Requires improvement

Kent and Medway NHS and Social Care Partnership Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXY04	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent ME16 9QQ	South West Kent Community Mental Health Team	TN1 2JN
RXY04	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent	Thanet Community Mental Health Team	CT12 6NT

Summary of findings

	ME16 9QQ		
RXY04	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent ME16 9QQ	Swale Community Mental Health Team	ME10 4DT
RXY04	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent ME16 9QQ	Dartford, Gravesend and Swanley (DGS) Community Mental Health Team	DA1 2HS
RXY04	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent ME16 9QQ	Medway Community Mental Health Team	ME7 4JL
RXY04	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent ME16 9QQ	Single Point of Access Team	CT1 3HH

This report describes our judgement of the quality of care provided within this core service by Kent and Medway NHS and Social Care 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 Kent and Medway NHS and Social Care Trust and these are brought together to inform our overall judgement of Kent and Medway NHS and Social Care Trust.

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community-based mental health services for adults of working age as requires improvement because:

- Staff had high numbers of patients on their caseloads which meant that they were not always able to offer sufficient time to all patients to ensure that they were monitored and kept safe.
- There were registered nurse vacancies in the teams which placed extra strain on the staff and the provider had found it difficult to recruit to these.
- Staff had not met the trust's target for the completion of mandatory training in 11 out of 24 courses.
- Not all staff were using the regular supervision times allocated because of the pressures of their workloads. The appraisal rates for staff were below the trust target of 90% at Swale (82%), Medway (72%) and Thanet (72%) CMHTs.
- Across the five community mental health teams that we visited there were 1290 patients who were waiting to be allocated to a permanent named worker who would act as their care co-ordinator. The trust was missing its target of 28 days to provide an initial assessment for patients who had been referred to the service. At the South West Kent team patients waited for 11 months before being able to access the team psychologist.
- There was a lack of clear service admission criteria for referrers to the service which meant that the teams were receiving inappropriate referrals. This delayed patients being matched to the right service.

.However

- Physical health checks had been carried out for many patients and the teams were working to ensure that all patients received them.
- Medicines were managed safely in all teams.
- There were good systems in place to safeguard patients and staff were knowledgeable about the Mental Health Act and the Mental Capacity Act and had received relevant training.
- The service had made improvements to the quality of care plans and risk assessments were in place for all patients which were being regularly reviewed.
- People who needed an urgent assessment from the teams could be seen quickly in protected time slots.
- There were effective team processes in place to address clinical governance, access and discharge, incidents and complaints, and risk. The teams had an open culture and all professional roles were working effectively and supportively in a multi-disciplinary manner.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff had high numbers of patients on their caseloads which meant that not all patients could be appropriately monitored to ensure they were not at risk.
- There were substantial registered nursing vacancies in several teams which were partially covered by regular agency staff. The service was struggling to attract applicants for vacant posts.
- Staff had not met the trust's target for the completion of mandatory training in 11 out of 24 courses.
- The staff at the South West Kent team were not routinely carrying personal alarms and the team had not carried out drills to practice responding to potential incidents in the interview rooms.

However:

- Risk assessments were in place for patients and these had been updated and regularly reviewed.
- The rate of staff sickness across the teams was low.
- Staff were appropriately responding to, and recording, safeguarding issues.
- The environment in the patient areas was clean, equipment was well maintained and staff were managing medicines in a safe way.

Are services effective?

Good

We rated effective as good because:

- The quality of initial assessments for new patients to the service was good.
- There was evidence of good multidisciplinary working in all the teams.
- Improvements had been made in the quality of care plans and these were being audited regularly.
- Patients who used the team clinics received good quality physical health assessments and the teams were working to improve physical health care for all patients.
- Patients had access to a good range of psychological therapies.
- Most staff demonstrated a good understanding of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.

However:

Summary of findings

- Staff were receiving supervision but there was a frequent occurrence of missed supervision sessions because of pressures on their time.
- The appraisal rates for staff were below the trust target of 90% at Swale (82%), Medway (72%) and Thanet (72%) CMHTs.

Are services caring?

Good

We rated caring as good because:

- Staff were kind and respectful and responded to patient needs in a caring and compassionate manner.
- The patients using the services told us that they were treated with respect and that staff were caring and supportive.
- We observed good interactions between staff and patients which gave space for people to ask questions and discuss options about their care and treatment.
- Patients told us that they were given information about their care and treatment. We heard examples from patients where they were able to review options with staff and make changes in their treatment.
- The teams carried out carers' assessments and there was information for carers at all the team bases.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- The teams had high numbers of patients who were waiting to be allocated or transferred to a permanent member of the team. This meant that some patients were waiting for a worker or an appointment to be identified before they could receive their care and treatment.
- The teams were not meeting the trust's target of 95% of patients waiting no longer than 28 days to initial assessment. Performance had dropped as low as 35% in one team in December. This meant that patients referred to the community mental health teams were waiting longer to receive an assessment of their needs.
- Patients receiving care and treatment from the South West Kent team were waiting up to 11 months for access to psychological therapy.
- There was confusion about the criteria for referring to the teams and the teams received high numbers of referrals which did not always match the service offered by the community mental health teams. This meant that patients were not matched to the correct services in a timely way.

However:

Summary of findings

- There was good access for patients who required urgent or emergency appointments in the teams.
- The teams offered a range of different treatments and therapeutic interventions.
- There were robust complaints processes in place and staff gave feedback to patients about the outcomes of complaints and concerns.
- The team managers were knowledgeable about team performance and were supporting team processes to improve this.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Team processes were in place to monitor team performance but these had failed to address the high caseload numbers and the amount of unallocated patients.
- There was a lack of clarity about access criteria for the community mental health teams. The Thanet team was uncertain how their referrals would be managed in the future.
- Staff were struggling to balance the needs of high caseload numbers and protect enough time for other duties and this had an adverse effect on their morale.

However:

- There was good local leadership with managers and clinicians working cohesively.
- The staff attitudes towards colleagues and patients were positive and demonstrated a commitment to problem solving and improvement.

There were good internal governance arrangements in place so that staff and managers could meet and discuss quality, safety and performance. Staff and managers in the teams were open and candid about services successes and where improvements were needed.

Summary of findings

Information about the service

The community mental health teams (CMHTs) for adults of working age form part of the trust's mental health services in the community. They provide a specialist mental health service for adults of working age (18-65). They operate from 9-5pm Monday to Friday. The teams are made up of health and social care professionals including psychiatrists, social workers, psychiatric nurses, occupational therapists and support workers. The single point of access team manages urgent referrals for the CMHTs and operates 24 hours a day to receive referrals to mental health services by email, text or telephone.

This core service was last inspected as part of a comprehensive inspection in March 2015.

The service received an overall rating of requires improvement at that inspection.

It was found that the trust had breached regulations in two instances and community-based mental health services for adults of working age received two requirement notices. These were in relation to Regulation 18 (Staffing), as the trust had not ensured that the caseloads of staff across CMHT did not exceed its own established levels. We found that there remained high numbers of patients on the caseloads of community mental health team workers.

The other breach was under Regulation 9 (person-centred care), as the trust did not always assess the needs of patients or have up to date care plans across the CMHTs. At this inspection we found that improvements had been made to these areas.

Our inspection team

The inspection team was led by:

Chair: Dr. Geraldine Strathdee, CBE OBE MRCPsych National Clinical Lead, Mental Health Intelligence Network

Head of Inspection: Natasha Sloman, Head of Hospital Inspection (mental health), Care Quality Commission.

Team Leader: Evan Humphries, Inspection Manager (mental health), Care Quality Commission.

The team that inspected the community-based mental health services for adults of working age comprised two CQC inspectors, a mental health nurse specialist advisor, two occupational therapist specialist advisors and two clinical psychologist specialist advisors.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, 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?

During the inspection visit, the inspection team:

- visited five community mental health teams and the single point of access team which processes mental health referrals.
- spoke with 13 patients who were using the service and six carers.
- spoke with the service managers and team leaders for each of the teams.

Summary of findings

- spoke with 40 other staff members; including doctors, psychologists, occupational therapists, nurses and social workers.
- attended and observed six multi-disciplinary meetings including a risk forum, referral meetings and daily team meetings.
- observed two patient assessments and one patient home visit.
- collected feedback from 18 patients using comment cards.
- looked at 33 treatment records of patients.

looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke with 13 patients and six carers who were using the service. The patients we spoke with were universally positive about the service they were receiving from the community mental health teams. People told us that staff were friendly and caring and that they had a helpful and positive attitude. Patients told us that they had been given time, information and opportunity to consider options about their treatment and were able to regularly review their progress with their doctor and their care co-ordinator. Patients told us that staff were easy to talk to and if they had any concerns they were confident in raising these with team workers. Patients were aware of the patient liaison service and knew how to make a complaint if they needed to.

Most comments from carers were positive about the service. However at South West Kent CMHT several carers felt that changes to the organisation of the carers support group was not positive and they felt less supported. The group had changed to be facilitated by a provider external to the community mental health teams.

Patients commented that there were few community facilities close to the Medway CMHT and they suggested that a café or a drinks machine at the team reception would be beneficial for people who had travelled and were waiting for their appointment.

Good practice

- Pharmacy staff in the community teams were introducing a trial for the titration of the atypical antipsychotic clozapine at patients' homes. This meant that patients could be monitored at home while in the early stages of treatment rather than have a hospital admission.

Areas for improvement

Action the provider MUST take to improve

- The provider must address the high caseload numbers allocated to individual staff to ensure that all patients are monitored appropriately.
- The provider must review the waiting lists for those patients waiting for initial assessment and those patients waiting for allocation to a named worker to ensure patients receive a service in a timely way.
- The trust must ensure that staff meet its targets for compliance with mandatory training, in particular personal safety, conflict management and cardiopulmonary resuscitation

Action the provider SHOULD take to improve

- The trust should ensure that sufficient numbers of permanent staff are recruited and retained to enable the teams to operate effectively.

Summary of findings

- The trust should ensure that all staff receive individual supervision at regular intervals as per the trust's supervision policy.
- The trust should ensure that its target for staff to receive an annual appraisal is met in all community mental health teams.
- The trust should address the waiting times for access to psychological therapies for patients at the South West Kent team.
- The trust should implement the new operational policy for the community mental health teams and monitor its impact on the effective operation of the teams in relation to access criteria, caseloads and appropriate discharges of patients.

Kent and Medway NHS and Social Care Partnership Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
South West Kent Community Mental Health Team	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent ME16 9QQ
Thanet Community Mental Health Team	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent ME16 9QQ
Swale Community Mental Health Team	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent ME16 9QQ
Dartford, Gravesend and Swanley (DGS) Community Mental Health Team	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent ME16 9QQ

Detailed findings

Medway Community Mental Health Team	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent ME16 9QQ
Single Point of Access Team	Farm Villa (Trust HQ) Hermitage Lane Maidstone Kent ME16 9QQ

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 documentation in respect of the Mental Health Act was of an acceptable standard and completed appropriately.

There were copies of consent to treatment form within the records read but in some cases this had not been uploaded to the electronic notes. Staff explained patients' rights to them and this was recorded. Most staff had a good understanding of the provisions of the Mental Health Act and Code of Practice. Ninety eight per cent of staff had completed training in the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act and Deprivation of Liberty Safeguards was a mandatory training course for staff working in the community mental health teams, and 87% of staff had completed this.

Staff we spoke with had good knowledge about the application of the Mental Capacity Act within their team.

We saw issues regarding capacity discussed appropriately in multi-disciplinary clinical meetings and, where appropriate, there were records of capacity assessments within patients' clinical records.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- There was a good range of rooms for confidential meetings with patients across all the services. The team bases were bright, welcoming and clean with comfortable furnishings. However the clinical meeting rooms at the South West Kent team were all located in the basement. This meant that they lacked natural light and some rooms had alcoves and blind spots which could increase the risk to patients and staff.
- Staff had completed mandatory training in infection control and this was updated every two years. All the clinical areas had access to soap and handwashing facilities. There was evidence of good infection control processes at all the teams and clear information on good infection control protocols in all team bases.
- Staff either carried personal alarms when working in clinical areas or had wall mounted alarm points located in the interview rooms. The South West Kent team did not carry personal alarms although they were available at the team base.
- The South West Kent team did not carry out drills to practice responding when a team member required assistance. This placed staff at increased risk of harm if an incident occurred in an interview room. We raised this issue with the trust during our inspection and they immediately put in place a protocol to address staff responses to risks in the building.
- All the team bases had clinic rooms. These were well organised and equipment was regularly cleaned and maintained. There were locked cabinets for storing medicines and procedures for checking medical equipment. All clinic rooms had privacy screens, examination couches and personal protective equipment. Refrigerator temperatures were checked regularly.

Safe staffing

- Each team had clinical leads and team leaders who reported to a service manager based in the team. All the teams, with the exception of Medway, were integrated with social workers and social care staff located alongside health staff within the team. This meant that health and social care services could be delivered to patients from the same group of staff.
- The Medway team comprised 23 clinical staff, the Thanet team 29, the Dartford Gravesend and Swanley team 35, the South West Kent team 26, and the Swale team 20. The single point of access team had 12 clinical staff responding to all referrals for the community mental health teams in Kent.
- The average rate for staff sickness in the teams was low with a range of 1-3%. The manager of the Thanet team reported that the team had recorded the highest sickness rates within the community mental health teams in the previous 12 months. The team managers had been focussing on supporting people to return to work and the sickness rate had reduced to 2%. Managers told us they looked at creative and supportive ways, such as stress management and mindfulness, to manage sickness levels and avoid further pressure on the rest of the staff team.
- Several of the teams had vacancies within registered nursing roles and staff reported to us that recruitment remained a major issue. Some vacant posts which had been advertised at the Swale and Medway teams had attracted few suitable applicants to shortlist for interview. Thanet had three registered nurse vacancies, Medway had eight registered nurse vacancies, Swale had five and Dartford Gravesend and Swanley had three. The teams were using regular agency staff to fill some of the vacant positions but staff reported that vacancies of permanent staff were placing strain upon the team members.
- Trust data showed that there were 46 staff in the community teams working with caseloads sizes of over 45 patients. Staff we spoke with confirmed that this was the case.There were ten care co-ordinating staff at the Medway team with more than 55 patients on their caseload. Four of these staff had over 65 patients and one had 71 patients on their caseload. Staff we spoke

with told us that caseload sizes were discussed regularly at team meetings as a concern. They said that the pressure of responding to high caseloads meant that they had less time with patients planning their care.

- Some senior staff we spoke with had caseload sizes of 70 patients and they told us that it was normal practice for senior clinical staff to hold large numbers of patients while they were waiting to be allocated to a team member. This meant that staff were unable to effectively monitor and review all the patients on their caseload and respond to their needs in a timely way.
- All teams had well-staffed duty services which received and made calls to patients and GPs and made plans with the patient to respond to their situation such as arranging a home visit or making an appointment to see a member of the team. We observed that staff working in the duty rooms were very busy. Patients told us that they regularly used the team's duty service and that they found it a helpful way to contact the team workers.
- Trust data showed that staff were not up to date with 11 of the 24 mandatory courses. The trust target for completion of mandatory training was 85% The training courses with the lowest compliance to the trust target were personal safety breakaway (60%), conflict management (74%), and cardiopulmonary resuscitation (65%).

Assessing and managing risk to patients and staff

- Staff completed a risk assessment at the initial appointment when the patient was first seen by the community mental health team. The teams used a red amber green rating system to describe the current risk status of all the patients on the caseload. This was regularly reviewed at weekly risk forums and daily meetings which were held in every team.
- We observed a high risk forum meeting at Medway CMHT. The high risk forum was a monthly multi-disciplinary meeting which looked in an in-depth way at the care and treatment of patients whose risk levels were a concern to the team. The meeting was attended by the service manager, the team leader, a consultant psychiatrist and clinical leads for psychology and occupational therapy. The meeting was effectively led in a supportive and problem-solving manner and looked holistically at the risk issues of two patients. Their current situation was discussed in detail with good clinical information and plans made to address the issues discussed.
- We reviewed 33 patient records on the trust's electronic clinical records system. We found that risk assessments were in place for these patients. The assessments were complete and clear and regular reviews of risk had been recorded. However in three cases the risk assessment was older than 12 months and there was no record that it had been reviewed. The risk assessments we saw were detailed and included a description of any safeguarding concerns affecting the patient. This helped ensure that safeguarding issues were included when staff were formulating plans to mitigate risk and keep patients safe.
- Medicines in all the teams were stored securely in the clinic rooms. Medicines were correctly recorded as prescribed and audited monthly by a pharmacist. There were good protocols and checks around medicines management, which had previously been identified as a concern in Thanet. The team had recently recruited a registered nurse to the role of nurse clinical lead who was in the process of developing further monitoring procedures.
- We observed close liaison between the pharmacist and the clinical lead nurse in the Thanet and Dartford teams to ensure medicines were managed safely and risks were monitored.
- Staff we spoke with knew how to report a safeguarding concern and had received mandatory training in safeguarding children and adults at risk. Trust data showed that 95% of staff had completed safeguarding adults level one, and 83% had completed level two. Ninety seven per cent of community mental health staff had completed safeguarding children level one, 92% level two, and 85% level three. These courses were refreshed every three years. Team bases had a safeguarding flow chart on notice boards and we observed safeguarding issues being discussed at multi-disciplinary meetings, and in supervision records. There were well documented team spreadsheets detailing the safeguarding alerts open for patients using the services of each team. These included the type of abuse, the level and who was responsible for investigating

Requires improvement

Are services safe?

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

- Staff were able to describe the teams' lone working protocols and we saw how staff kept track of team member's location when they were away from base. The staff used a code word to indicate they needed assistance when calling back to base. Joint home visits were undertaken at times when higher risk was identified and other precautions were taken when required, which were supported by risk assessments and reviewed regularly.
- Staff were clear about procedures to follow if a patient did not attend their appointment. This included telephone contact, making home visits, sending out letters and requesting a safety check from police if needed.

Track record on safety

- The trust had been involved in three external investigations in the last year. Some of the leaning from these reviews included recommendations that the community mental health teams should develop their relationship with carers, develop staff supervision to improve patient care, and improve care planning to ensure that these were patient centred. The trust response to these recommendations included developing the open dialogue approach to working with individuals and their carers as equal partners, to relaunch the carer's protocol which helped carers identify for warning signs in an individual's behaviour. We saw good carers' information at all the team bases we visited.

Reporting incidents and learning from when things go wrong

- Staff were aware of what to report and how to report incidents. The community mental health teams used the trust's electronic system to record incidents and we saw evidence that this was being used to capture incidents in each of the teams.
- The community mental health teams had reported 76 serious incidents in the 12 months prior to this inspection. The majority of incidents related to unexpected or unavoidable deaths or severe harm (96%).
- The team managers were well informed about the serious incidents that had occurred in their team and showed us the progress of investigations and how actions from investigations had been shared with the team.
- We tracked one serious incident and saw that the incident had been correctly escalated and investigated as a serious incident, including a full root cause analysis. Recommendations relating to staff performance in the investigation action plan had been followed up by the team manager. The learning from the incident had been shared with team members via email, and in a discussion at the multi-disciplinary team meeting.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- The community mental health teams stored all clinical information on the trust's electronic system. All staff had access to this via laptop computers. The trust had recently updated the version used in the teams and we found information presented in different formats in the clinical notes. This was true for the care plans as three versions of care plans had been used by staff in the teams. Staff told us that they found the newest template for care plans to be the best version.
- Assessments were carried out by clinically qualified staff and included current mental health needs, a history of mental and physical health issues, risks, social care needs, housing and employment needs. After assessment a patient would be allocated to a member of the clinical team to commence their treatment. We found in all teams that patients were waiting after assessment to be allocated to a worker and this meant the start of their treatment was delayed.
- We reviewed 33 care records in five teams. The majority of records contained a comprehensive assessment of patient needs including historic and current mental health issues. Staff had also completed a risk assessment and most records demonstrated that this was being regularly updated.
- There was evidence in the care plans of a broad range of issues being addressed including psychological needs, housing and participation with local community services. In most cases the plans were personalised to the needs of the patient and some plans recorded the views of the patient. We reviewed at least six plans in each team at random and found that there was variation in the care planning in all the teams. The quality of most care plans was good with holistic goals based on patient strengths and clear evidence of patient involvement in the creation of the plan. However the quality of all the plans was not consistent across the five teams. This was also the case for the completeness of the crisis and contingency planning parts of the care plan. Some patients had a detailed crisis and contingency plan with specific actions detailed should their mental health deteriorate, however other patients' plans were sparse with solely guidance to telephone the community health team or attend accident and emergency if they became unwell.
- Staff we spoke with told us that the quality of care plans was discussed in team meetings but, due to the pressure of responding to large caseloads, completing and updating care plans could slip in their priorities. The team managers carried out a monthly team audit of the quality of the care planning and this was reported back to the team at the multi-disciplinary team meeting. Ten care plans were audited by the team manager each month against thirteen questions relating to the quality and completeness of the care plan. We reviewed two teams care plan audit data for December 2016 and saw that these results were being discussed with the team at business meetings.

Best practice in treatment and care

- There was evidence that during assessments staff had considered the guidance from the National Institute for Health and Care Excellence (NICE) when planning and delivering treatment. We heard this discussed at clinical meetings and staff were able to describe NICE recommendations when we spoke with them. This included access to psychological therapies, including cognitive behavioural therapy, medicines reviews and advice and support with benefits and housing.
- The doctors we spoke with confirmed that they regularly reviewed NICE guidance in relation to care and treatment and these were regularly sent to the team in the form of email updates and printed out along with the British National Formulary guidance on medicines for patients.
- Staff and patients had access to a local team pharmacist who offered time to give advice on medicine related issues. The pharmacist liaised closely with the senior registered nurses to provide support around medicines management and ensure best practice guidelines were being followed.
- Patients using the depot clinic and those receiving regular blood tests for clozapine treatment had regular physical health assessments and these were very detailed and clearly recorded on their clinical notes.

Are services effective?

Good

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.

There was evidence that other patients' physical health data was being monitored however this was less detailed than in the case of patients who were using the team clinics.

- Staff we spoke with recognised that access to physical health assessments was an area where they needed to improve more and how to do this was discussed within the multi-disciplinary meetings. At two team meetings we observed staff identifying which patients needed to be offered physical health assessments.
- Psychological therapies were a separate service, but each team had good connections with psychology. A link psychologist attended the multi-disciplinary meetings and received referrals from team workers. Treatments run by psychological services included 1:1 therapy, a metallisation based therapy group for people with a personality disorder, a psychosis group and an art therapy group.
- The teams used the Health of the Nation Outcome Scale and the Glasgow Antipsychotic Side-affect Scale to monitor patients' treatment and measure progress or relapses in patients' overall health.
- The trust reported a range of ongoing clinical audit activity within the community mental health teams and staff we spoke with confirmed that clinical audit was supported by the trust. Current audits included: an audit of compliance with NICE guidance for Bipolar affective disorder (Dartford and Medway CMHTs), person centred care plan audit (all CMHTs), and a proposed audit for the physical health monitoring in patients attending consultant psychiatrist outpatient clinics (Thanet).

Skilled staff to deliver care

- Staff in all teams were appropriately qualified and consisted of a range of professional backgrounds including nursing, medical, occupational therapy, social work and support worker.
- The larger teams were divided in to pods which were a sub division of staff members including a doctor. These were aligned geographically and accepted referrals for people living within that area and its GP practices. This enabled closer working with the GP referrers and helped the staff better manage their caseloads across a boundary area. The teams had two or three consultant psychiatrists depending on size, a team leader for each pod, and clinical leads for nursing and occupational therapy. Staff told us in all teams that all the professions worked cohesively and supportively in meeting patients' needs.
- Trust information showed that all medical staff had received an annual appraisal. However the appraisal rates for all other staff was below the trust target of 90% at Swale (82%), Medway (72%) and Thanet (72%) CMHTs.
- The trust information for completion of supervision for non-medical staff in the 12 months prior to inspection ranged from 16% to 50%. On examining supervision records and speaking with staff we found that supervision was happening more regularly than the trust data suggested. However team records showed that managerial supervision was not happening as a matter of course for all staff in all the teams every six weeks as per trust policy. Staff told us that due to workload pressures, they would occasionally use supervision time to carry out other duties. All doctors in the teams were receiving regular supervision.

Multi-disciplinary and inter-agency team work

- Staff told us that the different professions in the teams worked well together and doctors, psychologists and senior staff were available to them for advice and support and to consult on clinical issues.
- All the teams held regular weekly multi-disciplinary meetings within the pod divisions and came together for whole team business meeting attended by all the staff in the CMHT. These meetings discussed allocations, risk, patients on community treatment orders and information sharing.
- The senior clinical and medical staff, and managerial staff, met in a seniors meeting to review caseload and staffing issues affecting the team. They also attended a monthly governance meeting which had representatives from the early intervention team, the acute services and mental health services for older people.

Are services effective?

Good

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.

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

- The staff we spoke with had a good understanding of the MHA code of practice and its guiding principles. There were approved mental health professionals (AMHPs) in each team who carried out their AMHP duties as part of a rota within the separate AMPH team.
- Staff told us that medicine leaflets were given to patients along with explanations about rights, how to appeal, legal advice, and recall details so they had this information if they needed it.
- Training records showed that 98% of community mental health team staff had completed mandatory training in the Mental Health Act

Good practice in applying the Mental Capacity Act

- Notice boards in the team bases contained information about the Mental Capacity Act (MCA); with contact telephone numbers for further advice. This included how patients could access an independent mental capacity advocate.
- There were assessments of patient's mental capacity and records of best interest meetings in several of the patient records that we viewed.
- The MCA formed part of the mandatory training completed by the community team staff. There was variation in knowledge about the MCA among the staff we spoke with.

Training records showed that 87% of community team staff had completed mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- The staff demonstrated a caring and respectful attitude to each other and also to the patients of the service. We observed staff engaging with patients on two home visits and saw their approach as thoughtful, caring and kind. Staff showed skill and sensitivity to patients in all interactions we observed.
- All the patients we spoke with told us that the teams had helped them in managing their mental health. They said that staff were friendly and helpful and responded whenever they had contacted the service.
- Patients told us that they had been given information about their treatment and had been listened to when they wanted to make changes to their treatment.
- A patient told us that team workers had helped them return to work and had called them during their lunch break to offer encouragement and reassurance on their first day. They said this had made all the difference in their confidence to be at work.

The involvement of people in the care that they receive

- Managers told us that they were working to monitor and improve patient involvement in the care planning process and there was evidence that patient involvement in care plans was being regularly monitored via regular team care plan audits. We saw that the teams were auditing care plans to monitor the levels of patient involvement recorded in setting goals to meet patient needs and reported outcomes to the team.
- Assessments for carers were provided by team staff or via a referral to the local authority social care workers. We saw that the Swale team had 52 carers' assessments from July to December 2016.
- The trust had a patient and carer consultative committee which met bi-monthly and was chaired by the patient experience team. The committee provided patients and carers with a forum to share experience of accessing the trust's mental health services and shape improvements in the services. This was well attended by patients and carers, and representatives from the trust's mental health teams.
- We saw advocacy information on the notice boards in patient areas at all sites that we visited.
- Three carers were unhappy with recent changes to the carer support group at South West Kent team which was now organised by an external provider. They felt that this was less useful to them than involvement with team members and they felt their views were not heard.
- Patients told us that they had been given assistance with housing and given advice on benefits.
- The Swale CMHT had trained and supported patients to be part of the recruitment panel selecting new members of the team.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- The response times for standard referrals were 28 days to assessment from the time a patient was referred and 18 weeks to start treatment. Referrals came from GPs, crisis teams, psychiatric liaison service and other mental health services. Patients could also self-refer to the community mental health teams.
- Data provided by the trust showed that none of the teams we visited were achieving the trust target of 95% of referrals being seen in 28 days. In December 2016 Swale CMHT completed the highest number of in time assessments. The team received 51 referrals and assessed 41 (80%) patients within 28 days.
- Medway CMHT completed the lowest amount of in time assessments. The team received 31 referrals in December 2016 and assessed 11 (35%) within 28 days. The average for all teams to achieve initial assessments of patients referred to the service within 28 days was 61% in the previous month (November 2016) and 85% in December 2016.
- The figures for patients commencing treatment within 18 weeks ranged from 69% to 97% in the teams that we visited. The trust target was 95%.
- All the teams had high numbers of patients who had been referred and accepted for treatment but were not yet allocated to a worker in the team. South West Kent had 47 unallocated patients, Thanet had 190, Swale had 216, Medway had 393, and Dartford, Gravesend and Swanley had 444. Most of the unallocated patients were waiting for allocation to a care co-ordinator, or to see a doctor for a review of their medication. Some patients were unallocated because their care co-ordinator had left the team, or due to staff vacancies, or because the current staff could not increase the numbers of patients already on their caseload. This meant that patients who were assessed as needing a service from the community mental health teams were not yet receiving that service. The unallocated patients were held by the senior clinicians in the team and were rated for risk and this was reviewed by the team at caseload review meetings. This meant that senior clinical staff were holding caseloads of up to 70 patients whilst they were waiting to be allocated to a team member.
- All the teams had weekly processes in place to review referrals, current assessments and allocate patients to team members. We saw in all teams that this process was under strain as many patients were on waiting lists and had yet to be allocated to a worker to start their treatment.
- The waiting times for access to psychological therapies at the South West Kent team were significantly longer than other teams. There were 57 patients on the list who were waiting up to 11 months for treatment to start. During this wait time the care co-ordinator reviewed the needs of the patient and discussed these in pod meetings.
- The team managers we spoke with told us that they felt under pressure to respond to the demand of new referrals within target times and this was complicated by most staff already holding high caseloads, meaning they were less flexible to offer time for assessment appointments or accept new patients on to their caseload.
- Staff told us that they were hampered in dealing with referrals as the service did not have clear access criteria. Many of these referrals came from GPs. Team managers told us that the number of GP referrals that they were turning away was increasing. The Swale team was tracking the number of referrals that they had redirected and these had increased from 8% and were now at 33%. The team was addressing this locally by discussion and sharing information with GP referrers. The trust informed us during the inspection visit that they would be producing an operational policy for the CMHTs which would clarify referral criteria. They told us that this would be in place from the end of January 2017.
- All urgent referrals for the CMHTs were handled by the single point of access team (SPoA), based in Canterbury, which had been in operation since April 2016. This service was available for all referrers 24 hours a day by telephone, email or text and responded to all mental health referrals including patient self-referrals. The team comprised a service manager, three team leaders and 12.5 whole time equivalent band 6 clinical staff who took information from the referrer which included mental health history, safeguarding and risk issues, carers concerns and the help needed at the time of referral.

Are services responsive to people's needs?

Requires improvement

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

- We observed that the team had person centred processes in place to capture information from the referrer to enable them to place them on the emergency (four hours response), urgent (72 hours response) or routine (28 days response) pathways. The team also held an information database of community services which they used to signpost referrers to the best service which met the needs of the patient.
- All the community teams protected time each day to offer two assessment slots where the single point of access team could place urgent and emergency referrals.
- The Thanet CMHT and the single point of access team were currently trialling all referrals for the Thanet team going via the SPoA team. This had been in place since November 2016. We heard mixed feedback about the impact of the trial. The SPoA held data which showed that the number of referrals sent to the Thanet CMHT in November 2016 was 53, of which the team rejected two, and in December it was 76 of which they rejected four.
- However we observed a local commissioning team meeting at Thanet CMHT attended by senior team members and representatives from the clinical commissioning group where concerns were discussed regarding high return rates to GPs from SPoA referrals to the Thanet team (66%), and a delay in receiving urgent referrals meaning it was difficult to assess patients within the 72 hour deadline. Staff at the team told us they were unclear about whether the pilot had been evaluated and how their referrals would be managed in the future.
- All the teams had procedures in place to review patients and make decisions about discharge from the service. The primary care mental health workers were an option for some patients as a step down from the CMHT. These workers worked closely with GPs and could hold a small caseload of patients discharged from the community mental health teams. Staff told us that they would discharge more patients through this route if there was more capacity within the primary care service.
- We attended a patient home visit where a possible outcome for the patient was a referral to the crisis team. We observed that when the CMHT worker spoke with the crisis team her referral was refused whilst she was still at the patient's home because they had not sent the correct version of the referral paperwork. The patient was therefore left not knowing whether they were going to receive this service until the referral process had been further discussed. We escalated this situation to the service manager at the time of inspection to ensure that the team put in plans to keep the patient safe.
- The trust had been successful in prioritising using local area beds and had reduced the number of patients who needed to be placed out of area when needing acute services. Staff commented how this meant that there were more able to maintain contact with patients during their time in hospital and be involved with making plans for their discharge from hospital.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms and equipment at all services inspected and areas were clean and well furnished. However patients commented that the basement rooms at the South West Kent team felt dark and there were issues of design, such as anterooms and alcoves, which could increase risks in the interview rooms.
- Reception areas of all services were generally bright and welcoming with a range of information available for people who used services.

Meeting the needs of all people who use the service

- There were information leaflets and posters in the public areas of all team bases which included advice on advocacy services, how to make a complaint, carers support, substance misuse support and physical health. There was access to leaflets in different languages if required. The teams had access to interpreting and advocacy services and contact numbers were advertised.
- Staff were able to tell us how they accessed interpreting support for people using services who needed communication assistance during appointments or to have written communications translated.
- Parking was generally available at all sites, or on the roads nearby, and there were disabled parking bays allocated near the entrance to the buildings. However at Dartford Gravesend and Swanley parking was more problematic as it was in the centre of the town and in a busy commercial area.

Are services responsive to people's needs?

Requires improvement

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

- All the patient areas that we saw had access for anyone with problems with mobility.
- Some care co-ordinators told us that they were less likely to offer home visits due to their high caseload numbers which meant that more patients needed to travel to the team base for their appointments.

Listening to and learning from concerns and complaints

- Data provided by the trust documented that between October 2015 and September 2016 the community mental health teams received 168 complaints. Thirty five complaints were about inadequate overall care and treatment. Twenty five complaints related to a lack of provision of information, and 16 complaints related to staff attitude and behaviour. Of the 168 complaints received, 116 were upheld and one was referred to the health service ombudsman.
- There was evidence of a robust process to respond to complaints and concerns in all teams. Each team logged the complaints received and also recorded the outcome of the complaint and the actions the team had taken to address the issue or prevent it re-occurring. We reviewed lessons learned which included ensuring that messages are passed on to staff who are out of the office by trialling email messages, and obtaining a music licence so that the radio could be played in the waiting area. The contents and outcomes of complaints were shared with the whole team at business meetings.
- The Thanet team displayed a poster in the clinical area which showed the outcomes and learning from complaints and incidents in the service. Staff we spoke with were able to discuss outcomes from complaints and what learning had taken place.
- Patients told us that they were confident about raising any issues or concerns that they had with the team and most were aware of the complaints process and support available from the patient advice and liaison service.
- 'You said, we did' posters were displayed in the patient waiting areas of the team bases. This was an initiative which encouraged feedback from patients and summarised actions taken by the service as a result.
- Staff were aware of the formal complaint process and felt that the teams acted to resolve complaints quickly. During our visit the team leader and another member of staff at the Thanet team went to a patient's home to try to resolve a complex complaint.
- The core service had received 107 compliments between October 2015 and September 2016. Managers ensured they fed back compliments as well and complaints in order to support the morale of the team.

Are services well-led?

Requires improvement

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.

Our findings

Vision and values

- There was information and posters about the trust's vision and values on display in the team bases. Staff we spoke with were aware of the trust's values of respect, openness, innovation and working together. Staff knew the names of most of the senior management team and were aware of the trust's values and behaviours. Most staff spoke positively about recent appointments to the trust board and were aware that the trust had a transformation agenda.
- Overall the staff we spoke with showed pride in their team and spoke positively of the support they received from their colleagues and the managers in the team. Staff expressed a sense of everyone pulling together and in conversation staff were candid about issues in the service where they wished to make improvements.
- All staff we spoke said that they felt their team was cohesive. We observed professional and respectful interactions between team members at all teams. In meetings all professional disciplines and grades of staff were able to make contributions to the discussion and were focussed on the wellbeing of the patient.
- However in the Thanet team where the single point of access pilot was taking place some of the staff told us they were unclear on the future plans for the team referrals, or details about the progress of the referral management pilot.

Good governance

- There were regular and varied focussed meetings to support staff. Staff had the opportunity to discuss people with complex needs, risk, incidents, performance, caseloads, safeguarding and learning. Managers felt confident that team leaders had a good grasp of the needs of staff and people who used the service
- There were systems in place to monitor team performance. This included supervision, case review meetings, pod team meetings, business meetings, risk forums, clinical meetings and a senior staff and medical staff leadership meeting.
- We did find that although supervision was happening there were gaps in most staff records where the supervision meeting had not happened. Staff told us they were using this time to prioritise the high demands of their clinical caseloads.
- The teams were regularly reviewing and reporting on their performance and each service manager had access to a dashboard showing the current team status against a range of operational and clinical indicators. We saw from the dashboard that none of the teams were meeting the trust's access targets of 28 days to assessment and 18 weeks to treatment.
- Despite internal team management processes such as regular caseload review meetings the numbers of patients who had not been allocated to a team member had reached several hundred patients in four of the five teams we inspected.
- Team managers told us they had difficulties in discharging patients safely from the team due to capacity issues within the primary care service and the inability to discharge patients back to the GP because they were receiving depot medicines.
- The team managers told us that they received inappropriate referrals and this was difficult to address because of insufficient clarity in the definition of the teams and the eligibility criteria for referral to the teams.

Leadership, morale and staff engagement

- Staff spoke to us of the pressure they were under in dealing with very high caseloads and high numbers of unallocated patients. Staff vacancies had meant that caseloads had increased to numbers which were difficult for them to manage safely. This was adversely affecting the overall morale of care co-ordinators. Staff told us that this was contributing to staff turnover which was at an average of 20% in the community mental health teams in the period October 2015 to September 2016.
- Data supplied by the trust showed that sickness rates within the teams we inspected was between 1-3 % which is lower than the NHS regional sickness average of 4%
- During our inspection visit the trust informed us that they were introducing a standard operating model for the CMHTs which would be launched at the end of

Are services well-led?

Requires improvement

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.

January 2017. A document was being prepared to address the areas of service pathways, eligibility and discharge criteria, waiting list management, clinical effectiveness and governance and a protocol for caseload review clinics.

- Staff we spoke with told us that the service was preparing for a zero-base staffing review. This would look at staffing levels in all the teams to establish the appropriate staffing numbers and staff skill mix for that team. The trust confirmed to us during inspection that this process would start with the Swale CMHT in February 2017.

Commitment to quality improvement and innovation

- The trust had made a commitment to strengthen the peer-supported open dialogue approach and is now training a second cohort of students. Open dialogue involves regular network meetings between a patient and their family, or peer network, and mental health professionals.
- Pharmacy staff in the community teams were introducing a trial for the titration of the atypical antipsychotic clozapine at patients' homes. This meant that patients could be monitored at home while in the early stages of treatment rather than have a hospital admission.
- There have been six clinical audits involving the community mental health teams in the period October 2015 to September 2016. These have included an audit of compliance with NICE guidance for bipolar affective disorder, compliance with intramuscular injection medication in the community mental health clinic procedure, and recognition of hyperlipidaemia and hyperglycaemia in those on clozapine medicine.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust had not ensured that the caseload sizes did not exceed the number of patients that an individual team member could safely monitor. The trust must ensure that sufficient numbers of suitably qualified, skilled and experienced staff are employed to ensure the care of all service users on staff's caseloads can be safely managed. The trust had not ensured that patients referred to the service were assessed within the trust target times. The trust had not ensured that patients assessed as needing a service from the community mental health teams were allocated to a named worker. The trust must ensure that sufficient numbers of suitably qualified, skilled and experienced staff are employed to ensure that waiting times for patients to initial assessment and allocation to a named worker are safe and appropriately managed. This was a breach of Regulation 18 (1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Staff were not reaching the trust target of 85% in all mandatory training courses. The trust must ensure that all community mental health team members complete mandatory training as per trust policy. This was a breach of Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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