Oxleas NHS Foundation Trust

Community-based mental health services of adults of working age

Inspection report

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Ratings

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

Our findings

Community-based mental health services of adults of working age

Requires Improvement 

We carried out this short notice announced inspection because at our last inspection we rated this service overall as requires improvement.

Oxleas NHS Foundation Trust provides a range of community-based mental health services for adults of working age. Community mental health teams support patients who have complex mental health and social care needs. They provide medium to longer term support to patients. The pathway of care includes:

- Hubs (previously known as primary care plus (PCP)) directly linked with primary and secondary care services. The hubs provide a single point of access to trust mental health services. Staff focus on telephone triage of patients, providing advice and support to GPs and directing patients to the pathway that meets their needs.
- The ADAPT pathway provides focused, therapeutic interventions to patients needing treatment for anxiety, depression, affective disorder, personality disorder and trauma.
- The intensive case management for psychosis (ICMP) pathway provides care and treatment for patients diagnosed with schizophrenia and bipolar disorder.
- The early intervention pathway (EIP) for patients aged between 18-65 experiencing psychosis for the first time, or at risk of developing psychosis.

We inspected the following services:

Bexley ICMP

Bexley ADAPT

Bexley hub (PCP)

Bexley EIS

Greenwich West ICMP

Greenwich West ADAPT

Greenwich East ICMP

Greenwich EIP

Greenwich hub (PCP)

Bromley West ICMP

Our findings

Bromley hub (PCP)

In addition, we collected feedback and information about some of the trust's other services, including the attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorders (ASD) teams, commissioned to provide assessments.

Our rating of services stayed the same. We rated community-based mental health teams for adults of working age as requires improvement because:

- Patients gave some mixed feedback about the care and support received from the teams, particularly when they were in crisis. They reported some difficulty being accepted by some teams and getting through to some services by phone.
- Risk management or crisis plans were not always updated as patients' risks changed, although we found some improvement in staff recording patient risks, as required in the last inspection report published in August 2020. We also found some patients at risk of being missed due to gaps in the electronic waiting lists which had recently been introduced.
- Teams used a zoning system to monitor patients' level of risk, and inform caseload management for staff, but records did not always make clear why patients were allocated to or had changed risk zoning levels and what extra support was needed.
- Patients were still waiting too long for neurodevelopmental assessments and some psychological therapies. The trust had taken a wide range of actions to address long waits as required at the previous inspection. However, as demand had increased for these services, there were still excessive waiting times for assessment and treatment.
- There was insufficient oversight of medicines management across the community mental health teams, including some errors in the management of prescription charts for patients.
- The trust was not monitoring delays in Mental Health Act assessments and Community Treatment Order recalls for patients in the community mental health teams.
- Staff had improved their systems for collecting feedback from patients, but there was insufficient feedback collected from carers. There was also insufficient communication from the service, about improvements made as a result of patient or carer feedback.
- Staff were not sufficiently recording the needs of patients with a protected characteristics and how they met these.
- Some staff including some managers had very high caseload sizes including complex cases on their caseload due to ongoing issues with staff recruitment and retention.
- Staff were not always clear about the new protocols for recording care plans, particularly staff in the hubs using the new care planning tool for assessments.
- The teams had taken significant steps to improve monitoring of the physical health needs of patients and make sure that patients who needed an electrocardiogram received them regularly as required at the previous inspection. However, further work was needed to ensure that this continued, particularly when staffing levels were low.

However:

- Most staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patient feedback was particularly positive for the early intervention services, with patients particularly appreciating access to family therapy.

Our findings

- Staff provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients.
- Teams had improved monitoring of patients on waiting lists to detect and respond to increases in their level of risk. They had also provided and were developing more groups for patients waiting for psychology services.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff followed good personal safety protocols.
- The teams included or had access to the full range of specialists including peer support workers who met the needs of the patients. The trust employed lived experience practitioners who were able to work with patients from a position of personal experience.
- There was effective joint working with voluntary sector provision, and staff were embedding roles in GP practices, and a move to a 'no wrong door' approach to the services.
- Staff were strongly motivated, working very hard to meet demand, and felt well supported by their immediate managers. New roles had been created, such as band 4 nursing associates with career pathways, to address gaps in staffing.
- Leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed. Staff described strengthened management within the last year with improved processes, and systems and support. Staff reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.
- Teams were undertaking a wide range of quality improvement projects including projects to improve patients' physical health, increase patient feedback, working to reduce appointments which patients did not attend, looking at barriers to discharge, and a project led by patients looking at their experience of coming off medicines without discussions with healthcare professionals.

How we carried out the inspection

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

• visited 11 services and looked at the quality of the environment

• spoke with 29 patients and 9 relatives/carers

• spoke with 63 staff including team managers, consultant psychiatrists, registered mental health nurses, psychologists, occupational therapists, social workers and lived experience practitioners

• attended and observed 9 meetings, including zoning, bed management, referral screening, and cases of concern meetings

• reviewed 50 care and treatment records

Our findings

• reviewed medicines management including over 60 prescription charts

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

• met with 6 senior managers within the service by video conference

• contacted 6 local GP practices, and 3 advocacy services, to request feedback, but we did not receive any feedback from them

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

What people who use the service say

Patients said staff treated them well and behaved kindly. Although some patients and relatives expressed concerns about waiting times, almost all spoke positively about the individual staff supporting them. Patients described staff as reliable, respectful, caring, and listening to them. Some patients spoke positively about regular contact with staff, offering emotional support and advice when they needed it, helping them to manage stress, and supporting them with practical tasks such as benefit claims, and housing issues. Most patients said staff were compassionate. A small number of patients did not always feel respected and listened to by staff working with them.

Patients valued therapeutic groups and other activities arranged by staff such as walking groups, and a picnic. Patients were very aware of staff shortages in the teams, and some felt this had impacted on the frequency at which they were seen, and the amount of time staff had to speak with them on each occasion. Several patients said that it was hard to get accepted by the teams on referral. Some patients noted that it could be hard to get through on the phone to the Heights office base.

Patients' feedback was mixed about the service overall, with suggestions for improvement in waiting times, responses from the crisis team, more frequent reassessment, and improving transition from children to adult services.

Patients told us that it was not always clear how their feedback was used to improve services.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as **requires improvement.**

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, and well maintained.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. All interview rooms had alarms and staff available to respond.

Our findings

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. Staff in all teams adhered to infection prevention and control guidelines to reduce the risk of infection including Covid-19. All areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control guidelines, including regular handwashing, social distancing, and use of personal protective equipment when required. At the time of the inspection, following the peak of the Covid- 19 pandemic, most staff had returned to work from the office bases, but some staff continued to work from home. Patients could be seen in person or virtually depending on their needs and preferences.

Some sites, for example Beckenham Beacon, did not have enough space for regular group sessions to be held, but alternative sites were being sought.

Staff made sure equipment was well maintained, clean and in working order.

Safe staffing

There were staff vacancies, but this had significantly improved in recent months, following low levels of staffing over the last year. Active recruitment was taking place, and most teams had enough staff, who knew the patients and received appropriate training to keep them safe from avoidable harm. The trust were using creative solutions where there were staffing shortages, including the introduction of new posts.

However, staff told us that the number of patients on the caseload of some teams, and of individual members of staff, was too high to give each patient the time they needed.

Staff

The service had some vacancies in nursing and social work staff, but had systems in place to keep patients safe.

The highest vacancy rates of the teams we inspected were at Bexley intensive case management for psychosis (ICMP) team at 39%, Bromley West ICMP at 36%, Greenwich East ICMP at 33%, and Bromley early intervention pathway (EIP) at 20% in September 2022. These teams also had relatively high vacancy rates in April 2022.

Managers limited their use of bank and agency staff as far as possible and requested staff familiar with the service to cover shortfalls. They made sure all bank and agency staff had a full induction and understood the service before starting their shift and arranged for covering staff to work on fixed term contracts of at least 6 months. Teams using the highest number of bank or agency staff within the last 6 months included Greenwich East ICMP with 447 shifts covered, and Bexley PCP and ADAPT (anxiety, depression, affective disorder, personality disorder and trauma) teams combined at 443 shifts, followed by Greenwich Hub at 240 shifts.

The service had variable turnover rates. Overall turnover for the service was at 2.5% in March 2022 and 1.9% in August 2022. The highest rates in March 2022 were 16% for Greenwich PCP, and 13% for Greenwich West ICMP. In August 2022 the highest rates had fallen to 10% Bexley EIP and 9% Bexley ICMP.

There were high rates of sickness in some teams. Managers supported staff who needed time off for ill health. Over the last year average staff absence (largely due to sickness) was highest in Greenwich hub and Bexley ICMP at 11%. Managers made arrangements to cover staff sickness and absence. Staff spoke of the stress experienced by teams where there were multiple members of staff off sick. Managers spoke of the need to take action to address staff retention issues, particularly in teams which were harder to access due to their geographical location.

Our findings

Managers used a recognised tool to calculate safe staffing levels, and this had been rolled out to all teams since the previous inspection. The trust determined safe staffing levels by calculating the number and grade of members of the multidisciplinary team required, using a systematic approach taking account of the duty system, groups and clinics run by staff. Where possible the number and grade of staff matched the provider's staffing plan, with recruitment taking place to fill vacancies.

The trust noted that in most teams the ideal caseload for staff would be approximately 25 patients. At the time of the inspection the highest staff caseloads of the teams we inspected were in Bexley ICMP, including the team manager with a care coordinating caseload of 45 and senior social worker with a caseload of 51, two other staff in the team had caseloads of 37 and 38. In Bexley ADAPT the highest care coordinating caseload was 26, and in Bexley EIP the highest caseload was 20. In Bromley West ICMP the highest caseload was 33, with some staff having caseloads of 32. In Greenwich East ICMP two staff had caseloads of 35, whilst the highest caseload in Greenwich West ADAPT was 31, in Greenwich West ICMP was 30, and in Greenwich EIP was 18.

At the time of the inspection, we were concerned to find that the senior social worker and team leader in Bexley ICMP were both covering significant caseloads (of over 70 each), in addition to other duties, due to several nurse and social worker vacancies and episodes of staff sickness. Senior management were aware of the situation and supporting them to reduce their caseloads with support from the duty team. In Bromley East ICMP the team manager held a caseload of 40 patients whose needs were addressed by duty staff.

Most staff told us that their caseloads were generally manageable, unless they had patients in mental health crisis, when the caseloads could become difficult to manage. Managers monitored care coordinators caseloads. For example, new referrals that came into the team would be allocated by the manager after they had reviewed each staff member's caseload size and the complexities of those patients, to ensure they could care for another patient safely.

Medical staff

The service had some vacancies for medical staff, but these were filled by locum doctors. Staff noted that there had been challenges to fill medical posts over the last year. In Bexley ICMP there was a vacancy for one of the two doctor positions, in Greenwich PCP there was a vacancy for 0.8 WTE (whole term equivalent) days out of 1.8 WTE posts; and in Greenwich West ADAPT there was a vacancy of one out of 1.6 WTE posts. These were covered by agency or NHS locums.

Managers could use locums when they needed additional support or to cover staff sickness or absence and made sure all locum staff had a full induction and understood the service.

Staff told us that they could get support from a psychiatrist quickly when they needed to. In Greenwich hub staff told us that the recruitment of medical staff had helped reduce waits for medical reviews from a wait of 8-9 weeks (4 months previously) to under 4 weeks.

Medical staff reported being busy with an increasing number of referrals leading to a higher workload.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. The mandatory training program was comprehensive and met the needs of patients and staff. The overall compliance for mandatory training in the teams we visited was 90% or above in all teams except for Bromley West ICMP with a compliance rate of 88%.

Our findings

Compliance with training in breakaway techniques and life support was lowest in Bromley hub at 67% (3 staff to complete) followed by Greenwich West ICMP at 75% and 74% respectively (5 staff due to complete). Greenwich West ICMP also had relatively low staff training in data security at 75% (5 staff due to complete). Managers monitored mandatory training and alerted staff when they needed to update their training.

Where training was incomplete staff were booked onto training courses or there were particular reasons for non-completion such as long-term sickness absence.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. However, staff did not always keep risk assessments and crisis plans up to date to reflect changes in patients' circumstances.

Staff monitored patients on waiting lists to detect and respond to increases in the level of risk but there were some gaps in follow up of patients after initial triage.

Staff followed good personal safety protocols.

Assessment of patient risk

We reviewed the care records of 50 patients. Staff completed risk assessments for each patient using a recognised tool and reviewed this periodically. The risk assessments highlighted the main risks affecting patients. However, we found that risk assessments were not always updated after changes in patient's circumstances. For example, after a patient was discharged from a hospital stay, concerns had been received from the police, or a patient went into prison. Care or crisis plans were also not always current, most concerningly in the case of a pregnant patient.

Where appropriate staff completed a historical, clinical and risk management tool (HCR-20) to assess the risk of violence. Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. Staff told us that it was very rare for patients to make advanced decisions but could give examples of when this might take place, such as for patients who were pregnant. Not all patients had crisis plans, but patients told us, and notes indicated that they had accessed the trust's crisis line (so knew how to access support).

Crisis and contingency plans identified each patient's warning signs, relapse indicators and who to contact in an emergency. Most patients and relatives we spoke with said they knew who to contact in an emergency, even if they were not clear about having a crisis plan in place.

Management of patient risk

In the previous inspection report published in August 2020, we found that patient risk management plans and care plans did not always address the potential risks to patients.

At the current inspection we found an improvement in linking care plans to initial risk assessments, and some good examples of patient involvement in the process. However, in several teams we found that these were not always updated as risks changed. This included several patients' risk management plans in Bexley EIP, Bromley West ICMP, Bromley hub, and Greenwich West ICMP.

We also found several patient records where some parts of the risk management plans had not been completed including sections such as 'what keeps me safe,' 'professional view,' 'protective factors' and crisis or contingency plans.

Our findings

The multidisciplinary teams met regularly in 'zoning meetings' to review the risks affecting patients and consider whether they were receiving the appropriate level of support. Staff used a red, amber, green system to indicate the level of risk for each patient. A patient at a higher risk level was in the red zone. However, we found some gaps in linking the teams' system of zoning patients with the risk assessments in their case notes. For example, we found that patients' allocated zone sometimes changed without a recorded explanation of the rationale for this. In Greenwich West ICMP we found a patient allocated to the red zone who had no recorded follow up by staff. We reported this to the team manager, who undertook to address this issue without delay.

When patients were considered to be at high risk of harm to themselves or others due to poor mental health, staff could arrange for a mental health act (MHA) assessment, to be undertaken. Staff reported that there were sometimes delays in arranging for these to be undertaken, due to lack of availability of police officers to support access to patients, or available hospital beds. However, the trust was not monitoring delays for MHA assessments, and the reasons for these, in order to ensure that the causes of delays could be addressed appropriately.

At zoning meetings staff discussed patients needing depot injections and considered risks to patients and ways to support patients who were refusing their depot injection. Staff also held cases of concern meetings to discuss how best to meet the needs of patients they were worried about.

Patient allergies and other significant risks were flagged on the electronic record keeping system as appropriate. Staff generally responded promptly to any sudden deterioration in a patient's health, and this was evident in the case notes we reviewed. However, some patients we spoke with described insufficient support from staff when they were in crisis. In Bromley PCP we found three patient records which did not indicate that the patients had received any follow up after an initial assessment, or that they were on a waiting list for treatment.

Staff monitored patients on waiting lists for changes in their level of risk and responded when risk increased, with allocated staff dedicated to carrying out this task. However, we found two examples where referral documents had not been uploaded in Bexley EIP which may have impacted on the quality of assessments. Staff noted that this was due to a long period of time without sufficient administrative support for the team.

Staff used an appropriate tool to monitor patients' physical health. In the previous inspection report published in August 2020, we found that staff did not always monitor the physical health needs of patients and ensure that patients needing an electrocardiogram (ECG), had these carried out regularly. We found significant improvements in this area at the current inspection. Teams had clear guidelines on which patients needed to have an ECG, how frequently, and where to record this, in line with trust policy. All sites were issued with appropriate equipment, and staff completed competencies to use this equipment. The trust audited teams' compliance in this area and could demonstrate a significant improvement since the previous inspection, bearing in mind that not all patients agreed to physical health monitoring. In September 2022 overall compliance was 40% for Bexley, 51% for Bromley and 35% for the Greenwich teams. Patients who did not agree to physical health monitoring, were prompted to reconsider at subsequent appointments. The trust had established a Physical Health Steering Group meeting where ECG completion was discussed regularly.

Staff followed clear personal safety protocols, including for lone working. Staff in each team had chosen a particular system of safety protocols for home visiting. The service had adapted safety protocols during the height of the Covid-19 pandemic to ensure staff were safe. Staff kept their electronic calendars up to date, showing their whereabouts, and these were accessible for managers and staff. In some teams staff carried personal alarms when out on visits.

Our findings

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Most staff were up to date with their safeguarding training. Staff compliance with safeguarding training was over 85% in all teams with the exception of Bexley hub and ADAPT team combined, with 76% compliance in training for Safeguarding Children at level 3 (4 staff to complete); Greenwich EIP with 83% compliance in training in Safeguarding Adults level 3 (2 staff to complete); and Greenwich hub with 83% compliance in training in Safeguarding Children and Adults level 3 (2 staff to complete).

Where staff training was incomplete, they were booked onto training courses or there were particular reasons for non-completion such as long-term sickness absence.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns and gave us examples of when they had done so including cases of financial exploitation, and concerns about domestic violence.

Social work staff described improvements in staff taking action to address safeguarding concerns within the last year. They noted that previously staff had sometimes lacked time to make appropriate referrals, but this was much better since staffing in the teams had improved.

In the records we reviewed, staff recorded that they had considered any potential risks when patients had children. Staff made referrals or discussed child safeguarding concerns with the local safeguarding team for the borough. Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Most patient records were detailed. All records we reviewed had sufficient information about patients' care and treatment in the progress notes However, this information was not always available in the risk assessments and care plan sections which could cause delay in staff accessing it. Managers were aware of this and were working with staff to improve record keeping.

Records were stored securely. Staff were required to enter a username and password in order to access the electronic patient records.

When patients transferred to a new team within the trust, there were no delays in staff accessing their records.

Medicines management

Systems and processes to prescribe, administer, and record medicines were in need of improvement. There were some errors in the completion of prescription records, and they were not reviewed sufficiently regularly.

Staff stored medicines safely and regularly reviewed the effects of medications on each patient's mental and physical health.

Our findings

During the inspection we found 25 out of date prescription charts for antipsychotic medicines in the Bromley teams, and 9 out of date prescription charts in the Greenwich teams. These prescriptions had not been reviewed in the last year. We also found that different prescription charts were in use, some of which did not have a space to record allergies. There were some errors in the completion of prescription charts such as a missing prescriber signature, and the incorrect route of administration recorded.

Shortly after the inspection, senior staff described the action they had taken to address these concerns. This included checking that the correct version of prescription charts was in place and that prescriptions were reviewed at least annually, monthly checks by a pharmacist, prompts to check the charts during staff supervision, checking charts prior to administration and alerting doctors to any issues. An alert was sent to all teams about the improvements needed, and the pharmacy resource for the teams was increased to two days a week for each main team's base, and pharmacy technician support for other sites. They noted that the long-term plan was to move to electronic prescribing for this service.

Patient records indicated that staff discussed each patient's medicines regularly and provided advice to patients about their medicines. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff stored medicines and prescribing documents safely. Medicines were stored in locked cabinets as appropriate, at an appropriate temperature. Clinic rooms were clean and tidy, with adequate space for clinical procedures such as ECGs to be carried out. Emergency medicines were available, and all medicines were checked regularly to ensure that they were in date, and equipment was calibrated as appropriate. Patients who had no recourse to public funds could collect their medicines from the teams. Medicines were transported in secure containers when staff needed to take them off the premises including a sharps bin for disposal of injection needles.

Staff told us that they learned from safety alerts and incidents to improve practice and could access the latest British National Formulary online.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence guidance. There was a significant improvement in this area since the previous inspection.

Track record on safety

The service had a good track record on safety.

The trust reported that there had been 24 serious incidents involving the community-based mental health teams for working age adults since September 2021. Twelve of these related to the Greenwich teams, 7 to Bexley, and 5 to Bromley. All but 2 of these incidents related to unexpected deaths of patients.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff told us that they raised incidents such as self-harm, violence and aggression in line with trust policy. Staff were aware of incidents that had occurred in their own team and across the wider trust. They said that managers debriefed and supported them after any serious incident.

Our findings

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers shared lessons learned with the whole team and the wider service. For example, staff told us about a recent serious incident resulting in the death of a patient under the Bexley EIP team. Learning from this included making a home visit (where consent had been provided) if a patient did not attend an appointment and could not be contacted. In the Greenwich ICMP team staff spoke of learning from a serious incident, to ensure that patients rated in the green zone were contacted at least once or twice a month. This was added to the staff supervision template for all staff.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care, at regular team meetings, and in supervision sessions. There was evidence that changes had been made as a result of feedback. These included further involvement of family members and seeking their views (where the patient agreed), following up safeguarding concerns with the multi-agency support hub, and liaison work with domestic violence advocates.

The trust periodically sent all staff a newsletter with learning from incidents. Training areas identified for staff following incidents included approaches to hoarding, neurodiversity, domestic abuse, cultural competence, and trauma informed approaches.

Is the service effective?

Good 

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

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Most care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented. However, not all patients had care plans in place, or up to date to reflect changes in their needs.

Staff completed a comprehensive mental health assessment of each patient. They made sure that patients had a full physical health assessment and knew about any physical health problems.

Staff stored patient care records electronically. There was some variation in the quality of care plans in place for patients but most met their mental and physical health needs. Where particular needs had been identified there were care plans in place to address them. Some teams had started using DIALOG+ (an interactive format) as a way of recording care planning information more collaboratively with patients. The templates for this new record were personalised, holistic and recovery-orientated with 11 questions for patients about their level of satisfaction with areas such as their health, employment, social situation, safety, medicines, and care and treatment from the team. We found some good examples of these being used to facilitate patient engagement. However, these were not always being completed in full, with agreed goals and actions. Managers acknowledged that there was some variation in their use, as staff were learning to use these new formats. Staff told us that this new format was particularly difficult to use in the hubs to record initial assessments.

Our findings

Staff did not always review and update care plans when patients' needs changed. Frequently we found that care plans were not recorded in the allocated tab, but could often be found in the progress notes of patients. This could cause delay in accessing important information about meeting the current needs of patients.

Teams had carried out audits of care and treatment records. Where shortfalls were identified these were addressed through individual supervision and in team meetings. Staff discussed audits in team meetings and devised action plans where needed to improve the way the service was provided. For example, results of recent care note audits for each team indicated that Bexley early intervention pathway (EIP) team was top performing for allocation of a care coordinator within two weeks of referral, and patient uptake of cognitive behavioural therapy, but needed to improve family interventions and support with employment. All three borough EIP teams were identified as needing to improve interventions for smoking, substance misuse, obesity, hypertension, and diabetes.

In the previous inspection report published in August 2020 we noted that patients on the Care Programme Approach (framework for effective care for people with severe mental health problems) did not always have opportunities to meet all members of their care team regular to contribute to their overall plan of care. The trust had taken steps to increase opportunities to meet with their teams and this had improved since the lifting of Covid-19 restrictions. Since August 2022, the trust was piloting a new 'care team approach' to address increased caseload and an increase in patient acuity. This involved support from a team of 4 members of staff providing assertive outreach work, instead of one care coordinator. The team included 2 registered mental health nurses/social workers, and two band 4 staff to undertake nonclinical/non-social work tasks. There were plans in place to review the new process at least monthly, with a review of the care team approach by leadership on a three-monthly basis. This pilot was initially for one year.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff delivered care in line with best practice and national institute for health and care excellence (NICE) guidelines. Prescribing guidelines were available to staff on the trust intranet.

Patients in all three boroughs had access to psychological therapies. Psychologists and psychotherapists were integrated into the teams. Overall each team had improved their offer of psychology and had a range of therapies available for patients. There were clear pathways for trauma, Eye Movement Desensitization and Reprocessing (EMDR) and trauma stabilisation. For personality disorders there were pathways for Mentalization-based therapy (MBT) and dialectical behavioural therapy (DBT). For anxiety, depression and obsessive-compulsive disorder there were options of cognitive behavioural therapy (CBT) and a mindfulness-based approach. In Bromley they were piloting two groups - structured clinical management in ADAPT East and a DBT skills group in ADAPT West. The groups had rolling entry points, so patients could join every six weeks, reducing waiting times. There was a move toward an intervention-based model with care coordinators co-facilitating groups with support from psychologists. Six staff were trained in EMDR in each borough (previously there were only two).

Staff worked in partnership with local voluntary sector organisations to provide social inclusion programmes which supported patients' recovery.

Our findings

EIP teams offered NICE compliant packages of care to patients within two weeks of their referral to the service. Staff offered a range of evidence based therapeutic interventions including CBT for psychosis, family interventions, family therapy and multi-family groups.

ADAPT team staff used cognitive behavioural therapy to treat social anxiety in line with NICE guidelines. In the ADAPT teams the psychologists described a stepped approach to care, which focused on group work. They held mental health skills workshops to bridge the gap between primary and secondary care using a psycho-educational approach. Workshops included improving sleep, managing depression, relationship issues for personality disorder, mentalisation for personality disorder, mindfulness, and anxiety management. They also had moderate term groups of MBT and CBT for anxiety and depression, a trauma group and a mindfulness group (often for people before discharge from the service).

ADAPT teams also offered individual psychology and psychotherapy sessions and longer-term groups, such as art therapy, an 18-month psycho-dynamic group and a young person's MBT pathway. Following feedback from patients, the team in Greenwich increased the number of sessions of MBT to eight weeks.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Staff made sure patients had support for their physical health needs, either from their GP or community services. We found significant improvements in this area. During physical health clnics, depot and clozapine clinics, staff monitored patients' physical health working closely with GPs to ensure that people get the support they need. In Bexley the role of advanced clinical practitioner had been introduced to focus on physical health and the side effects of medicines, booking patients for blood tests and ECGs. This role was overseen by the team psychiatrist. The Community Mental Health directorate held a monthly Physical Health Working Group to monitor compliance with physical health support provided.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Staff told us that they were using the Lester tool for physical health care planning, and the Glasgow anti-psychotic side-effects scale every six months to assess the effects on patients. This enabled staff were able to compare medication changes with any increase or decrease in side-effects. The trust used audits from the Prescribing Observatory for Mental Health UK to improve prescribing practice in the use of clozapine and prescribing for depression in adult mental health services.

Staff used technology to support patients. The new interactive care planning model using DIALOG+ enabled patients to be more involved in their care planning, setting goals and evaluating the support they received. Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements. In the Bromley teams, the junior doctors had led an audit reviewing clozapine and constipation, leading to a review of laxative prescribing. They were also doing work reviewing the frequency of depot injections of antipsychotics, to improve compliance, as some patients found frequent injections painful. Other projects included looking at the possibility of short-term care co-ordination and moving to a brief intervention model.

The teams had been contributing to work to set up primary care networks, making it easier to discharge patients to primary care. Teams supported patients with their housing needs, benefits and employment, and also conducted Care Act assessments. When needed advisors supported patients to self-advocate in the workplace or attended meetings with patients and employers.

Each team participated in a number of quality improvement initiatives including initiatives to improve physical health monitoring in each team. In Greenwich this work had led to establishing a regular physical health clinic, leading to a

significant improvement in the rate of completion of electrocardiograms, at 89% at the time of the inspection. There was also a depot compliance project which had led to an improvement in patients engaging. The ICMP project had a barriers to discharge project undertaken by a psychology student. In Bromley ADAPT there were projects on the impact of staff stress on perceived quality of care and examining local routes of referral into EIP services. Bexley ICMP undertook a 'lone ranger project' led by patients looking at their experience of coming off medication without discussions with healthcare professionals. They looked at why patients did this, and what was helpful in this case.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of each patient. Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. All new staff including locum staff received an induction to their area of work and responsibilities. Permanent staff received a three-day corporate induction when they started.

Managers supported staff through regular, constructive clinical supervision and appraisals of their work. Supervision was carried out at least every six weeks. Most staff received regular supervision in line with trust expectations. Team managers were able to monitor this through an electronic system. Staff also had access to reflective practice sessions with a psychologist. Occupational therapists received professional supervision from a senior occupational therapist. Staff in all teams had annual appraisals. All staff we spoke with were positive about the support available to them within their team. In Bexley the psychologists noted that it had been hard having a high turnover of senior managers (due to staff turnover in band 8 roles) but this had improved recently. Managers made sure staff attended regular team meetings and gave information to those who could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were able to undertake further training to equip them for their role and develop their knowledge and skills. They confirmed that they were encouraged to book training through the trust. In Greenwich, psychologists had been running workshops to support staff to develop their skills in crisis planning. They were planning to offer workshops with patients also. Staff were encouraged to undertake training in phlebotomy (taking blood samples) and carrying out ECGs.

Managers made sure staff received any specialist training for their role. The trust offered specialist training in autism spectrum disorders (ASD) and was able to link patients with the specialist ASD service. There was also a support group for newly qualified therapists which staff found helpful. A nurse in Bromley told us that she was due to undertake a one-year course in family therapy.

Managers recognised poor performance, could identify the reasons and dealt with these. They noted that they attempted to support staff to avoid the risk of work-related stress as far as possible, reducing caseloads when possible.

Our findings

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Teams were multidisciplinary and made up of a range of disciplines including nurses, occupational therapists, doctors, social workers, psychologists, psychotherapists, health care support workers, and peer support workers. Staff held regular multidisciplinary (MDT) meetings to discuss patients and improve their care. These included daily zoning meetings, frequent cases of concerns meetings, and monthly team meetings.

Since the transformation of the teams to the current structures the hubs included workers from third sector services providing social interventions, including support with housing and employment and support for carers. This meant that patients had a wider and more varied network of support, and alternative provision to prevent further deterioration in patients' mental health.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. We attended a range of multidisciplinary team meetings and observed that different disciplines worked effectively together. For example, in cases of concern meetings, each team member contributed their professional perspective and experience to the meeting. This helped achieve a holistic approach to addressing patients' needs. Teams benefitted from having nurse and social worker care coordinators working together collaboratively. In Greenwich, the senior social worker has provided mini learning sessions for the team on social work topics such as the Care Act.

Staff had effective working relationships with other teams in the organisation. Teams worked closely with the home treatment teams to prevent patients being admitted to hospital if they could be supported more intensively at home.

Managers attended meetings with community child and adolescent mental health service (CAMHS) teams to identify young people who were approaching the age of transfer to adult teams. This enabled them to provide support to young people and facilitate information sharing. Managers also attended monthly maternity safeguarding meeting to support and strengthen the teams' work with pregnant and perinatal women.

Staff had effective working relationships with external teams and organisations. Bexley teams described having close links with a responsive local police officer. They noted that police liaison was available for joint visits with the team if there were concerns.

Primary care plus (hub) staff in particular liaised with GPs to inform them about the service and offer support when patients were discharged back to the care of their GP. Managers in all teams were working to develop relationships with GPs, as part of the re-designed model of care.

Managers attended regular meetings with local Improving Access to Psychological Therapies (IAPT) services. Staff recognised high levels of drug and alcohol use amongst patients and teams had links with local drug and alcohol services.

Psychologists felt well embedded in the MDT, involved in meetings and supporting the formulation of risk assessments, with some shared work with occupational therapists. They described a shift to more group-based work. However, they sometimes felt that they were rushed to implement work to reduce the waiting lists and noted that lots of turnaround in the teams meant that there had been less reflective practice than previously.

Our findings

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Doctors received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and this was covered in nurse preceptorship training. All staff had access to support and advice on implementing the MHA and code of practice, and MHA training, although it was not mandatory for all staff. Most nurses and social workers had detailed knowledge of the Act. Approved mental health professionals in the teams had received advanced training.

Patients had access to information about independent mental health advocacy. Where relevant staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. For patients subject to a Community Treatment Order (CTO), staff completed all statutory records correctly.

Staff attended bed management meetings for patients admitted to hospital. They noted that housing was a particular concern leading to delays in patients being discharged. They also noted that there were frequently delays in arranging for patients in the community to be assessed under the Mental Health Act when this was needed. If a warrant and police support was required, this would often take a minimum of two weeks due to lack of police availability and availability of inpatient beds. This could also be true for CTO recalls requiring police input. Staff worked closely with police and attempted to expedite the process if they had significant safety concerns. The trust was not keeping records of delays in MHA assessments or CTO recalls to monitor this.

There were very few patients in any of the teams who were on CTOs. Staff reviewed patients to see how they could work with them in the least restrictive way. Patients were provided with more information about their diagnosis, care and treatment and encouraged to take responsibility for themselves. We reviewed one community treatment order and found staff had completed it appropriately.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act (MCA) and had a good understanding of the principles. Compliance with MCA training varied between teams, in Bexley ICMP compliance was at 71% (2 staff to complete), Bromley West ICMP at 75% (3 staff to complete), Bexley PCP and ADAPT combined at 82% (3 staff to complete), and Greenwich PCP 83% (2 staff to complete). The remaining teams had compliance of over 85%. Where training was incomplete staff were booked onto training courses or there were particular reasons for non-completion such as long-term sickness absence.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. All staff presumed that patients had capacity unless they had concerns that this was not the case. Staff carried out capacity assessments when they had concerns about a patient's capacity to give informed consent. Mental capacity assessments were not carried out routinely. Where there was concern about a patient's capacity staff conducted assessments which were clearly documented.

Our findings

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff understood the importance of gaining the informed consent of patients. The trust had a policy for consent to examination or treatment with detailed guidance to staff on when and how to seek and document consent.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Patients said staff treated them well and behaved kindly. Although some patients and relatives expressed concerns about waiting times, almost all spoke positively about the individual staff supporting them. Patients described staff as reliable, respectful, caring, and listening to them. Some patients spoke positively about regular contact with staff, offering emotional support and advice when they needed it, helping them to manage stress, and supporting them with practical tasks such as benefit claims, and housing issues. Most patients said staff were compassionate. A small number of patients did not always feel respected and listened to by staff working with them.

In addition to staff providing therapeutic groups, patients valued other activities arranged by staff such as walking groups, and a picnic arranged by staff from Bexley early intervention pathway (EIP) team over the summer.

Patients and relatives/carers were very aware of staff shortages in the teams, and some felt this had impacted on the frequency at which they were seen, and the amount of time staff had to speak with them on each occasion. Several patients said that it was hard to get accepted by the teams on referral. Some patients noted that it could be hard to get through on the phone to the Heights office base.

Staff supported patients to understand and manage their own care treatment or condition. Patients valued the support staff gave them to understand their conditions such as anxiety and depression, or psychosis. They appreciated support and advice on their medicines and other treatments available such as joining therapy groups, undertaking exercise and support with employment.

Staff directed patients to other services and supported them to access those services if they needed help. For example, they referred pregnant patients to perinatal consultants, and referred patients for autism or attention deficit hyperactivity disorder (ADHD) assessments. In the hubs staff worked together with third sector staff to support patients with housing and employment.

Our findings

Staff we spoke with understood and respected the individual needs of each patient. Staff spoke respectfully about patients during zoning and handover meetings and looked at ways of supporting them in the least restrictive manner. Staff followed policy to keep patient information confidential as appropriate, ensuring privacy before discussing patients, and keeping records secure.

Staff told us that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care plans. The use of a new format for recording care plans had increased patients' involvement in care planning. Although only about half of the patients we spoke with were aware of the contents of their care plans, all were aware of who to contact in the event of a crisis.

Staff made sure patients understood their care and treatment. Patients we spoke with understood the frequency of contact and treatment provided, although some said they would have preferred more regular contact.

Staff involved patients in decisions about the service, when appropriate. For example, at Bexley EIP patients were included on interview panels for new staff. Teams used feedback from patients to improve therapy groups provided, including changing the number and content of sessions offered.

Patients could give feedback on the service and their treatment and staff supported them to do this. At the previous inspection, we noted that staff were not collecting regular feedback from patients and carers about the care they received. At the current inspection we found that staff were regularly collecting feedback from patients. All teams collected feedback using a range of methods including paper, tablets, and text messaging. An electronic patient satisfaction survey was sent by text after appointments, automatically triggered by the electronic record keeping system. About 10% were returned every month (30-40 forms). Patients feedback was mixed about the service, with suggestions for improvement in waiting times, responses from the crisis team, more training for GPs, more frequent reassessment, and improving transition from children to adult services. However, patients told us that it was not always clear how their feedback was used to improve services.

Staff said that they were able to support patients to make advanced decisions on their care, but few had done this recently. Staff made sure patients could access advocacy services.

Staff conducted a remote appointment experience survey to understand patients' preferences for appointments in person or virtual or telephone. They received mixed responses, leading to use of a hybrid approach giving patients a choice of formats.

Involvement of families and carers

Staff ensured that families and carers were kept informed and involved in the decision-making process where appropriate. Relatives and carers we spoke with said that they were as involved as they needed to be.

Our findings

Relatives/carers were able to attend groups for carers in some of the teams, providing an opportunity to feedback about their experience. However, other than this relatives/carers were not aware of other opportunities to give feedback about the service.

Relatives/carers were also signposted to third sector services in their local area, and support from carers advisory workers (supervised by the trust staff).

Staff gave carers information on obtaining a carer's assessment and supported them in the process. Most recently the overall completion of carers assessments for the service was at 70%.

Is the service responsive?

Requires Improvement 

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

Access and waiting times

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly. However, some patients who did not require urgent care were waiting too long to start treatment particularly for neurodevelopmental assessments. There had been a reduction in waits for psychological therapies, despite an increase in demand. Although systems were being put in place to address waiting lists, some patients were at risk of not being followed up following their initial assessment.

There were effective links between the voluntary sector provision and trust services under the mental health hubs. The trust had moved to a system where there was 'no wrong door' to the services, and staff were embedding in primary care.

Service referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly. Referrals came from GPs, hospitals and other health professionals. Referrals came into the service through borough based single points of access known as the hubs linking primary and secondary care services.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. There were systems in place to ensure that patients referred to the service, were assessed appropriately and allocated to the correct pathways. All referrals went through the hubs where they were triaged. If a patient was likely to require a psychology referral this was highlighted, and the patient was assessed by a psychologist in the ADAPT team or intensive case management for psychosis (ICMP) team where possible. Similarly, if a patient's needs were identified as primarily social, they were assessed by a social worker in the appropriate team.

The service did not always meet trust target times for seeing patients from referral to assessment and assessment to treatment. In the previous inspection report published in August 2020, we found that patients did not always have timely access to assessment and treatment in the neurodevelopmental and psychological therapy teams.

Our findings

Action the trust had taken to address long waits for attention deficit hyperactivity disorder (ADHD), with recurrent integrated care system funding, included the appointment of a manager for the adult ADHD service, improved waiting list management, appointment of additional administrative staff, and recruitment of a substantive consultant psychiatrist due to start in October 2022. The trust was working with a neighbouring trust and commissioners to develop a common approach to assessment and treatment for ADHD. The trust advised that they now had sufficient resource to keep up with current demand but received non-recurrent funding to address the backlog of patients waiting, which they anticipated completing in approximately 18 months.

There had been a significant rise in referrals for ADHD assessments over the last 12 months, although this varied from month to month. Referrals were highest in Bromley at about 108 in September 2022, whilst Greenwich had 100 referrals, and Bexley had approximately 63 referrals in September 2022. In the last 12 months to September 2022, waiting times were significantly higher each month in Greenwich, and lowest in Bromley. Waiting times peaked in Greenwich in April 2022, at approximately 77 months. In September 2022, waiting times were approximately 57 months (just under 5 years). Waiting times peaked in September 2022 in Bexley at 43 months (over 3.5 years), and in Bromley at 22 months (just under 2 years).

Referrals for autistic spectrum disorder (ASD) assessments also varied in the last 12 months. In Bromley referrals peaked with 27 in March 2022, and there were 9 in September 2022. Greenwich referrals peaked in March 2022 with 20 referrals, and there were 6 in September 2022. Bexley peaked with 17 in September 2022. The trust noted that the previous model of commissioning was based on a small number of assessments per year for which demand had outstripped this capacity for several years. They were working together with a South East London development group to address this increase in demand and manage resources effectively. Recurrent funding to enhance the resources of the team, had enabled an increase in the number of assessments, most recently to provide 200 assessments a year. Non-recurrent funding was provided to meet the backlog of patients waiting, which will be addressed through external procurement. They expected to have waits of under six months as agreed with the integrated care system by March 2024.

Average waits for autism spectrum disorders (ASD) assessments over the 12 months to September 2022, were highest in Bexley, peaking in March 22 at 60 months (5 years), and at 42 months (3.5 years) in September 2022. Waits were lowest in Greenwich peaking at 40 months (3.3 years) whilst waits peaked in Bromley at 48 months (4 years) in September 2022.

Some patients were still waiting too long to access psychological therapy, and there had been a significant increase in demand for services since the previous inspection. To address psychology waiting times the trust had added band 4 assistant psychologist, and band 5-6 clinical associate psychologist posts, and a family therapist in Bromley. They had increased capacity for groups within the ADAPT services, running on a regular basis to ensure that people were not held on the waiting lists for longer than required. They had also increased training in Eye Movement Desensitisation and Reprocessing (EMDR) for Trauma based therapy and were piloting Structured Clinical Management in ADAPT to reduce the reliance on psychology alone.

Waiting lists were managed with routine three-monthly check in calls carried out by band 4 staff. The trust was also training other professional staff, such as nurses and social workers, to carry out low level psychological interventions with patients to help reduce the waiting times for psychological therapies.

The trust aimed for patients referred to a psychologist to be seen within 18 weeks. In September 2021, the longest waiting times for referral to treatment for psychology were in Bexley ADAPT at 17.3 weeks, followed by 9.1 weeks in Greenwich West ADAPT. In August 2022, Bexley ADAPT waiting times had improved to 10.6 weeks, but Greenwich West ADAPT waiting times had increased to 13 weeks. In August 2022, the longest waits were in Bexley ICMP at 17.2 weeks, followed by Greenwich West ADAPT at 13 weeks.

Our findings

The early intervention in psychosis teams (EIPs) aimed to see newly referred patients within 14 days. They were generally meeting this, although staff noted that some of the statistics indicated breaches when patients had left the area and could not be contacted. In Bexley and Greenwich EIPs, the longest average waits were in April 2022 at 23.7 days, and 13.3 days respectively. In July 2022 these average waits had reduced to 8 days and 7.3 days respectively.

For occupational therapy referrals over this period, the highest waiting times were 14.7 weeks in Greenwich West ICMP in July 2022, but these had reduced to 1 week in August 2022. In August 2022 the longest waits were 9.6 weeks in Bromley West ICMP.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. They attempted to contact people who did not attend appointments and offer support. They worked hard to avoid cancelling appointments and when they had to, gave patients clear explanations and offered new appointments as soon as possible.

The PCP services in the 3 boroughs were in different stages of transition into local hubs. They used systems to help them monitor waiting lists/support patients and noted a significant increase in referrals overall. Appropriately trained administrative staff screened all referrals and passed these onto the clinical team within the hubs to triage. Staff triaged all referrals that came into the service and either supported GPs with further advice, signposted patients onto other secondary services, provided a brief intervention support or referred them onto the ADAPT or ICMP teams for more intensive mental health interventions. The teams noted those referrals that appeared to be suitable for interventions from recovery support workers, where social issues were identified.

In the Bromley hub we found 3 patient records with gaps in follow up, despite risks being identified. Managers advised that this was due to the implementation of an electronic waiting list, and that they were auditing records to pick up on any that may have been missed. However, we were concerned that in the interim period some patients' needs could be missed.

In Bexley the PCP team were in the process of moving towards the hub structure, and due to relocate. Following a significant backlog of people waiting for assessments, the team had introduced effective risk management processes, recruited to permanent posts, and introduced daily referral screening meetings to improve performance. This had resulted in a decrease in average waiting times of 68 days in December 2021 to 25 days in September 2022. The team had created additional capacity at the weekend and evenings to complete assessments. There were 4 primary care nurses working in the local GP surgeries who could support GPs and patients. To address a high rate of patients not attending appointments, they had changed the system so that administrative staff contacted patients directly to fix an appointment time.

The Greenwich hub noted that in May 2022 the caseload hit 870. They completed a week-long caseload review, and the caseload reduced to 530 in July. They noted that 90% of referrals came from GPs, with others from the local authority, housing, and the police. To address a bottleneck in patients waiting to be seen, the team introduced an interface meeting between the services. They were reducing inappropriate referrals from GPs by meeting GP leads every 4-6 weeks, holding online meetings, and demonstrating other options, as well as having mental health nurses embedded within the surgeries.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

Our findings

The service had a full range of equipment to support treatment and care. Interview rooms were furnished appropriately, and sufficiently soundproof to protect privacy and confidentiality. However, some team offices did not have sufficient rooms available to accommodate regular patient groups. For example, staff told us that lack of space in the Beckenham Beacon site, had led to some patient groups being cancelled. Managers were looking at alternative sites at which to hold these groups.

Staff displayed information leaflets on a range of relevant topics for patients and carers in patient waiting areas. These supported people to make decisions about their care and treatment. Waiting areas were welcoming. They were bright and well-lit and had water dispensers available for people waiting, and access to toilet facilities.

Information was displayed in waiting areas on activities and groups available to patients provided by occupational therapists, occupational therapy assistants and other staff. For example, in Bexley ICMP there was information about pottery classes, a walking group, football, an allotment project, classes on cooking on a budget, and exercise classes. There was also information available about local foodbanks, safeguarding and speaking up. At Bexley EIP there was information about cookery classes, educational opportunities, social groups, and fishing, led by a social inclusion lead.

Other groups staff told us about included welcome groups for patients and carers, working partnerships with an animal charity shop, an allotment group, Pilates, women's groups, and men's wellbeing group, a group to meet up with the pharmacist, and a group for patients with concerns.

Staff also signposted patients and carers to groups run by local charities, including a young people's group, older people's groups, and workshops at the local recovery college.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The trust was working to ensure that there was 'no wrong door' to the services and embedding staff within primary care to provide support to patients before referral to secondary services. The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Patients with mobility concerns, including wheelchair users, could access all of the services. Consultation rooms were generally located on the ground floor. Where needed staff could carry out home visits to complete assessments if the patient was unable to come to the team base.

Staff made sure patients could access information on treatment, their rights, local services, and how to complain. Information about these topics was posted or available in leaflets in waiting areas.

The service had information leaflets available in languages spoken by the patients and local community. Staff could print information in different languages for patients. If information was not available in a particular language staff could request this. Staff said that information could also be made available in a variety of accessible formats so the patients could understand more easily. Managers made sure staff and patients could access interpreters or signers when needed.

Staff teams were diverse and spoke a range of different languages between them. Teams tried to honour patient requests to work with staff of a particular gender. If referrals were received for patients who did not speak English well, staff offered the patient a face-to-face interview with an interpreter rather than try to use an interpreter during a telephone assessment.

Our findings

Staff had training about supporting patients from the Traveller community and understanding the culture. Staff referred patients to specialist services when this was appropriate. For example, staff could arrange a specialist referral to a gender identity clinic for patients who were transitioning.

Staff were aware of community groups who could offer support to patients from diverse backgrounds, including lesbian, gay, bisexual and transgender (LGBT+) groups. Some staff wore rainbow lanyards to demonstrate that it was safe for people to speak with them about their sexuality.

As noted at the last inspection, staff were still not routinely recording information about patients' sexuality and sexual orientation, or the pronoun by which they liked to be addressed. Managers hoped that as the implementation of the new more collaborative care planning tool was rolled out, this might lead to more progress in this area, and holistic support for patients with their sexual orientation needs.

The trust had set up a lived experience network for staff who had experience of using mental health services themselves.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Information about how to complain was on display in patient waiting rooms in the services we visited. Some patients and relatives we spoke with knew how to complain or raise concerns, and most were aware of how to find out about this if needed.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints, and patients received feedback from managers after their complaints had been investigated.

Managers investigated complaints and identified themes. In the 12 months to 31 August 2022, 68 complaints were received about the service. None of these were referred to the parliamentary and health service ombudsman.

The highest number of complaints were received relating to Greenwich PCP (12 of which, comprising 75%, were at least partially upheld), followed by Bexley ADAPT (11 of which, comprising 64%, were upheld), and Bromley PCP (10 of which 50% were upheld). EIP teams received the lowest number of complaints.

Patients received feedback from managers after the investigation into their complaint. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers shared feedback from complaints with staff and the learning was used to improve the service. They also used compliments to learn how to replicate this satisfaction and celebrate success in the teams.

Complaints were discussed in team meetings and in management and governance meetings to make sure learning was identified and acted upon.

Is the service well-led?

Good 

Our findings

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable to patients and staff.

Staff told us that their managers had the integrity, skills and abilities to run the service, with support from the trust's senior leadership. Leaders understood the issues, priorities and challenges the service faced and supported staff to manage them. They supported staff to develop their skills and take on more senior roles. Team leaders had extensive experience working in adult community mental health services, and most had been working for the trust for many years. Since the previous inspection, a number of team leader vacancies had been filled, improving the performance of the teams. Staff described strengthened management within the last year with improved processes, and systems and support for staff, particularly within the hubs.

Each borough had an associate director and clinical manager that oversaw the clinical running of the services. During the Covid-19 pandemic senior leaders regularly sent out communications with updates on the latest guidance for public health and catching up on staff wellbeing.

There were no reported cases of bullying or harassment in the any of the teams we visited. Staff were aware of how to use the whistleblowing process. Staff were confident they could raise concerns and would be listened to by senior managers.

Managers told us there were opportunities for leadership training and development in the trust. Several managers had completed, or were completing, leadership and management learning modules.

Some staff described it being more challenging to influence things within the directorate, as the trust had moved to larger directorates. However, all noted that the trust was supportive and invested in professional development opportunities for staff in the community mental health teams.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff knew and understood the values of the organisation. These were: having a user focus, excellence, learning, being responsive, partnership and safety. Staff knew who senior managers in the trust were and said they were visible. Some staff said that senior managers and trust board members had visited the teams (although this had reduced during the Covid-19 pandemic).

The trust strategy for 2021-2024 was agreed in June 2021 including plans to achieve zero delays, deliver great out of hospital care, and make Oxleas a great place to work.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Our findings

Staff were positive about the trust as an employer and described a trust that looked after staff, supported their development, and had a no-blame culture. Staff felt supported by line managers and colleagues. The trust provided nursing forums where nurses could obtain peer support. Some staff were struggling to manage high caseloads, but most told us they felt valued and were supported to undertake further training and development. All described good teamwork. Staff were open and transparent and explained to patients when things went wrong.

We found strongly motivated staff working very hard to meet demand. Staff felt respected, supported and valued within their teams although some were also experiencing stress due to the high caseloads. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear. The staff we spoke with told us team members were very supportive of each other and respected the contribution of all professions.

Senior staff acknowledged that the teams had been through many changes in the last years as a result of the Covid-19 pandemic and transformation to a new structure of teams and new ways of working. Most staff felt the service promoted equality and diversity and provided opportunities for career development. The trust had staff networks for lesbian, gay, bisexual, transgender plus (LGBT+) and black, Asian and minority ethnic (BAME) communities, a disability network, a mental health staff network, and women's network, and staff were aware of these groups.

In 2020, the trust had launched Building a Fairer Oxleas, to address inequalities across the trust. Steps taken had included support for the staff networks and launching new groups; increasing representation of BAME staff in senior roles (increased by 3% - and comprising 40% of the trust board); having a float in London Pride; and equalising likelihood of being appointed after shortlisting for disabled candidates.

Over 300 members of staff within the trust had taken part in a workshop on ways to talk about race and racism, microaggressions and gaslighting, and how not to be a bystander. Staff we spoke with felt that things were improving within the trust in terms of more developmental opportunities for BAME staff, although this was still a work in progress.

Governance

Our findings from the other key questions were largely areas the trust was aware of, with plans in place to address them through governance processes. Staff told us that governance processes had improved over the last year, with effective working at team level and action taken to address any concerns about performance and manage risk.

At the time of the inspection, the current directorate structure had been in place for 11 months. Governance covered both cross-borough and in-borough working to ensure that they had a place-based focus as well as sharing risks. Clear governance structures supported the delivery of safe and effective care and supported the flow of communication from the teams to senior management and trust board and vice versa. Managers had access to real time information about the training and supervision of staff in their teams. They also received monthly reports of mandatory training, which highlighted when staff needed to renew or complete training. This enabled teams to achieve high levels of compliance with mandatory training, supervision and annual appraisals as found during the inspection.

Managers and staff met regularly in multidisciplinary meetings to discuss complex cases, learning from incidents and complaints related to the service, review monthly patient experience reports and consider team performance data including the results of recent audits. Managers escalated risks related to the service via their line managers and in regular performance meetings. Staff were aware of the key issues on the directorate risk register, including a steady growth in referrals and the risk that referrals may outstrip the services' capacity to respond.

Our findings

The directorate had a governance structure that linked to the Board and Executive. They provided performance data for the Executive report. The directorate had service and clinical directors, and associate directors and service managers for each borough. In addition to the teams we inspected, the directorate also included older adult and memory, perinatal, recovery, and approved mental health act practioner services.The directorate had three major priorities, filling workforce vacancies, addressing huge increases in demand, and addressing increased waits for treatment.

Community Mental Health team development meetings were held across the boroughs, most recently in January, March, and August 2022. Issues discussed included a zero-delay policy, referral cancellations and appointments missed by patients, and how this information was captured. Managers discussed various processes in place to manage waiting lists, and how this could be streamlined. The road map for community mental health transformation was also discussed, including reference to a NHS England webinar which gave a good overview of the long-term plan. Principles included integration with primary care, having a 'no wrong door' approach and no rejected referrals, and personalised care, co-produced with service users, carers and communities.

To support staff the directorate had developed a Community Mental Health Skills Programme called Headstogether, covering a variety of topics from lone working, crisis planning, medication competencies and safeguarding processes. These were developed based on feedback from the teams and also provided an opportunity to connect with colleagues and clarify expectations.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care, and managers had plans in place to mitigate risks to the service.

Leaders knew the risks in the services they managed, and systems were set up to identify, understand, monitor, and reduce or eliminate risks. The team leaders ensured risks were dealt with at the appropriate level. Staff could add concerns to the local risk registers. The local team risk registers contained pertinent risk issues to staff and patients within their teams. These included risks such as lone working, Covid-19, safe staffing, supervision compliance, increasing demand, and adequate medical cover. The teams operated a duty system, which meant that there was always a clinician available to assess risk and deal with immediate concerns. The trust had an out of hours crisis service for patients to access.

The trust had an action plan in place to support the teams in managing high caseloads, staff vacancies, and long waiting times for patients' therapies. Caseload reduction was anticipated through the implementation of the transformation programme in partnership with third sector organisations, delivering joint services through the community hubs. This meant that patients would have a wider and more varied network of support reducing the flow of patients into secondary care services by providing alternative provision and intervening to prevent further deterioration in patients' mental health.

The risk register for the service in September 2022 included the following risks rated as moderate: Greenwich approved mental health practitioner vacancies, a reduction in adult social care staff in Bexley, and general increased demand for services. Other risks rated as lower included learning from incidents and patient feedback, hub assessment waiting times, physical health checks, staff confusion about the new acceptance criteria, and workforce vacancies.

Leaders carried out reviews to monitor particular risk areas, for example a non-executive director led review was carried out in May 2022 to review the Referral to Treatment times for psychological therapies, with long- and short-term recommendations identified.

Our findings

At senior management meetings risks were reviewed regularly including un-outcomed appointments, 7 day follow ups, review of patients on the care programme approach, and waiting times for particular support and therapies.

To address challenges in recruitment of nurses, the teams were trialing a range of new staff positions. The Bexley teams had trialed developmental posts for one year to attract applicants such as band 5 nurses from inpatient services, and this had been successful. Many of the staff we spoke with were in new-style roles as the trust was thinking innovatively about meeting staffing challenges. The trust was recruiting a professional nurse educator at band 7 to be embedded in the clinical teams on a supernumerary basis, to support clinical practice, and the professional and educational development of the mental health nursing workforce. The trust was also implementing plans to address recruitment and retention issues for psychological therapies in the community teams.

The early intervention pathway (EIP) team in Bexley noted that they had less funding available compared to the other borough EIP teams, so that they were currently unable to expand the staff team.

Information management

The teams managed information effectively, to bring about improvements in patient care, whilst protecting patients' data appropriately.

Staff made notifications to external bodies as needed. For example, the teams made safeguarding referrals to the local authority when required and notified CQC of relevant incidents.

Managers had access to the information on their team's performance collected through clinical audits. This included information on completion of patient risk assessments, care plans and community physical health assessments.

Records were stored securely. Staff were required to enter a username and password in order to access the electronic patient records. When patients transferred to a new team within the trust, there were no delays in staff accessing their records.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. There was room for improvement in the collecting of feedback from relatives/carers, and communicating to patients on how their feedback was used.

In the previous inspection report published in August 2020, we noted that staff were not collecting regular feedback from patients and carers/relatives about the care they received. It was clear that the trust had made progress in gaining regular feedback from patients since the previous inspection, including regular feedback from text surveys sent after patient appointments. In May 2022, a Service user and Carer Engagement event was held to discuss the community mental health transformation programme. However, it was not always clear how this feedback was translated into producing improvements in the service. There was still limited feedback available from carers/relatives.

Managers engaged actively with other local health and social care providers to provide an integrated health and care system that met the needs of the local population. Meeting papers showed staff participating in system wide meetings highlighting how the community wide service redesign met the needs of population and improved care and support partnership.

Our findings

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. During the Covid-19 pandemic, managers ensured that staff from vulnerable groups, such as Black Asian and Minority Ethnic staff and staff with physical health conditions, were supported at work and followed national guidance to ensure that staff felt safe.

In the most recent staff survey, the community mental health teams overall scored more than 3% lower than the average for the trust in having a voice that counts, and always learning, and less than 3% lower than the trust in other areas. Greenwich had the most positive results, scoring above the trust average for being recognised and rewarded, working flexibly and morale. Bexley and Bromley staff scored all areas but one as more than 3% lower than the trust average. It should be noted that these results were from a time when the community mental health teams were being restructured. Teams were developing local level wellbeing support for staff, including a staff walking group in one team.

Learning, continuous improvement and innovation

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The teams told us about several quality improvement projects they had been working on within the last year. These included projects to improve patients' physical health including having regular electrocardiograms when needed, due to taking high dose antipsychotic medicines. Greenwich hub/PCP had carried out two quality improvement projects in the last year trying to increase patient feedback and working to reduce appointments which patients did not attend.

There were also projects across the teams to improve staff confidence in, and use of, the new Dialog+ format for interactive care planning. This included introducing an optional paper-based tool for care coordinators to use when a patient was too unwell to complete Dialog+. The clinical effectiveness group supported staff to improve usage of Dialog+ with staff seeing some benefits in the increased emphasis on the client.

Lived experience practitioners were being integrated within the teams with access to the same training as other staff, and support from a mentor. Some had accessed training and become occupational therapists. Teams tried to design individual roles around the knowledge and experience of the individuals, for example one lived experience practitioner was working particularly with Traveller communities in the local area.

Hub/PCP teams were positive about the work they were doing to establishing primary care networks embedded within local GP surgeries, noting that historically, they had not always had good relationships with GPs.

Our findings

Outstanding practice

We found the following outstanding practice:

- Staff were carrying out a large number of quality improvement projects across the teams. In Greenwich ICMP a psychology student had conducted a barriers to discharge project which found that many patients felt the team acted as a safety net and looked at alternative support structures available including the community crisis cafe. In Bromley there were projects on the impact of staff stress on perceived quality of care and burnout and examining local routes of referral into EIP services and duration of untreated psychosis. Bexley ICMP undertook a 'lone ranger project' led by patients looking at their experience of coming off medication without discussions with healthcare professionals. They looked at why patients do this, and what was helpful in this case.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must continue to work to ensure that all patients have up to date risk management plans in place, there are no gaps in the electronic waiting lists, and there are clear explanations for why patients are allocated to or change risk zoning levels, to ensure their safe care and treatment. **Regulation 12 (1)(2)(b)**
- The trust must continue to take action to address long waits for neurodevelopmental assessments and therapies to meet current demand. **Regulation 17(1)(2)(a)**
- The trust must ensure that there is improved oversight of medicines management across the community mental health teams**. Regulation 12 (2)(g)**
- The trust must monitor delays in Mental Health Act assessments and Community Treatment Order recalls for patients in the community mental health teams and the reasons for these in each case. **Regulation 12(2)(b)(i)**

Action the trust Should take to improve:

- The trust should continue to ensure that staff monitor the physical health needs of patients and make sure that patients who need an electrocardiogram receive one regularly.
- The trust should continue to address recruitment and retention of staff across the community mental health teams.
- The trust should ensure that staff collect more feedback from relatives/carers about the care they receive and provide clearer communication to patients and carers about how their feedback is used to improve services.
- The trust should continue to take action to improve how staff consider the holistic needs of patients by considering their sexual orientation and cultural needs proactively.
- The trust should take steps to ensure that patients/carers are able to get through to the services by phone when needed without undue delay.

Our findings

- The trust should provide further training, support, and monitoring for staff on protocols for where to record care plans, and particularly for staff in the hubs in using the new care planning tool for assessments.
- The trust should continue to plan ahead to meet increases in demands for the community mental health services, resulting in higher caseloads for staff.

Our inspection team

The team that inspected the service comprised two CQC inspectors, two inspection managers, a specialist advisor (nurse with experience of working in and managing adult community mental health teams) and four experts-by-experience (people with experience of using or caring for someone who has used community mental health services) who conducted interviews with patients and carers by phone.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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