Surrey and Borders Partnership NHS Foundation Trust

Services for people with learning disabilities or autism

Quality Report

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Date of inspection visit: 7-11 July 2014
Date of publication: 24 October 2014

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
April Cottage	RXXHK	Unit	RH6 0BG
Bramdean	RXXX1	Unit	TW18 1ED
Trust Headquarters	RXX	Community Team	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

Surrey and Borders Partnership NHS Foundation Trust provides community and inpatient services for people who have a learning disability (LD) or autism.

We found that staff assessed and planned care in line with the needs of each person. Most people who used the services told us that they were involved in their care and were offered a copy of their care plan. Staff recorded people's consent to care and treatment, and, where needed, best interest meetings were held. However, it was not always clearly documented that people's capacity to consent had been assessed.

People who used the services told us that staff had a good understanding of their individual needs and that they were treated with compassion, dignity and respect and did not raise any concerns about how staff treated them. People were involved in decisions taken about their care and information was discussed with, and provided to, people in an accessible format. This included the use of pictures and easy to read materials.

Treatment and support was provided by multi-disciplinary teams and staff worked well together, which benefited people who used the services. There was a single point of referral to the community teams. Each referral was screened and then passed to the most appropriate professional to take the lead on. Staff completed an assessment and developed a care plan for each person.

The inpatient services and community teams both shared good practice across their teams. Staff from the community teams continued to provide support and treatment to people when they were in hospital and provided training, support and guidance to staff when needed.

We found that staff were made aware of serious incidents and that lessons were learnt from these incidents.

We saw that staff worked positively with people, supported them well and were committed to their work. The trust reviewed the service's outcomes, including gathering feedback from people who used the service. Where improvements were needed an action plan was issued; however, feedback and action required were at times delayed in reaching the core services.

We saw good examples of leadership that was proactive and led to effective service delivery. Staff told us that they felt well supported by their line and clinical managers, and would feel confident in raising any concerns with senior staff, if required.

Summary of findings

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

Are services safe?

Staff understood how to report serious incidents and learning from incidents was discussed and put into practice. Staff also knew how to use safeguarding procedures.

Recruitment was taking place to address significant numbers of staff vacancies, especially in the inpatient services.

Staff had received training in how to support people with challenging behaviours.

The services had processes in place to manage any foreseeable risks to people and the service as a whole.

Are services effective?

Treatment and support was provided by multi-disciplinary teams and staff worked collaboratively, which benefited people who used the services.

We found that staff assessed and planned care to meet people's needs. Most people who used the services told us that they were involved in their care and were offered a copy of their care plan. People were supported to access physical healthcare input as needed.

Staff recorded people's consent to care and treatment and, where needed, best interest meetings were held. However, it was not always clearly documented that capacity to consent had been assessed.

A range of daytime activities was offered to people who used the services at April Cottage and Bramdean. However, there were few activities during the evening or weekend.

While staff had received a range of training to carry out their roles, the training records held in the unit had not been updated in the trust electronic staff records which meant some training was potentially not up to date.

Are services caring?

Staff worked positively with people, supporting them well and demonstrating a commitment to providing high quality care.

We saw that good information was available to people about services, including details of advocacy services, the complaints process and a section on 'taking part in your own care', which

Summary of findings

encouraged people to tell the provider what they would like in their treatment plan. The information was given to people in an accessible format. This included the use of pictures and easy to read materials.

The involvement and communication with carers has improved across the services.

Are services responsive to people's needs?

Community teams were flexible to respond to people's individual needs and saw people in a timely manner. The community teams worked collaboratively with inpatient services to ensure people's needs were met and to maintain continuity of care.

People using inpatient services were supported to plan when they would be discharged, although this could be delayed due to social services and clinical commissioning groups experiencing difficulty in finding appropriate community based placements.

People using the services were able to complain and staff were aware of the outcomes of recent complaints and had made changes in response to them.

Are services well-led?

Staff told us that they felt well supported by their managers and had regular clinical and management supervision. Regular individual supervision and team meetings for staff took place.

At Bramdean, staff and people who used the service told us they felt listened too and involved in some decisions. For example, they had been consulted about the recent re-design of the ward and were invited to share their ideas.

There were systems in place for seeking feedback from people who used the services, carers and family members.

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 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.

Surrey and Borders Partnership NHS Foundation Trust provides community and inpatient services for people who have a learning disability (LD) or autism.

Community Team Learning Disabilities (CTLD) services

The community teams for people with learning disabilities carry out assessments of people's health and social needs. They help plan and arrange care and support for adults with learning disabilities and their carers, and provide a range of specific health services such as: occupational therapy; physiotherapy; speech and language therapy; community nursing; psychology and psychiatry.

Inpatient services

- April Cottage is a seven-bedded mixed gender bungalow, providing an assessment and treatment service for adults with a learning disability and mental health problems.
- Bramdean is a seven-bedded mixed gender rehabilitation service caring for adults aged between 18 to 65 years of age, with learning disabilities and mental health problems or severe behavioural difficulties.

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.

The team that inspected the learning disability services, inpatient and community, included a CQC inspector and a variety of specialists: a social worker, a support worker, a Mental Health Act Commissioner and an Expert by Experience, who had used learning disability services.

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 inspection week 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 St Peter's Hospital.

Summary of findings

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

People who used the inpatient services told us that they felt supported by staff and felt that staff had an understanding of their care needs. People told us that staff encouraged them to be as independent as possible but provided appropriate support when needed.

We spoke with people who used the community team services who told us that they felt well supported to make decisions and that the treatment they received was specific to their needs.

Good practice

- People were supported by the behaviour specialists at the community team East, to make a 'how to book' of their recovery plan to help them and others understand the strategies they needed to cope with living in the community.
- Risk assessments were detailed and care plans were person centred and people were involved in decisions taken about their care and information was discussed with, and provided to, people in an accessible way. This included the use of pictures and easy to read materials.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure that locally held training records are updated on the trusts electronic staff records to ensure staff working in learning disability services undertake all the required statutory and mandatory training.
- The trust should ensure that where capacity assessments have been completed that this is recorded.
- The trust should ensure that staff have up to date training on the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The trust should ensure regular fire drills take place in their community team bases.
- People using inpatient services should have access to sufficient activities in the evening and weekend.
- The trust should make sure that actions arising from the trust Periodic Service Reviews (PSR's) are fed back

to the staff working in the learning disability service in a timely way to ensure that where changes and improvements are needed they are made as soon as possible.

Detailed findings

Surrey and Borders Partnership NHS Foundation Trust

Services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Unit	April Cottage
Unit	Bramdean
Teams	Community Learning Disability Teams

Mental Health Act responsibilities

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

The use of the Mental Health Act (MHA) 1983 was mostly good in the inpatient services. Mental health documentation reviewed was found to be compliant with the MHA and the MHA code of practice.

At Bramdean we looked at section 17 leave records for people who were detained under the Mental Health Act 1983. We saw in records sampled that one person was going out on regular section 17 leave but staff could not access a copy of the section 17 leave form on RIO and no paper copy could be located on the ward. Staff told us how many staff were needed to safely support the person but this was not clearly recorded. This meant that there was a risk to the safety of the individual, staff and public. We raised this issue with the ward staff and they immediately requested an up to date copy of the form be sent to them. This was received on the ward by the end of our visit.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that people who were not detained under the Mental Health Act 1983 had all been assessed to see if an authorisation of a deprivation of liberty safeguard (DoLS) was needed. At April Cottage there was one person subject to an authorised DoLS.

An assessment of people's capacity was incorporated into assessments and reviews of people's care. In the community teams, staff told us about situations where they had worked with people and their capacity to consent to complex decision's and the process for best interest meetings. However, it was not always clearly documented that capacity to consent had been assessed. For example, in the East community team a person was presumed to lack capacity and no formal assessment was documented but a best interests meeting was held.

Most staff in the inpatient services did not have up to date training in Mental Capacity Act (MCA) 2005 or Deprivation of Liberty Safeguards (DoLS). For example, at April Cottage the training matrix showed that out of 13 staff, eight staff did not have up to date training in DoLS and seven staff did not have up to date training in MCA. At Bramdean, out of 14 staff, nine staff did not have up to date training in DoLS and seven staff did not have up to date training in MCA.

In the community teams we saw that staff were mostly up to date with training in MCA and DoLS and were able to explain about consent and capacity.

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 understood how to report serious incidents and learning from incidents was discussed and put into practice. Staff also knew how to use safeguarding procedures.

Recruitment was taking place to address significant numbers of staff vacancies, especially in the inpatient services.

Staff had received training in how to support people with challenging behaviours.

The services had processes in place to manage any foreseeable risks to people and the service as a whole.

Our findings

Inpatient services

Track record on safety

Staff spoken with demonstrated that they knew how to report and recognise abuse, felt confident in raising concerns and how they would escalate these if necessary. We were shown the electronic system used for the recording and reporting of incidents. All incidents were reviewed by the managers and clinical governance team for the trust, who would then monitor them.

Learning from incidents and improving safety standards

Staff told us they had access to the trust safety alerts and resources on the intranet. Staff told us they felt supported in reporting incidents and lessons learnt were discussed in both individual supervision sessions and in team meetings. We saw meeting minutes and supervision records which confirmed this was done**.** While there had not been recent incidents in the inpatient services, staff were able to describe learning from incidents from other trusts.

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

People who used the service told us that they felt safe.

Staff had received mandatory safeguarding training and knew about the trust's safeguarding procedures. Staff we spoke with described their understanding of safeguarding and knew how and what to report to ensure that people who used the service were protected from harm. We saw information about safeguarding clearly displayed in the office and on noticeboards on the ward. Safeguarding concerns were also discussed during the weekly multi-disciplinary team meetings and at daily handover's.

Staff showed us a recent safeguarding referral that had been made with updates and actions recorded in the clinical notes. However, the RIO records were difficult to navigate and it took staff some time to be able to track through from the safeguarding referral to the case notes and any actions or outcomes.

Assessing and monitoring safety and risk

We reviewed care records and saw that people's needs and risks were assessed and well documented. The risk assessments detailed the actions that were required to minimise the risk to the individual and support them with their challenging behaviours.

The service managers told us there were vacant posts, for nurses, and support workers. The trust were aware of difficulties around staffing and effective service provision and were recruiting to all posts. For example, at April Cottage, four new members of staff had recently been recruited and were awaiting start dates.

At our last inspection of April Cottage on 12 February 2014 we found that the trust had assessed the unit as needing ligature points removed, however these had been removed inconsistently. At this inspection we found that all ligature points had be re-assessed and remedial action taken. Where the ligature points could not be removed or replaced, for example the down pipe and gutters in the garden area, risk management plans were in place. There were no ligature cutters available at either of the inpatient services. We raised this with the ward managers who informed us they would order some immediately.

Staff told us that they had received training in restraint and de-escalation techniques, and we saw evidence to support this.

Are services safe?

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

Understanding and management of foreseeable risks

There were processes in place to manage foreseeable risks to continued service provision, such as adverse weather, staff shortages due to vacancies or sickness or the spread of infectious diseases. Senior staff confirmed that trust wide audits were carried out and we saw copies of health and safety and infection control audits.

Community teams

Track record on safety

Staff spoken with demonstrated that they knew how to report and recognise abuse and felt confident in raising concerns and how they would escalate these if necessary. We were shown the electronic system used for the recording and reporting of incidents. All incidents were reviewed by the managers and clinical governance team for the trust, who would then monitor them for trends.

Learning from incidents and improving safety standards

Staff told us they had access to the trust safety alerts and resources on the intranet. Staff told us that they felt supported in reporting incidents and that lessons learnt were discussed in both individual supervision sessions and within team meetings. We saw meeting minutes and supervision records which reflected this.

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

Staff had received mandatory safeguarding training and knew about trust safeguarding procedures. The staff we spoke with described their understanding of safeguarding and knew how and what to report to ensure that people who used the service were protected from harm. People told us that they felt safe and would speak with staff if they had any concerns.

Assessing and monitoring safety and risk

The service managers reported having a small number of vacant posts for key professionals, such as a clinical psychologist and an occupational therapist. The trust was aware of difficulties around staffing and effective service provision.

Understanding and management of foreseeable risks

The community teams had dedicated space for people using the service to visit for appointments and meetings when needed, although the majority of appointments took place in the person's home or community bases. Senior staff confirmed that trust wide audits were carried out and we saw copies of health and safety and infection control audits.

Staff were aware of the lone working policy and we saw minutes from meetings which showed that lone working procedures were discussed. Staff told us that when a person was referred to the service, information was gathered about the person. This included details about their past history and any risk assessments. If concerns were identified two staff would be allocated to visit the person to ensure the safety of the people who used the service and that of the staff.

We looked at the fire safety procedure at the East community team. This stated that fire drills should be carried out at least twice a year in a day centre and admin buildings and that in the event of a fire; the designated person is responsible for the safe evacuation of all people in the building. However, staff we spoke with could not recall when they last had a practice fire drill, and were not aware who the designated person was. We looked at the log book and saw that fire alarms were tested weekly but the last evacuation drill took place on the 17 April 2013. This meant that there was a risk to the safety of the people who used the service and staff.

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

Treatment and support was provided by multi-disciplinary teams and staff worked collaboratively, which benefited people who used the services.

We found that staff assessed and planned care to meet people's needs. Most people who used the services told us that they were involved in their care and were offered a copy of their care plan. People were supported to access physical healthcare input as needed.

Staff recorded people's consent to care and treatment and, where needed, best interest meetings were held. However, it was not always clearly documented that capacity to consent had been assessed.

A range of daytime activities was offered to people who used the services at April Cottage and Bramdean. However, there were few activities during the evening or weekend.

While staff had received a range of training to carry out their roles, the training records held in the unit had not been updated in the trust electronic staff records which meant some training was potentially not up to date.

Our findings

Inpatient services

Assessment and delivery of care and treatment

Care records had clear plans and guidance for staff on how to support people who used the service to achieve their goals, while promoting independence. We saw evidence of people's diverse needs being met within care plans, for example, personalised information about people's sexual identity and sexuality.

Pre-admission assessments were completed prior to people being admitted to the services. This ensured that people were appropriately placed and the service could meet their needs. Risk assessments were all up to date and staff were able to talk to us about how they managed some of the people's individual risks.

We saw that health action plans (HAP) were in place and regularly updated. Staff were able to discuss issues around consent and capacity and how to undertake or organise an assessment for people as necessary.

At the last inspection we found that not all the care records were accurate, but at this inspection they were clearer.

Outcomes for people using services

People had regular health check and were registered with a local GP of their choice. They were supported to attend annual health checks.

A range of activities were offered and people were supported to choose what they wanted to do, for example attending the day centre services. However, people and staff told us that there were fewer activities available in the evenings and at weekends.

People who used the services told us that they felt supported by staff and felt staff had an understanding of their care needs. People told us that staff encouraged them to be as independent as possible but provided appropriate support when needed. Staff we spoke to demonstrated a good understanding of people's needs and the support they required and liked to have.

Staff, equipment and facilities

All staff told us that they felt well supported by their peers and line managers. Staff were committed and motivated to provide a positive service for the people they worked with. We observed on both of the inpatient units good team work and staff being respectful to one another. We saw evidence of regular individual supervision and appraisals and of monthly team meetings.

Mandatory training such as infection control, safeguarding and health and safety was provided by the trust. However, the local training records had not been cross checked to update the trusts electronic staff records. This meant that some training might potentially not be up to date. Staff spoke about long waiting times for some areas of training and the difficulty in having to travel long distances for courses.

Multi-disciplinary working

In records seen there was evidence that the multi-disciplinary team worked together. People's care was reviewed once a week, which included the consultant psychiatrist and the rest of the multi-disciplinary team. People told us that they were supported to attend their review meetings.

Are services effective?

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

We observed a multi-disciplinary review meeting and saw that each member of the team contributed. The discussion was effective and focused on people's treatment and discharge planning.

Mental Health Act (MHA) 1983

The use of the Mental Health Act (MHA) 1983 was mostly good in the inpatient services. Mental health documentation reviewed was found to be compliant with the Act and the MHA code of practice.

At Bramdean we looked at section 17 leave records for people who were detained under the MHA. We saw in records sampled that one person was going out on regular section 17 leave but staff could not access a copy of the section 17 leave form on RIO and no paper copy could be located on the ward. Staff told us how many staff were needed to safely support the person but this was not clearly recorded. This meant that there was a risk to the safety of the individual, staff and public. We raised this issue with the staff and they immediately requested an up to date copy of the form be sent to them. This was received on the ward by the end of our visit.

Community teams

Assessment and delivery of care and treatment

There was a process for assessing people referred to the service. Community teams had a single point of referral. Referrals were screened daily by the duty person in charge to ensure that anything urgent was dealt with promptly. A weekly meeting to discuss all referrals also took place. People were assessed by one or more people from the team. Staff told us this included a comprehensive assessment of people's needs. Care plans were developed with the involvement of people using the service and clearly documented the treatment and support they needed.

Staff were able to discuss issues around consent and capacity and how to undertake or organise an assessment for people as necessary. Consent was recorded, although it was not always clearly documented that capacity to consent had been assessed. For example, in the East community team a person was presumed to lack capacity and no formal assessment was documented but a best interests meeting was held.

Staff, equipment and facilities

Staff received regular line managerial and clinical supervision and appraisals. We saw that staff received all mandatory training from the trust, and were told by staff and managers that they were supported to keep up to date with their continuing professional development (CPD). However, we found that CPD was not always recorded, so it was unclear how the trust assured itself that the staff were appropriately skilled to meet people's needs.

Multi-disciplinary working

We saw that the approach to assessing and coordinating care ensured that people's needs were understood and continued to be met over a period of time. The referrals screening process ensured that people's needs were quickly identified and the appropriate team took the lead. Where it was identified that a person required more than one treatment, staff worked collaboratively to ensure that this happened.

Most of the community teams had a team of professionals which included nurses, a consultant psychiatrist, psychologist, speech and language therapist, occupational therapist, art therapist and behaviour support. The community teams maintained strong working relationships with inpatient services, schools, care homes and the police.

The community teams had established joint working relationships and links with other trust community teams in their area. For example, the community teams in Tandridge and Redhill now operated as the East community team. They had one central referral system and staff worked jointly across both locations. Staff believed this helped improve the service people received as it made communication between colleagues easier and promoted a better sharing of information and expertise.

Are services caring?

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

Summary of findings

Staff worked positively with people, supporting them well and demonstrating a commitment to providing high quality care.

We saw that good information was available to people about services, including details of advocacy services, the complaints process and a section on 'taking part in your own care', which encouraged people to tell the provider what they would like in their treatment plan. The information was given to people in an accessible format. This included the use of pictures and easy to read materials.

The involvement and communication with carers has improved across the services.

Our findings

Inpatient services

Kindness, dignity and respect

We observed that staff spoke about and to people who used the services with respect. We saw that staff engaged positively with people and were caring, committed and motivated to do their job and benefit people who used the service.

People told us that their cultural and religious needs were respected and supported. The chaplain visited the inpatient services approximately every six weeks to meet with people.

Mealtimes were protected to encourage positive relationships and engagement between people who used the service and staff. At lunchtime we saw that staff sat with people who used the service to eat. We saw that staff interacted well with people and supported them when needed to ensure their dignity.

At the last inspection we found that people were not always treated with respect as the environment in April Cottage did not always mean people had privacy when being supported with personal care. At this inspection we found that privacy was available.

When staff escorted people in the community, people's wellbeing and dignity was promoted as staff did not wear name badges or uniforms.

People using services involvement

People who used the service told us that they felt involved in their treatment and supported in making decisions about their care and had a copy of their care plan which they kept securely in their bedrooms. We saw that care plans reflected the individual person`s needs and choices as far as possible.

Emotional support for care and treatment

Staff had an understanding of people's individual needs and the importance of supporting people to maintain effective communication with their family. Some people who used the service told us that they have mobile phones but they could only use them in the garden at April Cottage as the service reception was not good. There was no payphone or separate phone for people who used the service to make or receive incoming calls. Relatives and staff told us that it could be difficult at times to get through to people or support via phone contact, as there was only one phone line and this was used by all staff and people using the service. We spoke to the manager about this who told, and showed us, that she had requested a further telephone line to be installed.

We saw that the care records included information about people's relatives and carers. Staff told us that family and carers were invited to meetings about their relative's care. At our last inspection of April Cottage on the 12 February 2014 concerns were raised that staff were not providing relatives with feedback about their relative's wellbeing, care or treatment. At this inspection, we found that some improvements had been made. Relatives and carers had been invited to, and attended, two meetings with the trust to look at ways of improving communication. This had now formed part of the operational policy for April Cottage and feedback on the proposed changes was also welcomed from the relatives. Some relatives we spoke with said they had not yet received or seen a copy of the updated operational policy but felt happy that they had been listened to.

Community teams

Kindness, dignity and respect

We observed that staff spoke about people who used the services with respect. The staff we spoke with spoke about people using the service in a positive and caring way and were motivated to ensure that people who used the services were safely cared for.

Are services caring?

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

People using services involvement

People told us that they were involved in their care planning and this was demonstrated in the care plans reviewed. People told us that they felt well supported to make decisions and that the treatment they received was specific to their needs.

Emotional support for care and treatment

Staff told us that in addition to working with a person who used the service directly, they also supported the family and other staff who provided direct care for them. For example, the community team East has approximately 50 care homes on their mailing list for positive behaviour support, who they offer training and support to, helping equip care staff with the skills to continue providing specific person-centred care.

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

Community teams were flexible to respond to people's individual needs and saw people in a timely manner. The community teams worked collaboratively with inpatient services to ensure people's needs were met and to maintain continuity of care.

People using inpatient services were supported to plan when they would be discharged, although this could be delayed due to social services and clinical commissioning groups experiencing difficulty in finding appropriate community based placements.

People using the services were able to complain and staff were aware of the outcomes of recent complaints and had made changes in response to them.

Our findings

Inpatient services

Planning and delivering services

The ward manager told us people's average length of stay on the wards was up to 18 months. They said that there were at times difficulties in transferring people to community services or rehabilitation wards because of the difficulties faced by social services and clinical commissioning groups in finding appropriate community based placements. This meant that some people's discharge was delayed.

We observed in a multi-disciplinary review, that staff worked with community teams to prepare for people's discharge. The care records we reviewed also demonstrated this. This meant that planned discharges took place so that people were supported when they left hospital or moved to other units.

Care pathway

April Cottage had an admission on the day of our visit and information was shared between the care providers to ensure a smooth transition. This information was then cascaded down to staff through the daily handover meetings so that they could continue to support the patient to settle in to the ward.

All of the care records we reviewed included details of people's ethnicity, religion and other information such as preferred names. We saw that people's needs and wishes were included in their discharge and planning. Some people who used the service told us that they had discussed where they would like to move on to and had been to see several places and were supported in making a decision as to where they would like to go.

We saw that there was a range of choices provided in the menu that catered for people's dietary, religious and cultural needs. A chaplain was available and visited the ward approximately every six weeks.

Learning from concerns and complaints

The trust provided a summary of complaints which showed that in the last 12 months, two complaints had been received from or about the care of people using the learning disability inpatient service.

People who used the service were given information about how to make a complaint in the 'welcome pack' they received and information was clearly displayed on the ward noticeboards. This included information for the Patient Advice and Liaison Service (PALS). People we spoke with felt confident that they could make a complaint if needed. Staff were aware of the process for managing complaints.

Community teams

Planning and delivering services

Community teams had a single point of referral. Referrals were screened daily by the duty in charge to ensure that anything urgent was dealt with promptly. A weekly meeting to discuss all referrals also took place. The referrals screening process ensured that people's needs were quickly identified and the appropriate team took the lead. Where it was identified that a person required more than one treatment, staff worked together to ensure that this happened.

People told us that they felt the service supported their individual needs.

Right care at the right time

The responsiveness of the community teams was monitored to ensure that people received a timely service. This included the monitoring of referral to assessment to treatment times. Referrals were screened daily to ensure that urgent needs were met and the weekly screening meetings ensured that people's care was reviewed. Staff told us and we saw, that there was a waiting list for services such as behaviour support and occupational therapy.

Are services responsive to people's needs?

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

Learning from concerns and complaints

The trust provided a summary of complaints which showed that in the last 12 months, four complaints had been received from or about the care of people using the learning disability community teams.

People who used the service were given information about how to make a complaint and information was clearly displayed on noticeboards. This included information for the Patient Advice and Liaison Service (PALS). People we spoke with felt confident that they could make a complaint if needed. Staff were aware of the process for managing complaints.

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 told us that they felt well supported by their managers and had regular clinical and management supervision. Regular individual supervision and team meetings for staff took place.

At Bramdean, staff and people who used the service told us they felt listened too and involved in some decisions. For example, they had been consulted about the recent re-design of the ward and were invited to share their ideas.

There were systems in place for seeking feedback from people who used the services, carers and family members.

Our findings

Inpatient services

Vision and strategy

Staff told us that they were aware of the trust's vision and strategy. Staff told us about the ongoing reconfiguration changes planned for the inpatient services but did not always feel they received timely information on these changes. This impacted on the support that staff could provide to people and also how well staff felt supported by the trust. For example, at April Cottage staff were aware of the plans to relocate the service but had not been told the anticipated timescales or where they would be relocating to. At Bramdean, staff and people who used the service had been consulted about their ideas for the re-design of the ward, but were concerned that the planned building works had been going on for over a year and information received about this was slow.

Responsible governance

We saw that there were clear reporting structures and staff were aware of their own responsibilities and the management responsibilities for the service. Staff told us they knew who to contact in the trust if they needed support or advice and felt comfortable in doing so.

There were governance arrangements in place at a local level with an emphasis on person centred care delivery and records. Governance issues were discussed in team meetings, quarterly service wide meetings, business support meetings and at the quality action group (QAG). Staff demonstrated a good understanding of confidentiality and information governance issues.

Leadership and culture

All staff spoken with told us that the service manager was a good leader and that they felt well supported. Staff told us that the service manager was responsible for the management of both April Cottage and Bramdean and although they were not always available on the unit, they were contactable by telephone if needed.

We saw evidence of regular individual supervision meetings and team meetings for staff. Staff were aware of the trust's whistleblowing policy and told us that they knew how to raise any issues through this process. The whistleblowing policy was available on the trusts intranet site for all staff to refer to.

Engagement

Staff told us that they received weekly email communication and blogs via the intranet, and felt that senior managers engaged with all staff in the trust. Some staff said that they did not always have protected time to be able to read the intranet updates and this at times meant that they did not receive certain information.

The trust had recently introduced a feedback tool across all services, which was an electronic tablet with questions for people to answer. Staff told us that because an electronic tablet was now used for feedback it appealed more to the people in the service and people wanted to engage and take part. The satisfaction survey is on an easy read format on an IPAD and the IPAD is shared between services. The results are displayed using colourful pie charts and futher pictorial dispalys are being produced. At the last inspection we found that the quality assurance system did not offer opportunities for relatives to give their views on the service, but with the new feedback tools this has now been addressed.

Staff were aware on how to access advocacy services for people and leaflets containing information about relevant local advocacy contacts were clearly displayed on noticeboards for people to see.

Performance improvement

Staff we met with demonstrated a good understanding of their aims and objectives with regard to their performance and learning. Staff told us they valued the supervision they

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.

received. We saw that monthly team meetings focussed on team objectives and direction particularly through the implementation of new ways of working. For example, at April Cottage, recent meetings held with carers and or family members led to improvements in service provision with regards to communication.

Across both of the inpatient services, we saw that local auditing of procedures, such as record keeping, occurred to ensure that areas for improvement were identified.

Community teams

Vision and strategy

Staff told us that they received information and were aware of the trust's vision and strategy and that they shared practice across all the community teams.

Responsible governance

There were governance arrangements in place at a local level with an emphasis on person centred care delivery and good record keeping. Governance issues were discussed in team meetings, quarterly service wide meetings, business support meetings and at the QAG. Staff told us, and we saw from the minutes of team meetings, that information from the governance meetings was cascaded down to staff.

Leadership and culture

Staff told us that the service manager was a good leader and that they felt well supported. Staff we spoke with were mostly positive about the service. They were positive about the joint working relationship between the trust community teams as information and expertise was shared and they believed that people experienced a good service. Some staff had mixed views about the workload, mainly due to current vacancies within the teams. Most thought their caseloads were manageable but others acknowledged that there were some waiting lists and it could be difficult at times to manage competing priorities.

We saw evidence of regular individual supervisions and team meetings for staff. Staff were aware of the trust's whistleblowing policy and told us that they knew how to raise any issues through this process.

Engagement

Staff told us that they received weekly email communication and blogs via the intranet, and felt that senior managers engaged with all staff in the trust. Some staff told us they did not always have protected time to be able to read the intranet updates and therefore did not receive certain information.

A recently introduced feedback tool was now being used across all services, which was an electronic tablet with questions for people to answer. Staff told us that each service had one electronic tablet which meant that it was not always possible to get feedback as it may already be in use by another team.

Performance improvement

Staff we met demonstrated a good understanding of their aims and objectives with regard to their performance and learning. In the community teams, we saw that service developments were being monitored in areas such as waiting times, risk and the number of referrals. This was then fed back to the trust.

We saw that monthly team meetings focussed on team objectives and direction particularly through the implementation of new ways of working. For example, at the North West Surrey community team, staff told us that one of the objectives this year was for better integrated working with A&E services to improve the service people with a learning disability receive. Across all of the services, we saw that local auditing of procedures, such as record keeping, occurred to identify areas for improvement.