APPENDIX 3

Kent and Medway NHS and Social Care Partnership Trust

Inspection report

Trust Headquarters, Farm Villa
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Tel: 01622 724100

Date of inspection visit: 9 October to 29 November 2018
Date of publication: 22/02/2019

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Kent and Medway NHS Partnership is a large mental health trust that provides mental health, learning disability, substance misuse and specialist to approximately 1.8 million people across Kent and Medway. The trust works in partnership with Kent County Council and works closely with the local unitary authority in Medway.

The trust is one of the largest mental health trusts in England and covers an area of 1,450 square miles. The trust has an annual revenue of £178 million and employs approximately 3,500 staff who work across 66 buildings on 33 sites.

The trust provides services around key urban centres including Maidstone, Medway and Canterbury and more rural community locations.

The trust is commissioned by eight clinical commissioning groups.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good 

What this trust does

The trust provides care and treatment to people with mental health needs, learning disabilities, substance misuse and other specialist services.

The trust provides a range of mental health services including acute, rehabilitation and forensic in-patient services for working age and older adults. The trust recently opened a specialist mother and baby mental health unit in October 2018. The trust provides community based mental health services such as outpatient and community clinics. The trust provides services for people experiencing mental health crisis such as crisis and home treatment teams and health based places of safety.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

During this inspection we inspected community mental health services for adults of working age and older adults, acute in-patient and psychiatric intensive care wards, forensic inpatient wards and crisis and home treatment teams and health based places of safety.

Summary of findings

We inspected acute wards for adults of working age and psychiatric intensive care units because they were previously rated as requires improvement overall in our inspection in January 2017.

We inspected community mental health services for adults of working age because we had rated them as requires improvement in January 2017. In addition, we undertook a further focussed inspection in January 2018 due to emerging concerns in these teams following which we issued a Section 29 Warning Notice to the trust which outlined they needed to make significant improvements to the safety and quality of the service provided by August 2018.

We inspected community based mental health services for older people because we wanted to ensure that the learning in relation to the working age adult community teams had been shared with the older people's teams. We had also received information of concern about caseload management and staffing issues through our national call centre about this core service.

We inspected forensic inpatient services because they had been rated as requires improvement for the safe key question in January 2017. We also had ongoing concerns about staffing levels and the support being provided to staff on these wards.

We inspected mental health crisis services and health based places of safety because, although they were rated as good for all key questions in January 2017, we had received information of concern that suggested people could not access timely crisis mental health care when they needed it.

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- Except for acute inpatient and psychiatric intensive care unit for adults of working age, the trust continued to deliver a range of good and outstanding core services. We inspected five core services. We rated forensic inpatient services as outstanding overall, community services for adults and working ages and older people and crisis and health based places of safety as good overall. We rated acute inpatient wards and psychiatric intensive care wards for working age adults as requires improvement.
- Across the trust, we found most of the core services we inspected to be safe, effective, caring, responsive and well led. We rated safe, effective, responsive and well led as good overall and caring to be outstanding.
- The trust had made the significant improvements in the overall safety and quality of the community mental health teams for working age adults that we required when we issued a Section 29A warning notice in February 2018.
- Community staff had manageable caseloads which were reviewed regularly. Patient care and staff morale had significantly improved in these teams.
- Patient safety was afforded sufficient priority in most of the core services we inspected. Staff kept patients safe from avoidable harm and abuse. When patient safety incidents occurred, the trust took a systematic approach to ensuring that learning was identified and practices improved where appropriate.
- In most services, there were sufficient numbers of suitably skilled and trained staff to deliver effective care and treatment. Staff were supported by skilled, motivated and engaged service managers.
- Medicines were mostly well managed. Staff received support from pharmacists, who visited each service.
- Staff followed best practice and evidence based guidance to ensure that patient outcomes were good. The trust were focussing on developing clear presentation pathways for patients to ensure patients received appropriate care.

Summary of findings

- Staff used seclusion and restraint only as a last resort. The trust had significantly reduced the number of restraint and seclusion episodes over the two years prior to our inspection.
- Except for female psychiatric intensive care beds, which the trust was not commissioned to provide, staff could access mental health beds for patients as needed. The trust had significantly reduced the numbers of private and/or out of area beds being used since 2016. This meant that most patients could receive hospital care near to their home.
- The trust had introduced quality audits on key documentation which had significantly improved the quality of risk assessments, care plans and progress notes.

However;

- Acute wards for working age adults and psychiatric intensive care units required improvement. We found these wards were not sufficiently safe, effective or well led.
- We rated the overall leadership of the trust good . Whilst we found that service level managers were highly engaged and delivering good leadership in the majority of core services, at board level the trust lacked focus in some key areas.

Are services safe?

Our rating of safe improved. We rated it as good because:

- We rated the safe key question as good in four of the five core services we inspected. We rated safe as requires improvement in acute wards and psychiatric intensive care units for working age adults.
- Staff knew how to safeguard vulnerable adults and children from avoidable harm and abuse. Staff in clinical services were well supported by the corporate safeguarding team.
- Staff assessed patient risks and acted to mitigate them where possible. Staff used risk assessment tools and risk assessments were detailed and up to date.
- Except for two of the acute wards for working age adults, staffing levels were sufficient to provide safe care and treatment. The trust were taking a proactive approach to recruiting and retaining staff.
- Community staff had manageable caseloads which were reviewed regularly. Patients awaiting allocation of a care coordinator were managed safely through the 'active review caseload'.
- In the community teams, staff shared risk appropriately with colleagues and had systems in place to ensure that higher risk patients were proactively managed. The trust recognised and responded appropriately to patients whose condition was deteriorating.
- Medicines were mostly well managed safely in clean, organised and well-maintained clinic rooms. Staff received support from pharmacists, who visited each service regularly.
- Records were well managed, clear and up to date.
- Except for one acute ward, all wards were gender specific. On the one mixed gender acute ward, the ward was segregated into male and female designated areas.
- Staff used seclusion and restraint only as a last resort. The trust had significantly reduced the numbers of restraint and seclusion episodes over the two years prior to our inspection.
- Staff we spoke with knew the procedure for reporting incidents and managers encouraged them to do so. Staff teams met regularly, to share information and learning from incidents. Staff were debriefed after incidents and received support from managers.

However:

Summary of findings

- Whilst staff managed the risks to patients, there remained numerous ligature risks and blind spots on the acute wards for working age adults. The Dartford health based place of safety had a remaining blind spot in the bathroom and we were not assured that all incidents were being reported in that service.
- Some areas within the ward environments were unclean, cluttered or worn. Some of the acute ward ensuite bathrooms had been flooded causing potential safety risks that had not been safely managed. On the Trevor Gibbens Unit the patient control for bedroom door viewing panels was not working in most of the bedrooms.
- Mandatory training compliance was below the trust's internal target of 85% in some services.
- The trust reported less incidents when compared with other similar trusts which can be suggestive of a poor reporting culture. The trust reported managers had been working to promote positive reporting of less serious incidents and near misses but incident reporting had not increased since 2016.
- Fridge and room temperatures at several sites were not maintained appropriately to keep an ambient temperature for patients or staff, or for the safe storage of medicines.
- Some teams reported that the risk assessment tool on the electronic patient record did not suit the needs of their patient group. Some staff reported the electronic patient record system could be slow to access, especially during busy times.
- Staff on some of the acute wards for working age adults did not safely manage the risks of patients smoking or bringing lighters onto the wards.
- The trust was not commissioned to provide a crisis service for people with dementia.
- Patients could not always access support by telephone in a timely way in the Dartford, Gravesend and Swanley community mental health team for working age adults.

Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- We rated effective as good in four of the five core services we inspected. We rated effective as requires improvement on the acute wards and psychiatric intensive care units for working age adults.
- Staff received training in the Mental Health Act and Mental Capacity Act. Staff we spoke with had a good understanding of the Mental Health Act and Mental Capacity Act and their guiding principles.
- Except for the acute wards for working age adults, patient care plans we looked at were consistently up to date, personalised, holistic and recovery oriented, incorporating patients' strengths and goals.
- Staff were skilled and competent in their area of work and reported they were supported to access supplementary training.
- Teams were multi-disciplinary and included doctors, nurses, occupational therapists, psychologists and healthcare assistants. Staff demonstrated effective working within the multi-disciplinary teams and external organisations.
- Staff provided patients with good quality care based on evidence-based, best practice guidelines produced by the National Institute for Health and Care Excellence (NICE).
- Staff assessed and monitored the physical health of patients using their services. Physical health nurses supported mental health staff across a range of services.

However:

Summary of findings

- On the acute wards for working age adults care plans lacked detailed physical health care plans for patients with identified physical health needs.
- The trust did not ensure that all staff received regular, recorded line management or clinical supervision.
- Staff on the acute adult wards and community teams for older people demonstrated an inconsistent approach to recording patients' capacity and consent to treatment.
- In the health based places of safety, the S136 rights leaflet being given to patients detailed a maximum detention period of 72 hours and not 24 hours, which did not reflect changes to legislation in 2017.

Are services caring?

Our rating of caring stayed the same. We rated it as outstanding because:

- We rated caring as good in three of the five core services we inspected. We rated caring as outstanding in forensic inpatient services and community mental health services for older people.
- Patients spoke positively about the way staff treated them. We observed highly caring, respectful and supportive interactions between staff and patients.
- Staff were knowledgeable about their patients and worked hard to develop strong relationships with them.
- Staff across the trust ensured that patients and their loved ones were fully included in all aspects of patients care and treatment.
- Patient experience surveys were used with the aim of improving services for patients. There were regular community meetings on every ward and a patient council.
- In forensic inpatient services, families and carers were offered an initial engagement meeting with the patient's consent. Patients led the production of a quarterly report about their progress, to be shared with relatives and carers of their choosing.
- The trust has a family and engagement lead, who worked to ensure families and carers were included where the patient wanted them to be. There were regular engagement events and an annual survey.
- The community mental health service for older people had a good provision of admiral nurses who supported families with all aspects of living with dementia. They provided families with education courses and worked flexibility around the needs of carers.

Are services responsive?

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

- We rated four out of five of the services we inspected as good for responsive care. However, we rated community based mental health services for working age adults as requires improvement.
- The trust planned admissions and discharges in a structured way that meant people did not stay in hospital longer than was clinically necessary.
- The trust had significantly reduced the use of out of area beds since 2016 which meant that patients could usually access hospital beds near to home.
- In most services the trust met the needs of all people using the service including those with specific or complex needs.

Summary of findings

- The community mental health service for working age adults had a robust system for ensuring patients waiting to receive a service were actively reviewed with clearly documented plans for contact or review.
- Teams worked well with other agencies to ensure that patients could access support with housing, finances and employment.
- The trust planned for the fluctuating needs of the people using services. The community mental health teams operated a duty system to ensure urgent referrals could be acted upon. Patients could access crisis support 24 hours each day, seven days a week.
- Staff knew how to access interpreters for patients if needed and we saw information available to patients in a range of languages.
- The trust had a clear and robust complaints procedure. Complaints were investigated in a timely way and learning from complaints was shared. Staff gave patients information about how to raise concerns if they were unhappy with their care.

However;

- Some crisis teams did not offer community based clozapine initiation meaning some patients would have to be admitted to hospital if they were to commence clozapine.
- In the community mental health service for older people, the buildings in which some patients were seen or received care were not always adapted to the needs of older people using the service. We observed a lack of dementia friendly signage in some areas and some sites did not provide adequate parking for people with disabilities.
- Some interview rooms used by the Maidstone community mental health service for older people did not provide adequate soundproofing to ensure patients privacy and confidentiality was maintained.
- There was a variation in length of stay across the acute wards for working age adults. Staff reported consultants were not consistent in how they followed the 72-hour crisis admission criteria for patients with an emotionally unstable personality disorder.
- On Samphire ward, patients were required to use the telephone in the nursing office which did not afford them privacy. On this ward, staff were not assured that detained patients had regular access to fresh air as the gardens were consistently locked. Patients could not always access the ward gym if they wished to. The trust submitted a robust action plan to remedy this immediately after our inspection.
- The community mental health teams for working age adults were regularly failing to meet the trust's response time of 28 days to initial assessment for newly referred patients to the teams. Patients waited a long time for access to psychological therapies in some of these teams.
- On the acute wards and psychiatric intensive care units for adults of working age, patients were not appropriately supported to access the gym, there was inconsistency in structured activities and some patients did not have timely access to psychology.

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Except for the acute wards for working age adults, we were impressed with the leadership across all the services we inspected. We rated the crisis teams and health based places of safety and the community teams for both working age adults and older people as good and the forensic inpatient service as outstanding for the well led key question. We rated the acute wards and psychiatric intensive care units for working age adults as requires improvement.

Summary of findings

- There was clear and visible leadership from the executive team who displayed the right values, skills and commitment to ongoing improvement.
- Service managers were highly motivated, skilled and had good oversight of their services. Managers ensured the provision of mostly good or outstanding services.
- Service managers had the skills, expertise and knowledge to lead teams to deliver care that was safe and of a high quality.
- The trust had a clear and well thought out approach to recruitment and retention.
- Staff at all levels in most services understood the trust values in relation to their daily roles and the values were used as a common language by staff when challenging poor practice.
- Managers acted to ensure that learning took place and was shared following incidents and complaints.
- Staff were aware of local and trust wide risk registers and knew how to escalate risks as they arose.
- Local leaders were empowered to lead effective and high functioning teams.
- Staff were motivated and inspired to improve patient care in every way possible. The trust were developing an organisational approach to quality improvement.
- Staff had access to timely and accurate information that was used to monitor and improve performance.
- The trust had implemented 'Cliq' checks which had proved an effective way of improving clinical documentation across services.
- Each service had clearly identified governance leads and clear reporting lines to and from the board.

However:

- Whilst the majority of services were rated good during this inspection, we had concerns about the trust board's ability to maintain safe and high quality care across all of its services.
- The trust board and service level managers did not have oversight of some of the issues we found during this and previous inspections. Two of the acute wards, Chartwell and Samphire Wards, were not well led at the time of this inspection. The trust had an action plan in place for one of these two wards.
- The trust did not ensure that all staff received regular, recorded line management or clinical supervision.
- Board meeting were not always chaired well and agenda items were not routinely given appropriate time to be discussed or reviewed.
- This trust reported a lower number of incidents when compared with other trusts nationally. Managers told us they had been trying to promote a positive reporting culture but it was not clear what difference this had made at the time of our inspection.
- There was variation in the quality of incident investigation reports, particularly those completed within the first 72 hours of an incident. Some reports lacked detail and did not demonstrate that carers had been involved in the investigation process.
- The trust did not apply Duty of Candour or routinely commission an investigation unless actual moderate or severe patient harm occurred. This meant they did not inform patients or identify learning in cases where the trust was responsible for the clear potential for harm but actual harm had not occurred.
- The board did not have a shared oversight of the trust's financial position, including how they would generate non-recurrent savings.

Summary of findings

- The trust did not have a clear approach to digital growth or development though the use of technology in delivering high quality services was a key strategic priority.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

In addition to services where we rated outstanding in the safe, effective, caring, responsive and well led domains or overall, we found other areas of outstanding practice. We found areas of outstanding practice in the community mental health services for older people and the forensic secure wards.

Areas for improvement

We found things that the trust should take action on to improve service quality including breaches of legal requirements that the trust must put right.

For more information, see the Areas for improvement section of this report

Action we have taken

We issued requirement notices to the trust. These notices related to breaches of Regulation 18 HSCA (RA) Regulations 2014, Staffing, across the whole trust and Regulation 12 HSCA (RA) Regulations 2014, Safe care and treatment, in the acute mental health wards for working age adults and psychiatric intensive care units.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

In addition to services where we rated outstanding in the safe, effective, caring, responsive and well led domains or overall, we found the following areas of outstanding practice -

Forensic inpatient services -

- The psychology team for this core service led a restorative justice programme, the ethos of which had become embedded within the culture of the wards. The psychology team trained staff in the application of restorative justice and wards had a nominated restorative justice champion. The focus of the first year of the programme had been to assist staff to resolve issues between patients.
- The Allington Centre was in the process of applying for a quality mark accreditation with the restorative justice council. The psychology team worked jointly with national health service and international partners for the ongoing development of the programme and to collectively apply for an international research grant.

Community based mental health services for older people -

Summary of findings

- The service had been involved in a pilot study to look at whether the dementia pathway could be supported in primary care. This had led to seven primary care nurse roles being commissioned. The service predicted this would have a positive impact on the referrals coming into the service.
- Teams in west Kent were involved in the kinesis project. This was software that enabled GPs to request advice from consultants in advance of a decision to refer. Advice was given on how best to continue the management of the patient within the primary care setting, hence reducing the number of referrals to the service. GP's involved had indicated that around 40% of patients, on whom advice is sought, are not referred to the service.
- The trust had employed two dementia service users who had lived experience of being diagnosed with dementia. They worked with community projects related to dementia; support people who shared a similar diagnosis; raised the profile of dementia in the community; and delivered talks to health care staff and community groups. They were also instrumental in the developed of buddy systems where patients supported each other.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Acute wards for working age adults and psychiatric intensive care units –

The provider MUST ensure that -

- The ward environment is safe from risks such as fires, flooding and that ligature risks are minimised.
- Equipment is stored safely and checked in line with trust policy.
- Medicines are stored safely and appropriate actions taken when prescribing and administering medicines.
- Patients with an identified physical health care need have care plans in place with details about how these should be managed daily.
- All staff receive regular, recorded line management and clinical supervision.

The provider SHOULD ensure –

- There is sufficient scrutiny of staffing issues and ward culture and continue to monitor actions plans for Chartwell and Samphire wards.
- All staff receive regular mandatory training and annual appraisals in line with the trust's target for compliance.
- There is consistent provision of psychology across the wards.
- Patients have access to appropriate structured activities and that staff are equipped to assist them.
- Service managers prioritise reviewing the numbers of readmissions focussing on those patients being readmitted within 24 hours of discharge from hospital.
- There are systems in place that provide assurance detained patients have regular access to fresh air on Samphire Ward.
- Staff understand the Mental Capacity Act (2005) and the five statutory principles.
- Service managers communicate any proposed changes effectively to staff and to try to minimise the impact of these on patients and staff.

Summary of findings

Forensic inpatient or secure wards –

The provider SHOULD ensure –

- The internal temperature on all wards should be kept at a comfortable level.
- Patient controls of all bedroom door vision panels are in working order.
- People with restricted mobility can access all areas of each ward.
- All staff receive regular supervision and an annual appraisal.

Community based mental health services for adults of working age –

The provider SHOULD ensure -

- Fridge temperatures are recorded consistently at the Canterbury and Coastal team so that patient medicines are stored safely.
- High temperature of the clinic room at the Dartford, Gravesend and Swanley team is adequately managed during hot weather.
- Telephone response time at the Dartford, Gravesend and Swanley team improves so that patients and carers can speak with team members in a timely way.
- All staff receive supervision at the frequency set out in its supervision policy, and have procedures in place to enable this to continue when key supervisory staff are absent.
- All patients in all teams receive their initial assessment within the trust target time of 28 days from their referral to the service.
- Waiting times for access to psychological therapies are within the trust's waiting time target and that senior clinical staff monitor and review the waiting list.
- The provision of dementia friendly features and access to disabled parking spaces is improved.
- Interview rooms have appropriate soundproofing to maintain patients' privacy and confidentiality.
- There is a consistent approach to all areas of clinical practice to avoid variation in standards across the teams.

Mental health crisis services and health-based places of safety –

The provider SHOULD ensure –

- The risks associated with the blind spot in Dartford's 136 suite is mitigated.
- All incidents occurring in the 136 suite at Dartford are properly reported.
- The information leaflet detailing patient's S136 rights is amended following changes to legislation in relation to maximum detention times.
- Leaders review the trusts approach to clozapine initiation in the community to ensure that all patients can start clozapine in their own homes where it is safe to do so.

Community based mental health services for older people –

The provider SHOULD ensure –

- The service improves their provision of dementia friendly feature and access to disabled parking spaces.

That interview rooms have appropriate soundproofing to maintain patients' privacy and confidentiality

Summary of findings

The service takes a consistent approach to all areas of clinical practice to avoid variation in standards across the teams.

Well led –

The provider MUST ensure –

- That all staff receive regular recorded line management and clinical supervision.
- Immediate management reviews and root cause investigation reports are sufficiently clear and detailed.
- Relatives are routinely offered the opportunity to contribute to serious incident investigations.
- The trust's policy framework for Duty of Candour supports staff in identifying where there is potential for moderate or severe harm but no actual harm has yet occurred.

The provider SHOULD ensure –

- The board have a shared view of its financial position, including how to generate recurrent cost savings.
- Board meetings are chaired effectively and, as such, all agenda items are given sufficient priority.
- The trust prioritises board development focussed on ensuring healthy challenge between the non-executive and executive directors.
- The trust continues to prioritise ensuring equality and inclusion for patients and staff through the provision of a Workforce Race Equality Standard action plan and further embedding the equality networks. The trust should also update the equality objectives and strategy on its public facing website and in line with its duties under the Equality Act 2010.
- Trust leaders review the approach to digital growth and development and ensuring this is shared through relevant strategy documents.
- There is a trust wide, overarching approach to quality improvement that is accessible to all staff at the trust.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated the leadership as good because:

- Except for the acute wards for working age adults, we were impressed with the leadership across all the services we inspected. We rated the crisis teams and health based places of safety and the community teams for both working age adults and older people as good and the forensic inpatient service as outstanding for the well led key question. We rated the acute wards and psychiatric intensive care units for working age adults as requires improvement.
- Service managers were highly motivated, skilled and had good oversight of their services. Managers ensured the provision of mostly good or outstanding services.
- Service managers had the skills, expertise and knowledge to lead teams to deliver care that was safe and of a high quality.

Summary of findings

- Staff at all levels in most of services understood the trust values in relation to their daily roles and the values were used as a common language by staff when challenging poor practice.
- Managers acted to ensure that learning took place and was shared following incidents and complaints.
- Staff were aware of local and trust wide risk registers and knew how to escalate risks as they arose.
- Local leaders were empowered to lead effective and high functioning teams.
- Staff were motivated and inspired to improve patient care in every way possible. The trust were developing an organisational approach to quality improvement.
- Staff had access to timely and accurate information that was used to monitor and improve performance.
- Each service had clearly identified governance leads and clear reporting lines to and from the board.

However:

- The trust board and service level managers did not have oversight of the issues we found during this and previous inspections. Two of the acute wards, Chartwell and Samphire Wards, were not well led at the time of our inspection.
- The trust did not ensure that all staff received regular, recorded line management or clinical supervision.
- Board meeting were not always chaired well and agenda items were not routinely given appropriate time to be discussed or reviewed.
- This trust reported a lower number of incidents when compared with other trusts nationally. Managers told us they had been trying to promote a positive reporting culture but it was not clear what difference this had made.
- There was variation in the quality of incident investigation reports. Some reports lacked detail and did not demonstrate that carers had been involved in the investigation process.
- The trust did not apply Duty of Candour or routinely commission an investigation unless actual moderate or severe patient harm occurred. This meant they did not inform patients or identify learning in cases where the trust was responsible for the clear potential for harm but actual harm had not occurred.
- The board did not have a shared oversight of the trust's financial position, including how they would generate non-recurrent savings.
-
- The trust did not have a clear approach to digital growth or development though the use of technology in delivering high quality services was a key strategic priority.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement 

Key facts and figures

Kent and Medway NHS and Social Care Partnership trust provides assessment and treatment for adults of working age in 10 acute wards and one psychiatric intensive care ward based in three hospital sites across the trust. Little Brook hospital based in Dartford has four wards; Willow Suite is a 12-bed male psychiatric intensive care ward, Amberwood and Cherrywood wards are both 17-bed mixed wards and Pinewood ward, a 10-bed male ward is based close to Little Brook hospital in Littlestone Lodge. St Martin's hospital in Canterbury has four wards; Bluebell ward is a 18-bed mixed

Summary of findings

ward, Foxglove ward is an 18-bed mixed ward, Fern ward is an 18-bed female ward and Samphire ward is a 15-bed male ward. Priority House is based in Maidstone and has three wards; Upnor ward is an 18-bed mixed ward, Boughton ward is an 18-bed male ward and Chartwell ward is an 18-bed female ward. At the time of our inspection, Pinewood ward had been decanted to Littlestone Lodge whilst the ward at Littlebrook hospital was being refurbished.

When we visited the wards, there were 12 patients on Willow Suite ward, 14 patients on both Amberwood and Cherrywood wards, seven patients on Pinewood ward, 17 patients on Bluebell ward, 18 patients on Foxglove ward and 15 patients on Fern and Samphire wards. There were 18 patients on Upnor ward, 17 patients on Boughton ward and 13 patients on Chartwell ward. Some of the patients were subject to conditions under the Mental Health Act (1983).

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs and well led?

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

At the last comprehensive inspection of this core service in January 2017 we rated acute wards for adults of working age and psychiatric intensive care units as requires improvement for the safe, effective and well-led domains and as good for caring and responsive. This resulted in an overall rating of requires improvement. We re-inspected all five domains as part of this inspection.

Our inspection between 9 and 11 October 2018 was unannounced, which means that staff did not know we were coming, to enable us to observe routine activity.

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust. These included NHS Improvement, local Healthwatch organisations, local clinical commissioning groups and local authorities.

During the inspection visit, the team:

visited all 11 wards, looked at the quality of the environment and observed how staff were caring for people using services

spoke with modern matrons, wards managers or deputy ward managers on each ward and the head of service who covered all the wards

spoke with 36 other members of staff including nurses, healthcare assistants, psychologists, occupational therapists, doctors, pharmacists, clinical leads and housekeepers

spoke with 16 patients

reviewed 36 patient care records

reviewed 20 medicine charts

attended three groups for people using services

observed three ward rounds, three staff handovers, one bed management meeting, one staffing allocation meeting and one seclusion review meeting.

looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

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

Summary of findings

- Most of the wards were clean but some ward areas and patient bedrooms were unclean and cluttered. Many of the patient ensuite shower rooms had flooded and some bedrooms were out of use because of this.
- Medicines were not always stored safely or at the correct temperature.
- Staffing was an issue on six of the 11 wards we visited. Low staffing numbers on Chartwell and Samphire wards meant that staff and patients reported those wards did not feel safe at times. Following our inspection, the trust provided us with an action plan that identified how they planned to address concerns we raised for both these wards.
- Seven of the 36 care plans we viewed lacked a detailed, personalised physical health care plan for patients with identified physical health needs such as diabetes. Not all patients who had started on Lithium medicine had been properly assessed prior to its commencement.
- Mandatory training compliance in immediate life support, cardiopulmonary resuscitation and safeguarding children were all below the trust's target figure of 85
- The level of input from clinical psychologists varied across the sites because some sites were recruiting staff to vacant posts.
- There was an inconsistency in the provision of structured occupational therapy activities. There was a gym available to patients but staff were not always trained to support patients to use this resource.
- Staff knowledge of the Mental Capacity Act (2005) varied across the wards and some staff were not familiar with the five statutory principles. There was no record that best interests' meetings had taken place for patients who lacked the capacity to consent to treatment.
- Leaders of the service did not always demonstrate full oversight of the risks we saw during the inspection.
- Leaders did not always ensure that service changes had been communicated to staff. Staff did not always feel they had adequate communication or input into other changes that were implemented within the trust.

However;

- The trust had implemented recruitment drives and staffing had improved on some wards. The development of 'releasing time to care healthcare assistants' and psychiatric intensive care liaison nurse posts on the wards to free up staff time for clinical work had been well-received by staff.
- Staff had been trained in safeguarding and were confident to know how to recognise and escalate a safeguarding concern.
- Staff had reduced the number of occasions when they resorted to the use of physical restraint to manage behaviour by patients that staff found challenging. Staff felt were trained in and felt confident in using de-escalation and we observed staff use this technique well during the inspection.
- There was good evidence of comprehensive mental and physical health assessments of patients on admission. There was a physical health care nurse situated on each ward who carried out physical observations and offered staff training in these areas.
- Staff demonstrated a good level of knowledge and confidence in applying the Mental Health Act (1983). Care records we viewed showed that staff proactively sought informed consent from patients and patients were informed of their rights weekly.
- Staff interactions we observed with patients were caring and respectful. Patients said staff treated them well and behaved appropriately towards them. There was good evidence of carer involvement across the wards.

Summary of findings

- Staff involved patients in their care and patients told us that staff took the time to discuss their care and treatment with them. Staff assisted patients to access advocacy and appropriate resources for patients with different communication or language needs.
- Staff planned discharges carefully from admission. Staff reviewed the 12 steps to discharge 'Meridian board' daily.
- There were weekly bed management meetings and beds were usually available when needed for patients living in the catchment area. With the assistance of the psychiatric intensive care liaison nurse, female patients requiring psychiatric intensive care beds were placed out of area.
- The trust hosted monthly quality improvement meetings and ward managers from each ward attended and fed back to their teams. Wards had piloted initiatives such as staff worn body cameras, mobile phone apps for section 17 leave and regular safety huddles.

Is the service safe?

Requires improvement 

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

- A few of the communal ward and bedroom areas we saw looked unclean, cluttered and worn. There was mould on the ceiling of one ensuite shower room and many of the ensuite shower rooms had flooded. Some bedrooms were out of use due to flooding and the smell of drainage. There had been a recent serious incident where a patient had sustained an injury after falling on a slippery shower room floor. Staff had been advised to tell patients to place towels on the shower room floors which could have presented an additional falls risk.
- There were numerous ligature risks on the wards and several blind spots.. To manage these, staff on the wards carried regular environmental checks, used the observation policy and there was supervised access only to gardens and rooms considered a ligature risk.
- There had been two recent fires on two wards. On another ward we observed patients smoking and the fire alarms did not activate. Staff told us they felt unable to manage patients smoking or bringing lighters on to the ward.
- Medicines were not always stored safely. Fridge and clinic room temperatures had frequently exceeded recommended ranges with no subsequent actions recorded. Insulin vials and some creams and oral solutions like lactulose had been opened but had no expiry date. Not all patients who had started on Lithium medicine had been properly assessed prior to its commencement.
- There were staff nurse vacancies on six of the 11 wards we visited. On two of the wards, staff and patients told us the low staff numbers made the wards feel unsafe at times. Several of the wards had moved and some were due to close or be refurbished. Staff reported these changes were connected to why some staff had left.
- The wards fell below the trust's mandatory training target of 85% in cardio-pulmonary resuscitation, immediate life support and safeguarding children level three. The recent trust wide change to the e-learning package used by staff and ward managers meant that managers had better oversight of staff training compliance.
- There was no seclusion room at St Martin's hospital. Staff reported the lack of seclusion room had led to the higher number of restraints on the wards at this site.
- Staff reported that the three-tiered electronic risk assessment tool was not entirely suited to acute in-patients and they had not received adequate training to use it.

However;

Summary of findings

- Staff had been trained in safeguarding, there were safeguarding leads on all wards and staff were confident to know how to recognise and escalate a safeguarding concern. There was a safeguarding log on each ward.
- Staff completed risk assessments for patients within 72 hours of admission and updated these at least weekly. The majority of the 36 risk assessments we saw were completed in detail and included patient risk formulation and protective factors.
- The number of restraints reduced from 951 to 803 over the two years prior to our inspection. Staff and patients told us that restraints were only used as a last resort. Staff were trained and confident in de-escalation and how to avoid prone restraints.
- Staff were confident in reporting incidents on the incident reporting system and some described over-reporting to be make sure all incidents were captured. Ward managers received serious incident bulletins that they shared with staff and these were discussed in team meetings.
- The psychology team provided post-incident debriefing to staff and offered weekly reflective practice sessions.

Is the service effective?

Requires improvement 

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

- Seven of the 36 care plans we reviewed lacked detailed, personalised physical health care plan for patient with identified physical health needs.
- Patients told us that they didn't always feel supported to access the gym as not all staff were trained to support patients in the gym.
- There was inconsistency across the sites regarding the planning and frequency of structured occupational therapy activities. Some occupational therapists were counted in the ward staffing numbers and as such told us they had less time to focus on therapeutic activities. On one ward, there were no structured activities available for patients at the time of our inspection.
- Staff knowledge of the Mental Capacity Act (2005) varied across the wards and not all staff were familiar with the five statutory principles. For patients who were assessed as lacking the capacity to consent to treatment, there was no recorded evidence that a best interests meeting had taken place.
- The level of input by clinical psychologists input varied across the sites because some sites were recruiting staff to vacant posts. This meant some patients did not have timely access to psychology to support their recovery.
- Though staff told us they received regular supervision, the service's overall recorded supervision compliance rate was very low at 25%. The trust reported they had not been able to capture supervision data accurately but had updated the system so expected compliance rates to improve.

However;

- Staff completed comprehensive mental and physical health assessments of patients on admission and patients mostly had good access to doctors throughout their admission.
- Staff had access to additional training that included electrocardiography and phlebotomy so these interventions could be carried out on the ward.
- There was one physical health care nurse (Registered General Nurse) situated on each ward. They carried out physical observations and offered staff training in monitoring patients' ongoing physical health care needs and physical observations.

Summary of findings

- On the wards that had minimal staff vacancies, staff told us they received regular supervision every four to six weeks.
`

- Ward rounds were attended by a wide range of representatives including psychologists, pharmacists, the early discharge planning team and the psychiatric intensive care liaison nurse. Care co-ordinators, family and others could join the care programme approach meetings via teleconference.
- Discussions with staff and care records demonstrated staff had a good level of knowledge and confidence in applying the Mental Health Act (1983).

Is the service caring?

Good 

Our rating of this service stayed the same. We rated it as good because:

- Staff interactions and the care plans we looked at demonstrated that staff understood the individual needs of patients, including their personal, cultural, social and religious needs.
- Staff interactions with patients were caring and respectful. Patients said staff treated them well and behaved appropriately towards them.
- There were regular patient community meetings on the wards in which patients could voice their requests and concerns. Where actions were taken against specific patient feedback, staff placed these on a 'you said, we did' board in the ward corridor.
- The majority of patients told us they were involved in planning their care and that staff took the time to discuss their care and treatment with them.
- There was a good level of input from advocacy services on the ward and staff assisted patients to access this. Staff across the wards knew the names of advocates as well as when they visited and during our inspection there were advocacy representatives visiting the wards.
- The three hospital sites were members of 'Triangle of Care.' This is a joint piece of work to emphasise the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental health problems.
- There was good evidence of carer involvement across the wards, including a carers welcome pack, carers meetings and individual engagement with carers. Carers had been involved in the decision-making process for the development of the new ward environment.

Is the service responsive?

Good 

Our rating of this service stayed the same. We rated it as good because:

- Discharges were carefully planned from admission. Staff reviewed the 12 steps to discharge 'Meridian board' daily at handovers and ward rounds. The 12 steps to discharge included barriers such as mental health, finances and accommodation.
- Home visits could be arranged prior to discharge and if an informal patient was leaving the ward early, staff would telephone the crisis team to discuss a plan. Staff sought carer involvement when appropriate.

Summary of findings

- There were weekly bed management meetings attended by a representative from the crisis team, a modern matron and ward managers. Decisions about admission were managed by the patient flow team who managed beds on the wards.
- Beds were usually available when needed for patients living in the catchment area. As there were no female psychiatric intensive care beds within the trust, female patients that required this were placed out of area. The regular interventions of the psychiatric intensive care liaison nurse expediated this process.
- Most of the wards allowed patients to keep their mobile phones which was risk assessed and reviewed on an individual basis.
- Patients either had access to an art room and games room on the ward or off-site.
- There were quiet rooms for patients on all the wards and on the mixed wards there were separate female quiet rooms situated in the female bedroom corridors.
- The wards had assisted bathrooms that were accessible to patients with a physical disability and contained a hoist. Some wards had extra care rooms or 'swing rooms' that could be opened onto the male or female corridors, if the ward was mixed, that were accessible to patients with a physical disability.
- Patients told us they had been informed how to complain if they needed to. Complaints and compliments were an agenda item for team meetings and the wards captured informal complaints and outcomes.

However;

- On Samphire ward, patients were required to use the telephone in the nursing office which may have impacted on their privacy. On this ward, staff could not be assured that detained patients had regular access to fresh air as the gardens were consistently locked. The trust submitted an action plan to remedy this immediately after our inspection.
- There was a gym available to patients but staff were not always trained to support patients to use this resource.

Is the service well-led?

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

- Leaders of the service did not demonstrate full oversight of the risks we saw during the inspection.
- Senior service leaders had highlighted the lack of a seclusion room at St Martin's hospital as an issue but ward level leaders could not describe how this might be addressed. Staff reported the lack of seclusion room had led to the higher number of restraints on the wards at this site.
- Some leaders could demonstrate they had the skills, knowledge and competence to lead their team in delivering high quality care. However, on Samphire ward, leaders did not always promote a person centred or recovery focused culture. On Chartwell ward, we found that staff morale was low.
- Senior leaders had not always communicated the impact and details of service changes to staff. As a result, staff did not always feel they had adequate communication or input into changes that were implemented within the trust.

However;

- Senior leaders had made efforts to improve the service. Staffing had improved on some wards and physical healthcare nurses had been introduced which had been well received by staff and improved care for patients.
- Senior leaders came on to the wards, attended handovers and offered a meet and greet for staff every six weeks. Senior managers we met were aware of the key areas across the wards that required development or action.

Summary of findings

- The trust hosted monthly quality improvement meetings and ward managers from each ward attended and fed back to their teams. Wards had piloted initiatives such as staff worn body cameras, mobile phone apps for section 17 leave and safety huddles.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Acute wards for working age adults and psychiatric intensive care units –

The provider MUST ensure that -

- The ward environment is safe from risks such as fires, flooding and that ligature risks are minimised.
- Medicines must be stored safely and appropriate actions are taken.
- Patients with an identified physical health care must have care plans in place with details about how these should be managed daily.
- All staff receive regular, recorded line management and clinical supervision.

The provider SHOULD ensure –

- There is sufficient scrutiny of staffing issues and ward culture and continue to monitor action plans for Chartwell and Samphire wards.
- All staff receive regular mandatory training and annual appraisals in line with the trust's target for compliance.
- There is consistent provision of clinical psychologists across the wards.
- Patients have access to appropriate structured activities and that staff are equipped to assist them.
- There are systems in place that provide assurance detained patients have regular access to fresh air on Samphire Ward.
- Staff understand the Mental Capacity Act (2005) and the five statutory principles.
- Senior managers ensure any changes are communicated effectively to staff and to try to minimise the impact of these on patients and staff.

Forensic inpatient/secure wards

Outstanding ☆ ↑

Key facts and figures

Kent and Medway NHS and Social Care Partnership Trust provides forensic/secure inpatient services for adults with mental health conditions. Patients are detained under the Mental Health Act 1983. The trust provides 85 beds across two sites, one in Dartford and one in Maidstone:

Trevor Gibbens Unit, Maidstone:

Penshurst ward is a 16-bed male medium secure admission and assessment unit

Groombridge ward is a 12-bed male medium secure sub-acute unit

Summary of findings

Emmetts-Bedgebury ward comprises a 20-bed male medium secure rehabilitation unit and a 4-bed male medium secure step-down unit

Walmer-Bedgebury ward comprises a 18-bed female medium secure unit and a 6-bed female medium secure step-down unit

Little Brook Hospital, Dartford:

The Allington Centre comprises a 15-bed male low secure unit and a 5-bed male low secure high dependency unit.

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

Our inspection took place on 09 and 10 October 2018. It was unannounced, which means that staff did not know we were coming, to enable us to observe routine activity.

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust. These included NHS Improvement, local Health Watch organisations, local clinical commissioning groups and local authorities.

During the inspection visit, the team:

visited all five inpatient wards, looked at the quality of the environments and observed staff caring for patients

spoke with 16 patients who were using the service

spoke with 25 members of staff, including ward managers, medical staff (including consultant psychiatrists), psychologists, nurses, nursing assistants and occupational therapists

attended and observed one multidisciplinary team review meeting

reviewed 50 patient medicine administration charts

carried out a specific check of the medicine management on the wards

reviewed 26 care and treatment records including the Mental Health Act documentation of detained patients

looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service improved. We rated it as outstanding because:

- We rated the service good for safe, effective and responsive care. We rated caring and well led as outstanding.
- The psychology team led a restorative justice programme within the service, which had become embedded within the culture of the wards. The psychology team trained staff in the application of restorative justice and wards had a nominated restorative justice champion. The focus of the first year of the programme had been to assist staff to resolve issues between patients.
- The Allington Centre was in the process of applying for a quality mark accreditation with the restorative justice council. The psychology team worked jointly with National Health Service and international partners for the ongoing development of the programme and to collectively apply for an international research grant.
- All wards in this core service were engaged with the quality network for forensic mental health services, operated by the Royal College of Psychiatrists. They gained accreditation by demonstrating that they met a certain standard of best practice in their area.

Summary of findings

- There was a strong culture of respect, in which staff demonstrated their "patients first" ethos. Staff adopted a person-centred approach to care delivery and had worked to promote equality and diversity to patients. Patients spoke very positively about the way staff treated them. We observed caring, respectful and supportive interactions between staff and patients.
- Staff were knowledgeable about their patients and worked hard to develop good relationships with them. Patients told us they enjoyed regular ward events, including those where patients and staff jointly prepared and ate a meal together.
- The service had an experienced, supportive and approachable management team. Staff felt highly engaged and valued. They spoke with pride and passion about their work. Managers utilised the skills and interests of staff to enhance the experience of patients and staff alike. Some staff had been given 'champion' roles within their team, leading in an area such as healthy eating or exercise.
- Patients were actively involved in care planning and in making decisions about their care. Patient experience surveys were used with the aim of improving services for patients. There were regular community meetings on every ward and a patient council.
- Patients moved between the medium secure wards and the low secure ward when clinically indicated. Staff supported patients when they were moving to another ward or preparing for discharge from the hospital. Multidisciplinary and management team members from both hospital sites met once a week at a referrals meeting, to discuss planned and potential patient admissions, discharges and moves within the service.
- All families and carers were offered an initial engagement meeting with the patient's consent. Patients led the production of a quarterly report about their progress, to be shared with relatives and carers of their choosing. The trust had a family and engagement lead, who worked to ensure families and carers were included where the patient wanted them to be. There were regular engagement events and an annual survey.
- **Some patients held voluntary jobs within the local community, including at the Lakeside Lounge Café on the Trevor Gibbens Unit campus. Patients could access educational courses during their time as an inpatient. Patients had access to agricultural activities on both the Trevor Gibbens Unit and Allington Centre sites.**
- Patients had good access to physical healthcare and a range of psychological therapies. The psychology team individually assessed each patient and formulated their personalised therapeutic plan. They provided sessions in trauma work, relapse prevention and substance misuse. The offenders group programme had three strands, namely: violence, fire setting and sexual offending.
- Staff completed mandatory training necessary to do their jobs. Staff teams met regularly, to share information and learning from incidents. Staff were debriefed after incidents and received support from managers and members of the psychology team. Staff used specialist risk assessment tools to assess the risks posed by each patient and used seclusion and restraint only as a last resort. Patient care plans we looked at were consistently up to date, personalised, holistic and recovery oriented, incorporating patients' strengths and goals.

However;

Summary of findings

- There were problems with the heating system on Walmer-Bedgebury and Emmetts-Bedgebury wards. On Walmer-Bedgebury ward (particularly the large communal area) could become uncomfortably cold at night, during winter months. Some areas of Emmetts-Bedgebury ward were cold. We reported these concerns to the service management team who took urgent action to begin addressing the issue.
- The patient control for bedroom door viewing panels was not working in most bedrooms on the wards at the Trevor Gibbens Unit.
- The lounge area on Emmetts-Bedgebury ward was located down several steps, adjacent to the ward's central dining area. This meant that anyone with restricted mobility would find it difficult to move between the two portions of the room. The trust informed us that they planned to resolve this issue, in likelihood by installing a ramp between the lounge and dining areas.
- The service did not meet the trust's targets for completion of staff appraisals and clinical supervision with some wards significantly below the trust target.
- The female portion of Bedgebury unit had only a small concrete yard allocated to it. The trust had a plan to develop a more inviting garden space for the unit.
- Some patients at the Trevor Gibbens Unit expressed dissatisfaction with their food, for example at the size of portions. The trust had recently agreed a contract with a new food provider who was due to start supplying the wards in November 2018.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- Staff carried out regular risk assessments of the ward environments and **t**he ward layouts allowed staff to observe different parts of the ward. Patient bedrooms and en-suite facilities had been equipped with anti-ligature furnishings and fittings. Staff carried a personal alarm to enable them to access assistance from colleagues when needed.
- There were two seclusion suites within this core service. Both were modern and purpose-built, with designs that eliminated ligature anchor points and blind spots.
- Clinic rooms on all wards were well maintained, organised and clean. They were fully equipped with accessible resuscitation equipment and emergency drugs which staff checked regularly. Medicines management was good. Staff received support from pharmacists, who visited each ward regularly. Staff monitored the effects of medicines on patients by carrying out regularly physical health checks, such as electrocardiograms.
- Whilst staff turnover and agency and bank use was higher than the trust's target, there were sufficient numbers of staff to provide safe care. When bank or agency workers were used, they were normally familiar with the ward and its patients. Staff had received the mandatory training necessary to do their jobs.
- All wards were gender specific, which meant the provider complied with guidance on same-sex accommodation.
- There was adequate medical cover across all wards day and night which meant that a doctor could attend quickly in the event of a medical emergency.
- Staff used specialist risk assessment tools to assess the risks posed by each patient. Risk assessments were detailed and up to date and stored in the trust's electronic recording system.
- Staff used seclusion and restraint only as a last resort. Staff actively sought to use verbal de-escalation techniques to resolve, and where possible pre-empt, situations where one or more patients were becoming agitated or aggressive.

Summary of findings

- Staff we spoke with knew the procedure for reporting incidents. Staff teams met regularly, to share information and learning from incidents. Staff were debriefed after incidents and received support from managers and members of the psychology team.

However;

- The patient control for bedroom door viewing panels was not working in most bedrooms on the wards at the Trevor Gibbens Unit.
- There were issues with the heating system on Walmer-Bedgebury and Emmetts-Bedgebury wards. On Walmer-Bedgebury ward (particularly the large communal area) could become uncomfortably cold at night, during winter months. Some areas of Emmetts-Bedgebury ward were cold. We reported these concerns to the service management team who took urgent action to begin addressing the issue.

Is the service effective?

Our rating of effective stayed the same. We rated it as good because:

- Patients had access to a range of psychological therapies that were delivered in line with guidance from the National Institute for Health and Care excellence. The psychology team individually assessed each patient and formulated their personalised therapeutic plan. The psychology team provided sessions in trauma work, relapse prevention, substance misuse. The offenders group programme had three strands, namely: violence, fire setting and sexual offending.
- Staff received training in the Mental Health Act and Mental Capacity Act. Staff we spoke with had a good understanding of the Mental Health Act and Mental Capacity Act and their guiding principles. The Mental Health Act administration team supported clinical staff in ensuring the Mental Health Act was delivered lawfully and undertook regular audits in this area.
- Patients had good access to physical healthcare via a comprehensive range of specialists, including visiting GPs, chiropodist and dentist. Staff supported patients in making healthier lifestyle choices in relation to their diet and physical exercise. The trust operated a smoke-free environment and staff supported patients with nicotine replacement therapy.
- Patient care plans we looked at were consistently up to date, personalised, holistic and recovery oriented, incorporating patients' strengths and goals. Staff used Health of the Nation Outcome Scales to measure the health and social functioning of patients on the wards.
- Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. Medical staff had completed revalidation. Managers utilised the skills and interests of ward staff to enhance the experience of patients and staff alike.
- The staff team on each ward had effective working relationships with other teams within the organisation (such as adult acute mental health wards and community-based adult mental health teams) and external partners (such as social services, advocacy services and GPs**)**.

However;

- Whilst the trust were taking action to improve their supervision compliance rates, they were below the trust's target at the time of our inspection. During the 12-month period July 2017 to June 2018, the ward with the highest supervision completion rate was the Allington Centre with 73%. The ward with the lowest supervision completion rate was Walmer ward with 64%.

Summary of findings

Is the service caring?

Outstanding ☆ ➔➔

Our rating of caring stayed the same. We rated it as outstanding because:

- Patients spoke exceptionally positively about the way staff treated them. We observed highly caring, respectful and supportive interactions between staff and patients. Staff were knowledgeable about their patients and worked hard to develop strong relationships with them.
- Patients reported that staff listened to them. Patient experience surveys were used with the aim of improving services for patients, there were regular community meetings on every ward and a patient council.
- There was a clearly visible person-centred culture throughout the hospital, where staff put patients first. We saw and heard examples of staff tailoring the delivery of care to meet patient's different needs.
- Every new patient was oriented to their new ward in a way and at a pace that suited them.
- Patients were actively involved in care planning and staff empowered them to make decisions about their care.
- All wards had a calm and relaxed atmosphere and patients felt there was a good range of activities available to them.
- There was a strong ethos of respect throughout the service. The trust successfully used restorative justice to embed this, and to resolve disagreements between patients.
- All families and carers were offered an initial engagement meeting with the patient's consent. Patients led the production of a quarterly report about their progress, to be shared with relatives and carers of their choosing.
- The trust has a family and engagement lead, who worked to ensure families and carers were included where the patient wanted them to be. There were regular engagement events and an annual survey.

Is the service responsive?

Good ● ➔➔

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

- **Some patients held voluntary jobs within the local community, including at the Lakeside Lounge Café on the Trevor Gibbens Unit campus. Patients could access educational courses during their time as an inpatient. Patients had access to agricultural activities on both the Trevor Gibbens Unit and Allington Centre sites.**
- All patients had their own single bedroom and so were not expected to share with other patients. Each patient had their own individually programmed fob bracelet to allow them unrestricted access to only their own bedroom. The fob system preserved a log of every entry to every room. This meant staff could avoid the unnecessary use of blanket restrictions on the ward.
- Staff supported patients to have escorted and unescorted leave from the wards when appropriate to ensure they developed and maintained relationships with other services and their friends and relatives.
- Patients moved between the medium secure wards and the low secure ward when clinically indicated. Staff told us that this happened rarely. A bed was available in an enhanced care area within both medium and low secure units if a patient required more intensive care for a brief period.

Summary of findings

- Staff supported patients when they were moving to another ward or preparing for discharge from the hospital. We saw evidence that staff completed extensive work to prepare and support the patient for their move, and to assist the staff at the new ward or service to ensure that the transition occurred as smoothly as possible.
- At the time of our visit, the provider was in the process of developing a new team, which they called the forensic outreach liaison service. The purpose of the new team was to bridge the gap between the inpatient wards and community services.
- Patients we spoke with told us they knew how to make a complaint and did not express any concerns about how staff followed the complaints process. Staff discussed the outcome of complaints during team meetings, to learn from any mistakes that had been made. Staff were happy with the level of feedback they received from complaints.
- The trust's chaplaincy service visited each ward every week. They could access spiritual support for patients from different religions and faiths upon request.
- Patients had the choice of eating food from different cultures and selections that met specific dietary requirements. Upon completing an occupational therapy assessment, some patients worked to a point where they were self-catering.

However;

- **The female portion of Bedgebury unit had only a small concrete yard allocated to it. However, the trust had a plan to develop a more inviting garden space for the unit.**
- The lounge area on Emmetts ward was located down several steps, adjacent to the ward's central dining area. This meant that anyone with restricted mobility would find it difficult to move between the two portions of the room. The trust informed us that they planned to resolve this issue, in likelihood by installing a ramp between the lounge and dining areas.
- Some patients at the Trevor Gibbens Unit expressed dissatisfaction with their food, for example at the size of portions. The trust had recently agreed a contract with a new food provider who was due to start supplying the wards in November 2018.

Is the service well-led?

Outstanding ☆ ↑

Our rating of well-led improved. We rated it as outstanding because:

- The clinical psychology team led a restorative justice programme within the service, the work of which had become embedded within the culture of the wards. The psychology team trained staff in the application of restorative justice and wards had a nominated restorative justice champion. To date, most of the restorative justice work has been internally focused, to assist staff to resolve issues between patients. However, the scope was being extended to include the resolution of issues between patients and staff; and, patients and external parties, such as the victims of their former offences. The Allington Centre was in the process of applying for a quality mark accreditation with the restorative justice council. If successful, they would be the first forensic mental health service in the country to receive the quality mark. The psychology team worked jointly with national health service and international partners for the ongoing development of the restorative justice programme and to collectively apply for an international research grant.
- There was a clear and effective governance structure, supported by a dedicated quality and governance team. The quality and governance team also co-ordinated quality improvement work within the service.

Summary of findings

- All wards in this core service were engaged with the quality network for forensic mental health services, operated by the Royal College of Psychiatrists. They gained accreditation by demonstrating that they met a certain standard of best practice in their area.
- There was a strong culture of universal respect, in which staff demonstrated their "patients first" ethos. Staff had worked to promote equality and diversity to patients.
- We observed an exceptionally positive culture where staff felt highly engaged and valued. They spoke with pride and passion about their work. Managers utilised the skills and interests of staff to enhance the experience of patients and staff alike. Some staff had been given 'champion' roles within their team, leading in an area such as healthy eating or exercise.
- The service had an experienced, supportive and approachable management team, who benefitted from leadership development opportunities.
- During our visit, we saw evidence of strong working relationships within each ward team and between staff teams from different wards within this core service and with the service management team.
- Staff engaged effectively with patients. Patients were invited to give feedback on the service in a variety of ways, including community meetings, a patient council and surveys.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Action the trust SHOULD take to improve

The provider SHOULD ensure –

- The internal temperature on all wards should be kept at a comfortable level.
- Patient controls of all bedroom door vision panels are in working order.
- People with restricted mobility can access all areas of each ward.
- All staff receive regular supervision and an annual appraisal.

Community-based mental health services of adults of working age

Good  

Key facts and figures

The community mental health teams for adults of working age 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 9-5pm Monday to Friday.

The teams comprise multi-disciplinary teams of health and social care professionals including psychiatrists, social workers, 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 to mental health services by email, text or telephone.

Summary of findings

During this inspection we visited six of the community mental health teams: Ashford, Canterbury and Coastal, South West Kent, Thanet, Dartford, Gravesend and Swanley and South Kent Coast.

This core service was last rated at a comprehensive inspection in January 2017 when it received an overall rating of requires improvement. The service was rated good in effective and caring, and requires improvement in safe, responsive and well-led. This core service received a focused follow-up inspection in January 2018 where significant issues were identified which led to the issuing of a warning notice to the trust in February 2018.

The warning notice we served identified actions that the trust needed to take by March 2018:

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

It also identified actions the trust must take by August 2018

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

Between 15-16 May 2018 the Care Quality Commission carried out a further focused follow-up inspection to look at whether the trust had made the necessary improvements as set out in the warning notice issued on 16 February 2018. At that inspection it was found that the trust had made improvements but some areas for improvement remained:

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 or updated following an incident or reviewed regularly.

The duty service at most community mental health teams continued to be pressured and had to respond to work outside of their emergency remit.

The community mental health teams had put systems in place to ensure that caseloads were formally handed over and monitored due to care co-ordinators planned or unplanned absence. However, these were not yet embedded across all teams.

At this inspection, we found that significant improvements had been made to the assessment of patient risks, the duty services, and that changes made to the teams had been embedded in their day to day practice.

Our inspection on 16-18 October 2018 was unannounced but the provider was given 48 hours' notice that we were inspecting this core service to ensure that everyone we needed to talk to was available.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

spoke with eight patients and one carer

spoke with the service managers and team leaders at each of the six teams inspected

spoke with 33 other staff including consultant psychiatrists, mental health nurses, social workers, clinical psychologists, occupational therapists, healthcare assistants and administrators

observed six daily red board meetings

observed four clinical assessments, one depot clinic and one review meeting

observed two multi-disciplinary team meetings

Summary of findings

reviewed 40 patient care records

looked at a range of policies, procedures and documents related to the services we visited.

Summary of this service

Our rating of this service improved. We rated it as good because:

- During this inspection, we found that services had addressed many of the issues that caused us to rate it as requires improvement following the January 2017 inspection. And that the concerns raised in the warning notice, issued in February 2018, which remained after the follow-up inspection of May 2018 had been addressed. Staff were recording and reviewing patient risks and updating these if there had been a change in the patient's circumstances. The duty service was provided by dedicated staff working solely on this function and that patients were no longer allocated to duty workers. The trust had embedded the buddy system which ensured that care co-ordinators had a named team colleague to cover supporting their caseload when they were absent.
- Staff caseload sizes had reduced to around 40 patients per worker which meant that staff were able to adequately manage the needs of the patients they were supporting. Team leaders were regularly reviewing the caseloads with staff.
- We reviewed 40 care records of patients in six teams and found that staff were completing a risk assessment upon initial assessment and regularly reviewing this and updating it after any patient incident. The teams had a duty system to respond to changes in risk or deterioration in the mental health of patients.
- Staff could access a consultant psychiatrist for routine or urgent appointments and urgent medical advice.
- Staff had completed safeguarding training and demonstrated a good awareness of safeguarding issues. Despite the changes in the role of social care staff, the pathway to register and investigate safeguarding concerns remained straightforward.
- All staff knew how to report an incident on the trust's reporting system. We saw that the learning from serious incidents was shared and discussed in the team's multi-disciplinary team meeting.
- The patient records that we reviewed contained comprehensive needs assessments. These were person-centred, holistic and recovery focused. Care plans reflected patient's assessed needs and recorded risks.
- Staff monitored the effects of medicine on the physical health of patients and reviewed this regularly in physical health clinics. Staff were using recognised scales to rate the severity of symptoms and monitor patient outcomes.. Staff offered a variety of treatment options to people including National Institute for Health and Care Excellence approved interventions such as access to cognitive behavioural therapy, and physical health monitoring for patients prescribed high dose anti-psychotic medicines.
- All teams were multidisciplinary and had good relationships with other teams within the trust. We saw evidence of regular communication and joined up working between the inpatient and community mental health services. This ensured that patients had a smooth transition between services.
- We saw evidence in patient notes of the involvement of people in their care planning. Care records showed that staff discussed care plans with patients and offered them a copy of their care plans.
- Patients told us that staff helped them understand their conditions so that they could learn ways of managing these more effectively. Staff were encouraging and optimistic with patients and supported them with positive choices such as smoking cessation.
- Staff provided patients with information about how to make a complaint and patients told us that they knew the process, and were confident raising concerns and complaints.

Summary of findings

- All services had a range of rooms to see patients, including clinic rooms. These were adequately sound-proofed to ensure confidentiality. Waiting areas had a range of information on local community groups, advocacy, and leaflets on mental health conditions and treatments.
- There were clearly defined roles for team leaders and service managers within the six teams we inspected. Team leaders were receiving regular information about the team's performance. The team leaders displayed a good understanding of the service they were providing and where it connected with the wider mental health pathway.
- The trust had developed a clear operational identity for the community teams. A Day in the Life of a Community Mental Health Team provided clear guidance to staff in how to deliver community mental health team processes to agreed standards.
- Staff we spoke with said that the services had improved. Staff could raise concerns and felt positive about their teams despite the pressure of recent changes regarding the integration of social care colleagues. Staff felt well supported by their team managers and colleagues.

However;

- There were issues with the recording of fridge temperatures at the Canterbury and Coastal team and the clinic room at Dartford, Gravesend and Swanley was very hot in summer months.
- Patients at the Dartford, Gravesend and Swanley team sometimes faced excessive waiting times when trying to contact the team by telephone.
- Trust data showed that staff were not receiving supervision at the frequency of the trust's supervision policy which was every six weeks. Several teams' recent supervision rates were 60% or lower. The trust acknowledged that supervisions had been missed as a high number of team leaders had been absent and the trust had implemented a series of actions for managers to improve the supervision rates and monitor the delivery of supervision.
- Not all the teams were meeting the trust target time of 28 days to initial assessment for newly referred patients. The total service reported seeing 73% of patients referred within 28 days. Performance had dropped as low as 46% in the Thanet team.
- Patients were waiting a long time for access to psychological therapies in some teams. There were 30 patients at Thanet and 39 patients at Dartford, Gravesend and Swanley teams who were waiting over 30 weeks for treatment to start. The patients on the waiting list were not routinely reviewed by psychological therapy staff.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- There was a range of consultation rooms for patients to meet with staff which were clean and adequately sound-proofed to aid confidentiality. The clinic rooms were clean and had the necessary equipment to carry out physical health examinations. Medicines were stored and administered safely according to trust policy.
- We reviewed 40 records of people using the service. Staff had assessed patient risks and reviewed these regularly and when things changed. Patients had crisis plans and knew who they could contact in a mental health crisis.
- Staff shared risk appropriately with colleagues and discussed complex risks at the team's risk forum. The teams' morning meetings, the 'red board' meeting, were embedded in to the daily team structure at all the teams we inspected. These meetings were an effective way of discussing current patient risks and setting the team's priorities for responding to patient needs.

Summary of findings

- The teams had a dedicated duty system to respond to risk or deterioration in the mental health of patients. Patients were no longer allocated to duty workers. Staff had an identified team buddy who covered for them during planned or unplanned absences which ensured that patient needs continued to be met safely.
- Staff could access a consultant psychiatrist for routine or urgent appointments.
- There were sufficient appropriately qualified staff in each team. The team leaders reviewed the caseloads regularly with staff and there were clear team guidelines regarding the maximum caseload size which were adhered to.
- Staff received training in most topics considered essential for their area of practice. This included protecting adults and children from abuse, fire safety and conflict resolution to carry out their role safely.
- Staff had completed safeguarding training and demonstrated good awareness of safeguarding issues. The trust had a safeguarding policy which referenced adult and children safeguarding processes.
- Teams reported incidents, trust staff investigated these incidents and shared any lessons learned with staff at team meetings. Staff were supported with difficult incidents and offered debrief sessions following a serious incident.

However;

- The temperature of the clinic room at the Dartford, Gravesend and Swanley team was not adequately managed during the summer heatwave.
- The fridge temperatures at the Canterbury and Coastal team were not consistently recorded.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff completed comprehensive assessments of patients' individual needs including a physical health assessment. Assessments were person centred, holistic and recovery focused. The patient care plans reflected their assessed needs.
- Staff provided patients with good quality care based on evidence-based, best practice guidelines produced by the National Institute for Health and Care Excellence. Interventions included access to cognitive behavioural therapy, and physical health monitoring for patients prescribed high dose anti-psychotic medicines.
- Each team was multi-disciplinary and included doctors, nurses, occupational therapists, psychologists and healthcare assistants. Staff demonstrated effective working within the multi-disciplinary teams and external organisations.
- Staff were using recognised scales to rate the severity of symptoms and monitor patient outcomes. Staff used the Glasgow Anti-psychotic Side-affect Scale to determine and monitor patients' experience with side-affects from their prescribed medicines, and the Health of the Nation Outcome Scales to measure patients' progress and outcomes.
- Staff assessed and monitored the physical health of patients using their services, and this included the physical health impacts of patients' prescribed medicines.
- All teams had good relationships with other teams within the trust. We saw evidence of regular communication and joined up working between the inpatient and community mental health services. This ensured that patients had a smooth transition between services.
- All staff working in the community mental health teams had received an annual appraisal.
- Staff training rates for the Mental Capacity Act and the Mental Health Act were meeting the trust target of 85%

Summary of findings

However;

- Trust data showed that staff were not receiving supervision at the frequency of the trust's supervision policy which was every six weeks.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated the patients using the services with kindness, dignity and respect. Staff spoke to patients in a meaningful way and were mindful of their individual circumstances.
- Staff worked with patients to help them understand their condition so that they could learn ways of managing these more effectively. Staff were encouraging and optimistic with patients.
- Staff ensured that information about patients was handled confidentially.
- Staff were able to respond to sudden changes in the mental health of patients and could provide advice and support outside of scheduled appointments. Each team had a duty service to respond to urgent referrals or to sudden changes in a person's mental health.
- We saw evidence in patient notes of the involvement of people in their care planning. Care records showed that staff discussed care plans with patients and offered them a copy of their care plans.
- The teams engaged with patients, families and carers to ensure that they had all the information they needed to make a decision about their care and treatment. Carers were invited to attend review meetings and care programme approach meetings with the permission of the patient.

Community-based mental health services of adu

Is the service responsive?

Requires improvement 

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

- The teams were regularly failing to meet the trust's response time of 28 days to initial assessment for newly referred patients to the teams. The total service reported seeing 73% of patients referred within 28 days. There was considerable variance in team performance across the six teams that we visited. Performance had dropped as low as 46% in the Thanet team. This meant that more than half of patients referred to this team did not have their assessment within the target time.
- Patients were waiting a long time for access to psychological therapies in some teams. There were 30 patients at Thanet and 39 patients at Dartford, Gravesend and Swanley teams who were waiting over 30 weeks for treatment to start. There was a variation across the teams in the length of waiting time from three months to 18 months. Those waiting for services were not routinely reviewed by psychological therapy staff.
- Patients at the Dartford, Gravesend and Swanley team sometimes faced excessive wait times when trying to contact the team by telephone.

However;

Summary of findings

- The service had introduced consistent processes and procedures which were embedded in the daily running of the service to ensure that those patients waiting to receive a service were safe. Patients who were waiting on a list to receive a service were allocated to dedicated active review workers in each team. They maintained regular contact, minimum three-monthly, with patients to ensure that they were kept safe whilst waiting for treatments to start.
- All services had a wide range of rooms in which to meet with patients, including clinic rooms. These were well sound-proofed to ensure patient confidentiality.
- Patients had access to emergency appointments when they needed them.
- Reception areas and waiting areas had a good range of information relating to mental health conditions and treatments, advocacy, and local groups and services.
- Team leaders had good links with other mental health service providers which ensured that patients could be referred to services which provided information and support with housing, benefits and employment.
- Patients knew how to raise concerns and complaints. Staff were open and transparent in respect of complaints raised by patients.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- Managers had made improvements to the service since the last inspection. There were clearly defined roles for team leaders and service managers within the six teams we inspected. Team leaders were receiving regular information about the team's performance. The team leaders displayed a good understanding of the service they were providing and where it connected with the wider mental health pathway.
- Staff we spoke with said that the services had improved. We saw that individual case load sizes had reduced which meant that staff were able to safely support the patients allocated to them.
- Staff could raise concerns and felt positive about their teams despite the pressure of recent changes regarding the integration of social care colleagues. Staff felt well supported by their team managers and colleagues.
- The teams had a clear framework of operational processes and standards. This included regular multi-disciplinary meetings which ensured staff were up to date with the clinical and business priorities of the team, and could share learning from incidents and complaints.
- Staff were confident in submitting cases to the team risk panel for advice and support from senior clinical colleagues with complex risks. Staff felt able to escalate risks within their teams to managers and were confident that actions would be taken as a result.
- The trust had developed a clear operational identity for the community teams. A Day in the Life of a Community Mental Health Team provided clear guidance to staff in how to deliver community mental health team processes to agreed standards set by the trust. We saw that staff were following this.

Click or tap here to enter text.

Areas for improvement

The provider SHOULD ensure -

- Fridge temperatures are recorded consistently at the Canterbury and Coastal team so that patient medicines are stored safely

Summary of findings

- High temperature of the clinic room at the Dartford, Gravesend and Swanley team is adequately managed during hot weather.
- Telephone response time at the Dartford, Gravesend and Swanley team improves so that patients and carers can speak with team members in a timely way.
- All staff receive supervision at the frequency set out in its supervision policy, and have procedures in place to enable this to continue when key supervisory staff are absent.
- Patients receive their initial assessment within the trust target time of 28 days from their referral to the service.
- Waiting times for access to psychological therapies are within the trust's waiting time target and that senior clinical staff monitor and review the waiting list.
- The service should improve their provision of dementia friendly feature and access to disabled parking spaces.
- The service should ensure that interview rooms have appropriate soundproofing to maintain patients' privacy and confidentiality.
- The service should ensure they take a consistent approach to all areas of clinical practice.

Mental health crisis services and health-based places of safety

Good 

Key facts and figures

Crisis teams are specialist teams of mental health professionals who provide short term support to people experiencing a mental health crisis. They aim to prevent admission to a hospital by providing treatment and support to a person in their own home.

Kent and Medway NHS and Social Care Partnership Trust have five crisis teams:

Dartford – based in Littlebrook Hospital, Dartford and covers the Dartford, Gravesham and Swanley areas.

North East Kent – based in St Martins' Hospital, Canterbury and covers the north east of the county

including Thanet.

South East Kent – based in St Martins' Hospital, Canterbury and covers the south east of the county including Ashford.

West Kent – based at Priority House, Maidstone and covers West Kent.

Medway – based at Medway Maritime Hospital, Gillingham and covers Medway and Swale.

A health-based place of safety, sometimes known as a 136 suite, is a place of safety for those people detained by the Police under section 136 of the Mental Health Act. It can be used where the Police find someone in a public space and they have concerns about the person's mental health. The order lasts for 24 hours. Once in the suite, the individual is assessed by mental health professionals to establish if treatment is needed.

Kent and Medway have two health-based places of safety, one of the suites has two rooms available:

Littlebrook Hospital, Dartford - has a 136 suite that offers an assessment room, this suite is used for adults and by a neighbouring NHS trust for under 18s.

St Martins Hospital, Canterbury - has a 136 suite with two assessment rooms for adults.

Priority House, Maidstone - has a 136 suite with two assessment suites* for adults. This suite is also shared with Medway.

Summary of findings

We inspected this core service as part of our next phase mental health inspection programme.

Our inspection took place on 21 and 22 November 2018. It was unannounced, which means that staff did not know we were coming, to enable us to observe routine activity.

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust. These included NHS Improvement, local Health Watch organisations, local clinical commissioning groups and local authorities.

During the inspection visit, the team:

visited all five of the crisis resolution home treatment teams at the four hospital sites

visited all three health-based places of safety

spoke with 12 patients who were using the service

spoke with two carers

spoke with ten of the managers or interim managers responsible for operational and clinical management of the crisis resolution home treatment teams and 136 suites

spoke with 25 other staff members; including doctors, nurses, occupational therapists and support workers

spoke with one approved mental health professional (AMHP) working alongside the 136 suite staff

attended and observed one hand-over meetings and one multi-disciplinary meeting

attended and observed two home visits

looked at 27 treatment records of patients with the crisis home treatment team

looked at 11 HBPOS records

looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

Teams were comprised a multi-disciplinary team of mental health professionals including psychiatrists, nurses, support workers, support, time and recovery workers, and occupational therapists. All services had access to a Mental Health Act Administrator.

The teams felt fully supported and spoke consistently of an open, caring culture. There was a clear management structure in place. Teams had direct management from an operational and clinical lead, who were supported by senior leaders in the trust, and all sites had access to a consultant psychiatrist when needed. The 136 suites had a dedicated clinical lead who supported the staff working there.

Overall, mandatory training was 95% compliant, well above the target of 85%.

Staff managed risk well and there were effective processes in place. All services had up to date risk registers and staff knew how to access this and add to it. All staff had received recent training in safeguarding and all staff that we talked with were aware of the safeguarding reporting process. Staff received appropriate debriefs following incidents.

All the teams had good medicines management practices, which were regularly audited. Each team had at least one medicines lead.

Summary of findings

Managers undertook regular audits to ensure processes were effective. Meaningful learning was shared within and across teams to improve practice.

People told us staff involved them in their care and treatment, and we witnessed staff completing care plans with patients. We saw evidence that all patients had been offered a copy of their care plan. Patients were given an information pack on their first meeting with the crisis teams, informing them of treatment and support services, how to complain and how to access advocacy.

The teams were committed to equality and diversity and each team had an equality and diversity lead. All 136 suites were accessible for people with disability or mobility issues.

None of the crisis teams had waiting times which meant people were seen without delay.

Staff told us about the different ways they tried to provide personalised support, such as matching staff with similar hobbies to people who were unwilling to engage and scheduling visits around school hours for people with children.

The services had good working relationships with other organisations including the police, ambulance services and local authorities, with regular joint meetings and appropriate information sharing.

There were effective handovers and multi-disciplinary meetings to share information and issues constructively. These were also a forum for learning from complaints, compliments and incidents and sharing good practice.

Staff understood and were very positive about the values of the trust and could tell us how they incorporated the values into their work with patients.

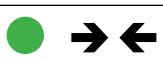
However;

Though overall mandatory training compliance was above the trust's target at 95%, some staff had not received mandatory training in all the key areas identified as essential to their role. Immediate Life Support training compliance was low at 66%, though the trust was taking action to improve this.

Although most of the risks from blind spots had been addressed since the last inspection, the bathroom at the Dartford health based place of safety still had a blind spot. This meant staff could not be assured of patient's safety at all times in this area.

The S136 rights leaflet being given to patients detailed a maximum detention period of 72 hours and not 24 hours which did not reflect changes in legislation in 2017.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

All health-based places of safety were clean, secure and appropriately furnished.

Mandatory training rates for staff were at 95% against the trust's target of 85%

All staff carried personal alarms that would summon urgent assistance from staff across the hospital if needed.

Managers used clear, risk based methods to decide on staffing numbers and could review this if necessary.

Risk assessments were thorough and clearly identified risks, enabling staff to manage this effectively.

We saw evidence of a robust system in place for recording and managing incidents.

Previous issues with lone working procedures had been addressed.

Summary of findings

However;

Although most of the blind spots had been mitigated since the last inspection, the bathroom at the Dartford health based place of site remained an unmitigated risk.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

Staff teams were made up of a range of health professionals working together effectively.

We saw effective multi-agency working with the police, ambulance services, approved mental health professionals and psychiatric liaison teams.

Support, time and recovery workers completed and monitored physical healthcare, and supported the patients with social care needs such as benefits, housing, employment, accompanying to groups and appointments, and offered support for carers needs.

All teams held full multidisciplinary meetings three times a week to discuss and review patient care and treatment, as well as handovers between each shift.

All health-based places of safety kept clear and concise records of all people brought into the place of safety in accordance with the Mental Health Act Code of Practice recommendations.

Staff followed best practice guidance including NICE guidelines when delivering treatment interventions.

The health-based places of safety had a clear and comprehensive standard joint operational policy.

However;

The S136 rights leaflet being given to patients detailed a maximum detention period of 72 hours and not 24 hours which did not reflect changes to legislation in 2017.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

People using the service told us they had been treated with kindness, dignity and compassion by staff and that they felt staff cared about them.

We observed the knowledge that staff had of individual patients and their needs, and heard them talking about patients respectfully.

We saw staff treating patients and their homes with respect on home visits.

We saw clear evidence that patients are fully involved in their care and treatment.

Patients were given plenty of opportunities to feedback on the services they received.

Each team had opportunities for carers to be involved, with the patient's consent, and each had at least one carer's lead.

Is the service responsive?

Good 

Summary of findings

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

There are no waiting lists for crisis services which means patients are seen without delay and within the trust's targets. The services were available 24 hours a day seven days a week.

Crisis teams had clear, inclusive referral criteria as part of the operational policy that all teams adhered to.

Interpreters were easily accessible through the hospital, all patient areas were wheelchair friendly, and staff of both genders were available.

- Staff tried to provide truly personalised care, such as working around school hours for parents, meeting in places the patient felt comfortable and appropriately matching staff to patients wherever possible.

However;

Some patients had to be admitted to hospital for clozapine initiation as not all crisis teams were offering support with this in the community.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

All teams had a clear management structure in place. Leaders were visible, effective and supportive.

Staff knew, understood and demonstrated commitment to the trust's vision and values.

We saw robust management systems, which managers regularly audited. Meaningful learning was shared within and across teams.

Risk registers were maintained and reviewed regularly. Risk information was shared and discussed with staff at each team meeting.

Staff, patient and carer feedback was used to make improvements, as was learning from complaints and incidents.

Staff consistently talked about an open, caring culture in which they felt valued and listened to.

The core service was running several pilot projects aimed at improving services, showing a commitment to innovation.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

The provider SHOULD ensure –

- The risks associated with the blind spot in Dartford's 136 suite is mitigated.
- All incidents occurring in the 136 suite at Dartford are properly reported.
- The information leaflet detailing patient's S136 rights is amended following changes to legislation in relation to maximum detention times.
- Leaders review the trusts approach to clozapine initiation in the community to ensure that all patients can start clozapine in their own homes where it is safe to do so.

Summary of findings

Community-based mental health services for older people

Good 

Key facts and figures

The community-based mental health services for older people form part of the Kent and Medway NHS and Social Care Partnership Trust's mental health services in the community. They provide a specialist mental health service to meet the mental health needs of older adults with acute, serious and enduring mental health problems, including dementia. The services provided include routine and urgent assessment, memory assessment, admiral nursing services and on-going treatment and review.

Services were divided according to clinical commissioning groups (CCG) and geographical boundaries. There were 11 teams which provided a community mental health service for older people across Kent and Medway. There were eight CCGs who commissioned services from Kent and Medway NHS and Social Care Partnership Trust, across Kent and Medway. Older adults requiring specialist services could self-refer or be referred directly from their GP.

Whilst most people referred to the service were over the age of 65, access to the service was determined by the needs of the individual as well as their age. Therefore, individuals of any age were accepted where dementia was suspected.

We inspected six Community Mental Health Services for Older People. These were: Swale, Tunbridge Wells , Canterbury and Coastal , Medway , Maidstone and Dartford, Gravesend and Swanley.

Our inspection was announced two working days before we visited (staff knew we were coming) to ensure that everyone we needed to talk to was available.

The team included three inspectors and three specialist advisors. Specialist advisers are experts in their field who we do not directly employ.

Care Quality Commission (CQC) last inspected the community-based mental health services for older people in January 2017 as part of a comprehensive inspection of Kent and Medway NHS and Social Care Partnership Trust. It was rated as good overall with all five domains, safe, effective, caring, responsive and well-led being rated as good.

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

During the inspection visit, the inspection team:

visited six community-based mental health services for older adults, looked at the quality of the environment and observed how staff were caring for people using the service;

interviewed all three service managers;

interviewed team leaders at all teams;

interviewed consultant psychiatrists at all teams;

spoke to 32 other staff including nurses, occupational therapists, psychologists, healthcare assistants and administration staff;

spoke to nine patients and seven carers both in person and on the telephone;

toured all teams' building and carried out a check of their clinic rooms;

observed one initial assessment and two medical reviews;

observed four risk management meetings and two multi-disciplinary meetings;

observed three psychology-led groups;

Summary of findings

looked at 29 patients' care records;

looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The team bases were safe for use by patients and staff.
- Patients who were prescribed anti-psychotic medicine received regular monitoring of their physical health.
- The service employed enough staff to meet the needs of the service. Staff felt supported by the trust, completed mandatory training, received supervision and had access to training opportunities.
- Staff had manageable caseloads that were reviewed regularly. They completed detailed risk assessments and had support from the multidisciplinary team when their patients presented as high risk.
- Staff had a good understanding of how to safeguard patients from abuse. They knew how to report incidents and were supported to gain learning from them.
- Staff had access to a secure system where they could access and record information regarding patients' care and treatment. Staff could to access this system remotely to record important updates and support their time management.
- Staff carried out comprehensive assessments of patients' needs and completed detailed care plans that addressed these identified needs.
- The service employed clinical psychologists and occupational therapists who provided a range of interventions to improve treatment outcomes and promote independence.
- The service had good links with internal and external agencies where patients, and their carers, could get support with social, dietary and physiological needs.
- The service carried out a programme of audits around clinical documentation and physical health monitoring of patients on anti-psychotic medicine.
- Patients, and their carers, were universally positive about the care and treatment they received. Staff knew their patients and treated them with compassion and respect.
- Patients, and their carers were fully involved in decisions about their care and treatment. The service offered them exceptional support in the early stages of their diagnosis.
- Admiral nurses supported families with all aspects of living with dementia. Healthcare assistants instilled hope in families by introducing them to emotional and practical support.
- The service actively collected feedback, from patients and their carers, about their experiences of the service. Responses received were extremely positive.
- The service was proactive in ensuring referrals were appropriately triaged and patients were seen and treated in a timely manner. All teams provided a duty service that could respond to emergencies.
- The service responded to patients' individual needs. Patients had a choice in what services they received support from. It was proactive in engaging patients and provided satellite sites to support patients from rural areas.
- The service promoted dementia friendly communities and supported the concept of patients supporting each other. The service used feedback from complaints and compliments as learning opportunities.

Summary of findings

- The service had experienced senior managers and team leaders who staff felt were supportive and approachable. Staff enjoyed their jobs and felt supported by their colleagues.
- The service maintained operational oversight through a well-structured schedule of meetings. Staff had access to an informative intranet site and the general public similarly had access to a user-friendly internet site.
- All teams were accredited, or in the process of applying for accreditation, to the memory service national accreditation programme. The service involved themselves in many innovative projects to improve patient experience.

However:

- Staff reported the current risk assessment template on the trust's electronic care record system did not cover all risk areas common to older people with mental health issues. They also told us this same system could be hard to access, or respond slowly, during busy times.
- The service did not have a consistent approach to some areas of clinical practice, such as recording supervision; measuring outcomes for patients who attended groups; and recording patients' capacity or consent to treatment.
- Due to commissioning arrangements, most areas of the trust were unable to provide a crisis service for patients with a diagnosis of dementia. Some teams were experiencing excessive waiting times for neuropsychology assessments.
- Some interview rooms did not provide adequate soundproofing to maintain patients' privacy and confidentiality. The service did not always have appropriate dementia friendly signage and features and some sites did not provide enough parking for people with disabilities.

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good because:

- The service provided interview rooms and clinic rooms that were clean and tidy. Systems and environmental checks were in place to ensure patients' and staffs' safety was maintained at all times.
- The service employed enough staff to meet the needs of the service. All vacancies were being interviewed for and bank and agency staff were being used appropriately in the interim.
- Staff had manageable caseloads that were proportionate to the hours they worked. Team leaders offered regular caseload reviews to ensure staff were managing patient risks safely whilst maintaining their own well-being.
- The service had sufficient medical input that was routinely available to support the medical needs of patients. Medical staff felt supported by the trust, received supervision and had access to training opportunities.
- Teams consisted of staff from all disciplines of healthcare with high completion rates of the trust's mandatory training courses.
- Staff completed appropriate risk assessments and corresponding management plans for patients. They had systems in place, such as regular risk handovers, to ensure all high-risk patients had appropriate input and response from the multi-disciplinary team.
- Staff had a good understanding of how to safeguard patients from abuse. Teams kept a record of all open safeguarding referrals and involved agencies that supported people at risk of abuse.
- Staff had access to a secure system where they could access and record information regarding patients' care and treatment. Staff could access this system remotely to record important updates and support their time management.

Summary of findings

- The service followed national guidance on prescribing anti-psychotic medicines in older people. All patients who used these medicines had their physical health monitored regularly.
- Staff knew how to report incidents. The service had a good approach to learning lessons from incidents. Teams had regular opportunities to discuss incidents and were provided with debriefs when required.

However:

- Staff felt the current risk assessment template being used by the trust did not appropriately cover all risk areas common to older people with mental health issues.
- Staff told us that the electronic care record system could be hard to access, or respond slowly, during busy times.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff carried out comprehensive assessments of patients' needs. Patients with suspected cognitive impairment were clearly explained the purpose of the assessment and carers were encouraged to be present.
- Staff completed care plans that addressed patients' identified needs. Staff adhered to the trust's policy around care plans and this ensured that patients with more complex needs received effective care and treatment.
- The service employed clinical psychologists who provided a range of psychological interventions to individual patients or within a group.
- The service employed occupational therapists who provided a range of intervention to support patients' independence in the community.
- The service had good links with local agencies where patients, and their carers, could get support with social needs such as housing, benefits, transport and volunteering opportunities.
- The service carried out a programme of audits around clinical documentation and physical health monitoring of patients on anti-psychoticmedication.
- Staff received regular individual supervision that addressed their clinical practice and well-being. They could also access group supervision and reflective practice sessions. Most staff had received an annual appraisal in the last year.
- Teams consisted of skilled staff who were encouraged and supported to enhance their knowledge and career progression through additional training and development days. In particular, healthcare assistants were of a high standard and were valued by the service.
- The service had good links with internal teams and external agencies where patients could access input from professionals such as dieticians and physiotherapists.
- The majority of staff had a sound understanding of the Mental Health Act and Mental Capacity Act.

However;

- The service did not have a consistent approach to measuring outcomes for patients who attended groups. This meant they were not monitoring the effectiveness of groups.
- Teams did not have a consistent approach to recording patients' capacity or consent to treatment.

Summary of findings

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- Patients, and their carers, were universally positive about the care and treatment they received. Staff went the extra mile to ensure patients received person-centred care.
- Staff were respectful and compassionate whilst engaging with patients and carers. They knew their patients well and discussed their needs and risks to other members of staff in a positive, non-judgement manner.
- Patients, and their carers were true fully involved in decisions about their care and treatment. Care plans were collaborative and identified patients' strengths to promote prolonged independence.
- The service offered exceptional support to patients, and their carers, in the early stages of their diagnosis. Healthcare assistants instilled hope in families by introducing them to emotional and practical support.
- The service had a good provision of admiral nurses who supported families with all aspects of living with dementia. They provided families with education courses and worked flexibility around the needs of carers.
- The service actively collected feedback, from patients and their carers, about their experiences of the service. Responses received were extremely positive.

Is the service responsive?

Good ● →←

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

- The service used initiatives, such as weekend clinics, appointments at short notice and pre-requesting scans, to ensure patients were seen and treated in a timely manner.
- All teams operated a duty service that could respond to emergencies and provide daily urgent assessments.
- Teams took a multi-disciplinary approach to triaging referrals. This ensured urgent referrals were identified and offered assessments in a timely manner.
- The service responded to patients' individual needs. Patients with functional conditions could be referred to community mental health teams for working age adults. Likewise, patients under 65 would be supported by the service in cases such as early onset dementia.
- Staff were proactive in engaging patients who were reluctant to use the service. The service operated out of satellite sites to support patients from rural areas.
- Many areas of Kent were dementia friendly communities and provided many opportunities for patients, and their carers, to engage with the wider community. The service supported the concept of patients supporting each other.
- The service used feedback from complaints and compliments as learning opportunities. Patients and carers were aware of how to complain and were supported by the service to do so.

However;

- Some interview rooms used by the Maidstone team did not provide adequate soundproofing to ensure patients privacy and confidentiality was maintained.
- Areas that were accessed by patients did not always have appropriate dementia friendly signage and features. Some sites did not provide adequate parking for people with disabilities.

Summary of findings

- Due to commissioning arrangements, most areas of the trust were unable to provide a crisis service for patients with a diagnosis of dementia.
- In some teams, patients were experiencing excessive waiting times for neuropsychology assessments.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- The service had experienced senior managers and team leaders who staff felt were supportive and approachable. They supported staff to following their clinical interests and achieve career progression.
- Staff enjoyed their jobs and felt supported by their colleagues. We observed hard working staff throughout the service working in friendly environments. The service had sickness rates and staff turnover rates lower than the trust average.
- The service maintained operational oversight through a well-structured schedule of meetings that communicated relevant information from the board down to front staff and vice versa.
- Staff had access to an informative and user-friendly intranet site where they could access relevant information such as policies or trust bulletins. The general public similarly had access to a user-friendly internet site.
- All teams were accredited, or in the process of applying for accreditation, to the memory service national accreditation programme.
- The service involved themselves in projects to improve patient experience, such as improving dementia care in primary care and supporting GPs to make appropriate referrals

However;

- Team managers were not consistently recording supervision on the trust's database. This meant the board did not have accurate oversight of this area of clinical practice.

Outstanding practice

We found examples of outstanding practice in this service.

- The service had been involved in a pilot study to look at whether the dementia pathway could be supported in primary care. This had led to seven primary care nurse roles being commissioned. The service predicted this would have a positive impact on the referrals coming into the service.
- Teams in west Kent were involved in the kinesis project. This was software that enabled GPs to request advice from consultants in advance of a decision to refer. Advice was given on how best to continue the management of the patient within the primary care setting, hence reducing the number of referrals to the service. GP's involved had indicated that around 40% of patients, on whom advice is sought, are not referred to the service.
- The trust had two dementia service user envoys who had lived experience of being diagnosed with dementia. They worked with community projects related to dementia; support people who shared a similar diagnosis; raised the profile of dementia in the community; and delivered talks to health care staff and community groups. They were also instrumental in the developed of buddy systems where patients supported each other.

Areas for improvement

We found areas for improvement in this service.

The provider SHOULD ensure -

- The service improves their provision of dementia friendly feature and access to disabled parking spaces.

Summary of findings

- That interview rooms have appropriate soundproofing to maintain patients' privacy and confidentiality
- That staff receive regular, recorded supervision and that this is monitored effectively.

Ratings tables

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ Nov 2018	Good →← Nov 2018	Outstanding →← Nov 2018	Good →← Nov 2018	Good →← Nov 2018	Good →← Nov 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ➔➔ Oct 2018	Requires improvement ➔➔ Oct 2018	Good ➔➔ Oct 2018	Good ➔➔ Oct 2018	Requires improvement ➔➔ Oct 2018	Requires improvement ➔➔ Oct 2018
Long-stay or rehabilitation mental health wards for working age adults	Good Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017	Good Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017
Forensic inpatient or secure wards	Good ↑ Oct 2018	Good ➔➔ Oct 2018	Outstanding ➔➔ Oct 2018	Good ➔➔ Oct 2018	Outstanding ↑ Oct 2018	Outstanding ↑ Oct 2018
Wards for older people with mental health problems	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Wards for people with a learning disability or autism	Outstanding Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017
Community-based mental health services for adults of working age	Good ↑ Oct 2018	Good ➔➔ Oct 2018	Good ↑ Oct 2018	Requires improvement ➔➔ Oct 2018	Good ↑ Oct 2018	Good ↑ Oct 2018
Mental health crisis services and health-based places of safety	Good ➔➔ Nov 2018	Good ➔➔ Nov 2018	Good ➔➔ Nov 2018	Good ➔➔ Nov 2018	Good ➔➔ Nov 2018	Good ➔➔ Nov 2018
Community-based mental health services for older people	Good ➔➔ Oct 2018	Good ➔➔ Oct 2018	Outstanding ↑ Oct 2018	Good ➔➔ Oct 2018	Good ➔➔ Oct 2018	Good ➔➔ Oct 2018
Community mental health services for people with a learning disability or autism	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Substance misuse services	Good Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017
Overall	Good ↑ Nov 2018	Good ➔➔ Nov 2018	Outstanding ➔➔ Nov 2018	Good ➔➔ Nov 2018	Good ➔➔ Nov 2018	Good ➔➔ Nov 2018

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

This inspection was led by Emma Bekefi, Inspection Manager and overseen by Natasha Sloman, Head of Inspection. The inspection of trust wide leadership was supported by Beverly Murphy, Executive Reviewer, who was the Director of Nursing within an NHS trust.

The team included one inspection manager, 15 inspectors, 15 specialist advisors and two medicines inspectors.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.