Kent and Medway NHS and Social Care Partnership Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXY04	Trust Headquarters	Canterbury and Coastal Community Mental Health Team	CT1 3HH
RXY04	Trust Headquarters	Canterbury and Coastal Community Mental Health Team	CT6 5DD
RXY04	Trust Headquarters	South Kent Coast Mental Health Team	CT19 5HL
RXY04	Trust Headquarters	Medway Community Mental Health Team	ME4 4JL

Summary of findings

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

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

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

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

Between 22 - 24 January 2018, the Care Quality Commission carried out an urgent responsive inspection of three teams within the community-based mental health services for adults of working age provided by Kent and Medway NHS and Social Care Partnership Trust. These were the Canterbury and Coastal CMHT, which included a satellite site; the South Kent Coast CMHT; and the Medway CMHT. Concerns had been raised with us, including insufficient staffing levels leading to high caseloads which were not being managed safely.

We took enforcement action and issued a warning notice on 16 February 2018. The warning notice we served notified the trust that the Care Quality Commission had judged the quality of healthcare being provided required significant improvement. We told the trust they must complete an immediate review of each of the community mental health teams for working age adults case load focusing on new referrals and case load allocation, risk assessments for all allocated and unallocated patients with safety plans being put in place where necessary, by 30 March 2018. They should use this to inform a comprehensive review of the assessment, planning and delivery of care and treatment for all patients and ensure they have systems and processes embedded into the service that effectively assess, monitor and improve the quality and safety of their service. This should be completed by 16 August 2018.

We found the following issues the trust needs to improve:

- Staff did not always assess patients' risks appropriately. This included risk assessments being updated after incidents or regularly reviewed.
- Community mental health teams did not have systems in place to ensure that caseloads were effectively managed. Staff did not have formal handovers, patients were not followed up if they did not attend and patients were not appropriately discharged from the service. This presented an ongoing risk to patients.
- Staff had not achieved the trust's completion target in a significant number of their mandatory training courses.
- Staff at the South Kent Coast and Canterbury and Coastal CMHTs could not always implement the new model of assessing new patients referred to the service effectively due to insufficient staffing levels. Furthermore, these important assessments were not consistently recorded or up to date. This led to inconsistencies in quality and rationale for patients meeting allocation criteria.
- Staff did not effectively record care plans or progress notes in patients' care records. This made it difficult for staff to follow a consistent approach and monitor patients' progress.
- Staff had differing access to supervision due to some team leaders being unavailable. We also found that supervision records were not always filed and recorded correctly.
- We found many examples of patients' appointments being cancelled with short notice given. The majority of these cancellations had been due to staff being unable to facilitate the appointments.
- Staff reported they were overworked and concerned for the risk of their patients. They did not feel supported by senior managers within the trust.

However, we also found the following areas of good practice:

- Staff demonstrated good understanding of safeguarding and lone-working procedures. They knew how to report incidents and learn lessons from them.
- We saw good examples of staff at the Medway CMHT carrying out detailed initial assessments which provided a foundation to the patient receiving good care and treatment.
- All CMHTs consisted of experienced staff from different care disciplines. This ensured that patients had access to a multi-disciplinary approach towards their care and treatment. They included primary mental health specialists who supported people between primary and secondary care.
- Staff were hardworking and felt supported by their local line managers and immediate colleagues.

Summary of findings

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

Are services safe?

We found the following issues the trust needs to improve:

- Staff did not always assess the risks to patients' health and safety or respond appropriately to meet their individual needs. Risk assessments were not always completed, updated following an incident or reviewed regularly.
- The trust did not have sufficient numbers of permanent staff to enable the CMHTs to operate effectively.
- Staff did not effectively monitor the needs and risks of numerous patients, across the CMHTs visited, who were awaiting allocation of a care coordinator.
- Community mental health teams did not have systems in place to ensure caseloads were effectively managed in the event of care coordinators being on annual leave or off sick.
- Staff were not always operating in line with their policy when they discharged patients from the service.
- Staff had not achieved the trust's target for completion of approximately a third of their mandatory training courses.

However, we also found the following areas of good practice:

- Staff demonstrated good understanding of safeguarding and lone-working procedures.
- Staff knew how to report incidents appropriately. This allowed the service to investigate incidents fully and extract learning from them.

Are services effective?

We found the following issues the trust needs to improve:

- Staff could not always implement the new model of assessing new patients referred to the service effectively due to staffing shortages.
- The Canterbury and Coastal CMHT were not consistently recording initial assessments onto patient's care records due to time restraints. Often this led to staff relying on previous initial assessments which did not contain recent information.
- Staff did not always include care plans in patients' care records and many that were present required updating. This made it difficult for all staff to follow a consistent approach.
- Information was often missing from patients' progress notes. This meant it was difficult to monitor patients' progress or deterioration.

Summary of findings

- Staff had differing access to supervision due to some team leaders being unavailable. We also found that supervision records were not always filed and recorded correctly.

However, we also found the following areas of good practice:

- The Medway and South Kent Coast CMHTs were recording initial assessments to a good standard. They contained guidance, for the GP, on treatment if the patient was not taken on by the service.
- All CMHTs consisted of experienced staff from different care disciplines. This ensured that patients had access to a multi-disciplinary approach towards their care and treatment.
- The service employed primary mental health specialists who supported people who historically alternated between primary and secondary care. They had also improved links with GP surgeries.
- All CMHTs had well-structured meetings where business and clinical issues were discussed in detail. We saw evidence that these were also used to promote other relevant services in the community.

Are services responsive to people's needs?

We found the following issues the trust needs to improve:

- Staff did not consistently follow the criteria for deciding whether a patient required care coordination following initial assessment.
- The service had improved waiting times from referral to assessment; however this had only contributed to the number of patients waiting to be allocated to a care coordinator for treatment.
- Staff did not always follow up patients who did not attend appointments. This often led to patients not being contacted for a number of months, if at all.
- We found many examples of patients' appointments being cancelled with short notice given. The majority of these cancellations had been due to staff being unable to facilitate the appointments.

However, we also found the following areas of good practice:

- The service had made recent improvements in waiting times between referral and initial assessment and this had decreased the number of patients not attending.

Summary of findings

- Medway CMHT ran a responsive and flexible clinic where patients received medication via injections. They had good systems to alert care coordinators of patients who appeared unwell or did not attend.

Are services well-led?

We found the following issues the trust needs to improve:

- The service did not have processes in place to ensure caseloads, discharges, waiting times and follow-up were managed effectively. This presented an ongoing risk to patients.
- Staff reported they were overworked and concerned for the risk of their patients. They did not feel supported by senior managers within the trust.

However, we also found the following areas of good practice:

- Staff were hardworking and felt supported by their local line managers and immediate colleagues.

Summary of findings

Information about the service

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

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

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

- The trust must address the high caseload numbers allocated to individual staff to ensure that all patients are monitored appropriately.
- The trust must review the waiting lists for those patients waiting for initial assessment and those patients waiting for allocation to a named worker to ensure patients receive a service in a timely way.
- The trust must ensure that staff meet its targets for compliance with mandatory training, in particular personal safety, conflict management and cardiopulmonary resuscitation.

We also informed the trust that

- The trust should ensure that sufficient numbers of permanent staff are recruited and retained to enable the teams to operate effectively.
- The trust should ensure that all staff receive individual supervision at regular intervals as per the trust's supervision policy.
- The trust should ensure that its target for staff to receive an annual appraisal is met in all community mental health teams.
- The trust should address the waiting times for access to psychological therapies for patients at the South West Kent CMHT.
- The trust should implement the new operational policy for the community mental health teams and monitor its impact on the effective operation of the teams in relation to access criteria, caseloads and appropriate discharges of patients.

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

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

Our inspection team

The team comprised one CQC inspection manager, three CQC inspectors', one assistant inspector, one CQC Mental Health Act reviewer and three mental health nurse specialist advisors.

Summary of findings

Why we carried out this inspection

We undertook an unannounced, focused inspection, following concerns we had received through intelligence monitoring, including feedback received from external stakeholders. These included insufficient staffing levels leading to unsafe management of high caseloads and the potential risk this presented to patients. These concerns mirrored actions we had already asked the trust to address following our comprehensive inspection in January 2017.

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

How we carried out this inspection

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

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

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 community-based mental health teams and reviewed how staff were caring for patients;
- spoke with the service managers and/or team leaders for each of the teams;
- spoke with 19 other staff members; including nurses, psychiatrists, occupational therapists, psychologists, social workers and administration staff.
- attended and observed one multi-disciplinary meeting and two referral meetings.
- looked at 165 care and treatment records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff assess the risks to patients' health and safety or respond appropriately to meet people's individual needs to ensure their welfare and safety during any care or treatment.
- The trust must ensure that staff provide safe care and treatment to patients' receiving, or awaiting to receive, a service from the adult community mental health teams.
- The trust must have systems in place to ensure patients are aware of any changes in their care provision and alternative plans that have been put in place to ensure their safety. This would include long or short term change of care coordinator and discharge to primary care.
- The trust must have effective audit and governance systems and/or processes in place that ensure care and treatment is provided in line with their policies.

Action the provider SHOULD take to improve

- The trust should ensure that sufficient numbers of permanent staff are recruited and retained to enable the CMHTs to operate effectively.
- The trust should ensure that staff meet the trust's target for completion of their mandatory training courses.
- The trust should ensure that all have regular access to supervision and that these sessions are recorded and stored appropriately.
- The trust should ensure that staff follows consistent criteria for deciding whether a patient requires care coordination following initial assessment.

Summary of findings

- The trust should ensure that staff follow up clients who did not attend appointments appropriately
- The trust should ensure that staff give patients adequate notice when they need to cancel appointments and have systems in place to ensure that alternative appointments are arranged in a timely manner.

Kent and Medway NHS and Social Care Partnership Trust

Community-based mental health services for adults of working age

Detailed findings

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

Are services safe?

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

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

Our findings

Safe staffing

- Across the Canterbury and Coastal CMHT the required number of staff was 31 qualified nurses and occupational therapists. The required number of nursing and occupational therapy assistants was nine. At the time of our inspection, there were vacancies for four qualified staff. There was one vacancy for a nursing assistant. Three senior managers were on long term sick leave.
- Across the Medway CMHT the required number of staff was 36 qualified nurses and occupational therapists. The required number of nursing and occupational therapy assistants was five. At the time of our inspection, there were vacancies for one qualified staff. There were no current vacancies for nursing and occupational therapy assistants.
- Across the South Kent Coast CMHT the required number of staff was 17 qualified nurses and occupational therapists. The required number of nursing assistants was three. At the time of our inspection, there were vacancies for four qualified staff. There was one current vacancy for a nursing assistant.
- The Medway CMHT had a 4% sickness rate for the last 12 months. The South Kent Coast CMHT had a 5% sickness rate for the last 12 months. The Canterbury and Coastal CMHT had an 8% sickness rate for the last 12 months.
- The Medway CMHT had an 11% turnover rate for the last 12 months. The South Kent Coast CMHT had an 18% turnover rate for the last 12 months. The Canterbury and Coastal CMHT had a 12% turnover rate for the last 12 months.
- Following our comprehensive inspection in 2017, we told the trust they must address the high caseload numbers allocated to individual staff to ensure that all patients were monitored appropriately. The trust provided data that suggested that average caseloads for community mental health care coordinators in the teams we visited were manageable. Average caseloads at the Medway CMHT were reported to be 48, at the South Kent Coast CMHT, they were 46 and at the Canterbury and Coastal CMHT, they were 33. However, during our visit to the satellite service we were told that, due to staff shortages and sickness, three care coordinators were managing caseloads significantly higher than this. These included individuals who presented with high risks. We found that reallocation of patients was not done in a timely or systematic way and communication of reallocations was poor. Patients on the caseload of a member of staff who had left the service had not been reallocated for five weeks meaning they had not been seen. Some of these patients also had high risk profiles. During this focussed inspection, we still had concerns in this area.
- We found evidence that the CMHTs did not effectively manage these caseloads. Across the Canterbury and Coastal CMHT we found patients were often duplicated on caseloads. Staff attended meetings to review caseloads but this had not solved the issue. We were told that patients had been moved between staff members' caseloads without this being communicated. This meant patients, some of whom were high risk, may be overlooked and not offered the support they required. The trust's electronic patient record system allowed this to happen without authorisation from management. One staff member from the Canterbury and Coastal CMHT had a caseload of 72 patients in residential placements, many with complex needs. Furthermore, one care co-ordinator in this CMHT had a caseload of 23 patients, 10 of whom required minimal input due to attending services such as the depot clinic. The service was unable to give rationale why some of the unallocated patients could not be allocated to this care coordinator's caseload.
- Staff across the service told us there was no system in place to ensure their caseloads were managed when they were required to cover the duty service. Furthermore, staff were often asked to cover duty at the last minute meaning they had to cancel pre scheduled appointments for patients on their caseload. Staff from the Canterbury and Coastal CMHT who covered duty were expected to make follow up calls to patients who hadn't been seen for a while, which they felt was outside of their remit and should have been carried out by the patients' care coordinators. Staff from the Medway CMHT told us the duty service operated with one staff approximately four times a month. Furthermore, we

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

were told of a medicine error that occurred in this CMHT's depot clinic due to only having one member of staff. This meant a second member of staff was not available to check the medicine before administration.

- All CMHTs we visited used bank and agency staff to fill vacant posts. Within the Canterbury and Coastal and Medway CMHT, eight agency staff were being used. They had been working for six months or over and consisted of nursing and medical and staff.
- All CMHTs we visited had access to psychiatrists during operational hours. Staff in the Canterbury and Coastal CMHT told us that often it was difficult to get a psychiatrist to see patients for urgent medicine reviews, which led to delays in patients being prescribed medicine. However, these delays were often due to the requirement for patients to receive essential physical health monitoring, such as ECGs and blood tests, to ensure safe prescribing. This is in line with The National Institute for Health and Care Excellence guidelines for prescribing antipsychotic medicine.
- Following our comprehensive inspection in January 2017 we told the trust they must ensure that staff meet its targets for compliance with mandatory training, in particular personal safety, conflict management and cardiopulmonary resuscitation. During this focussed inspection, we found the trust provided an extensive range of mandatory training courses relevant for staff working in the community. These included training in the care programme approach, risk assessment, medicine management and safeguarding for adults and children. Staff at the South Kent Coast CMHT had achieved the trust's target of 85% in 19 out of 29 mandatory training courses. Their overall average completion rate across all courses was 88%. The only significant low completion rates were for medicine management for community workers and safeguarding children level three which were 53% and 80% respectively. Staff at the Medway CMHT had achieved the trust's target of 85% in 17 out of 29 courses. Their overall average completion rate across all courses was 87%. Significant low completion rates were for medicine management for community workers, safeguarding adults level two and safeguarding children level three which were 62%, 81% and 69% respectively. Staff in both CMHTs had 100% completion rate in safeguarding adults and children at level one. We felt there had been progress in this area but felt that further improvements could still be made.

Assessing and managing risk to patients and staff

- We reviewed 45 care records of patients under the South Kent Coast CMHT. Thirteen did not have risk assessments, 17 had not been updated in the last six months and seven had not been updated for more than a year. One patient who had no risk assessment was on a Community Treatment Order, which means they should have supervised treatment in the community after leaving hospital. We found three patients, who presented with significant risks, who had not been appropriately followed up after missing arranged appointments. One patient with a history of self-harm had not been seen since July 2017 with no evidence that the service had been attempting to make contact. We reviewed 46 care records of patients under the Medway CMHT. In 28 records risk assessments were not up to date, with 6 not having been updated for over a year and one last updated in 2015. These included risk assessments for patients with history of self-harm.
- We found a significant lack of crisis plans with the care records we viewed across all sites. This meant staff had no consistent approach to follow in the event of a patient relapse. We reviewed many patients' progress notes that showed they had significant support from carers. However, we found little evidence of carers' assessments being carried out or the carer's role featuring in care plans.
- The Canterbury and Coastal CMHT did not have a system to ensure patients received a seven day follow up after discharge from the service. We found an example where a patient's GP had communicated this concern to the duty team. We checked their care record and found the patient had been allocated to a care coordinator who was on leave. Furthermore, this care coordinator had only recently been given a caseload as they had previously been a full-time duty worker.
- Following our comprehensive inspection in January 2017, we told the trust they must review the waiting lists for those patients waiting care coordinator allocation to ensure they received a service in a timely way. The Canterbury and Coastal CMHT currently had 171 patients awaiting care coordinator allocation, with this figure being 397 and 278 at the Medway CMHT and South Kent Coast CMHT respectively. These patients did not have their risk assessments recorded. Furthermore, staff did not make contact with these patients to monitor any changes in risk or determine whether their

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need for allocation had become more urgent. In the Medway CMHT approximately 300 patients were being overseen by the team's three operational managers, one of which had an additional working caseload of 35 patients. These managers also had extensive managerial and supervisory responsibilities. During this focussed inspection we still had concerns in this area.

- The service had recently carried out a three day workshop where unallocated patients or patients who hadn't been seen for six months were screened to ascertain whether they were suitable to be discharged. The Canterbury and Coastal CMHT discharged approximately 300 patients at this workshop. We were told that care coordinators, who knew the patients, were not involved in this workshop. Furthermore, patients were not personally informed they had been discharged as this was only communicated via their GP. Subsequently, ten complaints were received from patients and GPs following this lack of communication.
- We reviewed 31 care records of patients who had been discharged during this workshop and found that minimal clinical rationale for the decision to discharge was contained in care records. One of the criteria for closing a case had been due to lack of contact; but, we found that patients had been informed not to contact the service until a care coordinator was allocated. One patient who was discharged during the workshop had last been visited in April 2017 where a neighbour told staff they had not seen the patient. Progress notes showed that the GP had been contacted a month later to ascertain whether they had seen the patient. No outcome of this request was recorded and no further progress notes were recorded. We also found examples of patients being discharged before they had an initial assessment. In some cases we found that GPs had not been informed of the discharges and many examples of discharged patients being re-referred back to the service. We found some patients who were under the care programme approach were discharged without having a progress and planning review which was against trust policy.
- The CMHTs we visited had discharged 143 patients in the last three months following structured progress and planning reviews. Of these, 132 (92%) were followed up within seven days to check on their well-being and this was recorded in their care records.
- Staff at all CMHTs were aware of the procedure for raising safeguarding concerns with the local authority. However, they did not monitor ongoing progress of open safeguarding concerns via a local safeguarding log. This meant they did not have sufficient oversight on their current status. We were told there was a plan to introduce this process across the CMHTs in the near future.
- The South Kent Coast CMHT had generated 34 safeguarding referrals since 1 July 2017, whilst the Medway CMHT had generated six in the same period. It was unclear why safeguarding referral rates differed across the two CMHTs. We did not receive this data for the Canterbury and Coastal CMHT.
- Staff we spoke with had knowledge of the lone working policy and all CMHTs kept records of staff whereabouts. Staff had a good understanding of the potential risks involved with their role. Staff at the Medway CMHT gave us an example of how they had acted proactively when a colleague had not arrived back at the CMHT base as arranged.

Track record on safety

- Since 1 January 2017 the Medway CMHT had reported five serious incidents, the South Kent Coast CMHT reported three serious incidents and the Canterbury and Coastal CMHT reported 10 serious incidents. The majority of these were suspected suicide and full investigations had been completed and learning themes identified in all cases.

Reporting incidents and learning from when things go wrong

- Staff had appropriate awareness of what should be reported as an incident. We saw many examples of staff discussing incidents within meetings. We saw evidence that the service took learning from these incidents and recognised they needed to make improvements in areas such as patient allocation, staff supervision and improved communication with other agencies.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- The service had recently introduced the choice and partnership approach (CAPA). This model aims to make the initial assessment more patient centred so they could make an informed choice if they would benefit from the service. A key requirement of this model is that two people carried out the assessment so different views could be explored. However, we found many examples where the assessments were being carried out by one person due to staff shortages.
- We were told that the Canterbury and Coastal CMHT had the capacity to carry out 25 initial core assessments per week. However, data received from the trust showed they received on average 220 referrals per month that met the criteria for assessment. Staff at the Canterbury and Coastal CMHT were not always recording initial core assessments onto the patients' care records, and in some cases there was no record the assessment had taken place. Staff told us this was due to staff shortages and could lead to delays of many weeks. This presented a risk to patients and staff as important information was not available to staff. The South Kent Coast CMHT was completing an average of 15 initial core assessments a week. We reviewed a sample of these and found them to be of an appropriate standard. We reviewed 12 core assessments that had been completed by staff from the Medway CMHT. They were of a good standard and included detailed letters to the GP when patients did not meet the criteria for secondary mental health services.
- We found examples of patients being re-referred into the service who had not had their core assessment updated. This meant that new information could be overlooked as receiving teams often rely on the core assessment on admission to their service.
- We reviewed 15 patients' care records from the South Kent Coast CMHT and found that seven patients' care plans had not been reviewed or updated. We reviewed 28 patients' care records from the Medway CMHT and found that 16 did not include care plans. Furthermore, the majority that contained care plans required reviewing and updating.
- Staff across the service did not follow a consistent approach to writing patient's progress notes. This meant it was sometimes difficult to follow the plan and outcome of care provided. However, we saw some examples of detailed progress notes that included evidence of physical health monitoring and health promotion.
- We found an example of letters and forms being uploaded to patient's care records which showed interventions, such as consent forms being signed. However, no evidence of these events was recorded in patient's progress notes.

Skilled staff to deliver care

- All CMHTs we visited consisted of nurses, psychiatrists, occupational therapists and healthcare assistants. Social workers were also included in all CMHTs apart from at Medway where this staff group was employed by the local authority. All staff we spoke to were appropriately qualified, experienced and competent.
- Clinical staff at the Canterbury and Coastal CMHT were not receiving regular supervision. However, we found that administration staff, at these CMHTs, received supervision regularly. Data received from the Medway CMHT showed that clinical staff were receiving regular supervision. We reviewed three supervision records for staff at this CMHT and found they were completed to a good standard. However, one operational team leader was unable to locate three staffs' supervision records on our request.

Multi-disciplinary and inter-agency team work

- We observed referral meetings at the Canterbury and Coastal CMHT. They were well structured and attended by senior members of the multidisciplinary team. All referral were discussed in detail and the administrator recorded the outcome, however, these outcomes were not recorded on patient's care records.
- The service informed staff of new allocations to their caseload by email. This meant there was no formal process to mitigate against emails getting accidentally deleted or to allow the individual worker to discuss the patient before allocation.
- All CMHTs we visited had weekly clinical meeting where complex cases, safeguarding, assessments and referrals were discussed. We observed this meeting at the Medway CMHT which was attended by all staff from that locality team. Staff recorded information directly onto patients care records during this meeting. All CMHTs also had monthly clinical risk management forums

Are services effective?

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where complex cases could be discussed at length. We viewed minutes of these forums for the Medway CMHT and saw that detailed multidisciplinary discussions took place to support the care coordinator provide care.

- We reviewed minutes of the Medway CMHT's business meetings that were held monthly. Staff discussed performance and new working models being introduced. We also saw that discussion took place to enable staff to learn from serious incidents and complaints.
- At all CMHTs we visited we found no evidence of formal handovers within the team. This meant it was not clear how caseloads were covered in the event of staff being on annual leave or sick leave. This presented a risk to patients and put added pressure on the duty workers.
- We found that communication between different teams was not always clear. This meant that patients were often not referred to appropriate services. For example, a patient from the South Kent Coast CMHT was referred to a service where they were assessed as not meeting the criteria without being seen. Subsequently, this patient received a medicine review and remained an out-patient with three month follow up. A member of staff in the Canterbury and Coastal CMHT told us they had been allocated the role of chairing a progress and planning review for a patient they did not know.
- The service employed primary care mental health specialists who supported patients who had a history of multiple short term episodes of secondary care support. These staff worked closely with GPs and CMHTs and were able to quickly transfer their patients between the two services depending on need. Three staff worked within the Medway CMHT and this had recently increased from one. They had approximate caseloads of 45 patients and were attached to the three locality teams. They attended the weekly clinical meetings where they discussed patient movement between the teams. These workers had support from two healthcare assistants and were able to offer interventions such as social support, brief psychological therapy and supporting carers. They told us that their input had improved links with GP surgeries.
- Social work staff in the Canterbury and Coastal CMHT were carrying out a project called 'your life your home'. It was a local authority initiative and aimed to support patients gain independence in the community. Staff were positive about this project but felt there was little operational guidance to support them.
- The Medway CMHT invited guest speakers from local community support agencies to their business meetings. An example of this was the Medway engagement group and network (MEGAN) who offer groups to people with mental health issues.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- All CMHTs we visited had regular referral meetings where referred patients were discussed and triaged. They were either allocated for urgent assessment, routine assessment or deemed not to meet the criteria for secondary mental health services. The Canterbury and Coastal CMHT received on average 220 referrals a months that met the criteria for assessment. For the Medway CMHT and South Kent Coast CMHT the average monthly referrals were 149 and 105 respectively.
- Following our comprehensive inspection in January 2017, we told the trust they must review the waiting lists for those patients waiting for initial assessment to ensure patients received a service in a timely way. The trust had a target of seeing 95% of patients within their target of 28 days for routine assessment and 48 hours for urgent assessment. We reviewed data for referrals to the Canterbury and Coastal CMHT and saw that for the previous six months they had seen 60% of patients within target. However, we saw that in the last two months this had increased to 72% and 85% of patients being seen within target.
- The South Kent Coast CMHT had seen 78% of patients within the 28 day target for a routine assessment. Between 1 September 2017 and 31 December 2017 they had breached this target with 68 patients. Over the same period 106 patients had breached the target at the Canterbury and Coastal CMHT. The Medway CMHT had 141 breaches. We reviewed data at this CMHT and saw they were currently assessing the majority of patients who had been referred for a routine assessment within target. This was a marked improvement as the data showed that patients referred in 2016 were waiting approximately one year to be assessed. Staff said that these decreased waiting times had a positive effect on the number of patients who did not attend their assessment. During this focussed inspection we felt the service had made significant improvements in this area. However, we remained concerned that the improved waiting times from referral to assessment had only contributed to the number of patients waiting to be allocated to a care coordinator.
- Staff did not consistently follow the criteria for deciding whether a patient required care coordination. We found examples of patients being assessed who were deemed not appropriate for care coordination and patients with seemingly minor mental health issues that were receiving care coordination.
- Across the Canterbury and Coastal CMHT the 'did not attend' (DNA) rate for the previous six months was 23% for initial appointments and 15% for follow-up appointments. For the Medway CMHT these figures were 26% and 12& respectively and the South Kent Coast CMHT these figures were 26% and 14% respectively.
- The service did not appropriately follow up patients who DNA appointments as per the trust's DNA policy. We found an example of a patient under the Canterbury and Coastal CMHT, who was subject to the Mental Health Act, missing an appointment to have their depot injection administered. When the patient presented the following day they were unable to have their depot due to being outside of the clinic times. Furthermore, this information was communicated to a member of staff who was currently suspended so would be unable to access this information. At the time of our inspection, four days later, we could not find evidence the patient had received their depot. Staff from the Medway CMHT had been instructed to contact a patient's GP after they DNA for two appointments. We could not find evidence that communication to the GP had been made.
- We viewed records of patients' attendance at the Medway CMHT's depot clinic. We found that patients were seen every 15 minutes and attendance was high. Staff were flexible and would see patients if they presented outside of their allotted time. Patients who did not attend were clearly identified and emails were sent to their care coordinators.
- We found many examples of patients' appointments being cancelled with short notice given. Often an alternative appointment was not arranged in a timely manner. Across the Canterbury and Coastal CMHT 14% of appointments were cancelled, of these 6% were attributed to staff, 4% to patients and 4% unknown. The Medway CMHT had 10% of appointments cancelled, with 6% being attributed to staff, 3% to patients and 1% unknown. The South Kent Coast CMHT had 14% of appointments cancelled, with 10% being attributed to staff, 3% to patients and 1% unknown.

Are services well-led?

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

Our findings

Vision and values

- Staff across all CMHTs had limited understanding of the trust's vision for the service. We heard mixed view regarding the implementation of the new CAPA assessment model and some staff felt the focus on quantity of patient contacts, that were required, could have an impact on the quality of care provided. They told us that issues such as travel time between appointments had not been properly considered.

Good governance

- The service had processes in place to ensure important issues such as training compliance and incident reporting was monitored. However, we found a number of examples where staff were not carrying out clinical practice in line with trust policy. This was a systemic issue from senior management to frontline staff and presented an ongoing risk to patients.
- All CMHTs we visited had local risk registers. All included risks such as staffing levels, lone working, unallocated patients and high caseloads. The service had had an overarching risk register that included issues such as staff vacancies and use of agency staff. We saw that plans to reduce risk, such as the discharge workshop and caseload reviews had not been effective.

Leadership, morale and staff engagement

- Some staff expressed low morale. We heard that staff were getting behind with work and needed to catch up in their own time. Staff also had concerns for risks to patients due to high caseloads and lack of cover arrangements.
- The Canterbury and Coastal CMHT were considering a plan for the satellite service to integrate into the main base. Staff felt they had not been provided with much information about these plans. However, the trust informed us they had been open with staff about these plans and felt that operating from one site would benefit patient care and staff well-being. They assured us that a consultation process would be followed in line with their organisational change policy before any operational changes were made.
- Staff felt well supported by local management, however, they reported a disconnect between local and senior management. Staff across all sites we visited spoke positively about their colleagues and felt supported by them.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment. Staff did not always assess the risks to patients' health and safety or respond appropriately to meet peoples' individual needs to ensure their welfare and safety during any care or treatment. The trust did not provide care and treatment in a safe way for patients' receiving, or awaiting to receive, care or treatment from the adult community mental health teams. Staff did not document appropriate information that had been shared to ensure care and treatment remained safe for people using services. When staff were on annual leave or sick leave, a handover to another colleague or duty worker was not recorded. When patients were discharged back to their GP they were not always informed. These were breaches of Regulation 12(1)(2)(a)(b)(i).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance. The trust did not operate effective audit and governance systems and/or processes to make sure they assessed and monitored the service at all times and in response to the changing needs of people referred and / or accepted to the service. There were not robust systems and

This section is primarily information for the provider

Enforcement actions

processes in place to monitor and ensure compliance with trust policy and procedures as outlined in the trust's Community Mental Health Team Operational Policy and Transfer Discharge Policy.

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