Oxleas NHS Foundation Trust

Community-based mental health services of adults of working age

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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?	**Requires improvement**
Are services well-led?	**Good**

Summary of findings

Community-based mental health services of adults of working age

Requires improvement 

Summary of this service

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 consists of primary care plus, which directly links primary and secondary care services. Primary care plus staff focus on telephone triage of patients, provide advice and support to GPs and direct patients to the pathway that meets their needs. Primary care plus provides the single point of access to trust mental health services.

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 bi-polar disorder.

We inspected the following services:

Bromley West ICMP

Bromley West ADAPT

Bromley PCP

Bexley ICMP

Bexley ADAPT

Greenwich East ICMP

Greenwich East ADAPT

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

We inspected this service as part of an announced focused inspection. We decided to carry out this inspection following a series of interviews we conducted with patients and carers to gain their view of the service.

As this inspection took place during the Covid-19 pandemic we adapted our approach to minimise the risk of transmission to patients, staff and our inspection team. This meant that we limited the amount of time we spent in the service to prevent cross infection. One inspection manager visited a team base on 5 August 2020 for half a day to complete essential checks. Whilst on site they wore the appropriate personal protective equipment and followed local infection control procedures. The remainder of our inspection activity was conducted off-site. This included staff, patient and carer interviews over the telephone and analysis of evidence and documents. Our final telephone staff interview was completed on 14 August 2020.

Summary of findings

As this was a focused inspection, we only looked at specific areas concerning assessing and managing risk to patients and staff, patients' access to treatment, patients' ability to feedback about the service, how the service was running during the Covid-19 pandemic, the wellbeing of staff and patients and the culture within the trust.

During the inspection visit, the inspection team:

- visited the Bromley West team base at Beckenham Beacon;
- spoke with 82 patients, relatives and carers who were using the service;
- spoke with the managers or acting managers for each of the teams;
- spoke with 36 other staff members; including doctors, nurses, occupational therapists, clinical psychologists and social workers;
- looked at eight care and treatment records of patients:
- looked at a range of policies, procedures and other documents relating to the running of the service

Overall Summary

We undertook this focused inspection to look at specific areas concerning assessing and managing risk to patients and staff, patients' access to treatment, patients' ability to feedback about the service, how the service was running during the Covid-19 pandemic, the wellbeing of staff and patients and the culture within the trust.

We identified breaches of regulation in this focused inspection and this resulted in the overall rating of this core service going down.

We rated community mental health teams for adults of working age as requires improvement because:

- Although staff assessed the risks affecting patients they did not consistently put in place or update risk management plans to address these risks.
- Many patients had not received the physical health checks they needed. The trust could not be assured that patients who required an electrocardiograms (ECGs) to monitor their heart function had received one in the last 12 months. This potentially put patients at risk of avoidable harm.
- Some pathways within the service were difficult to access. Patients waited a long time to start psychological therapies or receive an assessment for Attention Deficit Hyperactivity Disorder (ADHD). Over a six-month period, most teams did not meet the trust target of 95% of patients to start a psychological therapy within 18 weeks of their referral. In addition, the demand for patients accessing an ADHD assessment had increased and far outstripped capacity, meaning that waits were very long. As of July 2020, across all three boroughs, 362 patients were waiting for an ADHD assessment. The trust had recently started taking steps to address these waiting times, but these were not yet resulting in patients receiving a timely service.
- Staff did not proactively seek feedback from patients or carers about the care they received from the service. The service needed to do more to inform and involve families and carers appropriately.
- Patients on the Care Programme Approach (CPA) did not always meet with their full multidisciplinary care team during their reviews. This may have impacted on their ability to be fully involved in decisions about their care.
- Staff did not always actively address the comprehensive needs of all patients, including those with a protected characteristic. The service could do more to encourage an open and inclusive environment to support patients' sexual, cultural and spiritual preferences.

Summary of findings

- Individual caseload sizes varied across the teams. The trust aimed for caseloads to be no higher than 35 per clinician. However, some staff reported caseloads higher than this with complex cases on their caseload. The trust needed to do more to embed their new case load weighting tool.

However:

- Staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- 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 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.
- Leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed. Leaders were visible in the service and approachable for patients and staff during the Covid-19 pandemic.
- Staff felt respected, supported and valued. Staff reported high morale amongst the teams and felt supported by their senior leadership. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression in most teams.

Is the service safe?

Requires improvement 

Our rating of safe went down. This inspection focused on specific areas of safety, such as staffing, assessing and managing risk to patients and safeguarding. As we found a breach of regulation, we have re-rated this key question to requires improvement. We found:

- Although staff assessed the risks affecting patients they did not consistently put in place or update risk management plans to address these risks. This meant patients may be put at risk of avoidable harm.
- Many patients had not received the physical health checks they needed. The trust could not be assured that patients who required an electrocardiogram (ECG) to monitor their heart function had received one in the last 12 months. This potentially put patients at risk of avoidable harm.
- Individual caseload sizes varied across the teams. The trust aimed for caseloads to be no higher than 35 per clinician. However, some staff reported caseloads higher than this with complex cases on their caseload. The trust needed to embed their new case load weighting tool.
- Patients on the Care Programme Approach (CPA) did not always meet with their full multidisciplinary care team during their reviews. This may have impacted on their ability to be fully involved in decisions about their care.

However:

- Staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Summary of findings

- 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 vacancies well. Staff used bank and agency to cover vacant posts.
- The teams had a good track record on safety. 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.

Is the service effective?

We did not include this key question in this inspection. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

Is the service caring?

Our rating of caring stayed the same. We did not inspect the whole of caring during this inspection and therefore did not rate the key question. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

We found:

- Staff treated patients with compassion and kindness. We spoke to 82 patient and carers altogether, with the majority providing positive feedback about how staff treated them. Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff gave patients help, emotional support and advice when they needed it. Patients described staff attending flat viewings with them and supporting them with their family dynamics during the Covid-19 pandemic.

However:

- Staff did not proactively seek feedback from patients or carers about the care they received from the service. The service needed to do more to inform and involve families and carers appropriately. Staff had suspended carers' forums during the Covid-19 pandemic because they could not facilitate a large gathering inside. Managers hoped they would be able to start them again soon.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. This inspection focused on specific areas of responsive, such as patients' access to the service. As we found a breach of regulation, we have re-rated this key question to requires improvement. We found:

- Some pathways within the service were not always easy to access. Patients waited a long time to start psychological therapies or receive an assessment for Attention Deficit Hyperactivity Disorder (ADHD). Over a six-month period, most teams did not meet the trust target of 95% of patients to start a psychological therapy within 18 weeks of their

Summary of findings

referral. In addition, the demand for patients accessing an ADHD assessment had increased and far outstripped capacity, meaning that waits were very long. As of July 2020, across all three boroughs 362 patients were waiting for an ADHD assessment. The trust had recently started taking steps to address these waiting times, but these were not yet resulting in patients receiving a timely service.

- Staff did not always actively promote the needs of all patients, including those with a protected characteristic. The service could do more to encourage an open and inclusive environment to support patients' sexual orientation, cultural needs and spiritual preferences.

However:

- The services referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly.

Is the service well-led?

Our rating of well-led stayed the same. We did not inspect the whole of well-led during this inspection and therefore did not rate the key question. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

We found:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed. Leaders were visible in the service and approachable for patients and staff during the Covid-19 pandemic.
- Staff felt respected, supported and valued. Staff reported high morale amongst the teams and felt supported by their senior leadership. They reported that the trust promoted equality and diversity in its day-to-day work and in providing opportunities for career progression in most teams.

Detailed findings from this inspection

Is the service safe?

Safe and clean environment

Staff in all teams adhered to infection prevention and control guidelines to reduce the risk of Covid-19 spreading.

Staff in all the teams we inspected followed infection control guidelines, including handwashing, keeping a minimum distance from each other and wearing personal protective equipment (PPE). Due to the current Covid-19 pandemic we limited our onsite visits to only one of the trust premises to reduce the risk of infection. We visited the Bromley West ADAPT and ICMP team base. At the beginning of the Covid-19 pandemic most staff stopped working from the office premises full time. Staff contacted patients virtually where they could but still met with high risk patients at their bases or in their homes to ensure they were safe. Whilst on the premises or visiting patients in their homes, staff wore appropriate PPE. To further reduce the risk of infection, staff worked on a rota basis to ensure that a minimum number of staff entered the team base to help maintain social distancing measures in offices.

Safe staffing

The service had enough staff, who knew the patients well. The service had a variety of disciplines to support patients such as medical staff, clinical psychologists, nurses, social workers and other allied health professionals.

The trust determined safe staffing levels by calculating the number and grade of members of the multidisciplinary team required, using a systematic approach. The trust recently created a safe staffing tool for the community mental health teams, which was modelled on their inpatient safer staffing tool. This took account of the shift system operated for duty work and the capacity and demand in each borough, but the roll out of the tool had been delayed.

Some teams had higher vacancy rates than others. For example, the Bromley West ADAPT team had the highest number of vacancies for clinical psychologists. The team had one vacancy for a band 8c clinical psychologist, one for a band 8b and one for a band 7 psychologist. In Greenwich East ADAPT, the team had two vacancies for care coordinators (band 6 and band 5) and a part time vacancy for an occupational therapist. In Bexley ICMP the team had one vacancy for a nurse and two vacant posts for clinical psychologists to cover maternity leave. The trust used regular locum staff to ensure that vacant posts were appropriately covered whilst they were recruited to.

Managers supported staff who needed time off for ill health. Since the Covid-19 pandemic some staff had been absent after contracting the virus, particularly in Greenwich, or were shielding. Greenwich West ADAPT had the highest sickness rate for health staff in April with 28% of staff being off sick compared to 11% of health staff off sick in March in the Greenwich East ICMP.

Managers covered staff sickness using bank and agency. In the beginning managers said it was a challenge to recruit bank and agency during the height of the pandemic. However, staff were redeployed from other services to help cover gaps. In Greenwich East ICMP, the manager recruited a long-term agency care coordinator to cover a staff member who was shielding. In addition, as more staff worked from home and had less face to face contact with patients, staff managed to cover individual caseloads with reduced home visits and increased contact with patients over the telephone.

Individual caseload sizes varied across the teams and staff members. The trust said they aimed for individual caseloads to be no higher than 35 per staff member. Care coordinators in Greenwich East teams had higher caseloads on average than other teams, between 22 and 35 patients. In the Greenwich East ICMP team most care coordinators had patients with complex needs that were on the care programme approach (CPA). A new member of staff had received a caseload of 30, which they reported was difficult to manage as they were new to the team. In addition to managing their caseload,

staff also had other tasks such as being on the duty rota and running clinics. In Bromley ADAPT West the average caseload size was 28 patients. Care coordinators in the Bexley teams reported having manageable caseloads ranging from 11-25. Two staff had caseloads over 35 and said these were manageable overall. However, when a patient was in a mental health crisis, their caseload quickly became much more 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. The trust had introduced a new caseload weighting tool in February 2020, but the teams had not started using it. A planned full review of the new tool had not been carried out to see whether it functioned properly because the Covid-19 pandemic had led to delays.

Medical staff

There were sufficient medical staff in the teams to provide safe care but there were vacancies. Each team had at least one whole time equivalent (WTE) consultant psychiatrist post. In addition, some teams had an extra WTE speciality doctor. Some teams had vacancies for medical staff. In Bexley ICMP posts for 1.5 consultant psychiatrists had not been filled. In Greenwich, the ADAPT team had a vacancy for one associate speciality doctor. In addition, the ICMP team had a vacancy for a consultant psychiatrist. The trust used locums to cover medical staff sickness or absence. Medical staff reported being busy with an increasing number of referrals and workload. Staff reported they could get support from a psychiatrist promptly when they needed to. However, four patients and carers reported waiting a long time for an appointment to see a psychiatrist.

Assessing and managing risk to patients and staff

Assessment and management of patient risk

Staff completed comprehensive risk assessments for each patient on admission to the service but did not always put clear plans in place to address those risks.

The multidisciplinary teams met regularly throughout the week 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.

We reviewed the care records of eight patients, four from Bromley West ICMP and four from Greenwich East ICMP. Records showed that all patients had a recent risk assessment in place. The risk assessments highlighted the main risks affecting patients. However, although staff assessed risks to patients, they did not always put clear plans in place to address or mitigate those risks. The patient risk management plans we reviewed did not make clear how risks to patients and others were being managed or addressed by the care team. As a result, there was a risk that known risks were not being managed or mitigated appropriately or consistently. This potentially put patients at risk of avoidable harm.

For example, one patient had a plan in place addressing their safety and risk concerns, but this had not been reviewed or updated since September 2019, 11 months prior to the inspection. The patient had been admitted to hospital twice in 2020 and was currently rated red in terms of their risk by the care team. The risk management plan did not reflect this. For another patient the recent progress notes highlighted a deterioration in their mental state and identified signs of relapse, such as throwing their belongings in the street and presenting at an emergency department in a manic state. Care plans in place to address the patient's needs and risks were dated January 2019 and consisted of a list of problem statements. Staff had not recorded any interventions and/or ways to manage or mitigate the identified risks or problems.

The risk assessment of a third patient stated they were likely a victim of 'cuckooing', and had been for some time, but there was no care plan or risk management plan in place to address the concerns in relation to the 'cuckooing'. 'Cuckooing' is a criminal offence where drug dealers take over a vulnerable person's home as a base for trafficking drugs.

Detailed findings from this inspection

There was no record that a safeguarding referral had ever been made in relation to the patient. We raised this with the trust after the inspection. They confirmed that a safeguarding alert had not been made at the time, but steps had been taken by staff to safeguard the patient, which included attending a cuckooing panel. The team had implemented appropriate measures to learn lessons from this and to raise a safeguarding alert retrospectively.

Another patient was receiving Clozapine to treat their mental health condition and was noted in more than one risk assessment since July 2019, and in the progress notes of 8 July 2020, to be at high risk in respect of constipation. However, no risk management plan or care plan was in place to address this. Constipation in a patient taking clozapine can cause clozapine toxicity, which in turn can increase the likelihood of serious side effects.

Across the teams, risks to patients' physical health were not always monitored often enough. The Bromley West ICMP team manager, who was new to the team, had developed a spreadsheet to track when patients who needed regular electro cardiograms (ECGs) received them. The tracker showed that most patients were overdue for an ECG. Patients receiving a high dose of antipsychotics, require regular ECGs as antipsychotics can sometimes cause heart problems as a side effect.

The manager told us that some delays had been caused because it was difficult for patients to access an ECG during the pandemic. There were plans in place to address this by creating a space within the Bromley West team base to keep an ECG machine and carry out ECGs on site. So far, these machines were only in use in Bexley and not all staff had been trained in how them. After the inspection, we requested further data from the trust to see how many patients in other teams had received an ECG in the last 12 months. The trust said it was not able to provide information on the completion of patients' ECGs as it did not collect this information centrally. The data held by the trust focused on physical health monitoring as part of commissioning targets and it was not clear what specific parts of a physical health check patients had received. The trust could not be assured that patients who required an ECG had received one in the last year. This meant risks to patients' physical health were not always monitored, putting patients at risk of avoidable harm.

The trust created a physical health monitoring task list and dashboard for clinicians to monitor cardio-metabolic risk factors. The trust was in the process of adding to this dashboard to include all non-routine physical health monitoring requirements such as ECGs. This work should be completed by the end of 2020.

All patients, whose records we reviewed, had taken part in a care programme approach (CPA) review in the last six months. Those that had taken place since March, during the pandemic, had generally included the care coordinator and patient only and had not been a full review of the patient's care. Some CPA records we reviewed had been left blank other than for the names of those attending the meeting. All patients had CPA meetings scheduled for later in 2020. The Bromley West team manager told us these were planned to involve the consultant psychiatrist and other key professionals involved in the patient's care.

In interviews staff reported that medical staff had not been attending patients' CPAs as the trust were moving away from this approach. Doctors were expected to send written reports ahead of the CPA meeting. Some staff expressed concern about this approach and that doctors were now not routinely attending CPAs. The trust stated that their policy did not require a psychiatrist to attend or input into every patient's CPA review. The minimum requirement for attendance at the meeting was the patient and their care coordinator. The trust reported that during the Covid-19 pandemic the redeployment of medical staff to inpatient services had contributed to this, as well as higher staff sickness levels and less face to face contact with patients. This approach may limit a patient's opportunity to meet with their whole care team together and ask the questions they wish to.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Once a patient was referred into the service, they received an assessment and then if appropriate, the manager allocated them to a care coordinator. In most teams the manager allocated patients to a care coordinator straight away. However, in Greenwich East ADAPT there was a wait for some patients before being allocated a care coordinator and for

an assessment. As of August 2020, 15 patients had received an assessment for the service but still waited to be allocated to a care coordinator. This was due to a delay in the administrative process rather than clinical care. These patients were awaiting transfer onto the care coordinators' caseloads. A further 19 patients were still awaiting an assessment to access the service and be allocated to the correct treatment pathway. Staff monitored the 34 patients waiting, regularly. Staff contacted these patients or their referrer over the telephone to update them and check on their welfare.

All patients on the waiting list for psychological therapy had a crisis plan in place. They were contacted and reviewed by a clinical psychologist every three months while they were waiting.

Staff completed crisis and contingency plans with patients to address their needs. 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 to said they knew about their crisis plan and who to contact in an emergency. All patient records we reviewed contained up to date crisis plans.

Staff followed clear personal safety protocols, including for lone working. The service had adapted safety protocols including lone working arrangements during the period of the pandemic to ensure staff were safe. Staff were working in the office on a rota basis to reduce the number of people on site in order to maintain appropriate social distancing in the offices. More staff were working from home. In Bromley West a staff member took the role of designated 'office cover' and was the main point of call for staff who checked in immediately before and after home visits. Staff kept their electronic calendars up to date, showing their whereabouts, and these were accessible for managers and staff.

Safeguarding

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give examples of how they had protected patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff described safeguarding alerts that they had raised related to financial exploitation or physical abuse.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. 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.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, in Greenwich East ICMP we identified a safeguarding concern where staff had not correctly recorded it as a safeguarding alert or what plans had been put in place to safeguard the patient. Staff did not appropriately escalate the concern to other professionals in the absence of the safeguarding lead.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

All staff knew what incidents to report and how to report them. Staff reported all incidents that should be reported. Staff reported that they raised incidents such as 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. Managers investigated incidents and shared lessons learned with the whole team and the wider service. For example, in Bexley, staff told us about a recent serious incident that occurred in the team and recommendations that came from the investigation. Recommendations included extra training for staff in substance misuse.

Learning from serious incidents was discussed at the community care forums. These involved senior clinical staff and frontline staff discussing clinical practice and serious incidents across the community mental health teams. These forums had only just recently re-started, as they were suspended during the height of the Covid-19 pandemic.

Detailed findings from this inspection

Staff received feedback from investigations of incidents across the trust. A serious incident that occurred in Greenwich ICMP East was still under investigation at the time of the inspection. However, staff reported that they felt supported and were able to debrief with senior managers immediately after the incident.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. We spoke to 82 patients who used the service, and relatives, over the telephone. Patients described staff as 'friendly and caring' and being very receptive. Patients said staff were compassionate. Patients particularly praised the reception staff saying they were 'lovely'. One patient said the psychiatrist was the best they had ever had.

Most patients felt supported by staff during the Covid-19 pandemic. Patients said staff had visited them at home during the pandemic, were very polite and listened to them. Another patient said their care coordinator attended a flat viewing with them during the Covid-19 pandemic, which helped them move into their own place. Patients said they could contact their care coordinator and seek support at any time.

Patients described how their care coordinator had done so much for them, with one patient saying they came out to visit them during the pandemic. Other patients said they 'would not be alive today if they [care coordinator] had not helped me.' Another patient also described how the medical staff helped them and took time to give them care and attention. Patients explained how staff had given them '100%' care and attention and supported them holistically.

However, some patients made negative comments about how care had been provided during the Covid-19 pandemic. For example, some relatives of patients using the Bexley ICMP team said they had not been contacted at all and said they had to find out everything themselves. One patient said it has been hard as their care coordinator has not been calling or visiting as much as they would like them to. A second patient said staff were not very responsive and did not call them within the agreed timeframes. Another patient in the Bromley West ADAPT team said they would like more contact from their care coordinator and that a phone call every two weeks was not enough.

Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. We received mixed feedback from patients about the information they were given about the service, and their care and treatment. In the Greenwich East ADAPT team patients described how the medical staff had helped them, especially when discussing their care and treatment. In Greenwich East ICMP patients praised the psychiatrist for helping them to reduce their medicines. However, some patients and relatives suggested that communication could be improved. A patient from Bromley West ICMP said that when the team moved premises towards the end of 2019, they were not informed of the changes that would happen. These changes included how to access physical health checks and where to go for a blood test.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Involvement in care

Involvement of patients

Staff said they tried to make sure patients understood their care and treatment and supported them to make decisions regarding their care. Staff offered patients information leaflets about certain aspects of their care.

Most patients told us they did not know how to give feedback about the service and staff did not support them to do this. Patients reported that they were not aware of a specific process but would speak informally to their care

coordinator. Patients in Bexley ICMP said that the online form for providing feedback did not work. Others said they were not given feedback forms to complete and that this was the first time they had been asked for feedback about their care and treatment. Overall, across the teams, patients and relatives said they were unsure how they would give feedback about the service.

Staff did not collect feedback routinely from patients. Staff said that they used to have devices in the waiting rooms that patients could quickly input feedback about the teams, but these had been removed. Staff could not describe where they had made improvements to the service as a result of patient feedback. This was a missed opportunity to discover whether the community mental health services for working age adults were meeting the overall needs of patients or whether improvements could be made to the way the service was provided. Less face to face appointments between staff and patients made it more of a challenge to complete feedback forms with patients. The trust had started to automate collecting feedback by sending patients a text message or an email at certain points in their treatment directing them to a survey to provide feedback. In addition, the trust collected feedback from patients across the trust about their experiences and support specifically during the Covid-19 pandemic. However, this did not ask for feedback regarding the specific needs of the patients using the community mental health teams overall.

Involvement of families and carers

Staff ensured that families and carers were kept informed and involved in the decision-making process where appropriate. Most relatives and carers said they were as involved as they needed to be and trusted staff to tell them what they needed to know. However, a small number of relatives and carers reported that staff did not always involve them in their loved one's care.

Staff did not always help families and carers to give feedback on the service. For example, due to the Covid-19 pandemic staff had not been able to facilitate the carers forum to aid and provide information to carers of patients using the community mental health teams. Staff had not implemented alternative ways for carers to receive information and support. In Greenwich, the trust was in the process of setting up a 6-week carers programme for carers across the inpatient and community settings. This aimed to help carers understand how their relative was cared for by the trust and give feedback on the service.

Is the service responsive?

Access and discharge

Some pathways within the service were not always easy to access, some patients waited a long time for an assessment or to start treatment within some neurodevelopmental and psychological treatment pathways.

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 primary care plus (PCP) teams. Staff in the PCP teams were the direct link between primary and secondary care services. Appropriately trained administrative staff screened all referrals and passed these onto the clinical team within the PCP 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 PCP teams aimed to assess routine referrals within 14 days and urgent referrals within 24 hours. The teams did not collect the data on how many patients were seen urgently within 24 hours. The teams said they always saw urgent patients within 24 hours and if they did not it would be reported as an incident. Managers told us that no incidents had been reported in the last six months.

Detailed findings from this inspection

Patients waited a long time to access psychological therapy. The trust aimed for patients to commence psychological therapy identified in their initial assessment within 18 weeks of referral. A patient in Bromley PCP reported that they would need to wait 12 months to receive cognitive behavioural therapy (CBT). Staff recommended they seek CBT privately because the waits were so long. Another patient from Bromley ADAPT West reported that they ended up paying for a private therapist because the wait for psychological therapy in the trust was too long.

Data submitted by the trust after the inspection showed that during the period January to July 2020 most teams did not meet the trust target of 95% of patients to start treatment within 18 weeks of their referral each month. For example, the Greenwich East ADAPT team did not meet the trust target in any month during this period. The lowest was in April when only 49% of patients were seen within 18 weeks. In Bexley ICMP, the team only met this target once, in January. The month of May 2020 saw the lowest number of patients receive treatment within 18 weeks at 52%. This meant that patients were not commencing treatment in a timely way.

In Bromley West ADAPT we looked at the waiting list for various psychological therapies during our onsite visit. The lists showed that 34 patients were waiting for psychological therapy. Nineteen of these patients had breached the expected target wait time. There were 19 people waiting for the Common Foundation Group, a first level intervention and part of the personality disorder pathway. Of the 19 people waiting, the longest wait was six months. Eight of the 19 patients were currently breaching the target. In addition, 11 people waited for integrative therapy, seven of these had breached the target waiting time. The person who had waited longest had been waiting since September 2019 (11 months).

There was a list of four people waiting for eye movement desensitization and reprocessing (EMDR), a form of psychological therapy used with people who have experienced trauma. All four were breaching the target wait time. The Bromley West team did not have any capacity to provide this therapy until staff had received appropriate training in EMDR. The service hoped to be able to provide the therapy before the end of 2020. The person who had waited longest had been waiting since October 2019 (10 months).

Performance against the 18-week target at Greenwich East ICMP team had improved. The team met the target in the months of January, March, May and July 2020.

The trust tried to address these waits by offering more group therapies, but these group programmes were suspended at the start of the Covid-19 outbreak. Virtual group therapies had presented a challenge as groups could not be more than nine people at a time. Extra software had been purchased to allow more groups to take place online. The trust was looking to train 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. Some patients were not able to take part in therapy virtually as they were not able to find an appropriate private and confidential space from which to take part.

Patients waited a long time for specific neurodevelopmental assessments. The service provided Attention Deficit Hyperactivity Disorder (ADHD) assessments for patients. These assessments determine whether a person has ADHD or not. A specialist can make an accurate diagnosis after a detailed assessment. In the boroughs of Bexley and Greenwich, the trust was commissioned to provide 2.5 assessments a month. In the borough of Bromley, the trust was commissioned to provide 6.25 assessments a month.

We requested further data from the trust to show the waiting times for patients in each borough between the period January to July 2020. This data showed that each month the number of referrals received increased and the length of time that patients waited to be assessed also increased. In Bromley, as of July 2020, patients waited on average 10 months for an assessment. This had slightly decreased over the 7 months since January, but the number of referrals increased to 157 in July. In the same month in Bexley, patients waited on average 12 months for an assessment. The length of wait had increased from five months since January. Referrals into this service had increased to 84. In

Detailed findings from this inspection

Greenwich, patients waited on average 22 months for an assessment as of July 2020. By July 2020 referrals into the service had increased to 121. As of July 2020, across all three boroughs of Bexley, Bromley and Greenwich a total of 362 patients were waiting for an ADHD assessment. Staff were not able to assess patients in a timely manner and the service did not respond promptly to patients' needs.

The ADHD service had recently changed management and clinical leadership and the service had reviewed its pathway to increase efficiency. This included liaising with another local trust to review their model of provision. The trust said it had seen some improvement in provision as a result of this but the challenge of meeting increasing demand with limited resources remained. The service was looking at ways to improve the productivity of the service such as using independent providers to help with the workload. In response to the growing number of referrals into the service, the trust said they were setting up a meeting with commissioners to discuss capacity and demand for this service and future sustainability.

Meeting the needs of all people who use the service

Whilst staff considered patients' cultural, equality and diverse needs; more work could be done to ensure that patients' holistic needs were met. For example, spiritual support was limited to staff asking if a patient was religious. Patients' cultural needs were mainly reduced to collecting information on what ethnic background a patient was from, when they were first admitted to the service. Staff did not always take a proactive approach to find out about other parts of a person's culture and religion.

Staff were not actively able to describe what they did to support the needs of lesbian, gay, bisexual and transgender (LGBT+) patients and did not routinely ask patients about their sexuality and sexual orientation or the pronoun by which they liked to be addressed. Some staff had taken steps to show they were inclusive and open to LGBT+ patients. For example, some staff wore rainbow lanyards and asked patients about their sexual orientation at the referral stage. But staff did not consider engagement with specific community groups. As a result, patients' holistic needs may not be met.

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles.

Team leaders were nurses who had extensive experience working in adult community mental health services. Most team leaders had been working for the trust for many years. They understood the issues, priorities and challenges their services faced. However, the team leader for Greenwich ADAPT managed both the East and West teams. This meant they had direct line management for about 16 members of staff and faced challenges in ensuring staff supervision was completed in a timely way. The team lead said they could get support from other managers within the service and their line manager was supportive.

Each borough had a clinical director that oversaw the clinical running of the services. The deputy medical director for the trust was covering the vacant post for clinical director for Greenwich until the new clinical director started in post.

Senior managers were visible in the service and supported staff to develop their skills and take on more senior roles. During the Covid-19 pandemic senior leaders within the boroughs regularly sent out communications with updates on the latest guidance for public health and catching up on staff wellbeing. In addition, staff reported that senior leaders had visited the premises to ensure staff and patients were safe. The deputy medical directors had weekly catch up calls with medical staff to ensure consistency of care and monitor staff sickness and wellbeing.

Culture

Detailed findings from this inspection

Staff felt respected, supported and valued. 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 six months as a result of the Covid-19 pandemic.

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 and staff were aware of these groups. BAME staff in Greenwich said things were starting to improve in terms of being provided the same opportunities as their white counterparts, but there was still some way to go.

Management of risk, issues and performance

Leaders knew the risks of the services they managed, and systems were set up to identify, understand, monitor, and reduce or eliminate risks.

The team leaders mostly 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 and adequate medical cover.

Managers understood the issues, priorities and challenges the service faced and managed them. The team managers knew the challenges they faced. 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.

Engagement

Whilst the service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services, the trust still had work to do to improve how they collected feedback from patients and carers to improve services**.**

The service engaged well with patient staff, equality groups, the public and local organisations to plan and manage appropriate services. For example, staff had access to the trust intranet that contained up-to-date information on trust news. The trust acknowledged that the number of patients and carers providing feedback about the service was low and this had been further reduced during the Covid-19 pandemic.

Managers supported staff during the Covid-19 pandemic. Managers ensured that staff from vulnerable groups, such as BAME staff and staff with physical health conditions, were supported at work and followed national guidance to ensure that staff felt safe. BAME staff have been disproportionately affected by Covid-19, especially healthcare staff. The trust ensured managers completed risk assessments of all BAME staff, especially those returning to work after shielding or being off sick. BAME staff we spoke to said that their manager supported them back to work and completed a risk assessment with them. Risk assessments identified the risks to staff and how the trust could reduce the risk to better ensure staff safety.

The trust had engaged staff in discussion of local and global current affairs. Staff reported that the trust responded well to the Black Lives Matter protests. The trust had set up virtual live chats so that staff and managers could start having honest and open conversations about racial discrimination in the workplace.

Areas for improvement

Action the provider MUST take to improve

Detailed findings from this inspection

- The provider must ensure that patient risk management plans and care plans address the potential risks to patients to minimise risk of avoidable harm. **Regulation 12 (1)(2)(b)**
- The trust must ensure that staff monitor the physical health needs of patients and make sure that patients who need an electrocardiogram receive one regularly. **Regulation 12 (1)(2)(b)**
- The trust must ensure that patients have timely access to assessment and treatment in the neurodevelopmental and psychological therapy teams. **Regulation 17(1)(2)(a)**

Action the provider SHOULD take to improve

- The trust should ensure patients on a Care Programme Approach (CPA) have opportunities to meet all members of their care team at regular reviews, to ensure patients are able to discuss and contribute to their overall plan of care effectively.
- The trust should ensure that the new caseload weighting tool is rolled out to all teams and embedded in practice.
- The trust should ensure staff collect feedback from patients and carers about the care they receive.
- The trust should ensure that staff consider the holistic needs of patients by considering their sexual orientation and cultural needs proactively.

Our inspection team

The team that inspected the service was comprised of seven CQC inspectors, an inspection manager, an assistant inspector and two experts by experiences with experience of using mental health services.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

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