Kent and Medway NHS and Social Care Partnership Trust

Community-based mental health services of adults of working age

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Community-based mental health services of adults of working age

Requires Improvement 

The community mental health teams for adults of working age form part of the trust's mental health services in the community.

We undertook an unannounced, focused inspection of this service because we had received information that raised some concerns about the safety and quality of the service. We visited four (of 10) of the trust's community mental health teams:

- South West Kent
- Dartford, Gravesend and Swanley
- Dover and Deal
- Medway

Staff in the teams work with people at the team bases, satellite services and patients' homes.

Our overall rating went down. We rated the service as requires improvement because:

- Across all the teams we inspected, staff did not always assess and manage risk well. We reviewed 31 patient records, which were a mix of Care Programme Approach (for people with complex or severe mental health problems) and standard care (for people with more straightforward needs) records and found that risk assessments and risk management plans were basic and did not have complete and detailed information. Crisis plans had not always been completed and, where they existed, they lacked detail. This meant that patients and carers may not have received the support they needed.
- Patients who did not require urgent care did not always receive timely treatment. Some types of treatment were not provided because there were not enough staff to learn how to provide it and then provide it. This meant some patients were left waiting for the care they needed. For example, specialist treatment for people with complex mental health needs.
- Although teams and individual members of staff had manageable caseloads, they could not provide all the care their patients needed (for example, specialist treatment for bipolar disorder) and some patients who needed non-urgent care were not part of caseloads because they were still on a waiting list to join a waiting list for specialist treatment.
- Trust-wide governance processes did not always ensure that key issues were picked up and addressed in a timely manner. In the months prior to our inspection, the South West Kent team had experienced difficulties with lack of leadership, affecting patient care (for example, patients did not see their care coordinators often enough) and poor staff morale. Trust systems had not identified this as an issue early enough which had resulted in a lack of appropriate, timely support being provided to the team and further deterioration and risk in the team.

However:

Our findings

- Patients who required urgent care were assessed and treated promptly by staff. The criteria for referral to the service did not exclude patients who would have benefitted from care.
- Staff monitored patients on waiting lists well to ensure that patients who required urgent care were seen promptly.
- The teams were well led at local level. Staff morale and culture was positive and supportive in the teams including the South West Kent team where a new leadership team had recently been introduced.

Background to inspection

This inspection was unannounced and was undertaken because we had received information that raised concerns about the safety and quality of the service. It focused on the areas of safe, responsive and well-led.

We last inspected the service as part of a comprehensive inspection between 9 October and 29 November 2018. Prior to this inspection, the overall rating for the community mental health teams for working age adults was good.

The inspection took place during Covid-19 tiered restrictions and we only looked at specific areas of concern and we did not look at all the key lines of enquiry. We did look at enough lines of enquiry across enough of the teams to re-rate the core service. We re-rated safe and well-led as requires improvement and this meant the overall rating for the core service now becomes requires improvement.

The teams form part of the trust's mental health services in the community. They provide a specialist mental health service for adults of working age (18-65) with significant mental health needs. Staff provide patients with care co-ordination and recovery-focused interventions, including psychological therapies. The teams also support patients with complex mental health needs who require an assertive outreach approach to meeting their needs. The teams operate from 9am-5pm Monday to Friday. The teams comprise multidisciplinary teams of health care professionals, including psychiatrists, psychiatric nurses, psychologists, occupational therapists and support workers. The service primarily receives referrals from GPs, but also other parts of the mental health system, such as acute and crisis mental health services. The single point of access team manages urgent referrals for the community mental health teams and operates 24 hours a day to receive referrals by email, text or telephone.

The trust has 10 community mental health teams (CMHT) for working age adults:

- Swale CMHT - Sittingbourne Memorial Hospital
- Maidstone CMHT - Albion Place Medical Centre
- Medway CMHT - Britton Farm
- South West Kent CMHT - Highlands House
- Dartford, Gravesham and Swanley CMHT - Arndale House
- Dover and Deal CMHT – Coleman House, Dover and Bowling Green Lane, Deal
- Thanet CMHT – The Beacon
- Canterbury and coastal CMHT – Laurel House, Canterbury and Kings Road, Herne Bay
- Shepway CMHT – Ash Eaton, Folkestone
- Ashford CMHT – Eureka Place

Our findings

The trust has a nominated individual.

How we carried out this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

The team that inspected the four community mental health teams comprised five CQC inspectors, two inspection managers, a head of hospital inspection, four specialist advisors and an expert by experience.

Before the inspection visit, we reviewed information that we held about the service.

During the inspection, we reviewed 31 patients' records, observed meetings and the duty service, spoke with staff and patients, and reviewed complaints, incidents and policies.

We also reviewed information such as performance data and policies supplied to us by the trust, both during and after the inspection site visit.

Is the service safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement because:

- In all the teams we inspected, staff did not always assess and manage risks to patients. Risk assessments and risk management plans were largely generic and basic and did not have complete and detailed information, with no clear evidence that patients had input themselves. There was no evidence of positive risk taking in the records or identification of the patients' strengths to manage their own risk and what they would need support with. There was limited evidence of collaboration with the patient's family and carers to develop crisis plans when required. Where we did see crisis plans, they did not contain helpful information such as early indicators of patients becoming unwell, or advice and coping mechanisms for the patient and their carer. Care plans did not always reflect the patients' assessed needs and their risks, and were not always personalised, holistic and recovery-oriented.
- Staff did not always keep a detailed record of patients' care and treatment. Records were not always clear or up to date.
- Patients of the Dover and Deal, Medway and Dartford teams told us that they found it difficult to get through to staff on the telephone in an emergency and non-emergency. There was only one telephone number for contacting the teams which was insufficient for the needs of the patients and the teams. After the inspection, the trust informed us that a digital solution to these telephone problems would be in place by April 2021.
- Staff in all the teams we inspected told us the teams did not have enough staff to provide safe care and effective treatment. Some types of care were not provided (for example, specialist treatment for bipolar disorder) because there were not enough staff to learn how to provide it and then provide it. Some patients were left waiting for the treatment they needed, such as non-urgent psychological therapies. The trust informed us that they had been successful in recent bids to increase the numbers of staff in the teams, and that each team was at a different stage in implementing the roll-out of new care pathways which could affect the availability of some treatments.

Our findings

- There were inconsistencies across all the teams in the use of the 'Red Board' process. The 'Red Board' meeting was a daily multidisciplinary discussion about high-risk patients. The minutes, and our observations from the meetings, showed that discussions varied from team to team. Some teams were better focused on risk than others where they seemed to discuss issues more generally. Patients who were becoming more at risk were not always identified early enough to prevent further deterioration before they became a high risk. Discussion about future risk and reoccurrence was not always evident when the team made the decision to remove a patient from the 'Red Board'.
- The trust had found it particularly difficult to recruit registered nurses, which put pressure on all the teams. There were also vacancies for physical health nurses in the teams. Staff across the teams reported feeling under pressure with their general workload, and patients we spoke with said that repeated changes to care coordinators due to staffing shortages had an unsettling effect on them. However, the trust supplied staff vacancy information and informed the inspection team that vacant posts were covered by agency and bank staff and the trust informed the inspection team that they were addressing the issue by trialling new recruitment approaches and upskilling staff.

However:

- The number of patients on the caseload of all the teams, and of individual members of staff, was within an expected range. Despite team leaders monitoring the caseloads closely the general workload and the complexity and needs of the patients varied which meant staff felt pressured.
- Managers monitored waiting lists well. Once a patient was accepted to the service, depending on risk, they were either allocated a care coordinator immediately or initially held on a team leader waiting list while they were awaiting their initial assessment. Once they had their initial assessment and their treatment pathway was agreed, patients were then allocated to 'Active Review Team'. Although this was another waiting list for treatment, it was overseen by a dedicated team and patients received a support call once every four weeks from their allocated support worker. Any concerns were escalated and discussed at the multidisciplinary team meeting or as part of the 'Red Board' risk meeting.
- Staff monitored patients on waiting lists to detect and respond to increases in level of risk. They generally responded promptly to sudden deterioration in a patient's health. We saw examples where staff would make unannounced visits at people's homes if they had not been able to make contact with them to check they were safe.
- Staff followed good personal safety protocols. All staff completed home visits with another colleague and had access to mobile phones.
- There were measures in all teams to manage sickness, leave and vacant posts. Bank and agency staff were used. The trust had a plan to overcome barriers to recruitment.
- Staff understood how to protect patients from abuse and all teams worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The teams had a robust system for recording, monitoring and reviewing safeguarding concerns. Staff were supported by the trust-wide safeguarding team.
- All the teams we inspected, had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- All information needed to deliver patient care was available to relevant staff when they needed it. This included when patients were transferred between teams. All records were electronic. When staff attended home visits, they completed their notes when they returned to their team base.

Our findings

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Patients who did not need urgent care had to wait, in some cases for months, for treatment to start. Information provided by the trust showed that 75% of all patients received an assessment within the four-week timeframe. The trust target was 95%. Trust information showed that many patients on the 'Active Review List' were waiting over six months for some of their treatment to start and some were waiting over twelve months. For example, at the Medway team, 28% of patients on the 'Active Review List' were waiting for six months or longer for some treatments that their assessment had shown they needed; at the Dover and Deal team, 18% of patients were waiting and at the Dartford, Gravesham and Swanley team, 44%.
- Staff vacancies across all the teams delayed patients' care, such as initial interventions, one-to-one psychology treatment and occupational therapy. Some patients who required psychological therapies and treatment for bi-polar had to wait a considerable time for these services. Most patients first received treatment via initial interventions. Patients could then either be discharged if no further treatment was needed or go on the Active Review waiting list and await their next treatment.
- Patients and staff, we spoke with told us that during the last year patients waited longer than usual for treatment. However, patients on the 'Active Review List' received a monthly review call from CMHT staff whilst waiting for their treatment. The trust told us that this was due to the Covid-19 pandemic and they were focusing their efforts to reduce waiting times using digital and video technology which helped contact with patients during the Covid-19 pandemic. However, they were working with commissioners to increase staffing levels and were introducing improvements to help patients access treatment. We saw that each team had processes to monitor those patients who were waiting for treatments.
- Despite having a care coordinator, some patients were still waiting for the treatment they needed to support their recovery. Staff told us there were not enough staff to be able to provide training so staff could learn new skills to support them to deliver the treatment patients needed.
- Patients from the Dover and Deal, Medway and Dartford teams told us they found it difficult to get through to staff on the telephone in an emergency and non-emergency. There was only one telephone number for contacting each of the teams which was insufficient for the needs of the patients and the teams. The trust did not ensure their systems supported patients calls to be answered in a timely way. The trust informed us that prior to the inspection, they were already reviewing phone systems across all the teams and would be improving telephone access for the teams by April 2021.

However:

- Most referrals came from GPs. The multidisciplinary team reviewed referrals daily. Where referrals were not appropriate for the teams, patients were signposted to other more suitable services.
- Staff assessed and treated patients who required urgent care promptly. The duty team responded to all urgent referrals and would either speak with or arrange a face-to-face meeting with the patient in the team base or at home.

Our findings

- Staff followed up patients who missed appointments. The teams had effective processes to ensure that people who did not attend their appointments were followed up to make sure they were safe and to try and re-engage them into the service. Staff clearly described the action they would take. The 'Red Board' risk meeting discussed people who did not attend appointments and agreed any action needed. Team managers monitored this daily to ensure staff were following the process.
- All of the teams engaged with patients who found it difficult or were reluctant to engage with mental health services. Staff met patients where they felt most comfortable. Patients we spoke with said staff asked what their preference was.
- Patients told us that staff, where possible, were flexible with appointment times. For example, we saw a home visit being arranged but staff were mindful to make it in the afternoon as the patient worked nights and they did not want to disturb their sleep. Although the working hours of the community teams is primarily 9am to 5pm, we saw many examples where staff had seen patients outside of these hours to accommodate child care or the patient's working hours.
- Due to staff sickness, routine appointments were, at times, cancelled. Urgent appointments were not cancelled, and the teams altered their planned workloads to accommodate these. Patients told us this was frustrating, but they were informed, and a new appointment was booked. We saw this at each of the teams we inspected.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Patients we spoke with were aware of how to complain if they needed to. They said they felt confident to contact either their care coordinator or the team. In each of the teams, staff were aware of the complaints process. Patient advice and liaison services (PALS) dealt with formal complaints. Staff, if possible, tried to resolve complaints informally. Learning from complaints and identification of common themes was discussed and shared as part of team meetings.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- The trust's governance processes did not always operate effectively, and performance and risk were not always well managed. The trust-wide audits repeatedly showed concerns with patient risk assessments, crisis plans, and care plans but improvements had not been made.
- The trust monitored patients who were awaiting treatment and had developed an improved clinical care pathway programme to address access to treatments. However, the trust was aware that some care and treatments had not been provided at all, across all the teams and they told us this was due to vacancies within certain clinical roles within all the teams.
- South West Kent CMHT had been experiencing difficulties since late 2019 that had impacted on patient care and staff morale. The trust audit process, Cliq checks, had confirmed the team performance as high-risk across key care indicators but sufficient action had not been taken in a timely manner to improve and address the issues. At the time of inspection, we saw evidence that new team leaders who had been post three months were beginning to improve performance in some areas. It was clear that the team still had some way to go to achieve trust targets and demonstrate good quality care.

Our findings

- There was a disconnect between the trust senior management and the local teams. Staff across all the teams felt trust senior leaders did not understand the unique dynamics of each team. They said they felt tension because, although local management was very effective and supportive, senior trust managers did not listen or learn and that was frustrating for the teams. A reoccurring theme raised by staff from all the teams was the lack of support from the trust to enable them to have the resources and confidence to deliver all the treatment patients needed.

However:

- Prior to the inspection, the trust had started to address concerns at the South West Kent CMHT. A new, temporary leadership team was put in to support the service. Because of this, the team made significant improvements to caseload management, management of patients' risk, and staff morale. A Head of Nursing action plan was used to monitor improvement. During the inspection, we were informed that a new permanent leadership team had been recruited and was due to start the week after the inspection.
- Local team and locality leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for staff.
- The staff worked well together in their teams and supported each other. Staff were very positive about the culture of all the teams, which they described as open and honest. We observed meetings and found staff had a good level of discussion and support was given. Staff acknowledged there were challenges in the teams but said that as a team they felt they all worked together well to deliver the best possible care they could with what they had.
- In all the teams we inspected, staff told us they felt respected, supported and valued by local leaders and colleagues. In addition, they reported that the trust promoted equality and diversity in its day-to-day work, and in providing opportunities for career progression. Staff told us about job secondments and promotions they had been supported to achieve. Other staff told us about additional responsibilities they were supported to take on to develop their skills and experience. Staff felt able to raise concerns without fear of retribution.
- All the teams were committed to improving services for patients and used team meetings and other forums to discuss and consider changes. The teams had continued to develop their management and oversight of patients who were awaiting treatment on the active review list. They had also implemented, within the last year, an initial interventions treatment which was achieving good outcomes for patients.

Our findings

Areas for improvement

Action the trust **must** take to improve

We told the trust that it must take action to bring services into line with three legal requirements. This action related to the community mental health teams for working age adults.

The trust must ensure that patients' risk assessments contain complete and good quality information, are updated, reviewed and reflective of identified risks, and that all patients have risk management plans (Regulation 12).

The trust must ensure that, where necessary, patients have a crisis plan that has been developed with the patient and, where relevant, their carer. Plans must contain complete and good quality information, identify the patient's triggers and any support available for the patient and carer (Regulation 12).

The trust must ensure that patients receive assessment and treatment that they need without extended delay and within trust target times (Regulation 17).

Action the trust **should** take to improve

We told the trust that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

We told the trust that it should take action to prevent it failing to comply with legal requirements in future, or to improve services.

The trust should ensure that they deliver on their plans to improve the telephone access for patients and staff to all teams as per their plan.

The trust should consider improving the process for 'Red Board' meetings to ensure consistency across the teams, capture patients who present with emerging risks to prevent a deterioration and record decisions for removing patients.

The trust should continue to regularly review the numbers of staff needed in each of the teams to be able to deliver safe and effective care to patients.

The trust should ensure that their governance systems are effective, and they respond to managing risk promptly.

The trust senior leaders should ensure that they improve relationships, support and communication with the community mental health teams.

Our inspection team

The team that inspected the four community mental health teams comprised five CQC inspectors, two inspection managers, a head of hospital inspection, four specialist advisors and an expert by experience.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance