Kent and Medway NHS and Social Care Partnership Trust

Mental health crisis services and health-based places of safety

Quality Report

Kent and Medway NHS and Social Care Partnership Trust
Trust Headquarters
Farm Villa
Hermitage Lane
Maidstone
Kent
ME16 9PH
Tel: 01622 724100
Website: www.kmpt.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXY3P	Littlebrook Hospital	Section 136 Suite	DA2 6PB
RXY6Q	Priority House	Section 136 Suite	ME16 9PH
RXY04	Trust Headquarters	Medway and Swale Crisis Home Treatment Team	ME7 5NY
RXY03	St Martins Hospital	Crisis Home Treatment Team and Section 136 Suite	CT1 1TD

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Kent and Medway NHS and Social Care Partnership Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Kent and Medway NHS and Social Care Partnership Trust and these are brought together to inform our overall judgement of Kent and Medway NHS and Social Care Partnership Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Requires improvement
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 Kent and Medway NHS and Social Care Partnership Trust as good because:

- We found that two of the health based places of safety were not effective in providing safe care and treatment. The environment did not meet current standards according to regulations around the safety and suitability of premises and guidance on good practice published by the Royal College of Psychiatrists (RCP). This put people who used the service and others at risk. However, the section 136 suite in Priority House provided safe care and treatment.
- Patients were assessed by the crisis teams or on admission to the section 136 suites. This included an assessment of their mental and physical health care needs, which resulted in a plan of care to meet their needs or a referral for further care or discharge.
- The crisis teams determined whether alternative care and support could be provided to people instead of admission to hospital. The health based places of safety (or section 136 suites) were designed to keep people safe.
- Concise data was collected to monitor the services, including information about age, gender and ethnicity. Within the section 136 suites they compiled data to assess when a doctor and AMHP were requested, time of arrival, the time the police left, outcomes and the total time the person spent in a place of safety.
- The teams had good multi-agency relationships and had joint working policies and protocols in place, especially when working with younger people.
- Staff were committed to providing high quality care for patients. Staff told us they found their local managers approachable and supportive and local managers felt they had the authority to carry out their roles effectively. Staff felt able to raise suggestions or concerns about the service without fear of reprisal.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Two of the section 136 suites did not provide a safe and suitable environment for assessment of patients detained under section 136 of the Mental Health Act 1983.
- The section 136 suite at Littlebrook Hospital was too small. The suite shared all facilities via a corridor linking another ward with reception and outside space was only accessible through the main reception.
- The section 136 suite at St Martins Hospital was not fit for purpose, furniture was in a poor state of repair and there was no access to outside space. The suite had two rooms for patients. These rooms were very sparse and the doors to the patient rooms opened onto a corridor with no way of locking the rooms off from the corridor so anyone passing could walk in the rooms, meaning privacy and dignity of patients could be compromised. The layout and design of the suite made observation of patients difficult and did not keep patients safe. There had been a recent reported incident which involved a patient entering the corridor from their room and they caused injury to themselves and damage to the suite resulting in the suite being closed for repair in February 2015. During this time clients had to be held in local police cells (there were 7 occasions of detention in custody in February against an overall total of 50). The suite could hold two service users at one time but the toilet and shower facilities were shared which compromised privacy and dignity. A business plan had been created to improve the site to make it fit for purpose but no dates for commencement or completion were known.
- All section 136 suites were staffed using staff from the crisis teams. This meant that staff capacity was affected and home visits had to be re-scheduled or cancelled at short notice if a patient was admitted to a section 136 suite.

Are services effective?

Good

We rated effective as good because:

- There were different practices and protocols should a young person need to be assessed.
- All staff received appropriate training so that they understood their roles and could fulfil their responsibilities.

Summary of findings

- All staff had access to regular clinical and managerial supervision to discuss work and professional and personal development.
- The crisis teams had developed clear information sharing processes and joint working arrangements.

Are services caring?

Good

We rated caring as good because:

- Patients and carers were positive about the care and treatment received from the crisis services. Staff spoke with patients in a caring and respectful manner and took account of, and addressed, their needs.
- All patients had access to advocacy services.
- People were able to make complaints and give feedback on the care they received with evaluation forms and complaints forms and procedures.
- The 136 Suite in Priority House had been designed specifically for the service users safety and comfort, including the comfort and practicality of the furniture and the protective flooring in the outdoor space that staff informed us was to protect the service user if the police had to use restraint and take a person to the floor.
- The crisis teams had developed welcome packs for all service users, explaining in detail treatment, complaints and feedback procedures and gave the service user a voice.
- At Littlebrook Hospital the staff were collecting games and books in order to try to entertain young people who when they were brought into the136 Suite.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- People had access to services 24 hours a day, seven days a week, not just working hours.
- The crisis teams were able to respond promptly and adequately when patients or carers phoned in.
- All services had facilities for disabled people.
- Staff ensured that assessments by the doctor and AMHP began as soon as possible, no matter what time the individual arrived in the section 136 suite.

Are services well-led?

Good

We rated well-led as good because:

Summary of findings

- There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act 1983.
- Staff were committed to providing high quality care for patients. Staff found their local managers approachable and supportive. Local managers felt they had the authority to carry out their roles effectively. Staff felt able to raise suggestions or concerns about the service without fear of reprisal.
- Staff received all mandatory training, which was all up to date.
- Staff received regular supervision and appraisals.
- The staff we spoke with all felt valued and had a high level of job satisfaction.

Summary of findings

Information about the service

The crisis home intervention team is a multidisciplinary team of experienced mental health practitioners providing an emergency assessment and home treatment service. The service was provided for people living in the Kent and Medway area experiencing a mental health crisis who would otherwise need admission to hospital. The service also liaised with inpatient services to facilitate an earlier discharge from hospital for patients for whom admission was necessary.

The team's aim was to provide short and intensive support and treatment in the community during difficult periods for services users and their carers.

The health based place of safety is a unit where people are taken by the police, under section 136 of the Mental Health Act, for an assessment of their mental health, for their safety. A person removed to a place of safety under section 136 may be detained there for a period not exceeding 72 hours for the purpose of enabling the person to be examined by a registered medical practitioner, to be interviewed by an approved mental health professional and to make any necessary arrangements for the person's treatment or care.

The trust has health based places of safety, or section 136 suites, on three sites: Littlebrook Hospital, Priority House and St Martins Hospital.

The crisis home treatment teams are based at St Martins Hospital and Medway Maritime Hospital.

The crisis home treatment team in St Martins Hospital covers the geographical area of North East Kent.

The crisis home treatment team at Medway Maritime Hospital covers the geographical area of Medway and Swale.

KMPT'S street triage service was based in the East Kent crisis resolution home treatment team at St Martins Hospital, Canterbury and comprises a police officer and a mental health nurse. The service commenced as a pilot in September 2013 and initially ran 3 nights a week on Thursdays, Fridays and Saturdays. From September 2014 it expanded to 7 nights a week.

Our inspection team

The teams that inspected the mental health crisis services and health-based places of safety consisted of six people: two CQC inspectors, a Mental Health Act reviewer, two senior nurses and a psychiatrist.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

Summary of findings

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited three section 136 suites (designated places of safety under the Mental Health Act) but were unable to speak with any service users as the suites were not in use while we were present
- Visited two mental health crisis home intervention teams;
- Met with and interviewed managers of the services;
- Spoke with two people who were using the crisis service in their own homes;
- Spoke with three relatives of people using the crisis service;
- Looked at six treatment records of people receiving a service from the crisis team;
- Looked at a range of policies, procedures and other documents relating to the running of the services;
- Attended and observed two multi-disciplinary handover review meetings at the crisis services
- Interviewed 20 staff across four sites. This included clinical staff, support workers, occupational therapists, psychiatrists, psychologists and an approved mental health professional (AMHP)
- Held three focus groups at St Martins Hospital

What people who use the provider's services say

The patients we spoke with who used the crisis service were positive and complimentary about the staff and their experiences and the support they had received.

We did not speak with any patients who had used the section 136 suites as there was no service users present during our inspections.

Good practice

The Medway and Swale crisis team used a crisis personality disorder pathway. This linked in with the crisis team and wards and was used for anyone who had a diagnosed personality disorder. The group ran five days a week and was on-going for 18 months. The crisis team encouraged their patients to attend. After assessment, the patient could start on the pathway the next day. The team demonstrated that use of the pathway had improved peoples' confidence, self-esteem and participation whilst also increasing capacity for the crisis team.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that the health based places of safety are safe and fit for purpose so that patients' privacy and dignity are maintained while they are using the health-based places of safety.

Kent and Medway NHS and Social Care Partnership Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Section 136 Suite	Littlebrook Hospital
Section 136 Suite	Priority House
Medway and Swale Crisis Home Treatment Team	Trust Headquarters
Crisis Home Treatment Team and Section 136 Suite	St Martins Hospital

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.

Staff were able to access the trust's policies on the Mental Health Act and its Code of Practice. The services had access to a Mental Health Act administrator, who gave advice on the use of the Act and monitored its implementation.

All services had access to local approved mental health professionals (AMHPs) who carried out the Mental Health Act assessments.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with were aware of the statutory requirements of the Mental Capacity Act.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated the mental health crisis services and health-based places of safety as requires improvement because:

- Two of the section 136 suites did not provide a safe and suitable environment for assessment of patients detained under section 136 of the Mental Health Act 1983.
- The section 136 suite at Littlebrook Hospital was too small, the suite shared all facilities via a corridor linking another ward with reception and outside space was only accessible through the main reception.
- The section 136 suite at St Martins Hospital was not fit for purpose, furniture was in a poor state of repair and there was no access to outside space. The suite had two rooms for patients. These rooms were very sparse and the doors to the patient rooms opened onto a corridor with no way of locking the rooms off from the corridor so anyone passing could walk in the rooms, meaning privacy and dignity of patients could be compromised. The layout and design of the suite made observation of patients difficult and did not keep patients safe. There had been a recent reported incident which involved a patient entering the corridor from their room and they caused injury to themselves and damage to the suite resulting in the suite being closed for repair in February 2015. During this time clients had to be held in local police cells (there were 7 occasions of detention in custody in February against an overall total of 50).
- The suite could hold two service users at one time but the toilet and shower facilities were shared which compromised privacy and dignity. Staff we spoke with informed us that the section 136 suite was not fit for purpose and that they felt unsafe working there.
- A business plan had been created to improve the site at St Martins Hospital to make it fit for purpose but no dates for commencement or completion were known.
- All section 136 suites were staffed using staff from the crisis teams. This meant that staff capacity was affected and home visits had to be re-scheduled or cancelled at short notice if a patient came into a section 136 suite.

Our findings

Safe and clean ward environment

- Two of the section 136 suites did not provide a safe and suitable environment for the assessment of patients detained under section 136 of the Mental Health Act 1983.
- The section 136 suite at Littlebrook Hospital did not have access to a clinic room. This meant that privacy and dignity were compromised for both patients of the section 136 suite and the ward.
- The section 136 suite at St Martins Hospital was not fit for purpose. The suite was sparsely furnished and furniture was in a poor state of repair. The suite had two patient rooms which opened onto a corridor with no way of locking the rooms off from the corridor so anyone passing could walk in the patients rooms, meaning privacy and dignity could be compromised. The suite had shared access for a shower and toilet which compromised patients' privacy and dignity.
- The staff we spoke with said that they did not feel safe working in the section 136 suite at St Martins Hospital as it was not fit for purpose. Also, staff told us there could often be delays in responding to the panic alarms at the section 136 suite because the suite was located in a separate building in the grounds of St Martins Hospital. Staff informed us that sometimes, if they needed to respond urgently to an alarm, the quickest way was to drive the distance rather than run to the section 136 suite location.
- The section 136 suite at Priority House provided a safe and clean environment.
- All staff had access to emergency alarms so they could call for support if necessary.

Requires improvement

Are services safe?

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

- All section 136 suites had a separate entrance.

Safe staffing

- All the crisis teams were staffed by nurses, doctors and health care assistants. There were also psychologists in some of the teams. Some of the teams had staff vacancies but these were covered by bank staff.
- The crisis teams staffed the section 136 suites which meant that capacity was affected if a patient came into the section 136 suite at short notice. Staff told us that patient care was the priority and that when they had to staff the section 136 suites they would try to make sure that home visits would not be cancelled.
- We saw that all permanent staff who worked in the section 136 suites had been trained in the use of physical interventions. However, we were told that bank staff were not always appropriately trained.
- All teams had access to medical staff day and night to undertake assessments.

Assessing and managing risk to patients and staff

- The crisis teams' criteria for referral required that there must always be an up to date risk assessment with the referral paperwork. When the patient was seen by the team, a further risk assessment would be carried out. This took into account the patient's previous risk history as well as their current mental state.
- On a patient's arrival to a section 136 suite, a doctor and a mental health practitioner would be notified regarding the assessment.
- Throughout the patient's time in the section 136 suite, processes were put in place to assess and monitor risks to individual.
- The staff we spoke with informed us that the trust were introducing new risk assessment training that was due to be rolled out in 2015.
- Staff received mandatory training on safeguarding vulnerable adults and all staff we spoke with knew how to recognise and raise a safeguarding concern .

Track record on safety

- When incidents had occurred, there was evidence that investigations had taken place, action plans created and changes implemented. For example, following an incident within one of the crisis teams, it was deemed that the offices were not suitable for seeing people who used services due to a high level of risk. Therefore, the teams changed their practice to see people who used services at their homes or within local community centres.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to record incidents on the trust's reporting system. All incidents were reviewed by the manager and forwarded to senior managers for further review.
- Significant incidents were discussed in staff team meetings, supervision and handovers.
- Staff were offered debriefing following serious incidents.
- After the incident in February 2015, while the suite was closed, the trust did not put locks onto the two doors that led onto the corridor during the refurbishment, even though the incident could have been avoided if the doors had been lockable.

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.

Summary of findings

We rated the mental health crisis services and health-based places of safety as good because:

- There were different practices and protocols should a young person need to be assessed.
- All staff received appropriate training so that they understood their roles and could fulfil their responsibilities.
- All staff had access to regular clinical and managerial supervision appraisals to discuss their work and caseloads. Staff had professional and personal development.
- The crisis teams had developed clear information-sharing processes and joint working arrangements.

Our findings

Assessment of needs and planning of care

- Patients seen by the crisis teams and in the section 136 suites had a physical health assessment. Physical health needs were followed up by the crisis teams.
- The care records in the crisis teams included an assessment of each patient's needs. The care plans reflected the patients' assessments, were reviewed regularly and changed if needed.
- The staff we spoke with described good working relationships between partner agencies.

Best practice in treatment and care

- A separate trust provided the children and adolescent mental health service (CAMHS). The section 136 suites had a clear and effective protocol when working with younger people across the two trusts.
- People being assessed in the section 136 suites were provided with information by staff which explained the powers and responsibilities under section 136. People were given information to help them understand where they were, what was happening to them and received an explanation of their rights.

Skilled staff to deliver care

- All staff had access to regular clinical and management supervision and appraisals. All were up to date and staff were able to discuss concerns, workload and development needs.
- The crisis teams included doctors, nurses, psychologists and support workers. They all took part in assessment, planning and working with patients. They met for team handovers and meetings for effective information sharing.

Multi-disciplinary and inter-agency team work

- The crisis teams held twice daily handover meetings.
- The links with police in the operation of the section 136 suites were good. Staff in the section 136 suites were in contact with the police prior to accepting a patient and there were regular local police liaison meetings.

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

- The staff we spoke with understood the Mental Heath Act and could access the trust's policies on its use.
- The crisis team had access to a Mental Health Act administrator who could give staff advice and guidance.
- All section 136 suites contacted their local approved mental health practitioners (AMHPs) who carried out the Mental Health Act assessments.

Good

Are services caring?

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

Summary of findings

We rated mental health crisis services and health-based places of safety as good because:

- Patients and carers were positive about the care and treatment received from the crisis services.
- Staff spoke with patients in a caring and respectful manner and took account of, and addressed, their needs.
- All patients had access to advocacy services.
- People were able to make complaints and give feedback on the care they received with evaluation forms and complaints forms and procedures.

Our findings

Kindness, dignity, respect and support

- The patients and carers we spoke with were positive about the staff and the service they received from the crisis service. They said staff were very respectful and caring and took into account their needs.

The involvement of people in the care that they receive

- Staff provided a range of support and care to people according to their needs and wishes.
- Staff involved patients, carers and relatives when appropriate.
- Patients who were detained under the Mental Health Act had their rights under the Act explained to them. There was access to information and advocacy services if required.

Are services responsive to people's needs?

Good

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

Summary of findings

We rated mental health crisis services and health-based places of safety as good because:

- People had access to services 24 hours a day, seven days a week, not just working hours.
- The crisis teams were able to respond promptly and adequately when patients or carers phoned the service.
- All services had facilities for disabled people.
- Staff ensured that assessments by the doctor and AMHP began as soon as possible, no matter what time the individual arrived in the section 136 suite.
- The street triage service based in the East Kent crisis resolution home treatment team at St Martins Hospital, Canterbury and comprised a police officer and a mental health nurse was reducing the need for patients to access a place of safety.

Our findings

Access and discharge

- The trust had three section 136 suites, with five rooms in total, to cover the Kent and Medway area. All suites were staffed by the crisis teams and located in hospital locations.
- The crisis teams attended the daily bed management meetings in order to gain information of available beds in the county. All staff we spoke with said that the biggest challenge for the team was lack of beds for people who needed to be admitted to hospital.
- KMPT trialling and evaluating a street triage service based in the East Kent crisis resolution home treatment team at St Martins Hospital, Canterbury and comprises a police officer and a mental health nurse. The trust's initial evaluation of the three day a week service in comparing S136 data between the same 6 month period for 2013 and 2014 there has been a 22% reduction in S136 assessments.

The facilities promote recovery, comfort, dignity and confidentiality

- All section 136 suites were in a separate and secure location. All rooms had access to toilet facilities but some were shared facilities.
- Patients were given food and drink while in the section 136 suites.
- The 136 suite at Priority House was very well equipped. It had two rooms, a toilet and bathroom and it had a separate safe seating area with a television and a clock. The suite had windows which allowed staff to easily observe the patient.
- The 136 suite at Littlebrook Hospital was very small and had no television or activities for the patient and no access to a toilet or clinic room without walking across a shared corridor.

Meeting the needs of all people who use the service

- All services were accessible to disabled people. Toilets and bathrooms were wheelchair accessible.
- Interpreters could be accessed through the trust if needed.
- Staff in the crisis team catered for clients' needs and respected their wishes. They saw people who used services outside of their homes, or where they felt more comfortable, if they did not want family members or children knowing of their health issues.
- Of the three 136 Suites, only one will take young people in crisis, this restricts access to the suite for young people across the county.

Listening to and learning from concerns and complaints

- Information about raising concerns and complaints was available to people who were assessed in both section 136 suites and crisis teams.

Are services well-led?

Good

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

Summary of findings

We rated mental health crisis services and health-based places of safety as good because:

- There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act 1983.
- Staff were committed to providing high quality care for patients. Staff told us they found their local managers approachable and supportive. Local managers felt they had the authority to carry out their roles effectively. Staff felt able to raise suggestions or concerns about the service without fear of reprisal.
- Staff received all mandatory training, which was up to date.
- Staff received regular supervision and appraisals.
- The staff we spoke with felt valued and had a high level of job satisfaction.

Our findings

Vision and values

- All staff were committed to providing a high quality of care for patients.
- Staff knew who their local managers were and all staff told us that they found them supportive and would go to them with any concerns.
- Most staff told us they were familiar with the trust's vision and values.

Good governance

- Clear governance arrangements were in place.
- All services collated all their own data. Local managers had systems in place to monitor performance at a local level.
- Local managers felt they had the authority to carry out their roles effectively.

Leadership, morale and staff engagement

- Evidence was seen of partnership working with other agencies, there were joint working policies for the implementation of section 136, with the local police.
- Staff in the crisis teams were very positive about the service they provided and felt they all worked in good teams, were well supported by colleagues and managers and loved their jobs.
- All staff we spoke to felt confident to raise suggestions or concerns without fear of reprisal. Staff were aware of the whistleblowing policy.
- Staff felt that they would be listened to by their manager and action would be taken if needed.
- Localised management were very good at developing their services and understanding the needs of their staff and client group. Managers who we spoke to were very involved with changes and initiatives that they were leading on but were sometimes unable to get effective help from senior management within the trust. A business plan had been developed in order to refurbish the 136 suite at St Martins Hospital as it was not fit for purpose but the trust had not given any timescales as to when this work would start, what contingency would be put in place during the work taking place and when it would be completed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that Kent and Medway NHS and Social Care Partnership Trust did not ensure that service users were protected against the risks associated with unsafe or unsuitable premises. The section 136 suites at Littlebrook Hospital and St Martins Hospital were not of suitable design and layout to ensure service users were safe and their privacy and dignity were respected. This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.