Requires improvement

Kent and Medway NHS and Social Care Partnership Trust

Community-based mental health services for older people

Quality Report

Trust Headquarters, Farm Villa
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Tel: 01622 724100
Website: www.kmpt.nhs.uk

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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	Thanet Community Mental Health Service for Older People	CT9 4BF
RXY04	Farm Villa (Trust HQ), Hermitage Lane, Maidstone Kent, ME16 9QQ	Ashford Community Mental Health Service for Older People	TN25 4BY
RXY04	Farm Villa (Trust HQ), Hermitage Lane, Maidstone Kent, ME16 9QQ	Swale Community Mental Health Service for Older People	ME10 4DT

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Kent and Medway NHS and Social Care Partnership 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 Partnership Trust and these are brought together to inform our overall judgement of Kent and Medway NHS and Social Care Partnership 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?	**Good** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Good** 

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 Mental Health Service for Older People (CMHSOP) by Kent and Medway NHS and Social Care Partnership Trust (KMPT) as requires improvement because:

There were social care pressures impacting the services provided by KMPT, such as closure of respite beds and care homes and lack of clarity regarding funding and commissioning requirements. The CMHSOP were undergoing service re-design and the trust was engaging with external stakeholders, including commissioners, to try and develop an effective model of care. However, teams were not always keeping within the assessment and treatment timescales agreed with local commissioners. The teams we visited told us that they were aware of difficulties in meeting targets and there was a backlog of both initial assessments and follow up appointments. The teams had incorporated a number of strategies to try and address this.

Older people who have dementia and experience mental health crises outside of office hours did not have access to crisis support which was available within KMPT for adults of working age, or older adults who did not have dementia. There were limited services for younger adults diagnosed with dementia.

We noted that there had been an impact on service provision across some of the teams due to unfilled vacancies and sickness, four teams had put the impact of staffing levels and availability on their risk registers. Service managers in the teams we visited told us that the staffing situation had improved and they felt able to provide a safe service. Whilst current staffing numbers within the teams we visited supported this, the teams were not always able to get interim staff to cover absences, this led to increased pressures across the teams.

We found that there were inconsistencies between the localities we visited, in relation to effective staff supervision, caseload management and service delivery. This meant that people may have a different experience of care or outcome of treatment, depending on where they received their care. We found that care plans and risk assessments varied in detail and quality, overall they did not reflect holistic, person centred care.

However, overall CMHSOP teams worked hard to meet the varied demands on the service. The community services have noted an increased acuity in the older adult population, particularly with the challenges of supporting people with co-morbid presentations of dementia and additional mental ill health concerns.

People using services told us they were treated with kindness, dignity and respect. Clinician`s knowledge and skills within the teams were highly regarded by all carers and patients we spoke with. The Admiral nurses were also consistently identified as being an invaluable support.

We saw good examples of local leadership from the all of the service managers we met. The trust had a system of governance in place, which service managers used to identify risks and monitor team performance. Staff told us that they felt well supported and able to raise concerns.

Summary of findings

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

Are services safe?

Good

Are services safe? We rated services safe as good because:

The trust had a system of governance in place, which service managers used to identify and monitor risks in the services they provided. Staff were able to learn from incidents occurring within their locality and were given time to discuss issues in either supervision or team meetings.

Most staff had received mandatory training on safeguarding, and knew how and where to report safeguarding issues. Staff felt confident in raising concerns and knew how to escalate them if necessary.

We noted that there had been an impact on service provision across some of the teams due to unfilled vacancies and sickness, four teams had put the impact of staffing levels and availability on their risk registers. Service managers in the teams we visited told us that the staffing situation had improved and they felt able to provide a safe service. Whilst current staffing numbers supported this, the teams were not always able to get interim staff to cover absences, this led to increased pressures across the teams.

We found that prescription pads were not stored securely at Swale. Action was taken immediately when we raised concern.

Are services effective?

Requires improvement

We rated Effective as Requires Improvement because:

We found that there were inconsistencies between the localities we visited in relation to effective staff supervision, caseload management and service delivery. This meant that people may have a different experience of care or outcome of treatment, depending on where they received their care. We found that care plans and risk assessments varied in detail and quality, overall they did not reflect holistic, person centred care.

However, CMHSOP teams worked hard to meet the varied demands on the service. For example, the community services have noted an increased acuity in the older adult population, particularly with the challenges of supporting people with co-morbid presentations of dementia and mental ill health issues.

Are services caring?

Good

Are services caring? We rated Caring as good because:

Summary of findings

People using services told us they were treated with kindness, dignity and respect and did not raise concerns about how staff treated them. We observed a home visit and saw the staff member was caring and respectful in all their interactions.

Clinician `s knowledge and skills within the teams were highly regarded by all carers and patients we spoke with. The Admiral nurses were also consistently identified as being an invaluable support.

Are services responsive to people's needs?

Requires improvement

Are services responsive? We rated Responsive as Requires Improvement because:

There were social care pressures impacting the services provided by KMPT, such as closure of respite beds and care homes and lack of clarity regarding funding and commissioning requirements. The CMHSOP were undergoing service re-design and the trust was engaging with external stakeholders, including commissioners, to try and develop an effective model of care. However, teams were not always keeping within the assessment and treatment timescales agreed with local commissioners. The teams we visited told us that they were aware of difficulties in meeting targets and there was a backlog of both initial assessments and follow up appointments. The teams had incorporated a number of strategies to try and address this.

Older people who have dementia and experience mental health crises outside of office hours did not have access to crisis support which was available within KMPT for adults of working age, or older adults who did not have dementia. There were limited services for younger adults diagnosed with dementia.

Are services well-led?

Good

Are services well led? We rated well led as good because:

We saw good examples of local leadership from the all of the service managers we met. The trust had a system of governance in place, which service managers used to identify risks and monitor team performance. Staff we met were clear about their clinical responsibilities and understood the importance of their role in direct care delivery. Staff told us that they felt well supported. Staff felt able to raise concerns and that they would be listened to.

The service managers reported they were supported by the senior management team. We saw there was a clear plan, with senior management oversight, to assess, monitor and address specific team performance issues where required

Summary of findings

Information about the service

Kent and Medway NHS and Social Care Partnership Trust (KMPT) provided specialist mental health services to meet the mental health needs of older adults with acute, serious and enduring mental health problems, including dementia. Services provided include routine and urgent assessment, memory assessment, Admiral nursing services and on-going treatment and review.

Services are divided according to clinical commissioning group (CCG) and geographical boundaries. There are nine teams which provide a community mental health service for older people (CMHSOP) across Kent and Medway. There are five CCGs who commission services from KMPT, across Kent and Medway. Older adults requiring specialist services can self-refer or be referred directly from their GP. Whilst the majority of people referred to the service will be over the age of 65, access to the service is determined by the needs of the individual as well as their age. Therefore, individuals of any age will be accepted where dementia is suspected.

Our inspection team

The team that inspected community mental health services for older people was led by a CQC inspector accompanied by two specialist advisors experienced in older person mental health service provision.

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?

We visited three of the community mental health services for older people locality teams and reviewed trust information relating to the whole service, as well as specific to these localities.

- We spoke with 10 carers;
- We spoke to three patients
- We spoke with 27staff from a range of disciplines, including service managers; consultants, administrative support staff, clinicians and allied health professionals;
- We undertook one home visit with staff;
- We attended one multi-disciplinary meeting;
- We attended one complex care meeting;
- We reviewed information and records used to manage the service; and
- We reviewed 17 patient care records

Summary of findings

What people who use the provider's services say

Clinician `s caring, knowledge and skills within the teams were highly regarded by all carers and patients we spoke with. The Admiral nurses were also consistently identified as being an invaluable support.

Good practice

Each locality had Admiral nurses integrated within the teams. Admiral nurses are specialist dementia nurses who give essential practical and emotional support to family carers, as well as the person with dementia. They offer support to families throughout their experience of dementia that is tailored to their individual needs and challenges.

Areas for improvement

Action the provider MUST take to improve
Action the provider MUST take to improve

Ensure that all staff have access to well-structured and effective supervision at Swale community Mental health service for older People (CMHSOP).

Ensure that care plans are patient centred and reflect service user involvement and preferences.

Ensure that capacity to consent, consent to treatment and information sharing is clearly and consistently recorded.

Ensure that there is capacity within teams to effectively meet assessment and treatment targets.

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

Continue to work with external agencies and commissioners to gain clarity in relation to funding and commissioning requirements, in order to develop an effective model of care in line with current and projected population changes.

Ensure consistency of service delivery, whilst reflecting the local population needs; including consistent access to out of hours crisis support. Evaluating service changes and sharing practice across the different locality teams, in order that people can access the same treatment options regardless of where they live.

Ensure that teams are adequately staffed to manage any foreseeable risks to continued service provision, such as adverse weather or staff holiday and sickness. The teams were not always able to get interim staff to cover absences, in these circumstances it has led to increased pressures and impact on care delivery across the teams.

Kent and Medway NHS and Social Care Partnership Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Thanet Community Mental Health	Farm Villa (Trust HQ), Hermitage Lane, Maidstone Kent, ME16 9QQ
Ashford Community Mental Health Team for Older People	Farm Villa (Trust HQ), Hermitage Lane, Maidstone Kent, ME16 9QQ
Swale Community Older Adults Mental Health 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.

We did not have a Mental Health Act Reviewer as part of our team. However, the teams we visited demonstrated a good understanding about when the Mental Health Act should be considered and reported they were able to access the appropriate professionals required to put this in place.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

• Most staff were up to date with training around the Mental Capacity Act. They were able to explain about consent and capacity, and how this was integrated in their daily practice. However, it was not always clearly documented that capacity to consent had been assessed, for example, where a person with cognitive difficulties wanted to leave treatment or where an individual's view may differ to their family.

• We observed that capacity was routinely discussed in MDT meetings and complex case reviews.

Good

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

Are services safe? We rated services safe as good because:

The trust had a system of governance in place, which service managers used to identify and monitor risks in the services they provided. Staff were able to learn from incidents occurring within their locality and were given time to discuss issues in either supervision or team meetings.

Most staff had received mandatory training on safeguarding, and knew how and where to report safeguarding issues. Staff felt confident in raising concerns and knew how to escalate them if necessary.

We noted that there had been an impact on service provision across some of the teams due to unfilled vacancies and sickness, four teams had put the impact of staffing levels and availability on their risk registers. Service managers in the teams we visited told us that the staffing situation had improved and they felt able to provide a safe service. Whilst current staffing numbers supported this in the teams we visited, the teams were not always able to get interim staff to cover absences, this led to increased pressures across the teams.

We found that prescription pads were not stored securely at Swale. Action was taken immediately when we raised concern.

Our findings

Safe Environment

- Access into the mental health centres for appointments and clinics was through a staffed reception with comfortable waiting areas. We did note there was a lack of dementia friendly signage, and the toilet locks at Ashford were stiff and difficult to use.
- We saw each base was equipped with clinic rooms, which were clean and contained the necessary equipment to carry out physical examinations.
- All the teams shared facilities with other services, for example, adult community mental health teams, and a room booking system was in operation. There were alarm and observation facilities in consultation rooms.

Safe Staffing

- Across CMHSOP eleven of the twelve teams had vacancies based on March 15 data; the three teams with the highest vacancy rates were Medway 3.39, Shepway 3.99 and Ashford 4.27. Of these three, only Ashford had made reference to staffing levels, the risk to the service and patients in their risk registers. Ashford, which has the highest rate highlighted 'the team are not meeting the required BI targets to see clients for assessment within 28 days and provide treatment within 18 weeks. Patient experience is therefore effected.' We noted that there had been an impact on service provision across some of the teams for example, team capacity to consistently deliver effective services, such as meet assessment and treatment targets, medical staff undertaking home visits and staff to run therapeutic groups. We saw that four of the other CMHSOP teams had placed staffing levels, including lack of substantive consultant, on their risk registers between August 2014 and March 2015. The trust told us, 'community staff in general do not cover with NHSP/agency staff'.
- The teams we visited had experienced staffing difficulties due to sickness, and in Swale, a lack of substantive consultant. The situation had improved with reduced sickness and there was now a substantive consultant in post at Swale. However, previous staffing issues had continued to have an impact on their ability to deliver an effective service, due to the backlog of assessments and reviews.
- In all three teams we inspected, staffing levels were close to the establishment set by the trust. However, there were vacancies in all teams, for different disciplines, for example, Thanet reported vacancies for one medical staff, psychologist, administrative assistant and one band 6 professional. Swale had a medical post vacant and Ashford two band 6 posts. The trust was actively attempting to recruit into these posts and the service managers of these teams told us that the situation had improved and they felt the staffing levels were safe. Staff in the teams we visited did not tell us

Good

Are services safe?

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

that they were pressured currently due to staffing levels. Whilst current staffing numbers supported this in the teams we visited, the teams reported that they were not always able to get interim staff to cover absences, and this had contributed to increased pressures across the service.

Assessing and managing risk to patients and staff

- We found that most staff understood the local safeguarding procedures, what their responsibilities were and how they could raise concerns. Most staff had undertaken the mandatory safeguarding training.
- There was a 'lone working' policy which ensured that there was a consistent system to ensure whereabouts of staff and how to raise alarm in case of emergency. Thanet and Ashford teams advised that initial assessments or visits where risks were not clearly known were undertaken with two members of staff. However, we noted that staff in the Swale team frequently carried out lone visits on initial assessments and the knowledge and implementation of the lone working procedure had been poor. Lone working concerns were on the Swale local risk register and one of the senior practitioners was taking responsibility to embed it within the team.
- We reviewed a sample of at least five people's records in each team we visited, and saw needs and risks were assessed and clearly documented. Risk assessments varied in detail and quality, however, the ones we reviewed were up to date and reflected current individual risks and relevant historical risk information. We saw that actions taken in progress notes were linked to the risk assessments.
- The teams had established a RAG rating system to highlight increased risks affecting people. We observed a multidisciplinary team (MDT) meeting at Thanet and saw that risks were appropriately discussed. We reviewed meeting minutes for Swale and Ashford, which also showed a range of risk issues, such as safeguarding, staff safety and clinical risks, were regularly discussed within the MDT. Complex case meetings were also held by the teams.
- We found that prescription pads were not stored securely at Swale, and there was no security log to ensure that regular stock checks were in place, or only authorised people were taking the prescription pads. This was not in line with the trust medicines management policy. Action was taken immediately when we raised concern.

Track record on safety

- The service managers showed us how they used the trust`s management information system and local risk registers to identify and monitor risks. This included systems to report and record safety incidents, concerns and near misses.
- Quality committee meeting minutes showed that it had been noted that there was an increase in level 5 serious incidents reported across the CMHSOP services, (level 5 incidents are those resulting in serious injury or death). Seventeen incidents were reported across the CMHSOP services, in 2013 - 2014, compared to eight reported serious incident 2012 – 2013. There was an agreed plan to review investigations, action plans and collate trends.
- In two of the three teams we inspected, there had been recent Level 5 serious incidents. We saw information about how these tragic events had been investigated and what lessons had been learnt. The reports were comprehensive and we could see evidence of the dissemination of learning to the local teams.

Reporting incidents and learning from when things go wrong

- Staff we spoke with described their role in the reporting process and told us they felt supported by their line managers following any incidents. They told us how debriefing was well organised and they could access effective support from within each team. Staff were able to learn from incidents occurring within their locality and were given time to discuss this in supervision and team meetings. We were given examples of how learning had changed practice within their teams.
- We saw the CMHSOP `quality and assurance` monthly meeting minutes. These reflected that a range of risk information, including incidents, were reviewed and discussed by the area management teams. The minutes outlined the impact to the local service, and any agreed actions for improvements to safety.
- The trust had acknowledged that the serious incident alert and manager reporting forms were not in line with NHS England and local Kent commissioners standards. This was leading in delays in completing reports. This system was being reviewed by the trust.

Are services effective?

Requires improvement

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

Are services effective? We rated Effective as Requires Improvement because:

We found that there were inconsistencies between the localities we visited in relation to effective staff supervision, caseload management and service delivery. This meant that people may have a different experience of care or outcome of treatment, depending on where they receive their care. We found that care plans and risk assessments varied in detail and quality, overall they did not reflect holistic, person centred care.

Overall CMHSOP teams worked hard to meet the varied demands on the service. For example, the community services have noted an increased acuity in the older adult population, particularly with the challenges of supporting people with co-morbid presentations of dementia and additional mental ill health concerns.

Our findings

Assessment of needs and planning of care

- We reviewed care records, spoke with staff, patients and carers. We observed a multidisciplinary meeting and a complex case review. We found that staff assessed and planned care in line with the needs of the individual, under the framework of the Care Programme Approach (CPA), although it was not always documented effectively.
- We found that care plans and risk assessments varied in detail and quality. Overall we found that 11 out of 17 did not reflect comprehensive, holistic, person centred care plans. We saw some very poor care plans, for example, advising staff to refer to a clinic letter from 2011 for the current care plan; or referring people to look at an occupational therapy assessment, which had not been uploaded onto the system. However, overall within the daily progress notes, we saw comprehensive detail about care that was being provided and plans agreed with people.
- We saw that Thanet had placed the lack of person centred care plans on their local risk register. Whilst the trust has developed an audit tool to try and improve the documentation and the teams we visited undertook monthly audits, it was not clear how the outcomes were evaluated and implemented within the teams to embed and monitor improvements.
- Consent to treatment and information sharing was not consistently recorded. It was not always clear who information could be shared with and in what format. We also found that it was not always consistently and clearly documented that capacity to consent had been assessed.
- Staff within the Ashford and Thanet teams told us their case loads were manageable, weighted by need and practitioner availability. We saw caseload figures assigned to clinicians in the teams we visited, and information relating to how the trust was monitoring caseloads across the service line. Consultants held high caseload numbers of due to the current system that they undertake the annual reviews, even where a person may not receive any other service from the CMHSOP.
- Swale had experienced caseload management issues due to historic poor managerial oversight of service delivery and clinicians not effectively discharging people. This had led to some clinicians having very high caseloads. We were concerned that some people's needs may not always be met in a timely way. For example, we saw progress notes that the consultant`s clinic letter in June 2014 stated the person was for 'on-going monitoring by their care coordinator', the next entry was from the Admiral nurse in January 2015 requesting that the person is reviewed. There was no evidence that the person had been reviewed by the care co-ordinator. We shared this information with the new service manager. The new service manager had a clear plan to address the caseload issues at Swale and steps had already been taken to reduce the caseloads and enable staff to get a good understanding of the needs of their caseloads.

Best practice in treatment and care

- In line with NICE dementia clinical guidelines and the Department of Health dementia strategy, KMPT provided early assessment and diagnosis for people of any age with a suspected dementia. This included a full physical health assessment.
- The teams offered a range of pharmacological, psychosocial, functional and psychological approaches to individuals with both organic (dementia) and functional mental health conditions.

Are services effective?

Requires improvement

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 noted that there was a variation in the groups and therapeutic input offered by the teams. For example, the Swale team currently only provided a cognitive stimulation group, in comparison to Thanet and Ashford teams who were offering a range of therapeutic and educational groups as well as individual interventions. For example, memory groups, post diagnosis clinics. This could mean that people had different experiences and outcomes depending on where they were accessing their treatment.
- A number of recognised multi-disciplinary assessment tools were used to plan and monitor care needs. health of the nation outcome scales (HONOS) was the agreed clinical outcome measurement used. We also saw patients were clustered in line with the 'payment by results' requirements, using the clustering assessment to allocate individuals to the appropriate care pathway for treatment. The trust monitored team compliance with clustering.

Skilled staff to deliver care

- We saw training records for all the CMHSOP teams, which showed that with the exception of Swale and Medway, who were 82% and 86%, overall teams had 90% - 95% completed required mandatory training. The trust compliance target for mandatory training to be met was 85%.
- Staff confirmed that they were able to access additional and external training where appropriate, if they were up to date with all the mandatory training. We met a number of staff who had been supported to undertake degrees and national vocational qualifications. Staff told us that they felt the trust invested in staff training and development. For example, a number of clinicians within community and inpatient older persons' services were trained in dementia mapping.
- Admiral nurses were attached to each locality team and were proactive in working with families and carers of people with dementia across Kent. Admiral nurses attended monthly supervision and had access to monthly practice development days with Dementia UK. There was no current steering group with KMPT and admiral nurses to look at service delivery, development and evaluation.
- At Thanet and Ashford CMHSOP, we found that staff had access to regular supervision. We reviewed a sample of supervision records which showed that clinicians were supported with caseload management and other work related issues. The consultants advised that appropriate supervision is in place for doctors and they also attend Peer Groups.
- However, at Swale, we reviewed five supervision records and found that none had received regular, well-structured supervision, in the last 12 months. One person had no records of supervision. Some staff we spoke with confirmed that they had not been receiving regular supervision. We found that the staff files and supervision records were poorly organised, with loose personal papers and we saw there were personnel files of individuals who were not working within the team. The newly appointed service manager had undertaken initial supervision with the senior practitioners within the team. There were a number of performance concerns noted at Swale, which had impacted on staff morale and the overall functioning of the team.
- We were concerned that there was not a clear supervision plan in place with the team consultant to support the nurse led clinics managed by the non-medical nurse prescriber at Swale.
- We saw examples of how staff performance issues, or additional staff support requirements, had been addressed effectively by service managers.

Multidisciplinary and interagency team work

- We saw the teams worked effectively with other healthcare providers, for example, GPs and psychiatric liaison teams.
- Some staff reported occasional tensions with care managers and difficulties in accessing increased care packages for people. There were monthly interface meetings with the CCGs and KMPT, which service managers attended and felt were useful to contribute to effective, collaborative working.
- Staff told us they felt integrated and part of a team. Each team had access to a consultant psychiatrist and approved mental health professional (AMHP) when required. Overall medical and nursing staff worked well with other specialities and therapy services to provide good multidisciplinary care.
- Each team had administrative support. Some administrative staff told us that it would be helpful to have additional training to support them taking frontline calls from distressed patients or carers.

Are services effective?

Requires improvement

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.

- The teams held weekly MDT meetings to discuss a range of locality service delivery issues, as well as specific patients. We attended the MDT meeting at Thanet, and saw that it was also attended by the in-patient team, who are based on the same site.
- Staff reported good relationships with other teams within the trust, such as the crisis team and inpatient teams; they attended in-patient meetings to support discharge plans where possible.
- KMPT have developed a training package in dementia for GPs, which will include an on-line element, followed by a session delivered by one of the older person`s psychiatrists. Teams have also been providing education and support to local care homes.

Adherence to the MHA and the MHA Code of Practice

- We did not have a Mental Health Act reviewer as part of our team, however, the teams we visited demonstrated a good understanding about when the Mental Health Act should be considered. The teams we visited reported they were able to access the appropriate professionals required to put this in place.

Good practice in applying the MCA

- Most staff were up to date with training around the Mental Capacity Act. They were able to explain about consent and capacity, and how this is integrated in their daily practice. However, it was not always clearly documented that capacity to consent had been assessed, for example, where a person with cognitive difficulties wanted to leave treatment or where an individual`s view may differ to their family.
- We observed that capacity was routinely discussed in MDT meetings and complex case reviews.

Good

Are services caring?

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

Summary of findings

Are services caring? We rated Caring as good because:

People using services told us they were treated with kindness, dignity and respect and did not raise concerns about how staff treated them. We observed a home visit and saw the staff member was caring and respectful in all their interactions.

Clinician`s knowledge and skills within the teams were highly regarded by all carers and patients we spoke with. The Admiral Nurses were also consistently identified as being an invaluable support.

Our findings

Kindness, dignity, respect and compassion

- People using services told us they were treated with kindness, dignity and respect and did not raise concerns about how staff treated them. We observed a home visit and saw the staff member was caring and respectful in all their interactions.
- Clinician`s knowledge and skills within the teams were highly regarded by all carers and patients we spoke with. The Admiral nurses were also consistently identified as being an invaluable support.
- We found that despite very limited resources and high caseloads, the Admiral nurses undertook valuable additional work in the community. For example, in Ashford a lunch club was run, which enabled carers to meet and be supported.
- Staff we met were all professional, caring and committed to providing the best service and care they could, within their current resources and commissioning agreements.

The involvement of people in the care they receive

- Within daily progress notes and in initial assessments we could see that involvement of people was promoted and wishes integrated into care, where possible. Patients and carers we spoke with confirmed that they were well informed and involved in their care, although did not always have a copy of their care plan. Care plans provided were not necessarily in a format that patients could understand, for example, the care plans we were shown were print-outs of the electronic records, which may be difficult for people to follow if they had a cognitive impairment.
- The trust has an active service user group called `forget me nots` and forum members are involved in various local and national events. We saw meeting minutes which reflected that the trust wide patient experience team engaged with people to help inform service delivery.
- There was evidence that carer's were involved where possible. The CMHSOP teams undertook carer's assessments and carers we spoke with confirmed that they received excellent information, care and support from the teams.
- There was limited data available from patient feedback, the service was in the process of initiating the friends and family test; however, we saw a collection of positive verbal feedback displayed in all the teams.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

Are services responsive? We rated Responsive as Requires Improvement because:

There were social care pressures impacting the services provided by KMPT, such as closure of respite beds and care homes and lack of clarity regarding funding and commissioning requirements. The CMHSOP were undergoing service re-design and the trust was engaging with external stakeholders, including commissioners, to try and develop an effective model of care. However, teams were not always keeping within the assessment and treatment timescales agreed with local commissioners. The teams we visited told us that they were aware of difficulties in meeting targets and there was a backlog of both initial assessments and follow up appointments. The teams had incorporated a number of strategies to try and address this.

Older people who have dementia and experience mental health crises outside of office hours did not have access to crisis support which was available within KMPT for adults of working age, or older adults who did not have dementia. There were limited services for younger adults diagnosed with dementia.

Our findings

Access, discharge and transfer

- KMPT have been working with a number of other organisations and key stakeholders to transform the way older adult services are delivered. This included the health and social care integration programme (HASCIP), a large scale change programme with health and social care providers to deliver integrated care. The community review programme is part of this and will review and map current KMPT older adults community services across Kent, to agree how services will be integrated. The anticipated benefits of the re-design are: improved access and patient experience, streamlined clinical pathways and improved partnership working with other stakeholders.
- There were changes to the CMHSOP service pathways and a single referral access point was being developed for the older persons community teams, it was hoped this would be in place by the summer 2015. In relation to the CMHSOP services re-design, we found that this was at the development and early implementation stage. There appeared to be a lack of clarity in relation to different commissioning requirements from different CCGs, this contributed to the teams implementing different models of care. For example, Thanet had established a specific urgent care team who worked short term with people who had increased needs, whereas Ashford and Swale did not have this system. There did not appear to be a clear audit and review plan in place, at a local level, to monitor and evaluate changes, in order to inform service development and share practice across the whole service.
- The CMHSOP teams have experienced increased referrals and demands on the services they provide. On average the teams were receiving approximately fifteen new referrals per week. Some teams have found it difficult to respond effectively to changing needs due to staffing and resource constraints. For example, Swale team have experienced high levels of staff sickness and a lack of substantive medical cover, which has impacted on the teams overall functioning.
- Ashford and Thanet teams had good access to appropriate room space on site in order to undertake outpatient appointments and clinics. However, Swale, had very limited access to room space and parking. This had an impact on the ability of the team to see people at the hospital base and therefore they undertook more home visits, which impacted on the number of people the team could see, affecting their waiting times.
- Quality assurance information provided by the trust reflected that the teams were not always keeping within the assessment and treatment timescales agreed with local commissioners. From information provided by the trust, between September 2014 and February 2015, there were 3635 assessments undertaken by the teams. Across all of the older persons' community services, approximately 75% of people were seen for an initial assessment within 4 weeks of referral, the target set by commissioners. However, four out of the eleven teams were below this, at between 50% - 75% of people seen within the 4 week target. Information provided in relation to the eleven memory services, showed that six teams were below 75%. We noted that some of the data was incomplete and one team did not provide any data.
- The teams we visited told us that they were aware of difficulties in meeting targets and there was a backlog of

Are services responsive to people's needs?

Requires improvement

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

both initial assessments and follow up appointments. We saw that four CMHSOP teams had placed not meeting assessment and treatment targets, or waiting lists for people to see the occupational therapist or consultant, on their risk registers. The teams had incorporated a number of strategies to try and address this. This included having fixed assessment slots, duty workers to manage day to day urgent contacts, nurse led review clinics and active caseload management in supervision.

- The trust was working with commissioners and GPs to encourage them to formally participate in the 'shared care' initiative, where patients identified as clinically appropriate for GPs to undertake reviews, rather than secondary mental health services. The locality teams were working to identify the number of cases that could be discharged under a 'shared care' arrangement with GPs. Once established, this would help reduce the increasing caseloads and improve waiting times and the ability of teams to provide effective services within the current resources.
- The teams had systems and capacity to respond to urgent referrals. Each team had established a duty system, where a senior clinician would respond to any urgent contacts to the team and review referrals each day. This was a relatively new aspect to the teams and we noted local variations in how this role was embedded and systems to monitor and support it.
- Older people who have dementia and experience mental health crises outside of office hours did not have access to crisis support which was available within KMPT for adults of working age, or older adults who did not have dementia. People were reliant on out of hours GP support in a mental health crisis. This meant that there was a risk that an older person or someone with a cognitive impairment may not have access to appropriate expertise and support.
- We saw information that reflected that 25% of admissions, for older people, occurred outside of office hours and the trust had found a contributing factor was a lack of specialist input at this time. Part of the future service redesign aims to provide urgent services to this client group and for services to operate from 8am – 8pm, in line with GP services.
- There were challenges in accessing local beds when required. There was also limited access to respite beds. The teams worked with the admissions and discharge coordinator when they required a bed. They told us that this worked effectively and the coordinator had an overview of the daily bed situation and discharge care pathways, including for people in out of areas beds.

The facilities promote recovery, dignity and confidentiality

- Some of the community team locations were hard for people to access due to distance and transport difficulties. Where this was identified all the teams would undertake home visits.
- Services used the trust electronic records system. Access to these records was secure and password protected.
- Staff had a good understanding of confidentiality, although it was not always clearly documented who they were able to share information with.
- Swale had very limited access to rooms to see people on site, and parking was difficult, for both staff and patients.

Meeting the needs of all people who use the service

- Staff told us that there were limited resources both in the community, and provided by the trust, for younger adults with dementia. The service manager at Ashford told us that two event days, for patients, were being arranged by their team psychologist, specifically for this client group.
- Staff worked with a variety of statutory and non-statutory providers to meet the needs of people. For example, supporting people to access day centres run by Dementia UK or an urgent sitting service provided by a local charity.
- The trust had access to interpreting services and patient information in a variety of languages.

Listening to and learning from complaints

- There was a complaints procedure, although in the first instance people were encouraged to speak with a member of staff involved in providing the care. Information on the patient advice and liaison service (PALS) was available in each base. People who were seen at home were provided with information on how to make a complaint or contact the PALS through the introductory pack of information. Patients and carers told us that they felt able to raise concern or make a complaint.

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 saw the trust `s complaints records which showed that there had been eighteen complaints across five of the CMHSOP teams, between January 2014 and February 2015.
- Each of the teams we visited showed us examples of how complaints had been responded to. Thanet and Ashford showed how they kept records of complaints that had been resolved at a local level.
- We saw that formal complaints were discussed in monthly quality and assurance management meetings.

However, some complaints were addressed at a local level and it was not clear that this system would identify themes and share learning points across all services, or ensure that there was senior overview about complaints relating to the individual localities. For example, we saw a complaint relating to a staff member had been dealt with locally and was not included in the overall trust complaints information.

Are services well-led?

Good

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

Are services well led? We rated well led as good because:

We saw good examples of local leadership from the all of the service managers we met. The trust had a system of governance in place, which service managers used to identify risks and monitor team performance. Staff we met were clear about their clinical responsibilities and understood the importance of their role in direct care delivery. Staff told us that they felt well supported. Staff felt able to raise concerns and that they would be listened to.

The service managers reported they were supported by the senior management team. We saw there was a clear plan, with senior management oversight, to assess, monitor and address specific team performance issues where required.

Our findings

Vision and values

- Staff were aware of the organisation`s values and felt that the senior management team were aware of what the teams did well and where they had difficulties and concerns.

Good governance

- The trust governance system enabled teams and senior managers to monitor quality and performance at a local level. The `business information` report was generated for each team to look at overall performance, and the administrative team supported this process with senior practitioners in each team.
- There were a number of trust-wide performance audits that each team used to monitor performance. However, there were limited local service led audits which have led to improvements in service provision, or effectively evaluated the work undertaken by the teams. For example, the Admiral nurses did not have any targets, or service audit and evaluation to demonstrate the service they provided or how this integrates with the other aspects of the CMHSOP.
- The information technology (IT) provision was inconsistent across the teams. Staff told us that IT systems were not always accessible when they needed them. This was time consuming and may lead to a loss of information. In Swale, there was a lack of available IT equipment, such as laptops, which had an impact on staff being able to fulfil their role. The trust was aware of IT issues.

Leadership, morale and staff engagement

- Staff told us that a service redesign was underway, and this had been a difficult process and there had been an impact on staff morale. Some staff did not always feel that senior trust management consulted with them and there was a varied understanding about what the redesign plans were, although this was also related to the varied requirements of the different CCGs. We were told however, that the CMHSOP service managers had been very open and supportive throughout this difficult process, and generally staff were positive about the proposed changes.
- We saw good examples of local leadership from all of the service managers we met. Staff we met were clear about their clinical responsibilities and understood the importance of their role in direct care delivery. Staff told us that they felt well supported. Staff felt able to raise concerns and that they would be listened to.
- The service managers reported they were supported by the senior management team. There were weekly telephone conference meetings to discuss performance and service issues, in addition to monthly Older Person`s Service meetings. We saw there was a clear plan, with senior management oversight, to assess, monitor and address specific team performance issues where required.

Commitment to quality improvement and innovation

- The trust intends for all memory assessment services to be accredited. All older persons community localities have joined the Royal College of Psychiatrist`s memory services national accreditation programme as affiliate members, although were in varying stages, from preparing, to final assessment for accreditation. Ashford was the first team to be accredited in January 2014.
- The teams participated in national research. Current research contributions include the `GERAS` study, an observational study for patients with alzheimers disease; and there was current research into improving

Are services well-led?

Good

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.

patient outcomes by offering additional sessions of Cognitive Stimulation Therapy. The Clinical Lead at Thanet CMHSOP is currently in the set up phase of the otsuke trial `, an international research project looking at a new medicine in treating alzheimers disease.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) had not protected people against the risk of people being cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard. Staff at Swale Community Mental Health Service for Older People did not receive regular supervision. This was in breach of regulation 23 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) had not ensured appropriate person-centred care and treatment through designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met. Care plans for patients receiving care from the community mental health service for older people were not always patient centred or reflecting service user preference. There was no access to a crisis service for older people who have dementia and experience mental health crises outside of office hours. Teams were not always keeping within the assessment and treatment timescales agreed with local commissioners.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 9(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) had not ensured that care and treatment was provided with the consent of the relevant person. Consent to treatment and information sharing was not consistently recorded. It was not always clear who information could be shared with and in what format. We also found that it was not always consistently and clearly documented that capacity to consent had been assessed. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.