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	Trust Headquarters	Canterbury and Coastal Community Mental Health Team	CT1 3HH
RXY04	Trust Headquarters	South Kent Coast Mental Health Team	CT19 5HL
RXY04	Trust Headquarters	Medway Community Mental Health Team	ME7 4JL
RXY04	Trust Headquarters	Maidstone Community Mental Health Team	ME14 5TS

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.

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.

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Overall summary

Between 15 - 16 May 2018, the Care Quality Commission carried out a focused follow-up inspection to look at whether the trust had made the necessary improvements as set out in the Warning Noticed issued on the 16 February 2018, following the focused inspection of the 22-24 January 2018. We went to four community teams for adults of working age provided by Kent and Medway NHS and Social Care Partnership Trust. These were the Canterbury and Coastal CMHT, the South Kent Coast CMHT, the Medway CMHT and the Maidstone CMHT.

The warning notice we served identified actions the trust must take by 30 March 2018.

- The trust must complete an immediate review of each of the community mental health teams for working age adults case load focusing on new referrals and case load allocation, risk assessments for all allocated and unallocated patients with safety plans being put in place where necessary.

It also identified actions the trust must take by 16 August 2018.

- The trust should use the caseload review to inform a comprehensive review of the assessment, planning and delivery of care and treatment for all patients and ensure they have systems and processes embedded into the service that effectively assess, monitor and improve the quality and safety of their service.

During this inspection, we found the following issues the trust needs to improve:

- Staff continued to not always assess the risks to patients' health and safety or respond appropriately to meet their individual needs. Risk assessments were not always completed or updated following an incident or reviewed regularly.
- The duty service at most community mental health teams we visited continued to be pressured and had to respond to work outside of their emergency remit. However, we saw some continuity had been installed with teams having regular duty workers who did not carry an individual caseload.
- Community mental health teams (CMHT) had recently put systems in place to ensure caseloads were formally handed over and monitored due to care coordinators planned or unplanned absence. However, these were not yet embedded across all teams.
- We found some improvement in the recording and quality of initial assessments on patients' care records. However, CMHTs were, on occasions, still relying on previous initial assessments which often did not contain recent information.
- The service had introduced daily meetings to allow CMHTs to have oversight of immediate risk on the team caseload. These were seen to be effective, however, they were not approached consistently across the CMHTs we visited.
- Staff continued to not always follow up patients who did not attend appointments. This was despite the trust making the did not attend policy simpler to follow.
- Some staff continued to report they had to complete work outside of their working hours and had concerns they would have an excessive workload to catch up on when they returned from annual leave.

However, we also found the following areas of good practice or where improvement had been made:

- The service had made improvements to the management of individual care coordinators' caseload. However, we found some inconsistencies around how psychiatrists and psychologists accepted patients onto their caseloads.
- The service had made improvements in how they monitored the needs and risks of patients who were awaiting allocation of a care coordinator.
- The service had made some improvements in their recording of recent crisis management plans in patients' care records. However, we still found some crisis plans that contained outdated information and a lack of consistency in where they were recorded.
- Staff were not always assessing new patients referred to the service in pairs. This was due to staff shortages

Summary of findings

and, in some cases, staff resistance. However, the trust felt that staff needed to be available to care coordinate their patients and had put measures in place, such as multi-disciplinary reviews of all assessments, to compensate for the assessments being carried out by lone workers.

- The service had improved on their consistency in following the criteria for deciding whether a patient required care coordination following initial assessment. This had been supported by the multidisciplinary reviews following assessment.
- The service had carried out an audit which identified the extent of inappropriate referrals from primary care. They were planning to use this information to put processes in place to support GPs when making referrals.
- The service had introduced clinical quality checks to support staff to improve their clinical documentation. Staff had welcomed this initiative and we noted they had a general positive impact on the quality of patients' care records. These checks were thorough and we found very few examples where shortfalls had been overlooked or where staff had not updated identified shortfalls.
- The service had introduced other systems and processes to monitor caseloads, discharges, waiting times and follow-up effectively. However, these were still being embedded and lacked a consistent approach across the service.
- Staff were hardworking and felt supported by their local line managers and immediate colleagues. They had welcomed recent changes to management and systems the trust had introduced.

Overall, we found that whilst the trust had made some improvements, they needed to further implement and embed the improvements required to the safety and quality of care provided if they are to meet to the requirements of the warning notice by 16 August 2018.

Summary of findings

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

Are services safe?

We found the following issues the trust needs to improve:

- Staff continued to not always assess the risks to patients' health and safety or respond appropriately to meet their individual needs. Risk assessments were not always completed, updated following an incident or reviewed regularly.
- The duty service at most community mental health teams we visited continued to be pressured and had to respond to work outside of their emergency remit. However, we saw some continuity had been installed with teams having regular duty workers who did not carry an individual caseload.
- Community mental health teams (CMHT) continued to not always have systems in place to ensure caseloads were formally handed over and monitored in the event of care coordinators being on annual leave or off sick.

However, we also found the following areas of good practice or where improvement had been made:

- The service had made improvements to the management of individual care coordinators' caseload. However, we found some inconsistencies around how psychiatrists and psychologists accepted patients onto their caseloads.
- The service had made improvements in how they monitored the needs and risks of patients who were awaiting allocation of a care coordinator.
- The service had made some improvements in their recording of recent crisis management plans in patients' care records. However, we still found some crisis plans that contained outdated information and a lack of consistency in where they were recorded.

Are services effective?

We found the following issues the trust needs to improve:

- Staff were not always assessing new patients referred to the service in pairs. This was due to staff shortages and, in some cases, staff resistance. However, they had put measures in place, such as multidisciplinary reviews of all assessments, to compensate for the assessments being carried out by lone workers.

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- Community mental health teams (CMHT) continued to not always have systems in place to ensure caseloads were formally handed over and monitored in the event of care coordinators being on annual leave or off sick.

However, we also found the following areas of good practice or where improvement had been made:

- We found some improvement in the recording and quality of initial assessments on patients' care records. However, CMHTs were, on occasions, still relying on previous initial assessments which often did not contain recent information.
- The service had introduced daily meetings to allow CMHTs to have oversight of immediate risk on the team caseload. These were seen to be effective, however, they were not approached consistently across the CMHTs we visited.

Are services responsive to people's needs?

We found the following areas of good practice or where improvement had been made:

- The service had improved on their consistency in following the criteria for deciding whether a patient required care coordination following initial assessment. This had been supported by the multidisciplinary reviews following assessment.
- The service had carried out an audit which identified the extent of inappropriate referrals from primary care. They were planning to use this information to put processes in place to support GPs when making referrals.

However, we also found the following issues the trust needs to improve:

- Staff continued to not always follow up patients who did not attend appointments. This was despite the trust making the did not attend policy simpler to follow.

Are services well-led?

We found the following areas of good practice or where improvement had been made:

- The service had introduced clinical quality checks to support staff to improve their clinical documentation. Staff had welcomed this initiative and we noted they had a general positive impact on the quality of patients' care records. However, these checks sometimes overlooked shortfalls and, when identified, staff did not always update in a timely manner.

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- The service had introduced other systems and processes to monitor caseloads, discharges, waiting times and follow-up effectively. However, these were still being embedded and lacked a consistent approach across the service.
- Staff were hardworking and felt supported by their local line managers and immediate colleagues. They had welcomed recent changes to management and systems the trust had introduced.

However, we also found the following issues the trust needs to improve:

- Some staff continued to report they had to complete work outside of their working hours and had concerns they would have an excessive workload to catch up on when they returned from annual leave.

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Information about the service

Kent and Medway NHS and Social Care Partnership Trust provide community-based mental health services (CMHTs) for working age adults, age 18-65. This includes continued support for people, who are already within the service, over the age of 65 if they have a functional psychiatric disorder. They operate from 9-5 Monday to Friday. The CMHTs are made up of health and social care professionals (excluding Medway which is no longer integrated with Medway council and so only provides health services) including psychiatrists, social workers, psychiatric nurses, occupational therapists, psychologists and support workers. The Single Point of Access (SPOA) team manages urgent referrals for the CMHTs and operates 24hrs a day to receive referrals.

The trust operates nine CMHTs for adults of working age across 12 locations. During our comprehensive inspection in January 2017, we inspected five CMHTs and the SPOA. We rated the community-based mental health services for adults of working age as requires improvement overall. We rated the key questions of safe, responsive and well-led as requires improvement with the key questions of effective and caring rated as good.

Following the comprehensive inspection in January 2017, the Care Quality Commission told the trust that:

- The trust must address the high caseload numbers allocated to individual staff to ensure that all patients are monitored appropriately.
- The trust 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, personal safety, conflict management and cardiopulmonary resuscitation.

We also informed the trust that:

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

We issued the trust with one requirement notice which related to the following regulation under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 18 HSCA (RA) Regulations 2014 - Staffing.

We carried out a focused responsive inspection in January 2018, due to concerns being raised with us around insufficient staffing levels leading to high caseloads which were not being managed safely. Following this inspection, the Care Quality Commission took enforcement action and issued the trust with a warning notice on 16 February 2018. The warning notice we served notified the trust that the Care Quality Commission had judged the quality of healthcare being provided required significant improvement. We told the trust they must complete an immediate review of each of the community mental health teams for working age adults' caseload focusing on new referrals and caseload allocation, risk assessments for all allocated and unallocated patients with safety plans being put in place where necessary, by 30 March 2018.

- The trust must ensure that staff assess the risks to patients' health and safety or respond appropriately to meet people's individual needs to ensure their welfare and safety during any care or treatment.

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- The trust must ensure that staff provide safe care and treatment to patients' receiving, or awaiting to receive, a service from the adult community mental health teams.
- The trust must have systems in place to ensure patients are aware of any changes in their care provision and alternative plans that have been put in place to ensure their safety. This would include long or short-term change of care coordinator and discharge to primary care.

We also told the trust they should use the caseload review to inform a comprehensive review of the assessment, planning and delivery of care and treatment for all patients and ensure they have systems and processes embedded into the service that effectively assess, monitor and improve the quality and safety of their service. We told the trust this should be completed by 16 August 2018.

- The trust must have effective audit and governance systems and/or processes in place that ensure care and treatment is provided in line with their policies.

Our inspection team

The team comprised five CQC inspectors, one assistant inspector and two mental health nurse specialist advisors.

Why we carried out this inspection

We inspected the trust's community-based mental health services for adults of working age to follow up on concerns identified during a focused inspection in January 2018.

Following the inspection in January 2018, we took enforcement action and issued the trust with a Warning Notice on 16 February 2018. The Warning Notice we served notified the trust that the Care Quality Commission had judged the quality of healthcare being provided required significant improvement. We told the trust they must complete an immediate review of each of the community mental health teams for working age adults' caseload focusing on new referrals and caseload allocation, risk assessments for all allocated and unallocated patients with safety plans being put in place where necessary, by 30 March 2018.

We also told the trust that they should use the caseload review to inform a comprehensive review of the assessment, planning and delivery of care and treatment for all patients and ensure they have systems and processes embedded into the service that assess, monitor and improve the quality and safety of their service effectively. We told the trust this should be completed by 16 August 2018.

Therefore, the purpose of this focused inspection was to make a judgement on whether the trust had carried out an appropriate review of the community mental health teams for working age adults' caseload and whether this had led to improvements to the quality of healthcare provided.

As this was not a comprehensive inspection, we did not pursue all key lines of enquiry. We visited four of the trust's community-based mental health services for adults of working age. Because we only focused on the issues of concern, we have not reconsidered the rating of this service.

We will inspect again after the final timescale of the 16 August to assess whether overall the requirements of the warning have been met.

How we carried out this inspection

During this unannounced, focused inspection, we considered aspects of the following key questions:

- Is it safe?
- Is it effective?

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

Before the inspection visit, we reviewed information that we held about these services. This included an action plan the trust had formulated in response to our findings, following the unannounced focused inspection in January 2018.

During the inspection visit, the inspection team:

- visited four community-based mental health teams and reviewed how staff were caring for patients;
- spoke with the service managers and/or team leaders for each of the teams;
- spoke with 28 other staff members; including nurses, occupational therapists, psychologists, social workers, senior managers and administration staff.
- attended and observed three risk management meetings and one multi-disciplinary meeting.
- looked at 75 care and treatment records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff assess the risks to patients' health and safety or respond appropriately to meet people's individual needs to ensure their welfare and safety during any care or treatment.
- The trust must ensure that community mental health teams use the systems in place to ensure caseloads are appropriately monitored in the event of care coordinators being absent from work. This should include patients being made aware of any changes in their care provision.
- The trust must ensure that staff follow up clients who did not attend appointments appropriately.

Action the provider SHOULD take to improve

- The trust should identify best practice being used within new assessment models, meeting structures and caseload management initiatives and ensure it is implemented consistently across all community mental health teams.

Kent and Medway NHS and Social Care Partnership Trust

Community-based mental health services for adults of working age

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Canterbury and Coastal Community Mental Health Team	Trust HQ
South Kent Coast Mental Health Team	Trust HQ
Medway Community Mental Health Team	Trust HQ
Maidstone Community Mental Health Team	Trust HQ

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 staffing

- Following our inspection in January 2018, we had concerns that staff caseloads were higher than reported as they did not take into consideration cover requirements for staff on long term absence. We also had concerns that patients on caseloads of staff on long term absence were not reallocated in a timely manner. This meant that caseloads, which contained patients with high risks, were not monitored appropriately. During this inspection, we found staff caseloads were around 40 for full-time staff and adjusted appropriately for part-time staff and newly appointed staff. We saw evidence at the Medway CMHT that caseload numbers included patients that had been shared from caseloads of staff on long term absence. We found there had been significant improvement in this area.
- Following our inspection in January 2018, we had significant concerns that the CMHTs did not effectively manage their caseloads. We found patients were often duplicated on caseloads; patients were moved between staff caseloads without appropriate handover or communication and patients were not distributed evenly to ensure staff had similar and manageable workloads. This was despite staff attending meetings to review their caseloads. This meant patients, some of whom were high risk, may be overlooked and not offered the support they required. During this inspection, staff told us their line managers supported their caseload management through supervision and caseload reviews were more structured and had a multi-disciplinary approach. However, they could be cancelled or not always attended by a psychiatrist or psychologist due to availability. Most staff felt their caseloads were managed safely and that patients allocated to them matched their discipline, whether it be a nurse, occupational therapist or social worker. They were also aware of patients that had been added to their caseloads due to colleagues being on long term absence. However, within the Canterbury and Coastal CMHT and South Kent Coast CMHT the business intelligence reports showed a variation in patient contacts made by care coordinators across the working week. Furthermore, at the Canterbury and Coastal CMHT, we found some care coordinators had caseloads containing many patients who were appropriate to be on a psychiatrist's caseloads as they only required medical reviews. This would have given staff more capacity to allocate more patients to their caseload. Also within this team, a team leader was holding a large caseload of patients who were accessing psychological services. They had no contact with them and had no handover from psychology regarding any risks they presented with. We were told that psychologists could not be allocated as care coordinators and would not routinely update risk assessments as part of their intervention with patients.
- Within the South Kent Coast CMHT, there was only one care coordinator with a nursing qualification. We found that patients on their caseload were not being monitored appropriately. For example, a patient with a forensic background and high risks had not had regular contact and it was difficult to find assurance that the risks were being managed. Their progress notes contained entries made retrospectively which contradicted information recorded in team meetings where the patient's risk had been discussed. We bought this to the attention of senior managers who agreed to do a full review of this caseload and follow up any areas of concern. We felt there had been some progress in this area but improvements could still be made.
- Following our inspection in January 2018, we had concerns there was no system in place to ensure staff caseloads were managed when they were required to cover the duty service or depot clinic. Furthermore, staff were often asked to cover duty at the last minute meaning they had to cancel pre- scheduled appointments for patients on their caseload. During this inspection, we found that all CMHTs had dedicated duty workers who did not carry an individual caseload. This meant staff with caseloads had to cover the duty service less frequently. In these instances, the Maidstone CMHT used their buddy system. In the other CMHTs, the

expectation was for staff to respond to urgent situations concerning patients on their caseload whilst other available staff covered duty. We felt there had been significant progress in this area.

- We spoke with duty workers from the Canterbury and Coastal CMHT, Medway CMHT and South Kent Coast CMHT. They felt that the role was pressured and required two staff to fulfil the role effectively. Within these three CMHTs there was often an expectation for duty to respond to patients who were on caseloads of absent staff. Furthermore, when a second worker was available they often had to cover choice and partnership approach (CAPA) assessments for absent staff. A senior manager was allocated to oversee the duty service to provide advice and escalation situations if required. However, they were not available to support with other clinical tasks. Due to staff resources, the Canterbury and Coastal CMHT had reduced the amount of assessment slots available for referrals from the single point of access from six to three per week. Furthermore, these assessments slots were often filled up to three days in advance meaning the service could not respond to urgent risk and assessment needs. Senior managers were aware of this issue and were looking at ways to address it.

Assessing and managing risk to patients and staff

- Following our inspection in January 2018, we had significant concerns around the way community mental health teams (CMHT) assessed the risks to patients' health and safety or responded appropriately to meet peoples' individual needs to ensure their welfare and safety during any care or treatment. During this inspection, we reviewed 18 care records of patients under the Canterbury and Coastal CMHT. All had risk assessments, however, three had not been updated within the last six months and two had not been updated for more than a year. Of the 13 care records that contained recent risk assessments we found four that did not include risks that featured in their progress notes meaning their risk rating was lower than it should have been. This included a patient's risk assessment that had not been updated after being deemed high risk after being seen by a psychiatrist. We reviewed the care record of one patient with a forensic history and found the risk assessment to be comprehensive. We reviewed 16 care records of patients under the South Kent Coast CMHT. All had risk assessments, however, four had not been updated within the last six months, including a patient with a forensic background, and one had not been updated for more than a year. Of the 11 care records that contained recent risk assessments we found two that did not include risk incidents that featured in progress notes. We also found three risk assessments that had not been updated with rationale why the patient had been discharged from the crisis team back to CMHT. We reviewed 22 care records of patients under the Maidstone CMHT. One patient, who had not engaged with the team and subsequently been discharged, did not have a risk assessment, although some risk information did feature in their progress notes. This meant that if this patient presented to services in the future it would be difficult to locate this historic risk information. Nineteen care records had recent risk assessments, however, two had not been updated within the last six months. This care record review included two patients with forensic histories and three patients with a diagnosis of emotionally unstable personality disorder. We found four of these five care records contained recent comprehensive risk assessments. The other care record had a comprehensive risk assessment but we found contact with the patient's care coordinator was not as regular as the risk assessment would suggest. We reviewed 17 care records of patients under the Medway CMHT. All had risk assessments, however, one had not been updated within the last six months and one had not been updated for more than a year. Of the 15 care records that contained recent risk assessments we found one that did not include risk incidents that featured in progress notes. We also found one risk assessment that had not been updated with rationale why the patient had been discharged from the crisis team back to CMHT. This care record review included two patients with forensic histories and two patients with a diagnosis of emotionally unstable personality disorder. We found three of these four care records contained recent comprehensive risk assessments, one patient had a very detailed risk assessment that involved carers and other agencies, such as probation. The other care record had a risk assessment that was out of date by over six months and showed irregular contact between the patient and their care coordinator. We felt there had been some progress in this area but improvements could still be made.

Are services safe?

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

- Following our inspection in January 2018, we had significant concerns around the lack of crisis and risk management plans contained within patients' care records. This was a concern as it meant staff had no consistent approach to follow in the event of a patient relapsing and presenting with increased risks. During this inspection, we reviewed 33 patients' care records, across the four CMHTs, for evidence of crisis and risk management plans and found that 25 contained them. We found a variation in the detail of these plans across the CMHTs. It was encouraging to find that crisis plans that had been written more recently were specific to the patient's needs and contained views from patients and carers. However, some crisis plans, which were written over a year ago, only contained generic contact numbers to access in emergency. It was also evident that staff were not always recording these plans in the same part of the patients' care record. This made them difficult to locate in an emergency. We were also unable to clearly establish, from the care record, whether patients had been given copies of their crisis plans to refer to when required. We felt there had been some progress in this area but improvements could still be made.
- Following our inspection in January 2018, we had significant concerns around the lack of systems the service had in place to monitor and manage the risk to patients who were awaiting care coordinator allocation. We found these patients did not routinely have their risks recorded and staff did not contact them to monitor any changes in risk or determine whether their need for allocation had become more urgent. During this inspection, all CMHTs we visited now had an active review programme in place to ensure they had oversight of all patients awaiting care coordinator allocation. The Maidstone CMHT allocated patients awaiting care coordination to the staff member who had carried out the initial assessment as they had likely formed a therapeutic relationship with them. Staff were then responsible for keeping patients updated on treatment timeframes and patients had a named contact if they needed to access the service. The other three CMHTs placed patients on the caseload of a team leader after they had their initial assessment and were accepted for care coordination. However, all had active review programmes in place to monitor these patients. The Canterbury and Coastal CMHT currently had 132 patients awaiting care coordination. The service manager monitored this group of patients and we saw a spreadsheet which identified their risk rating; the last time they were contacted and a brief plan to be followed. The Medway CMHT currently had 244 patients awaiting care coordination, psychological treatment or non-urgent medical reviews. This team assigned two staff to review this group of patients and they aimed to review 30 patients in each session twice a week. Again, they recorded action plans on a spreadsheet and, although patients were not risk rated here, staff could access risk information through their care records. The South Kent Coast CMHT had the highest number of patients awaiting care coordinator allocation at 374. They had responded appropriately and had formed an active review team, of six staff, who reviewed and monitored this group of patients during a recently introduced a Saturday clinic. The teams had found this process beneficial and reassuring as it had identified that many patients awaiting care coordinator allocation were getting regular contact from psychology groups, medical reviews, the depot clinic or support workers. We reviewed the care records of two patients who attended the service regularly to have blood tests and collect clozapine, and antipsychotic medicine that requires careful monitoring of physical health. We found the documentation around these contacts only recorded attendance and blood test results and did not gauge the patients' mental state presentation. They also felt that the active review programme identified patients with higher risks and more urgent needs and assured us that they would be allocated immediately. The trust had recently introduced standardised letter templates which included a letter to be sent to patients following their initial assessment. This informed the patient of expected time scales for treatment and included emergency contact numbers. We saw some of these letters uploaded in patients care records. We felt there had been significant progress in this area.
- Following our inspection in January 2018, we had significant concerns that patients who were awaiting care coordinator allocation or had not been seen for more than six months were being discharged with minimal clinical rationale and often without being informed. During this inspection, we found the active review programme had made significant progress in this area. We saw a letter to a patient under the Medway CMHT, apologising for inappropriately discharging them and subsequently referring them to a psychology group.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- Following our inspection in January 2018, we had concerns that the recently introduced choice and partnership approach (CAPA) model had not been implemented by all teams. This model aims to make the initial assessment more patient centred so they could make an informed choice if they would benefit from the service. A key requirement of this model is that two people carried out the assessment so different views could be explored. However, we found many examples where the assessments were being carried out by one person due to staff shortages. During this inspection, we found that only the Maidstone CMHT were regularly carrying out CAPA assessments with two staff. This team had a clear buddy system in place which allowed staff pairings to be allocated for CAPA assessments. The other three CMHTs we visited said that staff shortages did not allow the availability of two staff to carry out these assessments. Furthermore, staff at the Medway CMHT had shown some resistance to the buddy system as they were concerned they would be paired with colleagues who had poor sickness records and felt this could increase their own workload. To compensate, psychiatrists at this CMHT were seeing the patients after the CAPA assessment to address any urgent prescribing needs and give an opinion on a diagnosis. However, staff said that this often meant patients had to wait around for psychiatrists to be available. To further compensate, staff at the three CMHTs who carried out lone CAPA assessments could present their cases to the multi-disciplinary team before informing the patient of the outcome of the assessment. We were told that patients were informed of this during the assessment and would be informed of the decision by letter or telephone with three days. Team leaders and psychologists felt that staff were improving their ability to present cases through this process. Staff across the CMHTs were generally positive and felt supported with the implementation and administration surrounding the CAPA model. We felt there had been some progress in this area but further improvements could still be made.
- Following our inspection in January 2018, we had concerns that staff were not always recording initial core assessments onto the patients' care records, and in some cases there was no record the assessment had taken place. We also had concerns that patients being re-referred into the service did not have their core assessment updated. During this inspection, we reviewed 21 patients' care records to see the quality of core assessments. We found all contained core assessments and 15 were completed to a good standard. However, we found three that needed updating and three where staff had not updated the formulation and summary of a core assessment after being referred by another service, such as the crisis team. This meant that recent changes in the patients' presentation and subsequent risks and needs would not have been recorded in the core assessment. We felt there had been some progress in this area but improvements could still be made.

Multi-disciplinary and inter-agency team work

- The trust had recently introduced a daily 'red board' meeting across all CMHTs to support teams to identify patients who are presenting with risks. We attended this meeting at the Canterbury and Coastal CMHT, Medway CMHT and the South Kent Coast CMHT; and reviewed minutes of the meeting at the Maidstone CMHT. We found the meeting to be an effective process to monitor risk across the caseload. It identified patients who were due a seven-day follow-up after being discharged back to CMHT from inpatient or crisis team; patients who were due their depot after not attending the depot clinic and patients who were showing signs of relapse. However, we found a lack of consistency between how teams utilised the meeting. The South Kent Coast CMHT used it to generate a multi-disciplinary discussion on how best to manage the risks and delegated actions for staff. Whereas, the Medway CMHT, did not generate this level of discussion and staff were observed coming in and out of the meeting and were not wholly engaged. We also found each team recorded minutes of the meeting differently and there was no standard agenda used.
- All CMHTs we visited gave staff opportunities to present complex cases, safeguarding referrals, assessments and referrals. We observed a multi-disciplinary meeting at the South Kent Coast CMHT which was attended by all staff from that locality team including the two team consultants**.** One consultant led the meeting and allowed staff to present cases. Staff gave advice and

suggestions and proactive management plans were agreed. All teams also held a monthly clinical risk management forum to discuss complex cases. Staff could pre- book cases into this forum.

- Following our inspection in January 2018, we had significant concerns there was no systems in place to formally handover caseloads to other staff in the event of staff being on short term absence. This presented a risk to patients and put added pressure on the duty workers. During this inspection, we found the Maidstone CMHT had an established buddy system. Staff members' buddy would then take responsibility for managing their caseload when they were absent. This system supported continuity of care for patients by effectively providing them with a secondary care coordinator. The other three CMHTs had not adopted the buddy system. Therefore, when staff were absent patients' needs would be managed by the duty service. In the event of long term staff absence, apart from the Maidstone CMHT who used the buddy system, staff caseloads were monitored by team leaders who would disseminate the caseload to other staff if the absence was over two weeks. We were told that letters would be sent to patients informing them of this change in their care provision. However, at the Canterbury and Coastal CMHT, we found an example of a patient who had not been informed their care coordinator had been absent for four months and they had not had any contact within this time. The trust had provided an action plan, following our inspection in January 2018, which stated that a 'handover of care' model had been embedded in all teams. This was based on the standard operating procedure used by the Dartford, Gravesend And Swanley CMHT to follow up patients when their care coordinators were absent. We did not see evidence of this model being used across all CMHTs we visited. We felt there had been minimal progress in this area and significant improvements could still be made.
- We found two examples, at the Maidstone CMHT, of patients being allowed to their exercise their right to choose what CMHT they would like to be assessed and supported by. However, we also found an example of a patient who had experienced a difficult transfer of care from the Canterbury and Coastal CMHT to another CMHT within the trust.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- Following our inspection in January 2018, we were told that the trust had a target of seeing 95% of patients within their target of 28 days for routine assessment and 48 hours for urgent assessment. We found that the Canterbury and Coastal CMHT were seeing 85% of patients within this target. The South Kent Coast CMHT were seeing 78% the Medway CMHT were seeing 82%. During this inspection, we found these figures were being maintained within the Canterbury and Coastal team seeing 84% and the Medway CMHT seeing 86%. However, these figures had dropped for the South Kent Coast CMHT seeing 54%. The Maidstone CMHT were seeing 87% of patients within the target.
- The trust had a target of allocating 95% of patients to a care coordinator within 18 weeks of them being accepted for treatment. We found that the Canterbury and Coastal CMHT were seeing 90% of patients within this target. This figure was 90% for the Medway CMHT; 73% for the South Kent Coast CMHT and 87% for the Maidstone CMHT.
- Following our inspection in January 2018, we had concerns that staff did not consistently follow the criteria for deciding whether a patient required care coordination. During this inspection, we found that the CAPA model had supported staff to make more clinically accurate decision on whether patients required secondary mental health services.
- The trust provided clear referral criteria for both internal teams and external agencies, however, the service was still experiencing a high number of inappropriate referrals, particularly from GPs. This resulted in a lot of resources being used daily to screen referrals. A team leader from the Medway CMHT had recently carried out a three-month audit of GP referrals to this team. They found that only 19% percent were accepted for assessment and, following assessment, only 6% required care coordinator allocation. In response to this audit this CMHT had developed a new referral form for GPs to support them making more appropriate referrals. They had shared information on the audit and new referral form with the mental health lead for GPs, and they had agreed to present the findings to the local GPs. The CMHT were hoping the new referral form would be in use by July 2018. The service also accepted self-referrals and these often proved to be inappropriate. Senior managers told us they were considering reviewing the self-referral process.
- Following our inspection in January 2018, we had significant concerns that staff did not appropriately follow up patients who did not attend (DNA) appointments as per the trust's DNA policy. During this inspection, we found the DNA policy had been simplified to guide staff how to respond to DNA dependent on the patient's risk. Our review of care records across the CMHTs visited identified 16 incidents where patients had DNA appointments, however only five care records showed evidence that the DNA policy had been fully followed, with one care record showing partial adherence to the policy. The incidents where the policy had not been followed included patients who were deemed high risk or had a history of impulsive behaviour. The trust's action plan had given administration staff the authority to make entries in patients' care records as they often received contact from patients, or their carers, that they would not be attending or sent letters to patients to inform them of pending appointments. However, we saw little evidence of this happening. We felt there had been minimal progress in this area and significant improvements could still be made.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Good governance

- The trust had recently introduced an audit process called clinical quality (CLIQ) checks. These were carried out by three quality leads across the service and they would each audit 10 care records weekly against The National Institute for Health and Care Excellence guidelines. These CLIQ checks looked areas such as risk assessments, care plans and crisis plans. We found they had led to improvement in clinical documentation and found very few examples of where CLIQ checks had not picked up incidents of clinical documentation that needed updating or more detail. Furthermore, when actions had been identified, staff were regularly addressing them in a timely manner. Staff told us they welcomed the CLIQ checks as a way of monitoring their clinical documentation.
- The service had other systems in place to support staff to manage their caseloads. These included the red board meeting, the active review programme, clinical risk management forum, supervision and caseload reviews. However, we found that these systems were only effective when staff bought caseload concerns or safety issues to these forums. We felt that supervisors and senior managers could take more responsibility in appropriately challenging staff to identify areas of concern.
- The service had access to business intelligence software that allowed them to monitor individual community mental health teams' adherence to key performance indicators. However, at times it was unclear how this information was being used, for example when it identified a lack of recorded patient contacts.
- All the community mental health teams we visited had implemented a different approach to new systems, such as the red board meeting and active review programme. We felt some approaches were more effective than others and that a consistent approach across the service would lead to further improvement.

Leadership, morale and staff engagement

- Staff morale had improved since our inspection in January 2018. They were positive about the changes senior managers were implementing and how these supported their ability to safely and effectively support their patients and manage their caseloads However, staff were still, on occasions, feeling the need to catch up on work in their own time. Staff still expressed concerns regarding lack of cover arrangements when they were absent from work.
- Staff felt well supported by local management and acknowledged they had been appropriately informed about recent operational changes. However, some staff were showing resistance to some of the processes that had been introduced.

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.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment. Whilst we observed some improvements in some areas, our concerns from the January 2018 inspection remained. Staff did not always assess the risks to patients' health and safety or respond appropriately to meet peoples' individual needs to ensure their welfare and safety during any care or treatment. The trust did not provide care and treatment in a safe way for patients' receiving, or awaiting to receive, care or treatment from the adult community mental health teams. Staff did not document appropriate information that had been shared to ensure care and treatment remained safe for people using services. When staff were on annual leave or sick leave, a handover to another colleague or duty worker was not recorded. When patients were discharged back to their GP they were not always informed. These were breaches of Regulation 12(1)(2)(a)(b)(i).

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

Whilst we observed some improvements in some areas, our concerns from the January 2018 inspection remained.

The trust did not operate effective audit and governance systems and/or processes to make sure they assessed and monitored the service at all times and in response to the changing needs of people referred and / or accepted to the service. There were not robust systems and processes in place to monitor and ensure compliance with trust policy and procedures as outlined in the trust's Community Mental Health Team Operational Policy and Transfer Discharge Policy.

This was a breach of Regulation 17(1)(2)(a)(b)(c),