Good

Kent and Medway NHS and Social Care Partnership Trust

Community mental health services for people with learning disabilities or autism

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 Swale	CT1 3HH
RXY04	Trust Headquarters	Ashford and Shepway	TN25 4BY
RXY04	Trust Headquarters	Maidstone and Malling	ME14 5TS

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.

Summary of findings

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
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-based mental health services for people with learning disabilities as good because:

- We looked at ten care records for people who used the service. All of these included a risk assessment and all records had been reviewed recently. The trust, in collaboration with partners, had developed the complex care response procedure across the teams which meant people who used services could receive a same day assessment of risk to reassess needs in order to prevent any further deterioration of mental state, which may have resulted in a hospital admission. Comprehensive assessments were documented in each of the care records we reviewed and were carried out at the person's first appointment. All of the care records we reviewed had care plans. People's needs were assessed and care was delivered in line with their individual care plans. Assessments were completed in a timely manner and the care plans were detailed, personalised, focused on maximising independence and holistic. All of the records we looked at had a health action plan included.
- The teams were situated in buildings that were clean and well-maintained. There were clear protocols available to guide staff on how to respond should an alarm be activated on site and staff we spoke with were able to describe the response guidance.
- There were sufficient staff to deliver care to a good standard and the staffing rotas indicated that there were sufficient staff in each of the teams. Staff we spoke to understood the vision and direction of the organisation. Staff felt part of the service and were able to discuss the philosophy of the service confidently All of the staff we spoke with were highly satisfied working in the service. The senior management team held monthly leadership forums where senior clinicians and managers came together from the service line and discussed, for example, the quality of service provision and service developments.
- People who used services told us they were supported well to live safely in the community and that their needs were met, including if they needed additional support. The teams offered a treatment model based on individual care and treatment pathways. People were supported through transitions between services, for example from children's services to adult or from inpatient services to the community. People were involved in drawing up information to accompany them in their move. We observed interagency working taking place. Staff created strong links with primary care, the learning disability community teams, mental health acute inpatient services, social services and residential care homes being particularly positive examples.
- All of the people we spoke with and their relatives and carers complimented staff providing the service across the teams. People who used the service told us that they were treated with compassion, dignity and respect and that they were supported to make their own choices in their daily life. Staff we spoke with showed they knew the people who used services well. Staff told us confidently about their approach to people who used services and the model and philosophy of care practiced across all of the teams. They spoke about the emphasis they put on ensuring any treatment or support interventions were individualised and centred on the person and co-produced with them and their family or carer. Staffs' approach was person centred, highly individualised and recovery orientated. People or their representatives told us they were fully involved with every aspect of their treatment and care planning.
- Key performance indicators and performance data was available to staff relating to waiting times from referral to assessment and onto treatment. Information on performance in key areas was collated and summarised by senior managers and published monthly. Staff participated in clinical audits to monitor the effectiveness of services provided. They evaluated the effectiveness of their interventions. The teams carried out audits against the National Institute for Health and Care Excellence (NICE) guidelines on promoting good health and preventing and treating ill health for people with learning disabilities and autism. Staff told us that

they received feedback from incident investigations in regular team meetings and that they learnt key themes and lessons and developed action plans if they needed to make changes.

- People who used services and their families we spoke with all knew how to make a complaint, should they wish to do so. This included how to contact the Care Quality Commission. Staff confidently described the complaints process and how they would handle any complaints.

However:

- All relevant documentation about care planning was not filed in the care planning section of the electronic care records which made it difficult to locate information in a timely manner.
- There were 15 people waiting up to a year for psychology. We had concerns about psychology waiting lists during our inspection in 2015 and on this inspection we found improvements had been made however some people assessed as low risk were having to wait up to a year. These people were being supported by other community services and told to contact the mental health team should there be any concerns.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- The teams were situated in buildings that were clean and well-maintained. There were clear protocols available to guide staff on how to respond should an alarm be activated on site and staff we spoke with were able to describe the response guidance.
- There were sufficient staff to deliver care to a good standard and the staffing rotas indicated that there were sufficient staff in each of the teams.
- We looked at ten care records for people who used the service. All of these included a risk assessment and all records had been reviewed recently.
- The trust had developed the complex care response procedure across the teams, which meant people who used services could receive a risk assessment the very same day as the request was made. This was in order to prevent any further deterioration of mental state which may have resulted in a hospital admission.
- Staff told us that they received feedback from incident investigations in regular team meetings and that they learnt key themes and lessons and developed action plans if they needed to make changes.

Are services effective?

Good

We rated effective as good because:

- Comprehensive assessments were documented in each of the care records we reviewed and were carried out at the person's first appointment. All of the care records we reviewed had care plans. People's needs were assessed and care was delivered in line with their individual care plans. Assessments were completed in a timely manner and the care plans were detailed, personalised, focused on maximising independence and holistic.
- The teams carried out audits against the National Institute for Health and Care Excellence (NICE) guidelines on promoting good health and preventing and treating ill health for people with learning disabilities and autism.

Summary of findings

- All of the records we looked at had a health action plan included. This is a personal plan about what people need to do to stay healthy. It lists any help people might need in order to stay healthy and makes it clear about what support they might need.
- We observed interagency working taking place, with staff creating strong links with primary care, the learning disability community teams, mental health acute inpatient services, social services and residential care homes being particularly positive examples.
- All staff had received training on the Mental Health Act and the Mental Capacity Act and associated codes of practice

However:

- Not all relevant documentation about care planning was filed in the care planning section of the electronic care records. This made it difficult to locate information in a timely manner.

Are services caring?

Good

We rated caring as good because:

- All of the people we spoke with and their relatives and carers complimented staff providing the service across the teams. People who used the service told us that they were treated with compassion, dignity and respect and that they were supported to make their own choices in their daily life.
- Staff we spoke with showed they knew the people who used services well. Staff told us confidently about their approach to people who used services and the model and philosophy of care practiced across all of the teams. They spoke about the emphasis they put on ensuring any treatment or support interventions were individualised and centred on the person and co-produced with them and their family or carer.
- Staffs' approach was person centred, highly individualised and recovery orientated. People or their representatives told us they were fully involved with every aspect of their treatment and care planning.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- People who used services told us they were supported well to live safely in the community and that their needs were met including if they needed additional support.

Summary of findings

- The teams offered a treatment model based on individual care and treatment pathways.
- People were supported through transitions between services, for example from children's services to adult or from inpatient services to the community. People were involved in drawing up information to accompany them in their move.
- People who used services and their families we spoke with all knew how to make a complaint, should they wish to do so. This included how to contact the Care Quality Commission. Staff confidently described the complaints process and how they would handle any complaints.

However:

- Fifteen people were waiting up to a year for psychology. We had concerns about psychology waiting lists during our inspection in 2015 and on this inspection we found improvements had been made however some people assessed as low risk were having to wait up to a year. These people were being supported by other community services and told to contact the mental health team should there be any concerns.

Are services well-led?

Good

We rated well-led as good because:

- Staff we spoke to understood the vision and direction of the organisation. Staff felt part of the service and were able to discuss the philosophy of the service confidently. Staff told us that the purpose of the service was to offer a care pathway and to deliver high quality treatment and therapy programmes to people with learning disability who have complex health and social care needs.
- Key performance indicators and performance data were available to staff relating to waiting times from referral to assessment and onto treatment. Information on performance in key areas was collated and summarised by senior managers and published monthly.
- All of the staff we spoke with were highly satisfied working in the service. The senior management team held monthly leadership forums where senior clinicians and managers came together from the service line and discussed, for example, the quality of service provision and service developments.
- Staff participated in clinical audits to monitor the effectiveness of services provided. They evaluated the effectiveness of their interventions

Summary of findings

Information about the service

Kent and Medway NHS and Social Care Partnership Trust provides specialist mental health services in the community to meet the mental health needs of adults with learning disabilities and autism. A number of statutory organisations dovetail with each other in order to meet the needs of the learning disabled population of Kent and include the trust, Kent county council and Kent community healthcare NHS trust. In addition, statutory services work in partnership with the Kent challenging behaviour network (social care providers) and a range of residential care homes and supported housing providers.

There are seven teams which reflect the geographical localities across Kent. In addition there is a positive behavioural support team which is divided into two to cover East and West Kent:

Ashford and Shepway team

Canterbury and Swale team

Datrford, Gravesend and Swanley team

Dover, Deal and Thanet team

Maidstone and Malling team

Medway team

South West Kent team

East and West Kent positive behaviour teams

The teams focus primarily on services for people with a learning disability who have complex or significant mental health needs or challenging behaviour. Staff provide support to mainstream mental health services and other agencies across Kent in meeting the mental health or behaviour needs of people with a learning disability. Staff provide specially adapted interventions to individuals who are unable to benefit from the interventions available in mainstream services due to the complexity of their presenting needs.

We inspected these services previously in March 2015 and all the essential standards were met.

Our inspection team

The inspection team was led by:

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

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

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

The team that inspected community-based mental health services for people with learning disabilities comprised: one Care Quality Commission inspector, one nurse specialist advisor, one occupational therapist specialist advisor, one psychologist specialist advisor, for three days and one consultant psychiatrist specialist advisor, for one day.

Why we carried out this inspection

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

Summary of findings

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?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from people who used the service.

During the inspection visit, the inspection team:

- visited three community-based mental health services for people with learning disabilities, looked at the quality of the environment and observed how staff were caring for people who used the service
- spoke with six people who were using the service and eight of their carers
- spoke with the service manager with overall managerial responsibility for these teams
- spoke with 26 other staff members; including doctors, nurses, psychologists, psychologist assistants and administration workers
- spoke with six external health and social care staff
- observed four home visits
- observed seven multidisciplinary meetings where peoples' care was discussed
- looked at 10 care records of people who use the service
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with six people who used services and eight of their family members or carers. People were positive and complimentary about their experience of care from the community mental health services available for people with a learning disability or autism. They told us that staff were caring, kind, professional and supportive towards them. They told us that care and treatment interventions were effective in achieving recovery goals. Everyone we spoke with felt that staff actively involved them when making choices about their care and treatment. People said that staff were motivated, compassionate, skilled and developed good relationships with them to support recovery. Family members commended the teams for their responsiveness towards them.

Good practice

- The trust, in collaboration with partners, had developed the complex care response procedure across the teams which meant people who used services could receive a risk assessment on the same day the request was made. This was in order to prevent any further deterioration of mental state which may have led to a hospital admission.
- Clinicians from the teams facilitated a multi-agency professional forum to which they invited all partner organisations. Case presentations were discussed as well as key learning from a variety of national and local policy developments such as 'the Winterbourne concordat: Programme of action (2012)'.
- The trust had developed a clear and comprehensive dementia care pathway for people with learning disabilities. The protocol between the mental health learning disability teams and community mental health teams for older adults stated that all people with a learning disability had access to dementia

screening. A group of clinicians from both services set up a joint clinic for dementia assessment and treatment. This work was being audited to evaluate effectiveness of the service and for client and family satisfaction.

Areas for improvement

Action the provider SHOULD take to improve

- All relevant documentation about care planning should be filed in the care planning section of the electronic care records and not in the progress note section.
- Work should continue to ensure that people commence psychology treatment within the trust target of 18 weeks.

Kent and Medway NHS and Social Care Partnership Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Canterbury and Swale	Trust Headquarters
Ashford and Shepway	Trust Headquarters
Maidstone and Malling	Trust Headquarters

Mental Health Act responsibilities

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

All staff had completed training in the Mental Health Act, including the revised Code of Practice. Staff were able to confidently talk to us about the Mental Health Act, their responsibilities with the application of the Act and patients' rights under the Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act and Deprivation of Liberty Safeguards was a mandatory training course for staff working in the community mental health teams for people with a learning disability and all staff had completed this.

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

Detailed findings

We saw issues regarding capacity discussed appropriately in multidisciplinary clinical meetings and, where appropriate, there were records of capacity assessments within peoples' clinical records.

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

Our findings

Safe and clean environment

- The teams were situated in buildings that were clean and well-maintained. We had concerns during our inspection visit in March 2015 about the rooms used for meeting with patients as they were not fitted with alarms. This meant there was a risk if there was an incident, that other staff within the building would not be alerted and therefore not be able to respond in an appropriate and timely manner. On this inspection we found that considerable improvements had been made. Alarms were in situ at the Canterbury and Swale team base. In the other team bases staff had been issued with personal alarms. There were clear protocols available to guide staff on how to respond should an alarm be activated on site and staff we spoke with were able to describe the response guidance.
- None of the teams used clinical rooms however equipment for taking weight and height measurements, blood pressure, temperature and pulse were available across all of the team bases. Staff calibrated the machines and documented the outcomes as required.
- Staff adhered to infection control principles and there were posters on the walls in bathrooms and in other areas that reminded staff about the correct handwashing techniques.
- Staff undertook environmental risk assessments monthly and evidence was available of work carried out as a result, for example quiet spaces for people had been created as well as improved disability access. The environmental risk assessment work was audited as part of a wider service line compliance audit carried out monthly. Daily and weekly checklists were completed by staff to ensure risks were managed in the general environment.

Safe staffing

- There were 41 staff working in the mental health community teams for people with learning disabilities consisting of, nine qualified nursing staff, 15.6 doctors, 16 psychologists (including psychology assistants) and ancillary staff. Social care staff were employed and managed by Kent county council. There were low levels of staff vacancies across the units at 6.5 %, this equated to 1.6 psychology vacancies and 1 doctor vacancy. There were no nurse vacancies. Use of temporary staff was very rare and if used at all would be specialist mental health and learning disability trained staff. The senior management and clinical lead team posts were resourced in addition to these figures. The sickness rate was zero which is an exceptionally good achievement and lower than the trust target of 3%. Staff turnover rate was also zero which showed an excellent level of staff retention.
- All staff told us there were sufficient staff to deliver care to a good standard and the staffing rotas indicated that there were sufficient staff in each of the teams.
- Arrangements were in place to provide effective administrative support and processes to enable clinical staff to spend their time in direct contact with patients. This meant staff had time released to be able to prioritise the care and treatment of their patients. We noted the Dover, Deal and Thanet team had raised insufficient administration support as a risk for the risk register and that this was under review.
- All of the teams had adequate medical cover. Out of office hours and at weekends, community on call doctors were available to respond and attend patients in an emergency via the mental health crisis teams. Consultant psychiatrists were identified to provide cover during the regular consultants' leave or absence.
- Staff told us that the senior managers were flexible and responded well if the needs of the patients' increased and additional staff were required.
- Each team held an average caseload of between 60 and 100 patients for psychiatrists and the same for psychologists. The positive behaviour support team held a lower caseload of between 16-30.
- Staff were up to date with appropriate mandatory training. The average mandatory training rate for staff was 95% compliance, which was above the trust average. There were 19 courses which the trust had

Good

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classed as mandatory for this service and included safeguarding adults and children level two, personal safety awareness and clinical risk assessment and management.

Assessing and managing risk to patients and staff

- We looked at ten care records for people who used the service. All of these included a risk assessment and all records had been reviewed recently. The trust used an electronic care record system with a built in risk assessment template and associated documentation. Staff completed a risk assessment and crisis plan for people who used the service at the initial triage and assessment stage. Staff updated risk assessments every six months, during appointments and more frequently as necessary. Risks were highlighted using the red, green and amber rating system. Additional risk management assessments were used and included a structured decision support guide, called HCR-20 to assess risk factors for violent behaviour. The risk of sexual violence protocol was in place and all people received the short term assessment of risk and treatability.
- We observed two patient assessments accompanying a variety of staff from the multi disciplinary team. Staff explained what the service offered in detail, discussed consent to share information with carers and completed a detailed assessment of the people who used the services' assessment template paperwork. The people being assessed were given time and encouragement to share their concerns and the manner of the assessment was respectful, optimistic and inclusive.
- All of the teams held daily or weekly risk meetings and we observed two of these. These were opportunities for staff to raise risks and share awareness of any changing or potential risks. During the meetings staff fedback to the rest of the team any urgent contact they had had with people and identified the key risks and any safeguarding concerns. During the meetings staff supported each other and shared advice. Staff discussed the views of people and their carers. The discussions were holistic and recovery focused. A risk forum was held four times each year where people who used services were assessed as being high risk were discussed. The forum brought together professionals from the mental health learning disability teams, the generic learning disability teams, social services and forensic mental health services. This meeting offered an opportunity for risk management discussion and peer supervision to ensure that appropriate plans were in place to safely manage risk.
- The trust had developed the complex care response procedure across the teams which meant people who used services could receive a same day assessment of risk to reassess needs in order to prevent any further deterioration of mental state which may have resulted in a hospital admission.
- The service made four adult safeguarding referrals to the local authority during the previous 12 months. The Dover, Deal and Thanet team had made the highest number of referrals at two.
- Staff were trained in level two safeguarding adults and children at risk with updates every two years. One staff member in each team held the role of 'safeguarding champion' and was a point of contact for the rest of the team to discuss safeguarding concerns. Safeguarding champions were trained at level three in safeguarding adults and children. Staff knew how to make a safeguarding alert and did this when appropriate. We saw evidence of safeguarding alerts that staff had raised with the local authority safeguarding team and staff were able to talk us through these in detail.
- Each team kept a safeguarding log and these had been either actioned or closed as appropriate. The trust's safeguarding policy was accessible in hard copy or on the trust's intranet and staff were aware of the policy. We saw safeguarding information posters and leaflets on the walls in areas accessible to people and carers. Safeguarding was a standing agenda item on the team's weekly meetings.
- Without exception people we spoke with said they felt safe and that they were protected from harm. People also told us staff in the teams enabled them to take their own risks following discussion and planning. Relatives and carers confirmed that this was the case. We asked people who used the service and their nominated representatives if they knew how to report abuse and they confirmed that they did and had been given information about this at their assessment.
- We had concerns in our inspection visit in March 2015 as there was a difference in how the lone working system was operating across the teams. In some teams we were

Good

Are services safe?

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informed of a 'purple folder' system, by which a staff member concerned about their safety in the community could call the team and any mention of a purple folder would alert of the risk. The majority of staff with whom we spoke were not aware of the system. This meant there was a risk if an incident occurred staff would not be alerted and therefore not be able to respond in an appropriate / timely manner. The majority of visits were conducted in the community in people's homes. On this inspection we found that considerable improvements had been made. Every member of staff we asked was aware of the 'purple folder' alert system and they were all able to describe the system confidently. Each team had the same lone working policy which incorporated personal safety protocols. Staff who were out visiting were required to call in at the end of the day. At the end of the working day an allocated member of staff checked that every staff member out on visits had called in to the team base and if a staff member had not called in, the member of staff would make contact with them. Staff maintained a diary on the electronic patient care record system so that the rest of the team knew their whereabouts. Staff took other safety precautions by not visiting a person alone if there were any known risks or during an initial visit.

- We looked at the medicines management systems. Medicines were prescribed by general practitioners, following advice from the teams' doctors and there were no medicines stored on any site. In all of the clinical review meetings we attended prescribed medication was routinely reviewed at the person's care review or more often when needed. Effects of medication were monitored and we did not see any inappropriate or unnecessary use of medicines to restrain an individual or control their behaviour.

Track record on safety

- Trusts are required to report serious incidents to the Strategic Executive Information System. There was one serious incident requiring investigation in the previous 12 months across the service. This incident took place in the person's home. The category of the serious incident was 'unexpected or avoidable death' or 'severe harm of one or more patients, staff or members of the public'.

Reporting incidents and learning from when things go wrong

- We looked at the trust's incident reporting system and saw that staff had reported a range of incidents and they were appropriately recorded. All staff we spoke to told us that they knew what to report and how to report. The trust's incident reporting policy was in place and staff were aware of it. The policy had been transcribed onto a flow chart for easy reference and was widely advertised.
- Staff told us that they received feedback from investigations in regular team meetings and that they learnt key themes and lessons and developed action plans if they needed to make changes. Staff said there was always a debrief session arranged after a serious incident, and that a facilitated, reflective session would take place to ensure, as well as learning lessons, that staff felt adequately supported. Following incident investigations staff prepared case studies which summarised outcomes and learning points in order to better understand and interpret peoples' complex needs.
- The senior management team circulated a monthly learning review bulletin to staff with incident summaries for both the community mental health learning disabilities teams and wider trust services, along with emerging themes. The bulletin was called, 'learning, listening, and improving'. All staff we spoke to knew about the bulletin and the key messages contained within it. There was a section detailing key lessons for learning in order to prevent reoccurrence of the incident. For example, the quality of assessments was improved. In another example, teams were asked to always develop a care plan if a patients' physical health deteriorated or gave cause for concern.
- The provider was open and transparent with patients in relation to their care and treatment. This is known as the duty of candour and sets out some specific requirements that providers must follow when things go wrong with care and treatment. This included informing people about the incident, providing reasonable support, providing truthful information and an apology. All incidents were discussed with staff across all of the teams.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We reviewed 10 care records on the electronic patient record system. Comprehensive assessments were documented in each of the care records we reviewed and were carried out at the person's first appointment. All of the care records we reviewed had care plans. However we found a significant amount of care plan information in the electronic care record progress notes section and not in the care plan section. This meant it was not always easy to access the care plan information in a timely manner.
- Staff in all teams used the care programme approach as the overarching method for planning and evaluating care and treatmentStaff assessed people's needs using a number of nationally recognised good practice assessment tools such as the psychiatric assessment schedule for adults with developmental disability and a functional behavioural assessment.
- People's needs were assessed and care was delivered in line with their individual care plans. Assessments were completed in a timely manner and the care plans were detailed, personalised, focused on maximising independence and holistic. There was good detail about the presenting issues and how this was impacting on the person receiving services, their family or carer. Care plans were up to date and person centred. There was evidence efforts were made to make these 'easy read' or accessible for the individual person. Care plans included good information about holistic needs and the emphasis was on recovery and a person's strengths. Carers reported receiving a copy of the care plan and said they were aware of the support being provided.
- We spoke with people who used services and their families and representatives. They all confirmed they were receiving the right treatment for their condition, were receiving good quality physical and mental healthcare, had their care regularly reviewed and that they felt well supported and looked after well.
- Records showed risks to physical health were identified and managed effectively. Risks were identified on first assessment and updated as and when changes occurred. There were good links with general practitioners (GPs) and GP letters were uploaded onto the electronic system.
- All of the teams held either daily or regular meetings each week. We attended seven of the meetings where the teams discussed people's care and their support needs. Staff were aware of the needs of people and developed plans to address them.

Best practice in treatment and care

- The teams carried out audits against the National Institute for Health and Care Excellence (NICE) guidelines on promoting good health and preventing and treating ill health for people with learning disabilities and autism. The service complied with NICE guidelines regarding the use of antipsychotic medicines for the people who used the service and people also received regular physical health checks.
- In addition the teams provided services with due consideration to the findings and recommendations from, 'Three lives, Care Quality Commission and the Challenging Behaviour Foundation 2014', 'Challenging Behaviour: A Unified Approach, Royal College of PsychiatryPeople with Learning Disabilities, 2013, 'The Confidential Inquiry into Premature Deaths of People with Learning Disability (Bristol University 2013)', 'Meeting the Health Needs of People with Learning Disabilities, Royal College of Nursing, 2013, 'The Health Equalities Framework, 2013 and 'Valuing People Now, 2007'.
- Records showed that all people received physical health assessments by their general practitioner or by one of the teams' doctors. This was only done with their consent when they engaged with the teams. We noted that risks to physical health were identified and managed effectively. Care plans were available for those people with an identified risk associated with their physical health. The teams offered physical health checks for people who used services where this was considered more accessible and appropriate.
- The care programme approach was used as the overarching model to care delivery. This enabled patients' needs to be assessed, their treatment and

Are services effective?

Good

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

therapy to be planned, co-ordinated, delivered and reviewed. Multidisciplinary team members held six monthly care programme approach reviews in conjunction with people who used services.

- All of the records we looked at had a health action plan included. This is a personal plan about what people need to do to stay healthy. It lists any help people might need in order to stay healthy and makes it clear about what support they might need. All information about their health is written down in the health action plan and it can be used to show other people or professionals about their health care needs.
- The staff offered people who used the service a person centred approach, adopting a solution focused approach to promote recovery. People had a good level of access to a wide variety of psychological therapies either on a one-to-one basis or in a group setting as part of their treatment. Psychologists and psychology assistants were part of the multidisciplinary team and were actively involved in peoples' care and treatment. We looked at evidence of detailed psychological assessments and treatment interventions such as family and systemic therapy, positive behaviour support, cognitive behaviour therapy and wellness recovery action plans.
- The trust had developed a procedure called the complex care response to activate immediate additional support for people who experienced deterioration in their mental health, or who were assessed as being at a higher level of risk. The complex care response was triggered by staff to deliver additional intensive interventions, which may be from 24 hours to 12 weeks in duration, in order to, for example, prevent an acute hospital admission. Any people admitted into hospital received in reach support from the teams to facilitate prompt discharge and in addition to provide support for the inpatient staff.
- Staff participated in clinical audits to monitor the effectiveness of services provided. All staff participated at least weekly, in reflective practice sessions. They continually evaluated the effectiveness of their interventions. Audits carried out included a regular person centred audit to ensure people were fully involved in all aspects of care planning. In addition audits were carried out to ensure physical health needs were met for people receiving psychotropic medication, audits evaluating the effectiveness of the psychological therapies offered, audits on the effectiveness of positive behaviour support plans and audits were available which looked at patients' risk assessments and crisis relapse and prevention plans.
- Staff representatives from all of the teams had participated in a 'deep dive' audit of one another's' teams looking at the five key questions asked by the Care Quality Commission. We looked at the audits and the associated action plans for all of the teams.
- Staff assessed people using the Health of the Nation Outcome Scales for learning disabilities. These covered twelve health and social domains and enabled clinicians to build up a picture over time of their peoples' responses to interventions.

Skilled staff to deliver care

- The staff across the teams came from various professional backgrounds, including medical, nursing and psychology. Staff were experienced and qualified to undertake their roles to a high standard.
- All staff received a thorough induction into the service.
- Staff received appropriate training, supervision and professional development. Staff were encouraged to attend additional training courses. For example, staff had undertaken courses on positive behaviour support to better deal with behaviour which challenges, sexuality, autism, communication, epilepsy, mental health, physical health, learning disability and family therapy.
- All staff we spoke to said they received individual and group supervision on a regular basis as well as an annual appraisal. All staff had received regular supervision. All staff participated in regular reflective practice sessions where they were able to reflect on their practice and any incidents that had occurred. We noted that 81% of all staff had received an appraisal. The appraisals included objectives that incorporated the trust key values. The revalidation of the medical staff was up to date.
- Senior managers told us they were not performance managing any staff for capability issues at the time of our inspection.

Multi-disciplinary and inter-agency team work

Are services effective?

Good

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

- Fully integrated and well-staffed multidisciplinary teams worked across the service. Regular and fully inclusive team meetings took place. We observed care reviews and staff meetings and found all of them to be highly effective. Staff had space and time to feedback and add to discussions in meetings. Everyone's contribution was valued equally.
- Close working arrangements were in place between the trust's teams and a
- We observed interagency working taking place, with staff creating strong links with primary care, the learning disability community teams, mental health acute inpatient services, social services and residential care homes being particularly positive examples.
- Clinicians from the teams facilitated a multi-agency professional forum where they invited all partner organisations. Case presentations were discussed as well as key learning from a variety of national and local policy developments such as 'the Winterbourne concordat: Programme of action (2012)'.
- Teams ran a monthly clinic in conjunction with colleagues from the generic community learning disability teams, carrying out joint assessments and care reviews.
- The trust had developed a clear and comprehensive dementia care pathway for people with learning disabilities. The protocol between the mental health learning disability teams and community mental health teams for older adults stated that all people with a learning disability had access to dementia screening. A group of clinicians from both services set up a joint clinic for dementia assessment and treatment. This work was being audited to evaluate effectiveness of the service and for client and family satisfaction.
- We spoke with six external members of staff who commented on the responsiveness of the teams and that the staff within the teams were highly skilled and motivated in their work.
- Staff had received a trust award for the success of their partnership working in 2016.

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

- All staff had received updated training on the Mental Health Act, including the revised Code of Practice.
- Staff were able to confidently talk to us about the Mental Health Act, their responsibilities with the application of the Act and patients' rights under the Act.
- The use of the Mental Health Act across the teams was minimal however community treatment orders (CTO) were occasionally used. At the time of our inspection three people who used services were under a CTO. A CTO applies to people who have been in hospital under the Mental Health Act. A CTO means people will have supervised treatment when they leave hospital. The conditions of supervision can include where people will live or where they will get treatment. If the conditions of the CTO are not adhered to the person can be brought back to hospital.

Good practice in applying the Mental Capacity Act

- All staff had undertaken Mental Capacity Act training. There was a Mental Capacity Act policy in place and staff told us about the principles and how they applied to people who used the service.
- Where appropriate patients had a mental capacity assessment relating to care and treatment. Care records included best interest assessments where capacity assessments had been carried out with regard to patient wishes and preferences, and the involvement of family members. We received good feedback from carers about how they had been involved in the assessment and decision making.
- Staff told us they could speak to their clinical lead and service manager regarding any queries about the Mental Capacity Act.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- All of the people we spoke with and their relatives and carers complimented staff providing the service across the teams. Comments from people who used the services and their relatives included, “An exceptionally great team, wonderful staff, highly trained and it shows, an excellent team, this is a very helpful team, this is the best team I have ever come across”. Many individual staff were personally commended by people and their relatives.
- People who used the service told us that they were treated with compassion, dignity and respect and that they were supported to make their own choices in their daily life.
- Staff we spoke with showed they knew the people who used services well. They demonstrated kindness and compassion about the people they supported. Thoughtful and respectful interactions were observed consistently between staff and people who used services during community visits. All staff we spoke with had a very in-depth knowledge about their patients including their likes, dislikes and preferences. They were able to describe these to us confidently, for example, what triggers could cause anxiety with some people who used the service.
- When staff spoke to us about people and their families, they showed a good understanding of their individual needs. During the meetings we attended staff reflected the wishes and views of the people they were discussing.
- The service adhered to the trust’s policy on confidentiality. Everyone we spoke to said they felt their information was treated confidentially. They said they were asked for consent to share information with external organisations including with general practitioners. When we accompanied staff on home visits or in meetings, the staff members asked if the person was content for a Care Quality Commission team member to be present prior to the visit. Staff were aware of the need to ensure a person’s confidential information was stored securely. Staff access to electronic case notes was protected.

The involvement of people in the care that they receive

- Staff told us confidently about their approach to people who used services and the model and philosophy of care practiced across all of the teams. They spoke about the emphasis they put on ensuring any treatment or support interventions were individualised and centred on the person and co-produced with them and their family or carer. Staff spoke passionately about ensuring their people were supported to access the full range of mainstream health and social care services. Staff were non-judgemental towards their patients and empowered them to encourage their involvement.
- Colourful pamphlets in accessible and easy read format were available which gave detailed information to people and their families and carers about the services offered. The pamphlets included information about health needs, the multidisciplinary team, care and treatment options, medication, physical health needs, arrangements for health records, care plans and how to raise any concerns. We found the pamphlets helped to orientate people to the service and people we spoke to had received copies and commented on them positively.
- There was evidence of peoples’ involvement and their relatives or carers involvement in the care records we looked at. Staffs’ approach was person centred, highly individualised and recovery orientated. People or their representatives told us they were fully involved with every aspect of their treatment and care planning. We attended seven care reviews and four home visits and saw that people were fully involved in discussions about their care and treatment. People who used services told us they were involved in decisions about their care and that they were helped to keep in touch with family and friends.
- People who used the service and their families told us about the “great” support they received from the teams and that they felt involved in the development of care plans and decision making. One person told us, “I have always been put through to the right person whenever I ring in. They all know what we have agreed in my relative’s care plan and it is so reassuring to know that they know who I am and respond so promptly”.

Good

Are services caring?

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

- Local advocacy services were advertised widely on notice boards in all of the team bases and those people who used services and their families we asked had details on these services and knew how to contact them.
- A member of staff from each of the teams was identified as the, 'carers champion' and co-ordinated good communication with relatives and friends. The teams had implemented the 'triangle of care' initiative. This initiative had a number of good practice examples of how services ensured there was excellent joint working between people who used services, their families and carers and staff. The trust had developed a friends, family and carer partnership charter which laid out the commitments the trust's services would deliver in ensuring they worked closely and in partnership with families and friends.
- Patients could become involved and give feedback to the teams through a number of initiatives. The provider used patient reported measures to assess how effective the treatment and therapy programmes were. The trust carried out a monthly friends and family test, asking how likely a patient would be to recommend the services to family or friends if they needed similar care or treatment. Over 82% of patients asked in December 2016 said they were likely or extremely likely to recommend the services. The teams carried out their own satisfaction survey every year which showed in the preceding year that 94% of people who had used the services were satisfied with the services received. The trust had organised a patient experience group which looked at all aspects of peoples' experience of using services, such as how well accessible information was used and learning lessons to improve services from the friends and family feedback given.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Referrals into the community mental health teams for people with learning disabilities came from a variety of sources which included; the generic learning disabilities community teams, general practitioners, council social services, statutory health services including mental health acute inpatient units, children and family services and private and voluntary sector social care providers.
- The key performance indicators agreed with commissioners were a four week timescale from referral to assessment for routine referrals, maximum 18 week wait from referral to commencement of treatment for routine referrals and same day response time for complex care referrals (People in crisis).
- From March 2016 to February 2017, 2,206 routine referrals were made. The referrals were directed to each healthcare professional, 112 for nurses, 459 for psychiatrists and 532 referrals for psychology. (Please note the nursing team service started/ was commissioned in June 2016). From April 2016 to December 2016, 56 complex care referrals were made. During the same period of time 78% of people were assessed within the four week target period (100% for nursing assessments, 70% for psychiatrists and 65% for psychologists). 86% of people commenced treatment within the 18 week target period (100% for commencement of nursing service, 89% for psychiatry and 70% for psychology). All of the people who used services in crisis received a same or next day response as part of the complex care response pathway.
- We had concerns during our inspection visit in March 2015 aboutthewaiting lists for psychology which could be up to one year. On this inspection we found that waiting lists were still an issue although substantial improvements had been made. The lowest waiting list was eight people waiting for psychology at the Maidstone and Malling team and the highest number of people waiting was 55 at the Canterbury and swale team. This equated to a waiting time of between six to nine monthsfor the majority of people waiting. Fifteen people had been waiting to start psychology for up to a year however they were assessed as low risk and were being supported by health and social care professionals.The positive behaviour support team had no waiting list for psychology. There were no waiting lists for people to see either nurses or doctors.
- All of the teams were actively involved and engaged in the process of facilitating the return of patients who were being treated in out of the Kent area, in hospital wards. This work was planned and overseen by the, 'Kent and Medway transforming care working group and the discharge planning group'. Both of these meetings were multi-agency and included social services and commissioners of services. 27 patients in out of area hospital placements were identified for further work with the teams to enable their return to the Kent area.
- Teams held a daily or weekly referrals meeting where all prospective people were discussed based on the information received by the service. Urgent referrals were prioritised and processed via the complex care response care pathway.
- People who used services told us they were supported well to live safely in the community and that their needs were met including if they needed additional support.
- The teams offered a treatment model based on individual care and treatment pathways. These included pathways for mood and anxiety, neurodevelopment, complex and challenging behaviour and conduct. This model ensured that people received the most appropriate interventions, treatments and support which best met their needs. Interventions were provided by suitably trained and qualified staff.
- People were supported through transitions between services, for example from children's services to adult or from inpatient services to the community. People were involved in drawing up information to accompany them in their move.
- Staff followed clear procedures if people did not attend their appointments. For example, staff telephoned, sent text messages, made home visits and sent letters to people who failed to attend appointments. Staff were aware of and followed contingency plans. Very few people did not attend for appointments as many people were accompanied.

Are services responsive to people's needs?

Good

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

- Mental health crisis teams were available across Kent should people need additional mental health support during a crisis.
- Interventions offered to people included; medication monitoring and review, support with physical health needs and ongoing monitoring, a wide range of psychological therapy, advice on coping with symptoms of illness and support with accessing community facilities and resources.

The facilities promote recovery, comfort, dignity and confidentiality

- The facilities in all of the community bases we visited promoted recovery, dignity and confidentiality. All areas that people had access to were clean, tidy and well maintained. Furniture was in good condition and facilities were decorated to a good standard.
- There was an array of relevant information on display in all of the reception areas in the community bases. Information leaflets were available regarding local services, medication and how to make complaints.

Meeting the needs of all people who use the service

- The buildings we visited were accessible to wheelchairs and staff arranged to meet with people at other venues if they wished to. The majority of appointments and visits took place in the community or in peoples' homes and the needs of those with a disability were being met.
- Information leaflets about services were provided by the trust and included easy read leaflets. Information about how to contact advocacy and how to make a complaint were included in information. Accessible information booklets regarding health issues and conditions were also available. Information leaflets on equality and diversity were available in all of the buildings. Examples were given showing people how their individual and unique needs could be raised and met. Examples were sited of how patients' needs could be supported with their religion, ethnicity, race, traditions, sexuality and disabilities. preferences.
- The trust widely advertised information explaining why information about people who used services was collected and the ways in which it may be used, for example in the teaching and training of healthcare professionals.
- Interpreters and signers were available to staff to utilise as needed.

Listening to and learning from concerns and complaints

- There were two complaints in the year prior to our inspection and the provider partially upheld one of them and fully upheld the second. This showed us that the provider was fair and transparent when dealing with complaints.
- Copies of the complaints process were on display in public areas of the team bases. In addition at the assessment appointment people were given a leaflet which detailed how to contact the patient experience team in the trust and also how to make a complaint. People who used services and their families we spoke with all knew how to make a complaint, should they wish to do so. This included how to contact the Care Quality Commission.
- Staff confidently described the complaints process and how they would handle any complaints. Staff told us they tried to deal informally with concerns and to do this promptly in an attempt to provide a timely resolution to concerns. Informal complaints were logged and tracked as well as formal complaints.
- Staff met regularly to discuss learning from complaints. This informed a programme of improvements and training, for example, improving communication between staff and carers in relation to follow up arrangements. Further learning included developing clear policies and practices around the use of booked rooms in the team bases in order to avoid any distress with interruptions or double bookings.

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.

Our findings

Vision and values

- The trust's vision, values and strategies for the service were evident and on display on information boards in the team bases. Staff we spoke to understood the vision and direction of the organisation. Staff felt part of the service and were able to discuss the philosophy of the service confidently. Staff told us that the purpose of the service was to offer a care pathway and to deliver high quality treatment and therapy programmes to people with learning disability who have complex health and social care needs.
- The senior management team had regular contact with all staff. Staff said the senior management and clinical teams were highly visible and staff said that they regularly visited the services. All staff knew who the senior management team were and felt confident to approach them if they had any concerns.

Good governance

- Key performance indicators and performance data was available to staff relating to waiting times from referral to assessment and onto treatment. Information on performance in key areas was collated and summarised by senior managers and published monthly.
- Supervision, appraisal rates and mandatory training records were completed for all staff.
- There was an effective system in place to assess the risks to people whilst they were waiting for assessment or treatment.
- The multidisciplinary leadership team for the service worked very well and enabled those teams to deliver high service standards. Clinical and managerial supervision was taking place regularly. The senior clinical staff told us they felt they had the autonomy and authority to make decisions about changes to the service. They commented that they felt very well supported.
- Teams could raise items for the risk register when necessary. For example staff had raised risk items about administrative support and psychology waiting times and the impact staff vacancies have in such a specialised service.

Leadership, morale and staff engagement

- Staff told us they understood what was expected of them in their jobs, they felt supported by their line managers and felt they could safely raise concerns at work. They understood how their work helped to achieve the service objectives. All of the staff we spoke with were highly satisfied working in the service. The senior management team held monthly leadership forums where senior clinicians and managers came together from the service line and discussed, for example, the quality of service provision and service developments.
- The teams held regular team meetings and all staff described morale as very good with their senior managers being highly visible, approachable and supportive. Topics recently covered included research and performance. Staff were asked regularly about what they thought the service did particularly well and what the services could do to improve.
- Staff were encouraged to provide articles about interventions and skills they were particularly proud of in the quarterly publication, 'Connected'.
- Staff had received a number of awards from the trust which included awards for, 'high performance, going above and beyond, innovator of the year and special thanks and recognition award'.
- Sickness and absence rates were zero as of November 2016, much lower than the trust target rate for sickness of 3%.
- Staff said they felt very well supported in dealing with any concerns they had about any adverse behaviour from either fellow staff or people who used services.
- Staff were aware of the whistle blowing process. There was a policy, which the provider would follow for the investigation of concerns. No whistle blowing alerts had been received by the Care Quality Commission in the preceding year.

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.

- Staff were able to confidently describe the importance of transparency and honesty and their duty of candour.
- All of the staff we spoke with expressed their pride in the strong element of team working across the teams.

Commitment to quality improvement and innovation

- Staff participated in clinical audits to monitor the effectiveness of services provided. They evaluated the effectiveness of their interventions. This work was overseen by the quality meeting and the quality improvement team, which provided an overall review of quality, safety and effective clinical services. Three meetings reported to the quality group, the clinical and effectiveness outcome group, the patient experience group and the patient safety group. Staff had received a number of certificates from the trust awarded following audit projects undertaken such as audits of the quality of letters written following consultations.
- The mental health community learning disability teams held monthly research and development meetings. Ongoing projects included the publication of a new edition of, 'Mental health in intellectual disabilities' good practice guide and research on the effectiveness of the complex care response protocol.