Kent and Medway NHS and Social Care Partnership Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Forensic inpatient/secure wards	Trevor Gibbens Unit Allington Centre	RXYTR RXYL2
Community-based mental health services for older people.	Farm Villa (Trust HQ)	RXY04
Wards for older people with mental health problems	Frank Lloyd Unit Medway Maritime Hospital Littlestone Lodge Thanet Mental Health Unit St Martins Hospital Jasmine Centre Priority House	RXYF6 RXYM1 RXYAK RXYT1 RXY03 RXYJ1 RXYP8
Acute wards for adults of working age and psychiatric intensive care units	Littlebrook Hospital Medway Maritime Hospital Priority House St Martins Hospital	RXYL2 RXYM1 RXYP8 RXY03
Ward for people with Learning Disabilities	Tarenfort Centre	RXYA2
Service for People with Acquired Brain Injury	Knole Centre	RXYD2
Substance Misuse Service	Bridge House at Fant Oast	RXYF2

Summary of findings

Mental Health Crisis Service and Places of Safety	Littlebrook Hospital Priority House Farm Villa (Trust HQ) St Martins Hospital	RXYL2 RXYP8 RXY04 RXY03
Community Mental Health Services for Adults of Working Age	Farm Villa (Trust HQ)	RXY04
Community Mental Health Services for People with Learning Disabilities and Autism	Farm Villa (Trust HQ)	RXY04
Long stay/rehabilitation mental health wards for working age adults	St Martin's Hospital The Grove Ethelbert Road 111 Tonbridge Road Rivendell Medway Maritime Hospital Newhaven Lodge	RXY03 RXYT7 RXY1A RXT1C RXYR2 RXYM1 RXYF6

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for mental health services at this provider	Requires improvement 
Are mental health services safe?	**Requires improvement** 
Are mental health services effective?	**Requires improvement** 
Are mental health services caring?	**Good** 
Are mental health services responsive?	**Requires improvement** 
Are mental health services well-led?	**Requires improvement** 

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

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

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

Summary of findings

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Overall summary

Overall we rated the trust as requires improvement because:

- We had serious concerns about the quality of care at Littlestone Lodge. We identified poor practice including, staff not meeting the needs of patients and observed unsafe care. For example, we found patient's pain was not being managed; all patients were wearing incontinence pads without their needs being assessed and medicines were being administered covertly without rationale. There was also a lack of senior clinical staff presence on this ward.
- KMPT had failed to respond appropriately to the risks it identified on Littlestone Lodge. In December 2014 an acting ward manager was appointed to help improve the quality of care. In February 2015 one of the trust's senior managers had visited the ward and although had addressed some issues had failed to rectify all of the key risks, including the need to provide additional experienced nurses to support the day to day delivery of care. This left the acting ward manager to address a large range of serious issues with limited support. However, the senior manager did ensure advice from specialist nurses was made available, such as advice from the physical health nurse and also provided opportunities for the acting ward manager to discuss the improvements required with the service manager. We were also concerned about the culture on Littlestone Lodge, the lack of care by some staff, the lack of recording and lack of responsiveness by staff to the acting manager's attempts to improve the service along with the lack of detailed and appropriate recording in patient notes, care plans and prescription charts
- We asked the trust to take immediate action to address concerns and also took enforcement action, serving two warning notices. The two warning notices served notified the trust that CQC had judged the quality of care being provided as requiring significant improvement. The first warning notice was to ensure the safety, care and welfare of the patients. The second notice highlighted the trust's failure to monitor the quality of care it provided adequately. The warning notices expiry dates were 15 May 2015 (for further information see below)
- We also had concerns about the care and welfare of patients on other wards across the older persons' inpatient service. In particular, we were concerned about a number of issues related to poor care delivery and lack of care planning for patients' needs on Cranmer ward
- We identified clear gaps in the governance processes. For example, an overreliance on quantitative data and a lack of robust qualitative monitoring. In addition, the trust failed to act on some risks it has identified in a timely manner. There was some disconnect between the boards awareness of the quality of care in some area and this was evident in the trust's response to the concerns identified at Littlestone Lodge. Another key example of gaps in the governance was related to medicines practice; the processes in place were failing to highlight the pockets of poor medicines practice that we observed and identified to the trust. The systems for managing risk had also failed to highlight some key risks issues at ward/service delivery level, failed to identify the lack of action at ward level to rectify problems identified and also failed to identify the lack of reporting risks in some areas.
- The use of the Mental Health Act (MHA), Mental Capacity Act (MCA) and Depravation of Liberty safeguards (DoLs) was inconsistent across the trust with poor practice identified in several areas
- The quality of care planning was inconsistent across the trust and at times it was not evident how or whether people were involved in their care. However, we also found some outstanding examples of people being involved in their care.
- The trust has a vacancy rate of 17.4% in October 2014 and although had reduced this to 9.7% across the trust by March 2015 some wards and teams still had high vacancy rates. This meant there was a high usage of agency staff in the majority of areas, including large case loads in the community teams
- Risks to patients were not regularly reviewed in a number of services following a change in behaviour or an incident
- There was evidence of poor reporting of incidents both within the trust and to other agencies such as the local authorities and CQC

Summary of findings

- The environment in the health based places of safety (section 136 suites) and seclusion rooms across the trust did not meet establish national standards

However, care was delivered by kind, sensitive and caring staff that were passionate about their work and committed to delivering high quality services. Patients and their families told us that the majority of staff treated them with respect and dignity.

There was evidence of good leadership and commitment from the board, the executive team and senior managers. The majority of KMPT's board (executives and non-executives) had been in post for less than four years; the chief executive had been appointed in April 2012. We concluded that they were a cohesive team who shared a common purpose**.**

It was evident that there was a clear vision, set of values and cohesive strategy based around driving improvements in clinical practice and we saw evidence of this in some areas of the trust. However, there were several areas were practice was poor, inconsistent or not embedded. We heard of many new initiatives and the trust was continually looking for ways to improve, including through an ambitious transformation programme. However, it was clear that time was needed to fully realise the scale and complexity of the changes.

The trust was actively addressing staff morale and its below national average levels in the friends and family' test. We saw attempts to address these issues with innovative communication methods such as the 'big white wall' and 'green button'.

The trust was currently maintaining a financial surplus and a comprehensive programme to improve facilities and infrastructure was underway. For example, a new modular ward was being built at the trust's Maidstone site.

The dignity and privacy of the patients were not always protected due to failure to meet same sex accommodation guidance in a number of areas. However, the trust acknowledged that it did not always meet guidance but felt there was a clear clinical and safety rationale for this and was working to ensure guidance was met in all areas. In some areas we were shown clear plans or observed building work on the environment to rectify these issues.

We observed outstanding care planning and outstanding care interactions within the trust's forensic service line which included the learning disability and forensic inpatient wards. Despite both services being rated as requiring improvement in the safety domain, the overall patient and staff involvement and engagement impressed the teams who visited all these wards. The two teams visiting these wards were overwhelmed with the volume of evidence of innovative practice to support and include patients in their care. They observed early intervention and engagement which led to reductions in the levels of restraint and seclusion.

The trust was open and clear about the risks it faced regarding the level of vacancies, use of agency and bank and the number of unfilled/incorrect skills mix shifts it currently had. There had been attempts made to address the vacancies and to mitigate the risks such as longer term/contract agency staff.

Overall, we gave a rating of good for caring, with forensic and learning disability inpatient areas rated outstanding. This was because staff were found to be compassionate, kind, motivated to involve patients in their care and went above and beyond expectations in the manner in which they cared for patients.

High bed occupancy levels were having an impact on patient care, in particular in the wards for adults of working age and psychiatric intensive care unit (PICU). 88% of the wards had a average bed occupancy of 85% or more. In some areas the bed occupancy was over a 100% and PICU 107%. We found a handful of examples where a patient was sleeping on a bean bag, patients slept in other patients rooms that were spending time at home and section 136 suites being used to nurse patients that did not require section136 care.

Several of KMPT services participated in national service accreditation and peer review programmes. These included, the accreditation for inpatient mental health services (AIMS) on two wards, the home treatment accreditation scheme in one CMHT, the quality network for forensic mental health services, the community of communities – a quality improvement network for therapeutic communities and the memory services national accreditation programme. We also saw that the patient engagement programme had won external awards for engaging and seeking feedback in the community.

Summary of findings

It was our view that the provider had made significant progress in developing services and bringing about improvements and that, given time, the provider would realise its vision. However, some significant work was still required to improve the quality and consistency of its services across the trust.

We found that the trust was in breach of a number of regulations. We will require the trust to meet the requirements of the regulations within a specified time period and will return to check that it has done so.

Additional information relating to Littlestone Lodge

In March 2015 we inspected Littestone Lodge (now known as Littlestone continuing care unit (CCU) as part of a comprehensive inspection of Kent and Medway NHS and Social Care Partnership Trust. During our inspection we found that the trust was not meeting the standards expected in meeting the care and welfare needs of patients, and how it assessed and monitored the quality of the service at Littlestone CCU.

We found the trust was in breach of regulations 9(1) (2) and 10(1) ((2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued two warning notices under each of these regulations on 30 March 2015. We told the trust that it must comply with the requirements of the regulations by 15 May 2015. The trust sent us an action plan, and later confirmed that it believed it was compliant with the requirements (as of 15 May 2015).

We carried out an unannounced, focussed inspection on 21 May 2015 to assess if the trust had addressed the concerns identified at our inspection in March 2015, and to determine if it was now compliant with the requirements of the regulations. We found that the trust had taken action, that improvements had been made to the services delivered at Littlestone CCU since our visit in March, and that staff were positive about the changes to the unit. A number of new or revised processes had been implemented for ensuring that patient care and welfare needs were met. However, we found that these were not always carried out or recorded consistently.

Our inspection in March 2015 assessed compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These regulations were replaced with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on the 1 April 2015. As such, the inspection carried out on 21 May 2015 looked at the trust's compliance with the 2014 regulations (namely the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Due to the improvements made we were able to withdraw the warning notices. However, we found that the trust had not met all the requirements of the regulations and as such have issued a requirement notice in respect of Regulation 17(1)(2)(b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good Governance.

A separate report of the unannounced, focussed inspection of 21 May 2015 has been produced. This report describes our specific findings at Littlestone CCU (March 2015) and the related finding from our focussed inspection (May 2015). This report also provides details of the requirement notice that the trust must take action to address.

This can be found on our website.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The care and safety of the patients at Littlestone Lodge was inadequate.
- Seclusion rooms and places of safety facilities across the trust were not safe or suitable.
- KMPT's vacancy rate was 9.7%. This resulted in high level use of agency/bank staff, unfilled shifts or shifts staffing compliment being contrary to established staffing ratios.
- Several wards across service lines did not comply with the Department of Health gender separation requirements.
- The trust recognised and was actively trying to reduce the number of prone restraints being used in the trust. Despite the reduction in the use of prone restraint across the trust by 20% in 2014, prone restraint was used 294 times.
- Across some of the service lines safeguarding incidents had not been reported. Several areas were tracking and managing their safeguarding incidents, however, others told us they received no feedback from safeguarding incidents.
- In some areas there was unsafe use and management of medicines.
- The majority of service lines were meeting their mandatory training targets other than adult inpatient.
- The majority of staff told us they saw learning from incidents.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- We saw care plans vary in quality from outstanding to inadequate from ward to ward. Generally, care plans were not holistic, detailed or specific to patients' needs. Although there was some examples of good care planning in some services. Care planning and physical health checks in Littlestone Lodge were inadequate.
- We observed that physical health plans/checks were not consistently carried out across both inpatient and community services.
- Generally, we found cohesive and embedded multidisciplinary teams.
- Staff understanding and implementation of the Mental Health Act and Code of Practice was inconsistent across service lines.

Summary of findings

- DoLS application were being made inconsistently. The trust were not notifying CQC of their DoLS applications as required.

Are services caring?

Good

We rated caring as good because:

- We met with staff who were very compassionate and kind. We received mostly positive feedback from patients and their carers.
- Forensic inpatient wards were rated as outstanding due to the volume of work to involve people in the care they were receiving.
- We found many examples across the majority of services of people being involved in their care.
- Most services had written information available and these were in differing languages. Patients were all given welcome packs or leaflets describing services on offer. We saw evidence of interpreting service being used to help with the communication and repatriation of a patient.
- KMPT were actively seeking feedback from patients and carers for example, the 'effective care planning survey, 'carers survey', and 'help us get it right' feedback slips. KMPT won the Kent, Surrey, Sussex academic health science network (KSSAHSN) in January 2015 for the implementation of a survey sent to people who used the trust's memory assessment service. 94% of patients surveyed felt their families had been fully involved in their care.
- However, some staff on Littlestone Lodge did not demonstrate a caring attitude toward patients. There was inconsistency in the level of input patients had in their care planning. The inclusion of 'advance decision' in care plans were varied across the trust.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- 88% of the wards had an average bed occupancy of 85% or more. In some areas the bed occupancy was over a 100%. In some areas this was impacting on patient care.
- Patients and others raised the poor quality of food across many wards including in older persons' and forensic service lines.
- In general patients knew how to raise a complaint against the service. A few wards proved an exception.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

Summary of findings

- Risk management and board assurance process did not always identify or escalate the risk of harm to patients. For example, the inadequate care being provided at Littlestone Lodge. The current process may lead to similar gaps in governance assurance in the future.
- Staff vacancies, the high usage of bank and agency staff and number of shift unable to be back filled was a on going recognised risk to patient safety.
- The number and quality of service level and quality of service led audits was inconsistent.
- The trust were actively engaged in internal and external programmes of improvement.
- The trust was actively trying to improve morale and engage staff by introducing tools such as the 'green button', 'white wall' and senior team visits. Many staff could provided examples of how these tools had resulted in prompt, in person responses from the board and senior managers.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott, Deputy Chief Inspector of Hospitals at the Care Quality Commission.

Team Leader: Karen Bennett-Wilson, Head of Hospital Inspection for the South Central region at the Care Quality Commission.

The team included CQC inspection managers, inspectors, Mental Health Act reviewers, analyst and inspection planners.

There were also specialist advisors, which included consultant psychiatrists, psychologists, senior nurses, student nurses, social workers and pharmacists. In addition, the team included experts by experience who had personal experience of using or caring for someone using the types of services.

Why we carried out this inspection

We inspected these services as part of our on going comprehensive mental health inspection programme. The substance misuse service was inspected as part of a national pilot, therefore this service has not been rated at this stage. In addition, the services for people with acquire brain injury had not been rated.

The services included:

- Acute wards for adults of working age and psychiatric intensive care units (Acute);
- Long stay/rehabilitation mental health wards for working age adults (Rehab);
- Forensic inpatient/secure wards (Forensic);
- Wards for older people with mental health problems (OP);
- Wards for people with learning disabilities or autism (LD inpatient);
- Community-based mental health services for adults of working age (CMHSA);
- Mental health crisis services and health based places of safety (S136);
- Community-based mental health services for older people (CMHSOP);
- Community mental health services for people with learning disabilities or autism;
- Services for people with acquired brain injury; and
- Substance misuse/detoxification.

How we carried out this inspection

To get to the heart of the experience of people who use services', we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information that we held about Kent and Medway NHS and Social Care Partnership Trust (KMPT) and asked other organisations to share what they knew. We carried out an announced visit between 17 and 20 March 2015.

During the visit the team:

- Sent out questionnaires to gather the views of people who use services;
- Collected feedback from 62 people who use services using comment cards;
- Talked with over 219 patients, carers and family members;
- Observed how staff were caring for people;
- Carried out 3 home visits with staff to people receiving care;
- Looked at the personal care or treatment records of over 224 patients;

Summary of findings

- Interviewed over 329 individual frontline members of staff;
- Held focus groups at the three hub location with different staff groups;
- Attended multidisciplinary team meetings;
- Observed handovers;
- Reviewed information we had asked the trust to provide;
- Liaised with local stakeholders, commissioners and local authority representatives;
- Interviewed corporate staff and members of the board;
- Met with trust non-executive directors.

We visited all of the trust's hospitals and sampled a number of community mental health services. We inspected all wards across the trust including adult acute services, psychiatric intensive care units (PICUs), secure wards, older people's wards, specialist wards for people with learning disabilities, substance misuse ward and a ward for patients with acquired brain injury. In total, we inspected 37 wards and visited 12 community teams. We also visited and inspected 3 S136 places of safety and 2 crisis services.

The team would like to thank all those who met and spoke to inspectors during the inspection. We were impressed by the honesty and willingness of patients and staff to come forward and share their experience with us.

Information about the provider

Kent and Medway NHS and Social Care Partnership Trust was formed on 1 April 2006 bringing together East Kent NHS and Social Care Partnership Trust and West Kent NHS and Social Care Trust.

The trust provides mental health, learning disability, substance misuse and other specialist services for 1.7 million people across Kent and Medway from around 48 sites.

Number of total inpatient beds: 535

Number of locations providing inpatient beds: 38

Kent and Medway NHS and Social Care Partnership Trust are currently in the process of applying to become a Foundation Trust.

Inspection history:

There were 38 inspections at locations registered to Kent and Medway NHS and Social Care Partnership Trust since December 2010. All 19 active locations registered with CQC were inspected. All locations were deemed to be compliant at this time.

What people who use the provider's services say

Patient, carers and others we spoke to, in the majority, told us that their experience at KMPT was positive and that staff were caring. We placed feedback cards across all inpatient areas, we received sixty three completed feedback cards. Of those, 76% felt they had received positive care at KMPT.

Good practice

KMPT was able to demonstrate its commitment to continuous improvement from ward to the board through the number of external audits, external quality assurance programmes and new process for seeking patient feedback.

Forensic wards

- Accredited member of the Royal College of Psychiatrists quality network for forensic mental health services. (Penshurst, Groombridge, Emmetts and Walmer wards in 2014. Allington centre 2015).
- Adaptors of the productive mental health ward and 15 steps challenge (2014 all wards).

Summary of findings

- Clinical audit and effectiveness programme.
- Research and development programme.
- Peak of the week example of good practice.
- Service user and carer involvement (service improvement together initiative, patients' council, DVD, Skype initiative, triangle of care).
- Equality delivery scheme.
- The respect charter.

Learning disability inpatient

- Accredited member of the Royal College of Psychiatrists forensic quality network for forensic mental health services.
- We found staff were kind, respectful and inclusive of patients and relatives/carers. Feedback from patients who used the services was positive. They told us that they found the staff to be passionate about their work, caring and supportive and they felt involved in the therapies and treatments offered.
- The trust provided a 'carer support worker' service which offered advice, support and general non specific information to any person who provided unpaid care.
- The innovative user engagement approaches across the forensic and specialist service line ensured that patients and their families had a say in how the service was run.
- There was an excellent and robust psychology department that provided an innovative and individualised treatment programme tailored to patients needs.
- There was excellent provision of occupational therapy, access to therapeutic and recreational activities and strong links with community resources.
- Staff respected patients' diversity and human rights. The Brookfield Centre had information, such as ward activities and food menus displayed in English and Slovakian to support patients' language needs.

Summary of findings

Acute and PICU

- Priority House had introduced a number of initiatives which included the recovery clinic. Research into the effectiveness of the clinic was being undertaken by a member of staff as part of their PhD. We were told recovery clinics had also been rolled out across other acute wards.
- Peer support workers, who were people who had experience of mental health service employed by the trust, were a positive addition to the wards, and helped reinforce the patients' perspective.

Learning disability community service

- East Kent offered the community forensic psychology service. This worked to support allied professionals and organisations to work with offenders, in particular, sexual offenders with a learning disability and also provided access to advice and consultation from a professional in mental health.
- There was strong evidence of learning from incidents and staff members taking ownership of learning regardless of where the incident occurred. The seven location teams worked together to record risk, investigate incidents and disseminate the learning and actions.

Summary of findings

Wards for people with acquired brain injury

- The staff team produced a yearly outcome report to monitor and improve practice. This was available to the trust, the staff team and patients.
- There was a transitional living ward which was a self contained flat with its own bedroom and living area to assist patients to become independent.
- The team had completed specialist neurological rehabilitation training on Bridges self-management programme (the Bridges stroke self-management programme was developed in 2005 improved longer term support for stroke survivors) to enhance their practice and encourage patients to make and meet their own personal goals.

Wards for older people

- We found that the environment on Woodstock ward was age and gender appropriate, with a virtual bar and a barbers on site.
- Orchard ward provided a member of staff who undertook a family liaison role, spending time with families of patients in their homes or on the ward, creating a formulation tool that provided life details of patients.
- We found evidence on Sevenscore ward of good use of interpreting services and as a result staff were able to repatriate a patient to their country of origin.

Summary of findings

Community based services for older people

- Each locality had Admiral nurses integrated within the teams. Admiral nurses were specialist dementia nurses who gave essential practical and emotional support to family carers, as well as the person with dementia. They offered support to families throughout their experience of dementia that was tailored to their individual needs and challenges.

Crisis and health based place of safety

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

Summary of findings

Community based services for adult

- The administration team at Thanet had started a 'keeping staff well' project which looked at staffs' mindfulness and healthy eating practices.
- In the reception area of Tunbridge Wells we saw a Headlines magazine. This was a magazine written by people who use the services. Items included information on therapies available, the patients' charter and benefits update.
- The Tunbridge Wells team had introduced the 'buddy' system. This was a scheme where people who use the service act as 'buddies' to students.
- The trust had created a 'buddy app'. This is a digital short message service (SMS) which supports therapy services. Patients use text messaging to keep daily diaries of what they are doing and how they are feeling.
- Patients across the trust could access the 'live it library' which was located in the reception area of the community services. The library was an online resource of stories from people who have experienced or are experiencing mental health issues.
- The trust had introduced the 'patient portal'. This was a secure online website and gave people who used the service access to their personal health information.

Substance misuse service

- The service had introduced a care pathway to take patients from both the crisis team and local hospital who needed substance misuse treatment ensuring patients received the most suitable treatment for their needs.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider Must take:

Forensic wards

- The trust must protect patients and staff against the risks associated with unsafe or unsuitable premises, namely all seclusion rooms on three of the wards in the forensic service line.
- The trust must protect patients and staff against identifiable risks associated with poor cleanliness and infection control. Review policies, protocols, practices and training requirements in relation to hand hygiene and phlebotomy techniques in the Clozaril clinic.
- The trust must protect patients against the risks associated with the unsafe use and management of medicines on Penshurst ward by ensuring patients' and others do not have access to both the stock medicine cupboard and the mobile medicine trolley.

Acute and PICU

- The trust must ensure it has a system to maintain the privacy and dignity of women who are secluded on Willow suite (PICU).
- The trust must ensure that emergency equipment and medication are accessible and in date and ensure that effective systems are put in place for regularly checking emergency equipment and medication.
- Systems must be put in place to ensure that, following incidents of aggressive behaviour or restraint, the care plans for the patients involved are updated to describe how to prevent, manage and de-escalate potential future incidents.
- The trust must ensure that the Mental Health Act is consistently implemented in accordance with the Code of Practice; and that staff working on the acute and PICU wards have sufficient understanding of the Mental Health Act and its Code of Practice to ensure patients are given correct information about their rights and to ensure medication is administered lawfully under the Act.
- Trust managers must ensure that delays in finding PICU beds for patients are minimised.
- The trust must ensure that its monitoring processes identify gaps and problems in the services, and identify the reasons behind such issues.

Wards for older people

- The governance arrangements in place at Littlestone Lodge failed to identify that the level of care provided was inadequate. Other procedures such as medicine and care plan audits had failed to identify poor practice. The trust must ensure that it has systems in place to effectively monitor practice and procedures on all wards and that key risks are escalated appropriately and timely action taken as a result of monitoring.
- The trust must ensure Hearts Delight ward complies with the Department of Health gender separation requirements.
- The trust must take action to ensure all safeguarding incidents on Woodstock, Cranmer wards and Littlestone Lodge are referred to safeguarding teams in a timely manner.
- The trust must take action to ensure the administration and storage of medications on all wards, with the exception of Orchard Ward, are in line with national and local guidelines. This also includes ensuing policies and procedures, such as the medicines management procedures are in line with national guidelines and recognised good practice.
- The trust must ensure that all staff are competent in applying apply the MHA, MCA and DoLS at Jasmine and Cranmer wards.
- The trust must ensure and monitor that all wards complete ligature assessments on a routine basis, taking into account each individuals risk to ensure that all risks of harm are identified and that appropriate action is taken.

Summary of findings

- The trust must ensure that that patients' pain management and physical health needs are responded to on all wards and that it addresses and monitors issues relating to the delivery of safe and effective care to all patients.

Wards for people with learning disabilities

- The trust must review the seclusion facilities on Riverhill ward to ensure they are safe and meet current guidelines.
- The trust must take action to ensure that all safeguarding incidents are appropriately recorded and safeguarding alerts are raised where necessary.

Community based mental health services for older people

- The trust must ensure that all staff have access to well-structured and effective supervision at Swale CMHSOP.
- The trust must ensure that care plans are patient centred and reflect service user involvement and preferences.
- The trust must ensure that capacity to consent, consent to treatment and information sharing is clearly and consistently recorded.
- The trust must ensure that there is capacity within teams to effectively meet assessment and treatment targets.

Community based services for people with learning disabilities and autism

- There was a difference in how the lone working system was operating across the teams. This meant that if there was an incident other staff in the team would not be alerted and as such would not be able to offer effective support or take steps to ensure staff safety in a timely manner. The trust must ensure staff safety is addressed.

Crisis teams and health based places of safety

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

Community based services for adults of working age

- The trust must review the caseloads allocated to staff to ensure that all patients are appropriately monitored.
- The trust must ensure that care planning includes discharge planning and that service users' health checks are carried out in line with trust policy and national guidelines across CMHT teams.
- The trust must ensure that consent to treatment is clearly recorded. The trust must ensure that people's risk assessments are reviewed regular, up to date and recorded accurately.

Ward for people with acquired brain injury

- The trust must ensure that the requirements relating to separate facilities for men and women, according to paragraph 16.9 of the Mental Health Act Code of Practice, and national guidance regarding the provision of same sex accommodation, are adhered to.

Long stay/rehabilitation wards for working age adults

- The trust must ensure that following incidents the care plans for the patients are updated to describe how to prevent, manage and de-escalate potential future incidents. The trust must ensure that learning from serious incidents is shared across the rehabilitation service and must support staff to understand and use lessons to improve services.
- The trust must ensure that ligature risk assessments are carried out as a matter of routine for all wards and appropriate steps are taken to reduce ligature points and manage ligature risk for all patients.
- The trust must ensure it provides care in accordance with the Department of Health's same-sex accommodation requirements.
- The trust must ensure that the storage and recording of medication, including self-administration processes, is safe and secure and must ensure that staff follow its policies for the safe management and administration of medicines

Action the trust SHOULD take:

Summary of findings

Forensic Wards

- The trust should implement the capital works programme for anti-ligature work at both the Trevor Gibbens unit and the Allington centre. In particular, prioritise Walmer ward, where additional staffing resources are being used to mitigated existing ligature risks.
- The trust should develop a service model for the intensive care unit (ICU) on Penshurst ward as well as associated protocols which should include the use of the time out practice in the seclusion room on the ward.
- The trust should submit the capital works business case for approval to refurbish the ICU area on Penshurst ward, including the seclusion room.
- The trust should expedite the approval to extend the perimeter fence on Penshurst ward to include the tennis court area to increase the size of the available out door area for restricted patients.
- The trust should enable the patients on the ICU area on Penshurst ward to access an outside area which is conducive to their dignity and shows them a more respectful approach.
- The trust should review the blanket restrictions on Bedgebury ward regarding the locked front door and access to mobile phones.
- A review of the pay phone facilities across all wards should be undertaken to ensure all patients have access to make private phone calls and that a consistent approach is agreed across the service line in regards to equality of provision and cost.
- At the Allington centre, a review how patients access their money should be undertaken as the current arrangements are restrictive.
- The trust should consider introducing advance decisions at the Allington centre.
- The trust should review arrangements for provision of food at the Allington centre as some patients complained about food quality.
- The trust should review some information on display at the Allington centre which was in small print format and not conducive to be easily read.
- The trust should review the availability of emergency and resuscitation equipment in the HDU at the Allington centre and
- The trusts should expedite the work to repair the faulty access door to the HDU at the Allington centre.

Acute and PICU

- The trust should review the seclusion room to ensure it is equipped in accordance with the Mental Health Act Code of Practice.
- The trust should make sure staff have access to a reliable emergency alarm system.
- The trust should ensure they provide care in accordance with the Department of Health's same-sex accommodation guidance.
- The trust should ensure there are robust processes in place for assessing and managing environmental risks, and that these are followed.
- The trust should ensure there are adequate numbers of appropriately qualified and experienced staff.
- The trust should ensure that all patients have a risk assessment which is reviewed regularly and updated in response to changes.
- The trust should ensure that staff understand the circumstances and limitations within which quiet rooms can be used to nurse patients who are violent or aggressive.
- The trust should ensure that all incidents of restraint are recorded correctly, and ensure any use of prone restraint is consistent with Department of Health guidelines.
- All trust should have care plans that are individualised, incorporate their views, and are recovery focused.
- All staff should have an understanding of the Mental Capacity Act and DoLS.
- The trust should make suitable sleeping arrangements for patients who return from leave, and reduce the need for patients to change bedrooms for non-clinical reasons.

Wards for older people

- The Frank Lloyd unit should review the arrangements for patients to use the shared garden between the two wards. Currently male patients have to walk through the mostly female ward to gain access.

Summary of findings

- All wards should ensure that they are working, where possible, in collaboration with patients and relative to formulate individualised and personalised plans of care.
- The trust should ensure that it continues to actively recruit to vacant posts.
- All wards should ensure that patients are provided with information around access to advocacy services.
- The trust should work with its local commissioning organisations to address variations in how services are commissioned, giving particular attention to Cranmer ward and its lack of access to services such as dieticians and physiotherapy.
- During our inspection a large number of patients expressed concern about the quality of food. Therefore, the trust should seek to provide better quality food that is nutritious and that patients can enjoy.

Wards for people with learning disabilities

- The trust should review their systems for recording and monitoring of outcome measures to evidence whether people improved following treatment and care.
- Trust managers should review the use and monitoring of CCTV (closed circuit television) specifically in the visitors' room at the Brookfield Centre.
- The trust should review and appropriately implement the use of advance plans of care.
- The trust should review the provision for off duty medical cover.
- The trust should review the use of restrictive practices at the Brookfield centre.
- The trust should review the current available documentation for formally recording assessments for capacity to consent.
- The trust should review the provision and access for patients for their finances.

Community based mental health services for older people

- The trust should continue to work with external agencies and commissioners to gain clarity in relation to funding and commissioning requirements, in order to develop an effective model of care in line with current and projected population changes.
- The trust should ensure consistency of service delivery, whilst reflecting the local population needs; including consistent access to out of hours crisis support. Evaluating service changes and sharing practice across the different locality teams, in order that people can access the same treatment options regardless of where they live.
- The trust should ensure that teams are adequately staffed to manage any foreseeable risks to continued service provision, such as adverse weather or staff holiday and sickness. The teams were not always able to get interim staff to cover absences, in these circumstances it has led to increased pressures and impact on care delivery across the teams.

Community based Service for adults of working age

- The trust should review the management of medicines to ensure there are processes and procedures regarding the recording, storage and unsafe use of medicines at Thanet CMHT.
- The trust should review the peoples' records to ensure that people are actively involved in planning their care across CMHT.

Ward for people with acquired brain injury

- The provider should ensure that staff have access to all parts of the ward. Staff currently used adapted objects such as coins and spoons to turn the locks. We saw that if the lock is held in place then the staff could not gain access to the room. This presented as a potential risk to patients and staff in the event of a fire.
- The provider should ensure that the recording of medication given to patients is accurate. We saw there were incidents where staff had not signed to showed that medication had been given to patients. They told us this referred specifically to thickening agents for patient's food. We saw the agent had been prescribed by a GP should be recorded appropriately in line with the medicines policy.

Summary of findings

- The provider should ensure that the ward is adequately staffed with nurses in line with the levels set by the trust. There was a shortfall of two full time nurses positions. The ward used agency staff and occasionally the manager worked as a nurse to cover the ward and was counted in the qualified staff numbers. There was a recruitment plan in place.

Kent and Medway NHS and Social Care Partnership Trust

Detailed findings

Requires improvement

Are services safe?

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

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

Summary of findings

We rated safe as requires improvement because:

- The care and safety of the patients at Littlestone Lodge was inadequate.
- Seclusion rooms and places of safety facilities across the trust were not safe or suitable.
- KMPT's vacancy rate is 9.7%. This resulted in high level use of agency/bank staff, unfilled shifts or shifts staffing compliment being contrary to established staffing ratios.
- Several wards across service lines did not comply with the Department of Health gender separation requirements.
- The trust recognises and is actively trying to reduce the number of prone restraints being used in the trust. Despite the reduction in the use of prone restraint across the trust by 20% in 2014, prone restraint was used 294 times (Department of Health information indicates that this is an average use of prone restraint when compared to other similar trusts; benchmarking information indicates that the trust use of prone restraint is lower than similar trusts)
- Across the service lines safeguarding incidents had not been reported. Several areas were tracking and managing their safeguarding incidents, however, others told us they received no feedback from safeguarding incidents.
- In some areas there was unsafe use and management of medicines.
- The majority of service lines were meeting their mandatory training targets other than adult inpatient.
- The majority of staff told us they saw learning from incidents.

Detailed findings

Our findings

Littlestone Lodge

- The care provided at Littlestone Lodge, a continuing care ward for older people was inadequate and unsafe. In December 2014, a band six registered nurse had been temporarily promoted to the post of ward manager to bring about improvements. The new ward manager found poor standards of safety such as grade four ulcers, lack of fluid and nutritional monitoring and poor medicines practice. During our inspection in March 15 we found that the safety at Littlestone Lodge, despite some improvements having been made since the arrival of the new ward manager, was still inadequate and two warning notices were issued relating to regulations 9 and 10 of the HSCA 2008 (Regulated Activities) Regulations 2010.
- The doctor at Littlestone Lodge was a locum and had tried to address some of the issues of concern. However, there had been limited input from the consultant who was meant to cover the ward; the consultant had never visited the ward whilst the locum doctor had been at Littlestone Lodge although the locum doctor told us the consultant was contactable by telephone. There was also resistance to change from many of the nursing staff.
- Safety concerns at Littlestone Lodge included:
  - Lack of completion of ligature audits (since 2010)
  - No consultant input on the ward to respond to patient safety issues
  - Poor medicines practice and the routine use of unauthorised covert medicines
  - Lack of completed falls assessment
  - Poor nutritional and fluid monitoring
  - Patients' pain was not appropriately being responded to.

Safe Environment

- Despite the average PLACE score for cleanliness at the trust being 89%,which is below the national average for mental health wards (97%), we found the majority of the wards were clean and well maintained. Where wards were in need of refurbishment, such as Cranmer, we were assured that capital plans were in place. However, we found the flooring in female shower room in Davidson ward was in need of repair.
- We found that patients, staff and others were not protected against identifiable risks associated with poor cleanliness and infection control relating to poor hand hygiene and phlebotomy technique in the Clozaril clinic at Trevor Gibbens unit. We identified this immediately and staff responded quickly to rectify the situation.
- The trust carried out 148 seclusions in 2014; a reduction of 63% on the previous year. We found that in those services managed as part of the forensic service, which included the learning disability services, seclusion levels were low. Early intervention techniques were used effectively to reduce the need to seclude patients. The trust had audited the seclusion facilities in place in line with national guidelines in January 2014. The outcome of the audit found that several of the seclusion rooms did not meet national standards. For example, we found several rooms were less than 15sq meters in size, the Allington centre room was too small and it was difficult to provide mattresses in several rooms due to their size and inward opening door. There was also broken ceiling light fittings and no visible clock, no shower, no natural light, no working CCTV and toilets where loose fitting. The trust told us it was planning to reduce the number of seclusion rooms from seven to two and that it had placed a bid with commissioners for two to be re-designed, this was under consideration.
- Several of the section 136 suites did not provide a safe and suitable environment for assessment of patients detained under section 136 of the Mental Health Act 1983. The section 136 suite at Littlebrook Hospital was too small. The suite shared all facilities via a corridor linking with another ward with reception and outside space was only accessible through the main reception. The section 136 suite at St Martins Hospital was not fit for purpose, furniture was in a poor state of repair and there was no access to outside space. The suite had two rooms for patients. These rooms were very sparse, the doors opened onto the corridor and did not have any way of locking. The layout and design of the suite made observation of patients difficult and did not keep patients safe.
- Several wards across service lines did not comply with the Department of Health gender separation requirements. For example, Newhaven Lodge and Davidson ward in the rehabilitation services, Willow suite in adult inpatient services and Hearts Delight ward a ward for older people.

- The lone working arrangements in the community services for people with learning disabilities and autism was inconsistently used.
- In general, ligature risks had been identified and were being managed. However, across the rehabilitation wards and forensic wards risks were either not being managed or addressed properly.

Safer Staffing

- On 31 October 2014 the trust overall percentage of vacancies was 17.6% which it had reduced to 9.7% by the time of our inspection. However, a key issue was still the lack of registered nurses. The majority of the wards achieved an overall coverage even if it was not always at the agreed qualified/unqualified ratio. Thirty one wards used bank and agency staff to fill over a hundred shifts in the three months prior to 31 October 2014. Staffing levels were having an impact on the ability of staff to deliver care.
- Across the CMHSOP teams, staffing levels had impacted on the teams abilities to consistently deliver effective services. For example, meet assessment and treatment targets, medical staff undertaking home visits and staff to run therapeutic groups.
- The high number of caseloads in CMHTs meant that staff could not ensure that all patients were being appropriately monitored to ensure they were not at risk.
- We found example of staff working very long hours. For example, a member of staff in the rehabilitation services worked 13 shifts in 14 days.
- Generally, the trust were meeting their target of 85% of staff having received mandatory training.

Assessing and Managing Risk to patients

- Across the board patients' risk assessments were being carried out on admissions.
- Of the services inspected, three, including the forensic and learning disability inpatients/community services, were reviewing their risk assessments in line with established practice. We saw evidence of tools such as HCR-20, MEWS and structural assessment of protective factors (SAPROF) being used. In both substance misuse and acquired brain injury rehabilitation services risk assessment were being reviewed.
- Across the other services, the majority of the inpatient and community service provided, risk assessments were not reviewed regularly an were not updated following incidents or changes in behaviour. Risk assessments had not been completed for patients at Rosebud centre since the transfer from Dartford.
- The patient safety group received a paper on 24 February 2015 from the trust violence, restraint and seclusion monitoring group outlining the trust's progress with restrictive practices (restraint, seclusion and segregation). The trust had an overall reduction in the use of restraint between 2013 and 2014 of 42.5%. The majority of this reduction was attributable to the forensic service lines and older people, the number in the acute service line shows a very small reduction of approximately 2%. Despite the reduction in the use of prone restraint across the trust by 20% in 2014, prone restraint was used 294 times between 1 April 2014 and 1 September 2014 (lower than some similar trusts). Prone restraints accounted for 35% of all restraints at the trust. The trust told us it was reviewing this practice and starting to introduce positive behaviour plans beyond their learning disability service to reduce the use of prone restraints.
- The majority of staff were able to describe what, how and where a safeguarding incident should be reported. Staff we spoke to told us they had received and understood their safeguarding training. The services were meeting their mandatory training for all five different safeguarding training packages. There was an exception to this in the rehabilitation service, where staff told us there was confusion regarding where and how to report. Several staff told us only qualified staff could report safeguarding incidents although the trust said that all staff could report safeguarding incidents.
- We found evidence of safeguarding incidents not being reported. In particular, in the forensic service line and older people inpatient service.
- In the majority, environmental audits were being carried and ligature audits were in place, with the exception of the rehabilitation inpatient service and Littlestone Lodge.
- We found several incidents of informal patients having their movements restricted or staff saying that they would be placed on a 'section' if they tried to leave.
- Across the services there was evidence of patients' risk being discussed at MDT handovers and ward rounds.

- We found problems with medicines management in a number of services. For example, drugs cupboards not being secure. Some of the consistent or unaddressed medication issues found by the inspection team included:
- The medicines audits on most wards in the older persons inpatient service were not effective.
- We found evidence on Littlestone Lodge to show that covert medicines were being used without clinical reasons as routine practice and covert medicines charts were not being monitored.
- A pestle and mortar was being used to crush medicines which were not suitable for crushing and that the pestle and mortar was not being cleaned between medicines.
- Despite regular visits from pharmacists, on Cherrywood ward of the current 18 patients, there were 36 occasions when medicines had not been signed for as given, over the last month.
- On Cherrywood ward the fridge temperature was recorded as 17 degrees. This was well above the acceptable range and had been like that for several weeks but no action had been taken. On Amberwood ward the checks had last been completed a month prior to our visit, and at that time had been just above the acceptable range at 10 degrees.
- A patient had been admitted to Littlebrook Hospital to restart medication. However, after eight days they had still not been given the medication despite asking for it. The medication was prescribed for 10pm, but the patient was usually asleep by then so it had not been administered and alternative arrangements to administer the medication had not been made. The patient was discharged without having had the medication and was due to start it at home.
- Medication was not stored securely at Ethelbert Road, where a patient was storing their Clozaril in an unlocked room.
- On reviewing self medication charts in the inpatient rehabilitation service we found a patient had 27 unsigned entries (clozapine).

Reporting of Incidents and learning when things go wrong

- The trust used a paper based system to record their incidents. These were subsequently fed into IRIS database. Many staff across the service line told us this system was time consuming and cumbersome. The reporting systems were not always working as they were intended.
- KMPT had recently received a notice of contravention from the Health and Safety Executive for failing to report accidents in line with the requirements of Reporting of Injury, Disease and Dangerous Occurrences Regulations 2013.
- Incident records were not always fully completed in the older persons' inpatient service.
- Incidents not reported across the rehabilitation service.
- Between 1 December 2013 and 31 December 2014 - 84.2% of the incidents reported were categorised as Grade 1 with a 45 day investigation deadline, 37 of the serious incidents are currently overdue (currently awaiting action by the CCGs) .
- There has been one DoLS notification received into CQC in the last two years. The trust had reported that they had submitted 59 DoLS applications in the last six months.
- Our pharmacist was able to identify three medication errors and a further incident of a critical medication not being given that had not been reported in the previous week. The trust told us they received only a maximum of ten medicines incidents a month. There was under-reporting of medication errors across the trust.
- We identified a discrepancy between the number of medicine incidents being reported to board members and the volume we found not inaccurately reported in a week.
- Staff in the majority of areas were able to describe examples of learning from incidents in their own wards, other areas of the trust and from serious incidents. The exception was the rehabilitation inpatient service where there was very limited feedback or lessons learnt shared and Littlestone Lodge where there was limited evidence of learning.

Requires improvement

Are services effective?

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

Summary of findings

We rated effective as requires improvement because:

- We saw care plans vary in quality from outstanding to inadequate from ward to ward. Generally, care plans were not holistic, detailed or specific to patients' needs. Although there was some examples of good care planning in some services. Care planning and physical health checks in Littlestone Lodge were inadequate.
- We observed that physical health plans/checks were not consistently carried out across both inpatient and community services.
- Generally, we found cohesive and embedded multidisciplinary teams.
- Staff understanding and implementation of the Mental Health Act and Code of Practice was inconsistent across service lines.
- DoLS application were being made inconsistently. The trust were not notifying CQC of their DoLS applications as required.

Our findings

Care planning

- We found that care plans varied in detail and quality from wards to ward. Generally, care plans were not holistic, detailed or specific to patients' needs. Although there was some examples of good care planning in some services. We did find some audits and plans for improving care plans.
- Within the forensic service line we found excellent care plans due to their patient centred, holistic nature.
- In some services we found care plans did not reflect holistic, person centred care, include evidence of active patient or carer involvement in writing and reviewing care plans. We found examples of wards where patients personal details were missing in the majority care plans, we found MEWS charts were not being carried out, consent to treatment was not recorded and care plans were not signed. In several services the use of both paper and electronic care plans caused a lack of clarity and confusion. The trust was monitoring the patient experience of service user views relating to the effectiveness of their CPA as a quality account priority for 2014-2015 recognising their need for improvement.
- In several service lines including, wards for people with learning disabilities, forensic, older people and adult community and mental health wards for adults, consent for treatment was not been recorded in line with best practice or had not been completed in patients' care plans.
- There was no or limited evidence of advanced plans for care or advanced decisions in learning disabilities and adult community.
- In several areas we were told poor connectivity led to delays in accessing the RIO care planning software package.
- Care planning in Littlestone Lodge was inadequate.

Best practice in treatment and care

- NICE guidance were followed for prescribing medication in most areas, we saw examples of this in patients' records. However, we found evidence on Litttlestone Lodge to show that the covert administration of medicine was being practiced as a matter of routine.
- We had serious concerns that patients' physical health needs were not assessed or managed safely and effectively on Cranmer and Littlestone Lodge. There were further serious concerns regarding patients' fluid monitoring. We requested that immediate action was taken to address the physical health needs of two patients on both wards.
- The trust told us that physical health assessments were monitored for inpatients and were currently at 99.25% completion across all inpatients areas. We found these had not always been carried out at Littlestone Lodge. However, there was clear evidence in the forensic service line that physical health checks were carried out and monitored by the lead nurse.
- The trust told us the percentage of service users who have a physical health check in all community teams

across the Trust, was 24.16%. Physical health plans were not always in place in the community setting. We found that in some areas of the community the majority of patients did not have physical health check and plans in place (older people community in Thanet 42%, Swale 47%). We found examples where health checks were not being carried out in line with their plans.

- In the majority of areas we saw patients were assessed using the health of the nation outcome scales (HoNOS).
- The trust had a 'did not attend' (DNA) policy. Neither the crisis or adult community team logged or monitored the outcomes of DNAs and were unaware of the level of DNA across the services.
- Across the forensic service line patients had access to excellent psychological therapies recommended by NICE as part of their treatment either on a one to one or group basis. The patient's individualised treatment programme was innovative and tailored to their needs. However, in several other areas in particular learning disability service the wait for treatment was long up to twelve months.
- In the majority of services we saw clinical audits taking place; the outcome and responses to these audits were not always seen to be robust. In some areas such as older peoples' community there was limited evidence of staff being involved in clinical audit. In the forensic service line we found numerous examples including, "peak of the week" which identified a particular area of the service where a development or improvement had been identified.
- Access to input from different disciplines was inconsistent across older peoples' inpatient areas, including physiotherapy and dietetics, causing delays in treatment.

Skilled staff to deliver care

- The trust, in the majority, were meeting their target of 85% of staff having received mandatory training.
- The majority of staff told us they received appraisals and supervision. This was supported by the NHS staff survey which showed that 89% of recipients had received supervision (comparable to national average of 88%) and 48% felt that their supervisions was well structured (national average 41%). The inspection teams found that supervision was not always delivered and not always delivered to a high standard across the services, for example, areas of CMHSOP. In some areas there was limited evidence of clinical rather than managerial supervision.
- In the focus groups that we held, many staff told us of their personal experience of the development opportunities they had received. Within the forensic service line we noted that all wards had multidisciplinary team away days, that regular managers workforce development groups took place and the psychology department provided additional training such as boundaries awareness, autism and risk management awareness. Also, the trust offered a 'job taster programme'; a 12 week placement programme within the trust supported by the job taster co-ordinator.
- Medical staff told us that there were adequate doctors available over a 24 hour period, seven days each week who were able to respond quickly on wards in an emergency. However, we found this was not always the case. For example, we saw documentation that showed several delayed terminations of seclusion due to the unavailability of the duty doctor because they were conducting an MHA assessment in the local accident and emergency department.

Multidisciplinary teams (MDT)

- We attended handovers and MDT ward round and found them in the majority to be patient centres and effective.
- Medical leadership or senior medical input on Littlestone lodge was limited. Medical cover was provided by a locum doctor who had been working on the unit since October 2014 and had limited previous experience of caring for patients with dementia. The staff on the ward believed the doctor was a consultant psychiatrist specialising in older peoples' care, but she was an associate specialist. The locum doctor received supervision from a specialist consultant psychiatrist but the consultant did not visit the ward so patients and families did not have direct access to a consultant.
- We observed that all members of the multi-disciplinary team were given space and time to feedback and add to

discussions in meetings. We noted that everyone's contribution was valued equally. We saw clear clinical leadership on the wards without any negative impacts of a hierarchical structure. - forensic

Deprivation of Liberty Safeguards (DoLS)

- There had been one DoLS notification from KMPT received into CQC in the last two years. The trust have reported 59 DoLS applications in the last 6 months. Across the older people inpatients we saw evidence that DoLS were not consistently being made.

Mental Health Act

- Staff understanding of the Mental Health Act and Code of Practice was inconsistent across service lines. The findings correlated with the findings in the trust's audit in January 2015. The audit highlighted key issues of concern, including concern about the number of de facto detention of informal patients who were reported to not have capacity to consent to care and treatment/ or admission. Assessing capacity was seen as a doctor's role and capacity assessments lacked evidence. Some examples of staff not giving regard to MHA code of practice included:

- Records and patients' feedback identified repeated instances of patients being told, or care records documenting, that although they were informal (voluntary patients), if they wanted to leave they would be detained under the Mental Health Act.
- On Amberwood ward and Emerald ward, staff had not checked that drugs they had administered were included on the formal consent to treatment and emergency treatment forms. Thus the lawfulness of the administration of this medication was under question.
- Within the acute inpatient service line, all the wards were locked, and there were notices on most of the ward doors stating that informal patients should speak with staff if they wished to leave. We observed that informal patients did come and go from the wards. However, some patients described occasions where they had been prevented from leaving by staff but were not detained under the Mental Health Act. Other patients gave examples of when they had been told they would be detained if they asked to leave the ward.
- On Amberwood ward, patients were not informed of their rights in accordance with the Mental Health Act and Code of Practice; medication had been administered without the proper consent, and there was poor documentation of the treatment plan when a patient had a second opinion from a second opinion appointed doctor (SOAD).
- Consent to treatment and information sharing was not consistently recorded. It was not always clear who the information could be shared with and in what format. We also found that it was not always consistently and clearly documented that capacity to consent had been assessed and the reason behind their decisions. We observed this practice across the services lines, including in community based service for adult and older persons.
- In particular we found that the completion of capacity assessments in accordance with the Mental Health Act Code of Practice varied across the acute inpatient wards.

- Capacity assessments had not always been completed at Littlebrook Hospital, but they had been at Priority House. On Emerald ward patients had not all had their capacity to consent to treatment recorded in accordance with the Mental Health Act Code of Practice.
- In some areas we could not find evidence of formal capacity assessments in relation to consent to treatment. We spoke with qualified clinical staff who told us that capacity assessments were completed on a MHAC1 form. However, this was a review of treatment form and not a formal record for assessing capacity to consent.
- Capacity assessments were not clearly documented in the clinical notes on RIO.
- The majority of wards had access to advocacy service, Littlestone Lodge was a noted exception.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- We met with staff who were very compassionate and kind. We received mostly positive feedback from patients and their carers.
- Forensic inpatient and learning disabilities wards were rated as outstanding due to the volume of work to involve people in the care they were receiving.
- We found many examples, across the majority of services, of people being involved in their care.
- Most services had written information available and these were in differing languages. Patients were all given welcome packs or leaflets describing services on offer. We saw evidence of interpreting service being used to help with the communication and repatriation of a patient.
- KMPT were actively seeking feedback from patients and carers for example the, 'effective care planning survey, 'carers survey', and 'help us get it right' feedback slips. KMPT won the Kent, Surrey, Sussex academic health science network (KSSAHSN) in January 2015 for the implementation of a survey sent to people who use the trust's memory assessment service. 94% of patients surveyed felt their families had been fully involved in their care.
- The inclusion of 'advance decision' in care plans were varied

The level of care, respect and dignity shown to patients at Littlestone Lodge by some staff was not what would be expected.

Our findings

Kindness, dignity, respect and support

- Across most services we found that staff were caring, compassionate and kind. In the forensic service line (forensic and learning disability wards) we found that staff were outstanding in the care and passion they clearly demonstrated for their work.
- People were treated with respect and dignity.
- We observed many instances where staff were kind and caring towards patients. Despite staff working with increased levels of stress due to lots of demand for services staff were able to give time for one to one time with patients.
- Staff spoke with patients in a caring and respectful manner and took account of, and addressed, their needs.
- The patients at Littlestone Lodge were not always treated with dignity. For example, patients were not assessed for incontinence, they all wore incontinence pads. Patients' care was not individualised for their needs. Patients' were not supported when they raised concerns.

The involvement of people in the care they receive

- Forensic inpatient wards were rated as outstanding due to the volume of work to involve people in the care they were receiving, some of the examples included
- All patients had received a comprehensive handbook on admission to the wards.
- 'My shared pathway' documentation was person centred, highly individualised and recovery orientated.
- We saw that all patients were encouraged to plan for ward round meetings by completing a document, called, 'what I would like to say at ward round this week'.
- We saw a forensic expert by experience group had been launched in 2013 and that the steering group had met monthly to oversee quality improvements in the service, directed by ex- service users, carer representatives and health care workers. We noted the steering group was called, 'focus on service improvement together' and we saw that this group published a monthly newsletter which provided progress reports on service improvement initiatives.
- We saw numerous example of how the trust tried to involved patients in their care. Some examples included:
- An experts by experience research and development group, which had been running since 2009;the group published and shared its findings to support learning.

Good

Are services caring?

- We noted the majority of inpatient areas had patients community meetings, where possible.
- In the community setting the trust had created a 'buddy app' (a digital short message service (SMS)) which supported therapy services. Patients used text messaging to keep a daily diary of what they where doing and how they are feeling.
- We noted an initiative to enable patients and their relatives to keep in regular contact through the use of Skype.
- Families and patients, in the majority, were invited to MDT meetings across the majority of services.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as requires improvement because:

- 88% of the wards had a average bed occupancy of 85% or more. In some areas the bed occupancy was over a 100%. In some areas this was impacting on patient care.
- Patients and others identified the poor quality of food across many wards including inpatient older peoples' and forensic service lines.
- In the majority, patients knew how to raise a complaint against the service. A few wards proved an exception.

Our findings

Access, discharge and bed management

- The crisis teams were the 'gatekeepers' for the inpatient services, and decided who needed to be admitted. A 100% of referrals for beds were being dealt with by the crisis teams this was well above the national average.There was a daily bed management conference call across the trust, so beds were managed across the trust, not at a local level. There was a discharge co-ordinator who approved and reviewed patients in out of area placements, and co-ordinated their return to the service, though this was due to change.
- It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital. At KMPT mean percentage bed occupancy over the past six months (as at 13 November 2014) ranged from 18.5% to 107.4% (across 40 wards). 88% of the wards had a average bed occupancy of 85% or more. Willow suite (PICU) rate was 107.4% and Foxglove was a 100.3%. The trust learning disabilities bed occupancy rate between the Q3 2013/14 (September/ December) to Q2 2014/15 (April/June) was 100% throughout the period.
- Staff, in particular in the acute inpatients wards told us there was a lot of pressure on beds, and this was exacerbated by taking patients from out of the ward's locality. There was also pressure to discharge patients as soon as possible. The crisis teams worked with the wards to facilitate discharges.
- There was usually a bed available for patients when they returned from leave. However, in February, a patient returned from leave and as there was no bed available they spent two nights in the room of another patient who did not use their room. The patient who had returned from leave spent the first night sleeping on a bean bag and the second in the bed, until they were subsequently found a room of their own.
- There were delays in finding psychiatric intensive care unit (PICU) beds for patients. There had been at least three occasions (at Priority House, Samphire ward and Fern ward) where patients were nursed in the section 136 suite (health based place of safety) or in a quiet room/lounge as they were not suitable to be cared for in the main patient area of an acute ward. There was evidence of temporary transfers from acute wards into the rehabilitation inpatient service were reported by staff and ward managers as having a negative impact on the safety of the ward
- Over the last 12 months there were a 1916 days of delayed transfer of care, a majority (27.71%) of all delayed days were a result of 'residential home placement or availability', followed by 'housing - patients not covered by the NHS and Community Care Act' (22.65%).
- There was no service model for the intensive care unit (ICU) on Penshurst ward and a lack of associated protocols.
- Many services did not have local targets for referral to admission. Of those wards with targets, MHLD psychiatry, MHLD psychology, forensic community and neuropsychiatry were in breach of their target.
- The proportion of patients who were followed up within seven days of discharge from psychiatric inpatient care remained better than the England Average from 1 May 2014 to 13 Nov 2014.

Requires improvement

Are services responsive to people's needs?

The facilities promote recovery, comfort and dignity and confidentiality

- The dignity and privacy of the patients were not always protected due to failure to meet same sex accommodation guidance.
- We observed that the forensic service line had clear justification and rationale for any restrictive practice in place.
- The Brookfield centre, a forensic rehabilitation ward, had CCTV in operation. However, the rationale for this was not clear.
- The PLACE data provided by the trust give an averages score of 81.75% for food in comparison to 88.73% national average for mental health and learning difficulties. Patients and others raised the poor quality of food across many wards. Despite their reasonable PLACE scores, the areas patients told us that food was a key issue were Littlestone Lodge (78.19%), Davidson ward and Trevor Gibbens unit (90.74%).
- Patients had access to an interpreting service if English was not their first language. We found good practice and support for patients with limited English skills; an example of this was were the interpretation service assisted in their repatriation of a patient to their country of origin.
- We saw good examples of patients being able to make calls and use Skype to contact relatives. However, it was noted that the telephone in the learning disability wards were not always private.
- Patients were able to order food to meet their dietary requirements, such as vegetarian, halal or for patients with diabetes. Information was available on wards on how to contact local religious groups some wards were routinely visited by a chaplain.

Listening to and learning from concerns and complaints

- The total number of complaints received had increased in the last year. The trust data told us 386 formal complaints were made in the last 12 months (1 Dec 2013 - 13 Nov 2014). However, the proportion of complaints upheld has significantly decreased (from 48.95% to 44.95%). The majority of complaints received and upheld were about 'all aspects of clinical treatment' and 'attitudes of staff'.
- In the main, we saw that information was available for patients and carers either via leaflets or notice boards on how to make a complaint. Staff with the exception of Cranmer and Jasmine Wards were aware of their roles and the complaints policy. We saw evidence of active patient engagement in the complaints within the forensic service with the 'a change we made from you comment' process. In the majority complaints were dealt with informally at a local level where managers would meet with patients and others to resolve their concerns.
- We saw evidence of learning and responding to complaints in the majority of services visited.
- However, North Kent CCGs recently undertook an audit of complaints received by services across North Kent. Their findings highlighted that the responses to complainants and the level of investigation which was taking place varied. Overall, it was felt responses were dismissive, blunt and lacked empathy.

Requires improvement

Are services well-led?

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

Summary of findings

We rated well-led as good because:

- The Trust was actively trying to improve morale and engage staff by introducing tools such as the 'green button', 'white wall' and senior team visits. Many staff could provide examples of how these tools had resulted in prompt, in person response from the board and senior managers.
- Risk management and board assurance process did not always identify or escalate the risk of harm to patients for example the inadequate care being provided at Littlestone Lodge. The current process may lead to similar gaps in governance assurance in the future.
- Staff vacancies, the high usage of bank and agency staff and number of shift unable to be back filled is a on going recognised risk to patient safety.
- The trust were actively engaged in internal and external programmes of improvement.
- The number and quality of service level and quality of service led audits was inconsistent.

Our findings

Vision, values and strategy

- The trust has a clearly stated vision to 'deliver quality through partnership'. Creating a dynamic system of care so people received the 'right help at the right time, in the right setting, with the right outcome'. Its values were respect, openness, accountability, working together, innovation and excellence. Posters displaying these values were visible in many of the clinical settings that we visited. Differing views regarding the relevance of the trust's vision and values were raised by staff. However, the majority of inpatient areas reported that the values underpinned their values at ward level and one ward had displayed examples of this on their walls.
- The trust had developed a strategy with underpinning principles that included clinical leadership. It was in the process of implementing the strategy via a transformation programme with accompanying work streams and sound programme management. Both the executive and non-executive team were committed to delivering the strategy and the transformation programme. We met many staff who understood and supported the trust's strategic direction and examples of active engagement in the change in line with the strategic plan. Many staff, at differing staff grades told us of their engagement with 'clinical cabinet' in developing a clinical focus. Others were unaware of the new forums to drive and ensure clinical excellence. Senior clinicians view on their engagement in this change was polarised.
- The Trust was projecting a small surplus at year end. There was a comprehensive estates rationalisation plan (estates strategy 2015-2010) underway to enable the trust to be financially viable. Forty sites had been rationalised resulting in a 40% reduction in the trusts footprint. Consequently, the trust ensured financial viability while providing a capital investment fund to upgrade the remaining estates and building a new ward in Maidstone.
- The friends and family test results identified that:56.3% of staff would recommend the trust as a place to receive care (compared to a national average of 75.6%), 17.5% would not (compared to a national average of 7.7%).

Good governance

- The trust had the necessary governance structures. It had defined clear lines of accountability and decision-making. The weekly meeting of the executive management team was the main decision making forum. The finance and performance committee scrutinised decisions that required judgements about costs and quality. The integrated audit and risk committee was the central means of scrutinising and controlling risk. Non-executive directors were active participants in decision-making and chaired or co-chaired some of the key committees and boards. One of their roles was to provide robust and appropriate

challenge to the executive team. One example provided was the introduction by the quality group of 'deep dives'; to ensure the trust had a more qualitative approach to learning from incidents if required.

- The executive group made use of a wide range of indicators and other quality measures. At the highest level the trust had brought these together into a dashboard (board assurance performance indicators). The dashboards were recognised and understood at ward level. The community services displayed a dashboard which was discussed at team meetings monthly. We saw the dashboard for the community services showed that 100% of patients received a seven day follow up of the care programme approach (CPA) and 96% of patients had received a 12 month review.
- Senior managers had ready access to key items of information. For example, the director of nursing received regular reports on fill rates of nursing shifts on wards and use of agency and bank staff.
- However, despite this evidence of clear lines of accountability and information flows we found evidence that some aspects of governance were not working well.
- We found problems with medicines management repeated in a number of care settings such as drugs cupboards not being secure. Our pharmacist was able to identify three medication errors and a further incident of a critical medication not being given that had not been reported. We concluded that there was under-reporting of medication errors, the trust told us they receive only a maximum of ten medicines incidents a month. Some of the consistent or unaddressed medication issues found by the inspection team included:
  - The medicines audits on most wards in the older peoples inpatient service were not effective.
  - Despite regular visits from pharmacists, on Cherrywood ward of the current 18 patients, there were 36 gaps over the last month.
  - On Cherrywood ward the fridge temperature was recorded as 17 degrees, well above the acceptable range. This had been in at this temperature for several weeks but no action had been taken. On Amberwood ward the checks had last been completed a month prior to our visit, and at that time had been just above the acceptable range at 10 degrees.
  - We identified a patient in Littlebrook Hospital that had been admitted to re-start medication. The patient left the hospital without receiving their medication. When we discussed this issue with the ward they identified it as an incident that required investigation into the rationale behind the admission, and why it was not picked up sooner that the medication was not being administered.
- The monitoring processes had not identified many gaps and problems in the frontline services. Where problems had been identified, these were not always being rectified in a timely manner. For example, there were gaps in updating risks assessments and care plans; we found out of date and missing resuscitation equipment; and the reasons behind high levels of restraint, including prone (face down) restraint had not been identified.
- The trust audited the recording of consent to treatment provisions under the Mental Health Act and Code of Practice sampling Emerald and Brocklehurst wards. The trust found that 62.5% of the notes looked at were found to be not compliant with MCA on Emerald ward and non on Brocklehurst ward. We found there was still very limited compliance with MCA across several wards in the acute inpatient service line including informal patients on S17 leave.
- One of the two warning notices issued regarding Littlestone Lodge related to the trusts failure to comply with Regulation 10 (1)(2) of the Regulated Activities Regulations 2010, assessing and monitoring the quality of the service. The trust's processes had failed to identify that the standard of care in Littlestone Lodge was poor until a temporary ward manager had been introduced in December 2014. The acting ward manager had identified multiple problems in the service and developed an action plan to address them. The version of the action plan, updated 18 February 2015 showed that progress had been made, but there were a number of issues that had still not been addressed by the time of our inspection. Despite the risk being known at board level, none of these concerns were entered onto the local or corporate risk register. The local risk register had not had any risks added since 2012.
- The system to assess the quality of the service had not identified that the arrangements in place to ensure that service users are safeguarded against the risk of abuse were not suitable. For example, Littlestone Lodge had

no record of the safeguarding incidents that had been raised before January 2015. In addition, several incidents of safeguarding were not reported in the forensic service line.

- The trust had provided information on the proportion of staff who had received mandatory training. The trust was now working to an 85% target for all subjects except information governance which remained at 95%. The majority of service line were meeting the 85% target for their mandatory training. However, of the 28 pieces of mandatory training in the acute service line nine had not achieved the 85% (38%). Some of the training not met included life support, medicines, CPR and breakaway training.
- The majority of staff told us they received appraisals and supervision. This was supported by the NHS staff survey where 89% of recipients had received supervision (comparable to national average of 88%) and 48% felt that their supervisions was well structured (national average 41%). The inspection teams found that supervision was not always delivered and not always delivered to a high standard across the services, for example, areas of CMHSOP. In some areas there was limited evidence of clinical rather than managerial supervision.
- The executive management team's risk register highlighted that the trust had two areas, acute inpatient service line and liaison psychiatry service, that had highlighted vacancies and staffing levels as a high risk. Both these risks (3964 and 3905) were deemed to have inadequate control and therefore were reflected in the trust's risk register.
- The trust told us its overall percentage of trust vacancies on 31 October 2014 was 17.4% which it had reduced to 9.7% by the time of our inspection. Thirty one of the trusts locations or hospitals were identified as having a vacancy rate of 50% or more. These locations were across a number of the trust's service lines. The trust had made attempts to aid recruitment by offering incentives. However, many staff told us that the internal and external recruitment process was lengthy and unhelpful. The trust's 2014/15 recruitment strategy set a target of 80% of post being filled from close of advert. It was not meeting its target. However, it had improved from 22% to 67% in two quarters.
- The trust highlighted that the main issue with staffing was lack of registered nurses during the day. Overall, all wards achieved an overall coverage, even if this was not at the agreed qualified/ unqualified ratio. The executive management team's risk register recognised that the staffing and vacancy rate may result in 'breaches of response times set to safeguard patients from further injury to themselves or others' and ' in wards working below establishment or reliant upon poorly skilled bank/agency staff resulting in poor quality patient care'. Thirty one wards used bank and agency staff to fill over a hundred shifts in the three months before 31 October 2014. Archery House had the highest number of shifts not filled by bank or agency staff where there was sickness, absence or vacancies.
- KMPT continued to monitor its safe staffing levels as part of the national safe staffing agenda.
- KMPT was seen to be actively engaged in a large number of national clinical audits and other clinically relevant quality activities. However in some areas there was limited local service led audits. An example of the national audits quality improvement activities KMPT were involved in included:

- All wards took part in the 15 step challenge.;
- All forensic wards were accredited members of the Royal College of Psychiatrists quality network for forensic mental health services;
- All older peoples community localities have joined the Royal College of Psychiatrist`s memory services national accreditation programme as affiliate members, although were in varying stages, from preparing, to final assessment for accreditation. Ashford was the first team to be accredited in January 2014.
- The teams participated in national research. Current research contributions included the `GERAS` study, an observational study for patients with Alzheimers disease and research into improving patient outcomes by offering additional sessions of cognitive stimulation therapy.
- The trust carried out 148 seclusions in 2014, a reduction of 63% on the previous year. We found that in the forensic service line that seclusion levels were low; using early intervention techniques to reduce the need. The trust had audited the seclusion facilities in place in line with national guidelines in December 2013. The outcome of the audit found that several of the seclusion rooms did not meet national standards. For example, the Allington centre room is too small and it is difficult to provide mattress in several rooms due to their size.

Requires improvement

Are services well-led?

We found numerous problems across all seclusion rooms were still in place. For example, rooms were less than 15sq meters in size, with inward opening door, broken ceiling light fitting and no visible clock, no shower, no natural light, no working CCTV and toilets loose fitting. The trust told us it were planning to reduce the number of seclusion rooms from seven to two and it had a bid for two to be re-designed under consideration.

- The trust are updating its training programme for restraints, and told us that a 100% of staff would start being trained using the new training methodology in March 2015.
- The patient safety group received a paper on 24 February 2015 from the trust violence, restraint and seclusion monitoring group outlining the trust's progress with restrictive practices (restraint, seclusion and segregation). The trust had an overall reduction in the use of restraint between 2013 and 2014 by 42.5%. The majority of these reduction was attributable to the forensic service lines and older people services. The number in the acute service line showed a very small reduction of approx. 2%. Despite the reduction in the use of prone restraint across the trust by 20%, in 2014 prone restraint was use 294 times (lower than some similar trusts). Between 1 April 2014 and 1 September 2014 35% of restraints were prone. The trust told us they were reviewing this practice and starting to introduce positive behaviour plans to reduce prone restraints.
- The trust used a paper based system to record their incidents. These were subsequently fed into IRIS database. Many staff across the service lines told us this system was time consuming and cumbersome.
- KMPT had received a notice of contravention from the Health and Safety Executive for failing to report accidents in line with the requirements of the reporting of Injury, Disease and Dangerous Occurrences Regulations 2013.
- Incident records were not always fully completed in the older peoples' inpatient service.
- Between 1 December 2013 and 31 December 2014 - 84.2% of the incidents reported were categorised as Grade 1, with a 45 day investigation deadline, 37 of the serious incidents were overdue at the time of the inspection (awaiting CCG action).
- We found evidence that medical incidents were underreported.
- There had been one DoLS notification received into CQC in the last two years. The trust had reported that they have submitted 59 DoLS applications in the last 6 months.
- The trust had audited MHA and MCA twice in the previous six months, yet we were able to find serious concerns with the issues of consent and informal detention across numerous service lines.
- We found evidence of safeguarding incidents not being reported, in particular, in the forensic service line and older peoples' inpatient service.
- The trust operated a bottom up approach to risk management which included the use of local risk registers and service risk registers. These fed into the trust's risk register. The board minutes highlighted that the trust reviewed the top risks. In the October 2014 board meeting, 10 of the 15 top rated risks were adjudged to be 'inadequate', while a further three had 'uncertain' controls against them. Some of the top risks included, high sickness levels, staff competence, culture and their relationship with Medway Council. Only 'failure to recruit to new staffing levels' and 'the community team/psychological services were unwilling to accept care co-ordination for a patient' were adjudged to have 'adequate' risk mitigation controls against them.
- The provider had good working relationships with some of the local Clinical Commissioning Groups (CCGs). There was a history of a difficult relationship with the Medway Unitary Authority. The trust executives told us of the efforts that it was making to build bridges through joint operation groups. The trust's risk register identified the reputational risk of the continued poor relationship.

Leadership and culture

- The trust was actively trying to improve morale and engage staff by introducing tools such as the 'green button', 'white wall' and senior team visits. Many staff could provide examples of how these tools had resulted in prompt in person response from the board and senior managers. 43% of staff in the 2014 NHS staff survey reported good communication between senior management and staff compared to the national average of 30%. Staff consistently told us morale and communication were not where it should be, however, this leadership team were improving theses issues and it was better than what they had experienced previously.

Requires improvement

Are services well-led?

- All but one of the board members had been in post for less than four years**.** The chief executive was appointed in April 2012. We concluded that they were a cohesive team who shared a common purpose**.** The non-executive directors had a range of backgrounds which included experience in the private sector and finance.
- We interviewed the trust's chair and secretary regarding their implementation of the fit and proper persons test. We were assured all new directors would receive the required clearance and that all existing non-executive directors had received appraisals and completed their declaration. The chair advised us that the trust had not carried out DBS checks on existing non-executive chairs, this was a requirement of the new regulations. We reviewed a random sample of executive board members' personnel files and the appropriate documentation was available.
- Board members, including the non-executives, made regular visits to clinical areas. Indeed, each service line had a champion from amongst the NEDs who attended their leadership days and acted as a conduit for their voice to be heard at board level.
- Between 2013 and 2014 the trust performance in the NHS staff survey had improved for many items. However, staff at KMPT were more likely to report experiencing bullying, harassment or abuse from staff in the last 12 months that the national average (26% versus 21%). This particularly affected staff in community and inpatient mental health services for adults of working age. In view of this we explored this in our meetings with staff at all levels and did not find evidence of this being an endemic problem.
- Staff and patients actively raised their concerns regarding the temporary move (for two years) of Rosewood Lodge to the Rosebud centre due to upgrades to the estate. Prior to the move the trust had undertaken a consultation and told us that the option to move the service had not been selected lightly but was required to make comprehensive improvements to a number of services, including the rehabilitation service. The consultation took into account patients, carers and staff concerns. The chief executive had visited the unit shortly after the move to review first-hand how the service was adapting to its temporary environment. However, patients, carers and staff said that whilst they had expressed some concerns during the consultation the safety and unsuitability of the location had only been fully realised after the move. They said they felt their concerns had not been fully listened to by the chief executive at the time of the visit and that they continued not to be listened to. Patients felt that the quality of care had fallen and some felt they had taken a step backwards in their recovery as a result of the move. For example, the location of the site dramatically reduced their ability to engage with activities in the community.
- Staff sickness rates (HSCIC) at the trust had been above the national average for the period surveyed, except in August 2013 and March 2014. High levels of staff sickness had been recorded as a risk on the trust's register since 12/2/2012. Despite this it currently rates its control measures as 'uncertain'. The trust has set itself a target of 3.9% sickness absence by March 2015.
- The trust told us they have developed a policy for the implementation of “Duty of Candour". The board had received training and 'what it means to patients' leaflet were available.

Engagement with the public and with people who use services

- The senior trust managers expressed a commitment to engaging service users and carers in developing its services. It had established a patient experience group and a patient consultative committee. However, many boards and committees whose work was relevant to the patient experience did not have service users as members.
- The trust had a strong track record of engaging with patients at a more local level. It had conducted a number of patient surveys in recent years. It could demonstrate that these had resulted in improvements in service design. For example several wards had developed 'you said we did' feedback process for patients and carers. While, areas within the trust held carers consultative committees.
- KMPT were actively seeking feedback from patients and carers for example the, 'effective care planning survey, 'carers survey', and 'help us get it right' feedback slips. KMPT won the Kent, Surrey, Sussex academic health science network (KSSAHSN) in January 2015 for the implementation of a survey sent to people who used the trust's memory assessment service. 94% of patients surveyed felt their families had been fully involved in their care.

Requires improvement

Are services well-led?

- Evidence of shared learning from research were found in 'headlines', the service user involvement group newsletter.
- The trust developed an experts by experience research and development group in 2009.
- Not all services engaged patients and sought their views to improve their services. However, we saw, within the forensic service line, a forensic expert by experience group had been launched in 2013 and that the steering group had met monthly to oversee quality improvements in the service, directed by ex-service users, carer representatives and health care workers. We noted that the steering group was called, 'focus on service improvement together' and we saw that this group published a monthly newsletter which provided progress reports on service improvement initiatives. These included, improving food by sampling a variety of new providers and their menus; improving services for women by increasing the number of step-down beds available; the development of an introductory video for patients and carers; involvement in staff induction with the introduction of a poster which listed key areas which patients believed were important for new staff to know.

Quality improvement, innovation and sustainability

- Some KMPT services participated in national service accreditation and peer-review programmes. These included the accreditation for inpatient mental health services (AIMS) on two wards, the home treatment accreditation scheme in one CMHT, the quality network for forensic mental health services, the community of communities – a quality improvement network for therapeutic communities and the memory services national accreditation programme. AIMS is recognised by the CQC as an official information source.
- The trust also participated in the national audit of psychological therapies, the national audit of schizophrenia (NAS) and the prescribing observatory for mental health (POMH-UK).
- The trust clinical audit group was told us that it was managing the trust's active clinical audit programme; including its participation in the national clinical audits. The group, which reported to the clinical effectiveness and outcomes group, ensured that clinical audits resulted in action plans and oversaw their implementation.
- There were a number of trust-wide performance audits that each team used to monitor performance. There were some local audits being carried out, but this varied between the wards. For example, some wards carried out regular infection control, care plan, prescription chart and Mental Health Act audits. However, in some services there were limited local service led audits, for example, Admiral nurses did not have any target and we did not find any evidence to show clinical staff participated actively in clinical audits in the older patients inpatient service. We found evidence that the impact of several of the clinical audits were negated by lack of a robust response to implement change, for example. medicines audits.
- For 2014-15 the trust has set nine priorities for improvement divided into the three areas that constitute quality, the patient experience, patient safety and clinical effectiveness. The trust were auditing and monitoring their performance against these priorities. Some of the work carried out as a consequence include Woodstock ward had identified area where patients frequently slipped or had fallen and altered the surrounding space to minimise risks.
- The trust was actively encouraging participation in research through its KMPT research bulletin. Evidence of shared learning from research were found in 'headlines', the service user involvement group newsletter. Within the bulletin members of staff were recognised for their contribution to research. The trust were building relationships with Sussex and London Universities to boost their research activities.
- The trust finance and performance committee received information about both quality and financial performance. It scrutinised proposals for cost releasing initiatives and challenged the impact that these might have on quality of care. The trust provided us with examples of instances where proposals for such initiatives had been rejected due to their impact on quality.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) had not protected people against the risk of people being cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard. Staff at Swale community mental health service for older people did not receive regular supervision. This was in breach of regulation 23 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) had not ensured appropriate person-centred care and treatment through designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met. Care plans for patients receiving care from the community mental health service for older people were not always patient centred or reflecting service user preference. There was no access to a crisis service for older people who have dementia and experience mental health crises outside of office hours. Teams were not always keeping within the assessment and treatment timescales agreed with local commissioners.

This section is primarily information for the provider

Compliance actions

Patients were not receiving effective assessment and care for physical health and mobility needs, and pain management on Littlestone and Cranmer Ward.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not have procedures and processes in place to respond appropriately to any allegation of abuse.

We found evidence on Woodstock ward, Littlestone Lodge and Cranmer wards, where concerns had not been recorded and reported to the safeguarding team.

Safeguarding alerts had not been raised for all recorded safeguarding incidents in the learning disability inpatient wards (Tarentfort Centre)

This is a breach of regulation 11(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

This section is primarily information for the provider

Compliance actions

We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not take measures to ensure that service users were protected against the risks associated with the unsafe use and management of medicines.

We found unsafe covert administration of medicine of Littlestone Lodge ward. We found missed signatures on prescription cards and issues with the storage and disposal of medicines on Jasmine, Cranmer, Woodstock, Hearts Delight, Sevenscore and Littlestone Lodge.

Staff in the rehabilitation service were not following the trust policies and procedure in the storage, and recording of medication, including self-medication.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not have effective operations which enabled the registered person to regularly assess and monitor quality of the services and identify, assess and manage risks. The current governance processes are not effectively identifying risks and monitoring quality of services for older people wards which are not performing well, so that improvements can take place and be closely monitored. Throughout the rehabilitation service there was not an effective system to ensure that all staff were aware of when and how to report incidents and how to ensure incidents were minimised in the future. Systems for learning from incidents were ineffective.

This section is primarily information for the provider

Compliance actions

This is a breach of regulation 10(1)(a)(b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment We found that Kent and Medway NHS and Social Care Partnership Trust (KMPT) did not ensure the registered person acted in accordance with the Mental Capacity Act 2005 or if Part 4 or 4A of the Mental Health Act 1983 applies to a service user, where the person was unable to give such consent because they lack capacity to do so. We found that Deprivation of Liberty (DoLs) applications had been made but this was not a consistent practice across the whole older peoples' inpatient service. We found poor compliance and practice in older peoples' inpatient services in relation to the application of the Mental Health Act 1983 (MHA 1983). Consent to treatment and information sharing was not consistently recorded. It was not always clear who information could be shared with and in what format. We also found that it was not always consistently and clearly documented that capacity to consent had been assessed. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11(3)(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The trust did not ensure that service users were protected against the risks associated with unsafe or

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Compliance actions

unsuitable premises. The section 136 suites at Littlebrook Hospital and St Martins Hospital were not of suitable design and layout to ensure service users were safe and their privacy and dignity were respected.

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

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Compliance actions

The trust had not ensured that service users were safeguarded against the risk of abuse by responding appropriately to any allegations of abuse at Tarentfort Centre.

Safeguarding alerts had not been raised for all recorded safeguarding incidents.

This was in breach of regulation 11 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision We found that Kent and Medway NHS and Social Care Partnership Trust did not have a system to maintain the privacy and dignity of women who were secluded on Willow Suite. This is a breach of regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services We found that Kent and Medway NHS and Social Care Partnership Trust did not always have up to date care plans for patients that reflected their needs. Patients who had behaved aggressively, or who had been restrained, had not always had their care plans updated to describe how to prevent, manage and de-escalate potential future incidents.

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Compliance actions

In addition, the trust were not always assessing the needs of patients and have up to date care plans across CMHT. For example, patients physical health needs had not always been assessed, risk assessments were not updated, and they did not reflect the service user's consent to treatment.

This is a breach of regulation 9(1)(a)(b)(i)(ii)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(1)(3)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines We found that Kent and Medway NHS and Social Care Partnership Trust did not have safe and secure storage, and accurate recording of the handling of medication, including controlled drugs, on Cherrywood ward. This is a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment We found that Kent and Medway NHS and Social Care Partnership Trust did not always consistently implement the Mental Health Act in accordance with the Code of Practice. This included on Amberwood ward and Emerald Ward where patients had not been informed of their rights, informal patients had been told they would not be allowed to leave, medication had been administered without the proper consent, and there was poor documentation of the treatment plan when a patient had a second opinion from a second opinion appointed doctor (SOAD).

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Compliance actions

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services We found that Kent and Medway NHS and Social Care Partnership Trust did not always have psychiatric intensive care unit (PICU) beds available, which led to delays in finding a suitable bed for unwell patients. This is a breach of regulation 9(1)(b)(i)(ii)(iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision We found that Kent and Medway NHS and Social Care Partnership Trust had monitoring processes that did not always identify gaps and problems in their services. This included gaps in updating risk assessments and care plans, out of date and missing resuscitation equipment, problems with medication storage and recording which included in relation to consent to treatment and the Mental Health Act, and identifying the reasons behind high levels of physical restraint including prone restraint.

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Compliance actions

This is a breach of regulation 10(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises We found that Kent and Medway NHS and Social Care Partnership Trust had not protected people at risk as the premises where regulated activity was carried on was not protected against the risks associated with unsafe or unsuitable premises by means of suitable design and layout and appropriate measures being taken in relation to risks the premise posed to patients. Same sex accommodation did not meet the requirements of the Department of Health requirements at the Knole Centre, Davidson ward and Newhaven Lodge. Male patients' bedrooms, on Hearts Delight ward, were in view of female patients. Ligature risk management did not manage risks for all patients throughout the rehabilitation service, particularly for acute patients 'sleeping out'. Seclusion rooms on three of the wards at the Trevor Gibbens unit required significant upgrading and improvements to the facilities. The seclusion room in Riverhill ward was not of a suitable design and layout and was not adequately maintained to keep patients safe whilst secluded. The trust did not always have available and adequately maintained equipment in the event of a medical emergency. This included on Cherrywood ward, Amberwood ward, Emerald ward, and Samphire ward which did not have all their emergency equipment and medication accessible and in date, or have effective systems for regularly checking that this was the case. This is a breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Premises and equipment

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and corresponds to Regulation 15 HSCA (Regulated Activities) Regulations 2014 premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision We found that Kent and Medway NHS and Social Care Partnership Trust had not protected people at risk of inappropriate or unsafe care. There was not an effective system to ensure that all staff were aware of when and how to report incidents and how to ensure incidents were minimised in the future. Systems for learning from incidents were ineffective in the majority of the rehabilitation service and at Littlestone Lodge This is a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers and corresponds to Regulation 12 (Regulated Activities) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines We found that Kent and Medway NHS and Social Partnership Trust had not protected people against the risks associated with the unsafe use and management of medicines. Staff were not following the trust policies and procedure in the storage, and recording of medication, including self-medication. The provider had not followed its own policies. On Penshurst ward at the Trevor Gibbens unit there was inappropriate arrangements for the safe keeping of medicines.

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Compliance actions

This is a breach of Regulation 13 HSCA 2008 (Regulated Activities)Regulations 2010 Management of medicines

and corresponds to Regulation 12 (Regulated Activities) Regulation 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services We found that Kent and Medway NHS and Social Partnership Trust were not always assessing the needs of patients and have up to date care plans across CMHT. For example, patients physical health needs had not always been assessed, risk assessments were not updated, and they did not reflect the service user's consent to treatment. This is breach of regulation 9 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 (3)(b) - (h) of the Health and Social Care Act (Regulated activities) Regulations 2014

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing we found that Kent and Medway NHS and Social Care Partnership Trust had not ensured that the caseloads of staff across CMHT did not exceed its own established levels. The trust must ensure that sufficient numbers of suitably qualified, skilled and experienced staff are employed to ensure the care of all service users on staff's caseloads are safe and appropriately managed. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulations 18 (1) of the Health and Social Act 2008 (Regulated activities) Regulations 2014.

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Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Failure to ensure that the individual needs and the welfare and safety of service users were met at the older persons ward, Littlestone Lodge, Barrow Arrow Lane, Dartford, Kent, DA2 6PB.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Failing to assess and monitor the quality of service being delivered on the older persons' ward, Littlestone Lodge, Barrow Lane, Dartford, Kent, DA2 6PB