt supported by their immediate manager.

However we saw that in inpatient services there was an inconsistency in how concerns and difficulties in the service had been managed and there was a lack of evidence that lessons learnt in one part of the service were shared across the division reaching all the teams.

The governance processes were not working well as we saw that there was a wide variation in the quality of care delivered across the services for older people.

Our findings

Vision and strategy

We saw that information about the trust's vision and strategy was on display in the wards and the hospitals we visited. Some staff were aware of the visions and values of the trust and we noticed that more senior staff had a greater awareness of the trust values and visions.

Responsible governance

We saw that there were quality assurance systems in place. For example, there was a divisional meeting that took place every two months, the quality action group (QAG) which discussed quality issues which were identified at a ward level. We looked at the minutes of meetings which had taken place including the ward manager quality meetings which took place monthly and the action plan from the 'deep dive' review. We were also told about the periodic service reviews which are an audit of each ward or team completed by a peer from within the trust.

We saw that some services had been successful in responding to their action plans, for example, Albert ward, where there had been difficulties identified at a previous inspection and those issues had been addressed. However, on Victoria ward, we saw that issues were identified but had not been fully addressed. We were told that the service had improved since the previous inspection but had "fallen behind" again however it was not clear why there had been a lack of consistent improvement when the issues which needed to be addressed had clearly been identified.

The trust had put effort into developing quality action plans in specific areas such as falls however these were at the early stages of benchmarking and had not yet had a significant effect on the delivery of care in all the areas we visited, for example, the falls quality action plan for Victoria ward identified a number of areas, including completing falls risk assessments, which had not been completed at the time of our inspection.

We saw that each sector had a Quality Matron in post whose role was to support this quality improvement work going forward.

We saw that there were a lot of action plans which were running concurrently. Some wards had achieved significant improvements through these systems, for example, Albert ward, Spenser ward, Hayworth House and Willow ward. However some wards did not seem to have been identified as problematic through the governance systems which were in place. For example, we were told by one member of staff who told us it was their responsibility to audit systems on Victoria ward, that they were aware of the areas where there needed to be improvement but that this had not happened over a period of months due to weak leadership. This meant that the governance systems within the service were not clearly identifying areas for improvement and ensuring these took place.

Leadership and culture

Most staff we spoke with told us that they felt supported by their immediate managers and they told us that they felt able to raise any issues or concerns locally. We saw some evidence of strong leadership within the service and staff told us that they were able to share concerns. Most staff members we spoke with told us they enjoyed working for the trust.

There had been a number of changes in the services we inspected with several relatively new senior staff in the division. Most staff on the wards we visited told us that they felt more confident with the changes in management which had happened recently although there had not been significant time to embed the changes which had been made.

Some staff on Victoria ward told us that there had been a recent change in ward manager and that there was an interim ward manager in place. Most people told us that they felt that there had been a recent positive change in the

Are services well-led?

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culture on the ward as a result of this however, we heard that some staff had previously found it difficult to raise concerns with managers in the service and had not felt supported.

Engagement

We saw that people who used the service had the opportunity to give feedback about their care and treatment on the ward. The trust gathered data in order to inform the development of their services.

There were user groups which the trust set up such as the Focus group. However, there were no specific user or carer groups which targeted older people. This meant that the voices of this user group could be at risk of being lost.

The use of electronic feedback mechanisms through tablet computers had been rolled out to increase the feedback received by the service users and to monitor outcomes. Most wards and community teams collected feedback from people who used the service from tablet devices, such as iPads and through paper surveys. We looked at the feedback response from all the sites we visited and saw that most of it was positive.

Staff told us about their opportunities to engage with the work of the trust. They talked about the 'conversations' with the chief executive when members of staff were chosen at random to meet with the chief executive and provide feedback. Some staff told us that they felt detached from the trust particularly on wards where local management had been highlighted as a concern.

We were told that there were going to be changes to the configuration of inpatient services in the older peoples division. Staff were aware of possible changes however they were not aware of any formal consultation about wards which may be closing.

Community services for older people

Vision and strategy

Staff in the community mental health teams for older people were clearly focused on the trust's core purpose.

We saw evidence of teams doing preventative work. Staff in one team explained the initiative they had started working with local care and nursing homes to assist them in effective interventions at an early stage. This work was aimed at preventing unnecessary referrals.

Leadership and culture/Responsible Governance

Staff in the community teams told us they felt well supported and led and worked well as a team. Staff were open in talking with us and happy to raise issues if they thought it necessary. One staff member said they rarely saw senior managers, but was satisfied that their own manager fed issues upwards.

One site had suffered from having one senior health professional away for a long period. This had resulted in one complaint about long waiting times. The manager advised us that the support staff had done a good job explaining to people the reason for any delays, and the service had been given support by another team.

Engagement

Staff showed us feedback from service user surveys. The ones we looked at were generally positive and had a return rate of around 25%. Staff told us people also sometimes raised issues verbally. In one team this tended to be about transport, in another, about waiting times. Both teams showed they had been able to respond to this

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated activities) Regulations 2010** **Care and welfare of services users** **How the regulation was not being met:** The registered person had not ensured that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of carrying out of an assessment of the needs of the service user and the planning and delivery of care and, where appropriate, the treatment in such a way as to have met the service users' individual needs. They had not ensured the welfare and safety of the service user because there were not records demonstrating that skin integrity and falls risks were monitored and assessed on admission and were not identified in the management of care of people on Victoria ward. Service users on Victoria ward had not had regular physical health monitoring checks such as weight and blood pressure checks. **Regulation 9 (1) (a) (b) (i) (ii)**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:**

Compliance actions

The registered person must protect service users against the risk of inappropriate or unsafe care by means of an effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of services provided.

The current governance processes are not clearly highlighting services in the division for older people which are not performing well such as Victoria ward, so that improvements can take place and be closely monitored.

Regulation 10(1)(a)