Good

Oxleas NHS Foundation Trust

Community-based mental health services for older people

Quality Report

Pinewood House
Pinewood Place
Dartford
Kent
DA2 7WG
Tel: 01322 625700
Website: www.oxleas.nhs.uk

Date of inspection visit: 26 - 28 April 2016
Date of publication: 13/09/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RPGDL	Bexleyheath Centre	Older persons community mental health team - Bexley	DA6 8DX
RPGDL	Bexleyheath Centre	Memory service - Bexley	DA6 8DX
RPGDL	Bexleyheath Centre	Older people's intensive home treatment team	DA6 8DX
RPGDL	Bexleyheath Centre	Older persons community mental health team - Bromley	DA6 8DX
RPGDL	Bexleyheath Centre	Memory service - Bromley	DA6 8DX

Summary of findings

RPGDL	Bexleyheath Centre	Older persons community mental health team - Greenwich	DA6 8DX
RPGDL	Bexleyheath Centre	Memory service - Greenwich	DA6 8DX

This report describes our judgement of the quality of care provided within this core service by Oxleas NHS Foundation Trust . Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Oxleas NHS Foundation Trust and these are brought together to inform our overall judgement of Oxleas NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated Oxleas NHS Foundation Trust as good for older peoples' mental health community- based services because:

High standards of risk assessment and risk management were consistent across all of the services. Potential patient risks were reviewed regularly and patients had individualised crisis plans. In all of the services, there was an ongoing focus on patient safety.

Staff went above and beyond what was expected of them. All grades of staff were accessible, and went beyond service limitations to meet the needs of patients and carers.

The care home project worked with care home staff to effectively support their residents. The memory service also provided an early identification service for residents with suspected dementia.

Following referral, patients waited under six weeks until they were assessed by memory services. Six weeks is the target time for all memory services to achieve by 2020.

The advanced dementia service co-ordinated and provided palliative care to patients with dementia. Staff in the service supported and advocated for patients and carers, including decisions concerning where the patient wished to die.

Complaints were viewed as a learning opportunity. Incidents and complaints were thoroughly investigated. Learning from incidents and complaints was communicated to all services. There was an open and transparent culture.

The strategic direction of the directorate focussed on effective partnership working. Co-operation and collaboration with partners was seen as key to providing a holistic, high quality service to patients and carers.

The senior management team promoted a culture of high standards and continuous improvement. This culture was reflected in each of the services. Standards of care were consistently high across all of the services.

Summary of findings

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

Are services safe?

Good

We rated safe as good for community-based mental services for older people because:

- All of the services were clean and well maintained. Infection control procedures were followed.
- Care co-ordinator caseloads in community mental health teams were 25 patients or less. Patients did not wait to be allocated a care co-ordinator. Caseloads were actively managed and reviewed.
- High standards of risk assessment and risk management were consistent across all of the services. Patient care plans included actions which could reduce patient's risks. Potential patient risks were reviewed regularly and patients had individualised crisis plans.
- All of the staff in the services had a thorough knowledge of safeguarding adults and safeguarding children. All of the social workers, nurses and occupational therapists in Bromley CMHT were safeguarding investigators.
- When staff were duty workers they did not have booked appointments with patients. This ensured that they could respond urgently to patient's needs. Patients would be visited by the duty worker in their home the same day if required.
- All staff were aware of lone working policies and procedures. Staff practices regarding lone working were embedded in all of the services. There was a low threshold for staff to undertake visits in pairs.
- All incidents were reported. Learning form incidents was shared across all of the services.

However:

- In Bromley community mental health team and the intensive home treatment team medicines management practices were not sufficiently robust.

Are services effective?

Good

We rated effective as good for community-based mental health services for older people because:

Summary of findings

- Patients had a comprehensive assessment when they were referred to services. Patient assessments in memory services were in accordance with guidance from the National Institute for Health and Care Excellence (NICE).
- Patients were offered psychological treatment in accordance with NICE guidance. Medicines were prescribed cautiously and in accordance with NICE guidance.
- Patients care plans were of a high standard in all services. Care plans were specific, detailed, and covered all of the patients' needs. The focus of care plans were on patient's recovery.
- Patient's physical health was effectively monitored. Where indicated, patients had an annual physical health check.
- Staff had an excellent understanding of the Mental Capacity Act. They ensured that patients were involved in decisions and acted in their best interests when necessary.
- Staff were highly skilled and experienced. A range of training was available to staff. Services worked constructively with other agencies. The services offered support, training and guidance to others involved in patients care.

However,

- These services had not undertaken a staff training needs analysis.

Are services caring?

Good

We rated caring as good for community-based mental health services for older people because:

- Patient and carer feedback consistently recognised that patients were treated with dignity and respect. Patients and carers made very positive comments about staff being kind, caring and helpful.
- Staff demonstrated passion and commitment about providing a caring service to patients and carers. Staff were thoughtful, and took great care with how they communicated with patients and carers.
- Staff went above and beyond what was expected of them. All grades of staff were accessible, and went beyond service limitations to meet the needs of patients and carers.

Summary of findings

- Patients were involved in developing their care plans. Patients and carers were partners in care. Staff had a thorough understanding of patient's needs.
- Carers were offered a carers assessment. Services operated carers support and educational groups. A carers group was being re-arranged to the evening to increase attendance.
- Patients and carers were regularly asked for their feedback on services. Action was taken based on this feedback. Carers were involved with developing a new pain assessment tool. ResearchNET involved patients and carers in co-producing research.
- Ninety four percent of patients were likely to recommend the service to a family or friend, should they require it. Seventy four percent were 'extremely likely' to recommend the service.

Are services responsive to people's needs?

Good

We rated responsive as good for community-based mental health services for older people because:

- Patients were assessed by services a short time after they were referred. Memory services were exceeding the waiting time target for all memory services to achieve by 2020. Bexley memory service was starting a drop-in session. Patients who attended and required further support did not need a new referral.
- All of the services were able to respond to urgent referrals the same day. Access to services was based on need, not age.
- Discharge planning took place early in a patient's treatment. Patients were linked into activities and support groups. Services had strong links with a range of organisations that could support patients and carers.
- The care home project provided advice and guidance to care home staff. This reduced the need for patients to be referred to statutory services. The memory service provided early identification of dementia in care home patients, so they could received assessment and treatment.
- In Bexley and Greenwich, patients with dementia at the end of their life received palliative care from the advanced dementia service. The service co-ordinated support for patients and carers and advocated for them.

Summary of findings

- A range of recovery-based groups were available to patients in all of the services. These groups were focussed on maximising patient's independence.
- Services were comfortable, and took account of patients and carers needs. Information was available in a large print format and treatment leaflets had been adapted.
- Patient appointments were flexible. Community mental health teams had started an extended hours service.
- In Bromley, outreach work was undertaken with black and minority ethnic (BME) communities. Staff were aware of the specific needs of the local traveller population.
- Patients and carers knew how to complain. Complaints were investigated in an open and transparent way. Complaints were viewed by staff as a learning opportunity. Changes were made following complaints.

However:

- Information in languages other than English was difficult to access.

Are services well-led?

Good

We rated responsive as good for community-based mental health services for older people because:

- In all of the services, there was an ongoing focus on patient safety. Systems for risk assessment and risk management were operated to a high standard across all of the services.
- Complaints were viewed as a learning opportunity. Incidents and complaints were thoroughly investigated. Learning from incidents and complaints was communicated to all services. There was an open and transparent culture.
- There was an integrated governance system. This involved monitoring of safety, effectiveness, service performance and standards.
- Staff morale was high and staff described job satisfaction. Staff worked together to ensure the best outcome for patients and carers. The directorate had started an administrator's conference, as other staff groups also had conferences.
- All of the staff in all of the services were confident they could raise concerns with their manager. Staff and managers felt confident in raising concerns with senior managers.

Summary of findings

- The senior management team promoted a culture of high standards and continuous improvement. This culture was reflected in each of the services. Standards of care were consistently high across all of the services. The clinical effectiveness and patient safety groups supported this culture.
- The strategic direction of the directorate focussed on effective partnership working. Co-operation and collaboration with partners was seen as key to providing a holistic, high quality service to patients and carers.
- There was an ongoing programme of involvement with research. New and innovative ways of delivering and improving services were explored.

Summary of findings

Information about the service

The older persons' directorate at Oxleas NHS Foundation Trust provides the following community-based mental health services for older people:

Community mental health teams (CMHTs):

These services provide specialist mental health services to older people with mental health needs. The services aim to enable older people to live independently in the community for as long as possible. They provide specialist assessment, treatment and social support.

There are three CMHTs, in Bexley, Bromley and Greenwich. The Bromley CMHT includes the care home project.

Memory services:

Memory services provide assessment, diagnosis and treatment for people who are experiencing difficulties with their memory such as dementia.There are three memory services, in Bexley, Bromley and Greenwich.

Intensive home treatment team (IHTT):

The intensive home treatment team provides a service for older people living in Bexley, Bromley and Greenwich. The service is for people who are experiencing a mental health crisis and require short term intensive support and treatment.

Bexley and Greenwich advanced dementia service:

This service provides palliative care and support to patients with dementia at the end of their life. The service supports carers and co-ordinates patients care to improve their quality of life. The service supports patients to enable them to remain at home as long as possible.

Our inspection team

The comprehensive inspection was led by:

Chair: Joe Rafferty, Chief Executive, Mersey Care NHS Trust

Head of Inspection: Pauline Carpenter, Care Quality Commission

Inspection managers: Peter Johnson and Shaun Marten Care Quality Commission

The team that inspected Oxleas NHS Foundation Trust older peoples' mental health community services comprised of: a CQC inspector and four specialist advisors. Three specialist advisors were nurses and one specialist advisor was a social worker. All of the specialist advisors had experience of working in older adults services.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Summary of findings

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited all of the services and looked at the quality of the environment and observed how staff were caring for patients
- spoke with eight patients who were using the service
- met with three carers of people using the service
- interviewed the managers of each service
- spoke with 38 other staff members; including doctors, nurses, support workers, occupational therapists, psychologists, social workers, administrators, an administration manager and a student social worker
- interviewed the service director, clinical director and service managers with responsibility for these services
- met with a care home manager regarding the care home project
- attended and observed three home visits to patients using the service
- attended and observed two out-patient appointments
- attended and observed a visit with the care home project, a handover in the intensive home treatment team, a multi-disciplinary meeting and a patient group
- reviewed in detail 22 care and treatment records of patients
- collected feedback from 59 comment cards
- reviewed three staff appraisal records
- looked at a range of policies, procedures and other documents relating to the running of the services

What people who use the provider's services say

We spoke with eight patients and three carers. Patients and carers were extremely positive regarding staff in the services. They praised the staff saying they were helpful, caring and respectful.

Patients and carers felt that they received the right amount of information about their illness and treatment. They reported staff helped them with their practical and emotional needs.

Before the inspection we provided comment cards and a comment box for patients and carers, in each of the services. We received 59 comment cards. Forty five of the comment cards were all or mostly positive. Thirty four of these cards were positive regarding staff showing dignity and respect. Other positive comments related to treatment, communication, waiting times and the facilities. Five comment cards were neither positive or negative. Nine comment cards were all or mostly negative. Five cards were negative regarding staff treating people with dignity and respect. There were also negative comments regarding treatment, communication, waiting times and facilities.

Good practice

- Following referral, patients waited under six weeks until they were assessed by memory services. Six weeks is the target time for all memory services to achieve by 2020.
- Staff went above and beyond what was expected of them. All grades of staff were accessible, and went beyond service limitations to meet the needs of patients and carers.
- The care home project worked with care home staff to effectively support their residents. The project also provided an early identification service for residents with suspected dementia.
- The advanced dementia service co-ordinated and provided palliative care to patients with dementia. Staff in the service supported and advocated for patients and carers, including decisions concerning where the patient wished to die.
- The senior management team promoted a culture of high standards and continuous improvement. This culture was reflected in each of the services. Standards of care were consistently high across all of the services. In all of the services, there was an ongoing focus on patient safety.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that medicine management policy and practice is sufficiently robust in all services.
- The provider should ensure that staff training needs in each service are assessed so that all patients' needs are consistently met.
- The provider should ensure that written material for patients is easily accessible in languages reflecting the needs of the local population

Oxleas NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Older persons community mental health team - Bexley	Bexleyheath Centre
Memory service - Bexley	Bexleyheath Centre
Older people's intensive home treatment team	Bexleyheath Centre
Older persons community mental health team - Bromley	Bexleyheath Centre
Memory service - Bromley	Bexleyheath Centre
Older persons community mental health team - Greenwich	Bexleyheath Centre
Memory service - Greenwich	Bexleyheath Centre

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

No patients, in any of the services, were subject to community treatment orders. Staff were able to access psychiatrists and approved mental health professionals to undertake MHA assessments if required.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had undertaken training in the MCA. Staff undertook further training provided by the clinical lead for the MCA.

All staff had an excellent knowledge and understanding of the MCA. Staff knew the five statutory principles and the capacity test.

Staff undertook capacity assessments frequently, and when it was appropriate to do so. Patient's capacity was assessed for specific decisions, and patients were supported to make decisions.

Patients were informed that they could make advanced decisions regarding their care and treatment. When appropriate, best interest meetings were held for patients. Patients in memory services were advised about Lasting Powers of Attorney.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- Patient waiting areas, consulting rooms and group rooms were shared between CMHT and memory services in each borough. All of the rooms where patients were seen were fitted with wall alarms.
- Each service maintained a rota for clinical staff to clean the clinic room. Clinic rooms in the services had manual and electronic machines to measure patients' blood pressure. There were also weighing scales and a pulse oximeter. This machine measures the amount of oxygen in a persons' bloodstream. All of the equipment was clean and had been calibrated. Disposable equipment, such as syringes and thermometers, were stored appropriately and within their expiry dates.
- All areas in all of the services were clean and well maintained. The Bromley services had just moved into their building, which had been refurbished. Furniture was clean and undamaged.
- Hand gel dispensers were available at the entrances to services. Reception staff reminded visitors to use these. Sharps boxes, for disposing of needles, were available in clinic rooms. The dates when sharps boxes were opened was recorded. This followed infection control guidance.

Safe staffing

- In the IHTT, there were five nurse and three occupational therapist posts. There were also 3.5 support worker posts and a technical instructor post. One nurse and one occupational therapist post were vacant. An occupational therapist had been recruited to the post. The part-time support worker post was also a vacancy. The IHTT operated a shift system. The early shift worked from eight am to four pm. The late shift worked 12pm to eight pm. On weekends and bank holidays there was one shift nine am to five pm. Four staff worked each shift, two of which were nurses. On some occasions, three staff worked on the late shift. Staff from each CMHT were also based within the IHTT from five pm to eight pm. They were able to assist the IHTT when required.
- In Bexley CMHT, there were 7.8 nurse posts. There was also a part time nurse prescriber. There was 1.0 occupational therapist post and one support worker post. There was a 0.4 vacancy for a nurse. In Bexley memory service, there were five nurse and two occupational therapist posts. There were no vacant posts.
- In Bromley CMHT, there were nine nurse and three occupational therapist posts. The service had 3.8 social worker posts and two support worker posts. There were 1.8 social work vacancies and a 0.5 occupational therapist vacancy. The vacant posts had been advertised. In Bromley memory service there were seven nurse posts and a nurse prescriber post. There were also an occupational therapist and 0.5 technical instructor post. Three of the nurse posts were vacant.
- In Greenwich CMHT, there were 7.8 nurse posts. There was also one occupational therapist and three social work posts. There were 3.5 support worker posts. There was one vacancy, which was a nurse post. Greenwich memory service had a full time nurse prescriber and 1.2 nurse posts. There were two part time occupational therapists. There were no vacancies.
- Overall, the staff vacancy rate was 14%.However, the size of teams was small and each service had few vacancies. The staff in each service were able to cover the additional work. The services were actively recruiting to vacant posts. The rate of staff sickness was 3% in the previous 12 months. Greenwich CMHT and memory service each had a staff sickness rate above 4.5%.
- Qualified staff members in the CMHTs acted as the care co-ordinator for patients. The average caseload per care co-ordinator was 20 to 25 patients. In the memory services, qualified staff members' caseloads were 100-150 patients. However, in these services, a number of patients would be seen every two or three months.
- Patients in CMHTs services were allocated a care co-ordinator following assessment by the service. Patients did not have to wait to be allocated a care co-ordinator.
- Care co-ordinators caseloads were actively manager. This was undertaken during staff supervision, and during weekly multi-disciplinary meetings. When care co-ordinators workload was increased their caseload did not increase. Team caseloads were well managed. The number of patients accepted into services was closely matched to the number of patients discharged.

Good

Are services safe?

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

- The services used regular bank and agency staff to cover unfilled shifts and vacancies. Some of the staff undertaking bank shifts were regular staff members.
- All of the services were able to access a psychiatrist quickly when required. As services were co-located, a psychiatrist was always available.
- Mandatory training rates in all of the services were above 95%. Staff were required to undertake 12 types of mandatory training.

Assessing and managing risk to patients and staff

- Each patient had a risk assessment undertaken when they were first seen at the services. Risk assessments were detailed and comprehensive at all of the services. They looked at the patient's past risks and potential risks. Patients and carers were involved in developing risk assessments. Where appropriate, patients had a falls risk assessment. These assessments covered a number of areas and possible contributing factors. Falls risk assessments were undertaken in accordance with national guidance (Falls in older people: assessing risk and prevention, National Institute of Health and Care Excellence [NICE], 2015). Individual risk assessments led to risk management plans. Care plans included actions to reduce risk to patients and others. The severity of patient's risks and treatment needs were rated red, amber or green (RAG rated). A published tool assisted staff to rate patient's risks and needs appropriately. This rating clearly communicated to staff the degree of patient risks. The RAG rating system was used consistently across all of the services. Individual risks were reviewed by the multi-disciplinary team every week in all services. In IHTT patient risks were reviewed daily. Patient's RAG rating could change following these reviews. Individual risk assessment and management plans were also updated where risks had changed.
- Patients had personalised, individual crisis plans. These included contact numbers and sources of assistance in an emergency. Crisis plans also described action to take if a patient's carer was suddenly admitted into hospital. Patients were informed that they could make advanced decisions regarding their care and treatment. However, very few patients made an advanced decision. Some patients did not have the capacity to understand and make an advanced decision.
- All of the CMHT services had a duty worker system. Memory services had either a duty worker or referrals co-ordinator. This involved a nurse, social worker or occupational therapist being available each day to deal with urgent situations. In Bromley CMHT there were two duty workers each day. When staff were duty workers they did not have booked appointments with patients. This ensured that they could respond urgently to patient's needs. A senior member of staff or the manager would provide additional support to the duty worker when required. We observed duty workers responding quickly when patient's health had suddenly deteriorated. Patients would be visited by the duty worker in their home the same day if required. In some cases, patients would be visited within one or two hours. Whilst the duty worker was visiting a patient, senior staff members would undertake the duty worker role. In IHTT, the shift co-ordinator ensured that urgent situations with patients were responded to quickly.
- When patients were waiting to start treatment, patients and carers were provided with details of how to contact the service. They could telephone the service if circumstances changed. All of the services were able to conduct home visits the same day if client's risk level had changed.
- All staff in all of the services had undertaken safeguarding adults training. However, the provider had designated this training to be attended once. There was no requirement to attend updates. However, staff who were safeguarding investigators attended refresher training provided by local authorities. Safeguarding children training was undertaken at level three by all staff. All staff were up to date with this training. All of the staff in the services had a thorough knowledge of safeguarding adults and safeguarding children. All staff were able to describe the range of situations which could affect the safety of adults or children. Staff had particular skills and experience in recognising potential financial abuse of patients. In Bexley, staff knew when and how to make a safeguarding referral to the safeguarding team. In Bromley CMHT three senior staff members were safeguarding adult managers (SAMs). SAMs reviewed safeguarding investigations which had been undertaken. All of the social workers, nurses and occupational therapists in Bromley CMHT were safeguarding investigators. This meant almost any member of the team could undertake a safeguarding adults investigation. There was one SAM in the Greenwich CMHT. A social worker and a nurse were

Good

Are services safe?

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

safeguarding investigators. Safeguarding investigations were undertaken in accordance with the London multi-agency adult safeguarding policy and procedures (2015).

- Staff had a good understanding of the lone working policy. When staff undertook home visits their whereabouts were recorded. Their expected return time was also recorded. There was also a procedure if staff undertook a home visit immediately before finishing work. There were robust systems in place to check on staff member's whereabouts in the community. Staff in all of the services understood how to obtain urgent or emergency assistance when on a home visit. Where there were increased risks to staff, two staff members would undertake a home visit. In the IHTT two staff would always undertake home visits when it was dark.
- Overall, there was good management of medicines in the services. Procedures for ordering, storing, prescribing and administering medicines were robust. Expired medicines from patients were stored in the medicines cupboard. There was no robust system for ordering medicines or identifying what action was taken regarding the expired medicines. However, the CMHT was a new service, formed from two CMHTs six weeks before the inspection. The IHTT had also been recently formed from two home treatment teams. In IHTT, medicine administration records (MARs) were not used. When staff administered medicines to patients they documented this in the patient's care and treatment record. The way medicines were recorded, and home visits undertaken, did not increase risks to patients. The consultant psychiatrist and a pharmacist were developing a new medicines policy for the service. This was due to be in place shortly after the inspection, and included the use of MARs for patients.

Track record on safety

- There had been eight serious incidents in the services in the previous year. Four serious incidents occurred in IHTT, with the remainder in CMHTs. The serious incidents involved patient suicides. All serious incidents were reviewed by the directorate patient safety group.
- A review of patients suicides had been conducted. This review identified that three or four key factors were involved in all of the suicides. Training then took place with staff, so that they were aware of these factors when assessing patients.

Reporting incidents and learning from when things go wrong

- All staff in all services were aware of the range of situations which required reporting as an incident. This included medicines errors, falls and aggression. Staff described a low threshold for reporting incidents, including 'near misses'. All incidents that should have been reported were reported.
- Serious incident investigations were fed back to staff in a number of ways. The directorate quality newsletter was produced every two months. The patient safety section reported the number and types of incidents. It also reviewed completed investigations, and described the learning form the investigation. Each service had a staff team meeting. Incidents were a standing agenda item at each team meeting. Staff had the opportunity to discuss incidents and ways to improve working. The findings from an incident in one service were shared with all of the services. Staff were also able to discuss incidents in services' reflective practice groups.
- Following incidents, staff had a debriefing. Following serious incidents, specific meetings were held to support staff after the incident. Following one serious incident, a psychologist from outside of the team facilitated a staff meeting.

Duty of candour

- All staff were aware of what actions they should take if a mistake could have harmed a patient. Staff were able to describe in detail the process of apologising to patients. There was an open and transparent culture.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We looked at 20 care and treatment records. Patients referred to CMHTs had a comprehensive assessment completed in a timely manner. These assessments included the patient's physical health, symptoms, activities, culture and family and social networks. In memory services, patients were assessed after physical causes for their memory loss had been excluded. Part of the assessment for patients included a scan of their brain, to guide appropriate treatment. Where appropriate, a neuropsychological assessment was also undertaken. This was in accordance with national guidance (Dementia: supporting people with dementia and their carers in health and social care, NICE, 2006). Patients were asked if they wanted to know their diagnosis. Patients referred to IHTT already received care under the CMHT or memory service. IHTT staff assessed patient's risks and their need for intensive home treatment.
- The care plans we reviewed in each service were consistently of a high standard. They were detailed and specific and demonstrated the involvement of the patient and carers. In IHTT and CMHTs, care plans were recovery orientated and included social networks and activities. In IHTT, the psychologist provided input into care plans. In memory services, care plans sought to maximise patient's independence.
- All patient information was stored electronically and available to all staff.

Best practice in treatment and care

- Patients were prescribed a range of medicines in the services. These reflected the different care and treatment needs of patients. Patients with depression were treated with a limited number of antidepressant medicines. Medicines with a high level of side effects, or significant interactions with physical health medicines were avoided. The prescribing of antidepressant medicines was in accordance with national guidance (Depression in adults: the treatment and management of depression in adults, NICE, 2009). For patients with mild or moderate Alzheimer's disease, one of three medicines was usually prescribed. This was in accordance with best practice guidance (NICE, 2006). Patients with schizophrenia or psychotic symptoms were prescribed antipsychotic medicines. Low doses of these medicines were prescribed to minimise side effects and physical health complications. Antipsychotic medicines were prescribed in accordance with national guidance (Psychosis and schizophrenia in adults, NICE, 2014). Patients with dementia who displayed challenging behaviour were also prescribed antipsychotic medicines. However, these medicines were prescribed only when other non-medicine interventions had not been successful. The prescribing of antipsychotic medicines for patients with dementia was in accordance with national guidelines (NICE, 2006). Overall, less than 15% of patients in the services were prescribed antipsychotic medicines. A system was in place which ensured these patients were reviewed by a doctor every three months.
- In CMHTs, a range of psychological treatment was available to patients. This included cognitive behaviour therapy and family therapy. Providing such treatment is in accordance with national guidance (NICE, 2009; NICE, 2014). In memory services, patients attended group cognitive stimulation therapy, in accordance with best practice (NICE, 2006).
- Patients and carers were provided with assistance regarding housing and benefits. In some cases, this formed part of patient's care plans. In CMHTs, care co-ordinators undertook this role. In memory services, patients and carers were directed to appropriate support services. For instance, in Bexley memory service an Alzheimer's society dementia advisor attended the service. In Bexley and Greenwich advanced dementia service, staff co-ordinated care for patients at the end of their life. Staff provided palliative care to patients and support for carers. This was in accordance with national guidance (NICE, 2006).
- Patient's physical healthcare needs were assessed frequently in all of the services. When physical health needs were identified, action was taken. For instance, a patient was referred by one of the services to a pain clinic. When patients were taking antipsychotic medicines, they were reviewed by a doctor every three months. This included an assessment of the their physical health. These patients also had an annual health check, in accordance with national guidance (NICE, 2014). Individuals with hypertension (high blood pressure), diabetes and who smoked cigarettes also had an annual health check.

Are services effective?

Good

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

- Services used Health of the Nation Outcome Scales (HoNoS) and the Clinical Global Impression (CGI) scale as outcome measures. Occupational therapists used the Australian Therapy Outcome Measures (AusTOMS). Psychologists used the Clinical Outcomes in Routine Evaluation (CORE) -10 scale. All of the outcome measures used had been validated. All of the medical and non-medical treatment provided to patients was monitored by the directorate clinical effectiveness group.
- Clinical audits were conducted across all of the services, and for specific services. Audits were undertaken to monitor if patients were screened for depression and to monitor the effectiveness of MDT working. An audit to measure care against specific NICE guidance was due to commence. However, clinical outcomes were not benchmarked against other services.

Skilled staff to deliver care

- All services had a team of nurses, occupational therapists, psychologists, and consultant psychiatrists. There were also trainee doctors, and in CMHTs and IHTT, support workers. In memory services there were nurse prescribers. Social workers were also in CMHTs in Bromley and Greenwich. Pharmacists were not part of the MDT.
- All staff had significant experience providing care and treatment for older people. The majority of staff had worked in the same services for several years.
- When staff were first employed in the services they undertook a period of induction. A checklist was used to ensure that staff were knowledgeable about all aspects of the service.
- All staff received supervision every six weeks and had an annual appraisal. Staff appraisals were detailed and recorded challenges and areas for development. Positive feedback and training needs were also identified. All consultant psychiatrists had monthly peer supervision. This was part of the directorate medical advisory committee. Consultant staff could also access individual supervision.
- Consultant psychiatrists and senior psychiatrist trainees regularly requested clinical advice and opinions from colleagues. They would send an e-mail to colleagues, and would receive several responses within a day. Psychologists within the services met every six weeks to share information and learning.
- Staff undertook a wide range of specialist training. Training included motivational interviewing, 'breaking bad news', dementia awareness and nurse prescribing. Some staff were undertaking a 'train the trainer' course in skills development for people with dementia. Staff had also undertaken training in lesbian, gay, bisexual and transgender (LGBT) awareness. Staff were also supported to undertake further study, including masters degrees. However, services had not undertaken a training needs analysis to ensure staff could always meet patient's needs.

Multi-disciplinary and inter-agency team work

- The IHTT service had an MDT meeting twice per week. All of the other services had weekly MDT meetings. Patients were discussed in detail. All staff, including junior staff, were able to contribute to the discussion. Staff were able to challenge each other in a constructive manner.
- When patients care was being transferred to the IHTT, a joint visit with the CMHT care co-ordinator took place. This also happened when the patient was being transferred back to the CMHT. The IHTT had weekly teleconference calls with the in-patient wards. This was to discuss patients who were ready for discharge from hospital. Some staff worked in both the CMHTs and IHTT and the older adult inpatient wards. The IHTT covered a wide geographical area. A small team would be deployed some distance from the team base for the day. A midday teleconference between this team and the main team took place each day. Some staff in CMHTs also worked part-time on the inpatient wards. This enabled good communication between the services.
- Services maintained strong working links with other organisations and agencies. Services corresponded with general practitioners (GPs) frequently and there were good links with practices. Services operated shared care arrangements with GPs. Memory services had operated masterclasses for GPs. This was to assist GPs with improved referral information and to offer support. All of the memory services had links with the Alzheimer's society. In Bromley, the care home project had built strong links with 31 care homes. The service provided advice to care home staff on how to support patients with behaviour which was challenging. The Bexley and Greenwich advanced dementia service co-ordinated patients care with GPs and other health and social care services. The Bromley memory service had developed

Are services effective?

Good

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

strong links with Age UK and Mind. Every two months, memory services attended the tri-borough dementia strategy transformation group. Statutory and voluntary agencies attended this group to improve services for people with dementia. Managers, at all levels, had consistently worked with Bexley local authority to increase the social work presence in services. A social worker was planning to attend MDT meetings every two weeks.

Adherence to the MHA and the MHA Code of Practice

- No patients were subjected to community treatment orders. Staff accessed psychiatrists and approved mental health professionals to undertake MHA assessments if required.

Good practice in applying the MCA

- All staff had undertaken training in the MCA. An older adults psychiatrist was the providers' lead for the MCA and provided further training to staff in the services. Staff were aware of the MCA policy.
- All staff had an excellent knowledge and understanding of the MCA. Staff knew the five statutory principles and the capacity test. In Greenwich CMHT, one of the social workers was a best interests assessor and a Deprivation of Liberty safeguards (DoLs) assessor.
- Staff undertook capacity assessments frequently, and when it was appropriate to do so. Patient's capacity was assessed for specific decisions, and patients were supported to make decisions. Patients were informed that they could make advanced decisions regarding their care and treatment. When appropriate, best interest meetings were held for patients. Patients in memory services were advised about Lasting Powers of Attorney (LPA) in accordance with best practice (NICE, 2006).

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff treated patients with respect and dignity. They expressed genuine interest in patients and carers, and displayed patience, empathy and warmth. Staff communicated with patients and carers with skill and sensitivity.
- From administrators to senior managers, all staff demonstrated passion and commitment when talking about patients and carers. An administrator noted that an entrance door was not easily opened. They expressed their concern that this could affect patients and carers and immediately took action. Consultant psychiatrists provided families and carers with their mobile telephone numbers. During a home visit, a nurse recognised that a carer displayed signs of mental health problems. They arranged to speak with the carer later to arrange appropriate support. Staff in the Greenwich advanced dementia service advocated for patients and carers with other professionals. They ensured, wherever possible, that patients died at home if that was what they wished. A staff member visited a patient's family outside of working hours to provide specific support to them. Staff in a memory service recognised that when patients were told they were to be discharged, they became distressed. Staff now told patients they were being transferred back to their GPs care. When a staff members' car broke down, an administrator drove the staff member for the day. This was so patient appointments were not cancelled. When staff assessed patients in same sex relationships, they were sensitive to patient's dignity. They asked the patient who were the most important people to them. Patient's partners were, where appropriate, referred to as their 'companion' or 'close friend'. There were many examples of staff being thoughtful, compassionate, and going above and beyond their role.
- Patients and carers were extremely positive regarding staff in the services. They praised the staff saying they were helpful, caring and respectful.
- Staff clearly understood patients and carers needs. Patients had clear, thoughtful care plans. Care plans covered a range of health and social needs. When staff spoke with patients, it was clear that they had in-depth knowledge of the patient.
- When patients started treatment they signed a form indicating who they consented for information to be shared with. Patient's care and treatment records showed that information was only shared with patient's carers or relatives when they had agreed this. On one occasion, a letter to a patient was copied to a member of the public. The letter was intended for the patient's relative. When the service became aware of this, a system was put in place to prevent this happening again.

The involvement of people in the care they receive

- Patients were involved in developing their care plans in all of the services. Care plans were person centred and demonstrated the patient had provided input. Patients own views were clearly recorded. Patients, and with consent carers, were given copies of the care plan. In memory services, patients could attend a group 'coming to terms with your diagnosis'. These meant patients could be more knowledgeable and involved with their care. Following an occupational therapy assessment, staff used electronic tablets to enable patients to choose adaptations. Patients and carers were partners in care.
- Carers of patients were offered an assessment of their needs when patients were accepted into services. Services operated groups and forums to support carers. The memory clinic support groups in Bexley and Greenwich were not well attended. The services planned to change the group times to the evening to increase attendance. In memory services, staff cared for patients so that carers could attend groups. The 'valid' research project consisted of a 12 week programme for carers of patients with dementia. Bromley CMHT had recently moved into a new building, which was unsuitable for carers groups. Action had already been taken to find a suitable venue for a carers group. Carers were also signposted to other organisations. These organisations were able to provide ongoing support specific to carers needs.
- Patients and carers could become involved in decisions regarding the services. A pain assessment tool for patients with dementia was being developed with carers. Focus groups across the memory services had led to ResearchNET. This was a patient and carer group co-producing research into patient and carer experience.

Good

Are services caring?

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

- In IHTT, patients were asked to complete a patient experience questionnaire (PEQ) on discharge. In the other services, patients were asked to complete them every six months. We reviewed the results of 127 PEQs received in the previous three months. All of the patients felt their privacy and dignity were respected. In the questionnaire's, there was space for patients to write comments. Comments included 'very caring service', 'Dr, nurses and staff are very kind', 'they don't give up on me' and 'very caring and understanding'. The PEQ also asked patients if they would recommend the service to a family or friend, if they needed it. In all, 94% of responses indicated they were likely to recommend a family member or friend. Overall, 74% of responses were extremely likely to recommend a family or friend. A patient and carer survey in Greenwich memory service led to improvements. The service was made more accessible and information packs were made clearer. The results of the survey were used to change services. The directorate patient experience group led on improvements to services based on patient and carer feedback. However, there were no patient or carer representatives at the directorate senior management meetings. Patients and carers were not involved in staff interviews.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- In the CMHTs, patients were assessed within a week of their referral to the service. Patients had an appointment with a doctor within three weeks. In memory services, the expected waiting time was six weeks. This is the target time set for all memory services to achieve by 2020 (Prime minister's challenge on dementia 2020, DH, 2015). In the previous year, the average wait for the Bexley memory service was under four weeks. For Bromley the waiting time was under five weeks, and for Greenwich slightly over five weeks. Bexley memory service was starting a drop in clinic for ex-patients. The ex-patients would be able to attend to talk with a professional. If the patient needed further support from the service a new referral was not necessary.
- All of the services were able to respond to urgent referrals. Referrals to the services were reviewed each day by a senior staff member. Where the referral was urgent, action was taken to see the patient as soon as possible. The patient could be seen the same day in all services. If required, this could be a home visit. In IHTT, an experienced member of staff was always available to receive an urgent referral. Patients were seen later the same day or the following day.
- When patients and carers telephoned in, services responded quickly to calls. When the call was urgent, this was passed to the duty worker to respond to.
- Each service had an operational policy which clearly stated which patients were suitable for the service. There were no age restrictions for patients to receive a service, and access to services was based on need. Memory services provided assessment and treatment to people of all ages with memory problems. In Greenwich memory services some patients were under 40 years of age. These patients usually had complex health problems and required significant support. The IHTT provided a service to all older adults in crisis, based on need. Patients with a diagnosis of dementia or personality disorder were not excluded from the service.
- When patients appeared unwilling to engage with services, attempts were made to engage them. Appointment dates and times were sent by text. This happened a few days before the appointment and on the day of the appointment. Patients with memory problems also received texts. When patients did not attend appointments, staff contacted the patient. This continued, even where patients had previously missed two appointments.
- Patients and carers had flexible appointment times. When home visits were planned, they were arranged to suit patient's needs. In some cases patients wanted a family member present. Appointment times were re-arranged so this could happen. In IHTT, patients and carers expressed a preference not to be visited in the evening. This was being monitored so that the service could meet patient's needs.
- Patients appointments operated on time. They were only cancelled by the service when absolutely necessary.
- Before patients were discharged from services, they were linked into a variety of activities or support groups. Activities for patients ranged from a walking group to a woodwork class. Patients specific needs or interests determined which groups they were introduced to. Services had strong links with a range of organisations which could offer patients and carers support. Discharge planning began early in patient's treatment, so that they could maintain their independence wherever possible.
- Bromley CMHT had experienced a high number of referrals from care homes. The memory clinic had a low number of referrals from care homes.To address these issues, Bromley CMHT developed the care home project. The small staff team working in the project received direct referrals and visited the care homes. Staff had developed a specific assessment tool. This covered patients physical health, mental health, their activities and the environment. The assessment tool was thorough and specifically developed for patients in care homes. Following a patient assessment, staff provided education to care home staff. They discussed the patient with the care home staff and worked with them to develop appropriate care and support plans. After the service was introduced, the number of patients referred to the CMHT from care homes decreased significantly. The assessment of some patients in care homes indicated they may have memory problems. These patients were then assessed at the memory service. A separate referral was not necessary. This meant patients with early stage dementia could benefit from effective treatment.
- CMHTs had commenced an extended hours service. This operated from five pm to eight pm each week night. One

Are services responsive to people's needs?

Good

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

member of staff from each CMHT was rostered to work each evening. Staff also provided additional support and capacity to the IHTT. The use and need for the extended hours service was being monitored.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had appointments with staff in private interview rooms. There were enough rooms in all of the services. Rooms suitable for groups were also available at the services. All of the rooms in the services were decorated in bright colours with enough light. Interview rooms had appropriate sound proofing.
- All of the services had a range of information available for patients and carers. This included information regarding complaints, treatments and patients' rights. Other information was also available for patients and carers. For instance in Bromley, police information regarding doorstep tradesman was available. As the IHTT only undertook home visits to patients, patients were provided with an information pack.
- The advanced dementia service in Greenwich ensured patients at the end of their life maintained their dignity. Staff co-ordinated, and worked with, other health and social care staff to ensure patient's needs were met. Staff in the service supported and advocated for patients and carers. When patients wish was to die at home, staff ensured wherever possible, that this happened.
- Patients in the services could attend day groups. Groups included anxiety management, 'getting going' and 'better sleep'. The focus of groups was to aid patient's recovery and maximise their independence.

Meeting the needs of all people who use the service

- All of the services had access for patients and carers in wheelchairs. There were toilets for people who were disabled in each service. The seating in the services was suitable for patients and carers with hip and knee problems.
- Bromley and Greenwich services had large signs with the name of the service. However, in Bexley, a sign directing people to the service was small. The writing on the sign was small. Patients or carers with impaired vision or memory problems may have had difficulty finding the service.
- Information in the services was available in large print for patients' and carers with poor eyesight. Information regarding medicines and treatment had been adapted by services for patients with memory problems.
- In Bromley, nurses in the memory services undertook outreach work with black and minority ethnic communities. This work increased the visibility of the service and reduced stigma amongst the local population. Staff in all of the services set up stalls at community events to promote the services in the community. Bromley staff also had awareness of the specific needs of traveller groups in the community.
- Information was available for patients in different languages. However, this information was difficult to access, and was not used frequently. All of the services were able to access interpreters whenever necessary.

Listening to and learning from concerns and complaints

- In the previous 12 months there had been seven complaints regarding services. Six of these were complaints about CHMT services and one was about a memory service. Two of the complaints were upheld, and the rest were partly upheld. This demonstrated that complaints were investigated thoroughly. Services were open and transparent when things had gone wrong.
- All patients and carers were provided with information on how to complain when they first accessed services. All of the patients and carers knew how to complain.
- Staff were fully aware of the procedure to deal with complaints. They understood that complaints should be addressed to the manager or to the patient advice and liaison (PALs) team.
- Staff and managers viewed complaints as a learning opportunity. Complaints were a standing agenda item at all of the service team meetings. Complaints led to changes in practice. For instance, a patient's relative had complained that the patient had been asked about their sexuality. Following the complaint, staff developed ways to obtain the information without directly questioning patients. A complaint from a patient involved them seeing a number of staff whilst under the care of the IHTT. Following this efforts were made for patients to see a small group of staff. There was also more attention at the start of treatment in explaining to patients how the service operated. Complaints from across the directorate were shared so that all services could learn from them.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff were aware of the provider's vision and values. The standards of the services reflected these values.
- Staff knew the most senior managers in the organisation. Every three months the service director and clinical director visited services. There was an opportunity for staff to discuss their work and any concerns.
- Central to the directorate strategy was to strengthen relationships with partner organisations. Integrated care networks had commenced in each borough, and the directorate was identifying how best to support primary care services. There was an aim for more integrated physical and mental health care whilst maintaining specialist knowledge and experience. Challenges, such as an increasing population of older people in some areas, were also viewed as opportunities. The directorate management team were identifying new models of care for the services.

Good governance

- The standard of care plans, risk assessment and risk management were consistently high across all of the services. All of the services, at different locations, provided high quality care to patients and carers. Care and treatment was provided in accordance with national guidance and best practice. In all of the services there was a continuous focus on patient safety. Systems were in place to ensure that the safety of individual patients was regularly discussed. All of the services were able to respond quickly when risks to patients safety increased.
- There were high rates of staff mandatory training and completed appraisals. A range of opportunities for supervision and reflective practice were available. The development of staff was a priority for the services. Staff undertook a range of courses for professional development.
- Administrative staff undertook a wide range of tasks, such as monitoring the whereabouts of staff on home visits. This allowed clinical and social work staff more time for patient care.
- Incidents and complaints were thoroughly investigated. Complaints were viewed as a learning opportunity. Changes were made following incidents and complaints. Learning from incidents and complaints was communicated to all services.
- The services had comprehensive operational policies. These described who the services were for and how they should they operate.
- All of the services had a shared business continuity plan. This plan explained the actions to be taken due to severe disruption of a service. The plan was detailed and comprehensive.
- The use of mobile technology to mitigate several risks was included.
- Services were monitored by a range of key performance indicators. These included how many patients had care plans, crisis plans and regular reviews. The number of carers assessments offered and cancelled appointments were also monitored.
- Effective partnership working took place at senior and service management level. Co-operation and collaboration with partners was seen as key to providing a holistic, high quality service to patients and carers.

Leadership, morale and staff engagement

- Staff sickness rates in the services were 3%, below the NHS average of 6%.
- One staff grievance had been raised in one service. This grievance related to bullying and harassment. This was being investigated at the time of the inspection.
- Staff were aware of the whistleblowing policy. All of the staff in all in the services were confident they could raise concerns with their manager. Staff told us they could also raise concerns with more senior managers. Team managers felt confident in raising concerns with senior managers in the directorate. A staff member had observed an incident of concern in another of the providers' services. They reported this directly to their manager.
- Although some services had recently been through service reconfiguration, overall morale amongst staff was high. Whilst the demand on services had increased, staff felt able to undertake their role. Staff described job satisfaction.

Are services well-led?

Good

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

- The management team considered the role of administrators had not always been fully appreciated. Other staff groups had annual conferences, and the directorate set up an administrator's conference. This was in its second year.
- The senior management team promoted a culture of high standards and continuous improvement. This culture was reflected in each of the services. There was strong leadership in each of the services, and managers consistently promoted best practice. Managers and staff consistently described a culture of person-centred care. The directorate clinical effectiveness and patient safety groups supported this culture.
- Managers undertook leadership courses. Managers felt supported by senior managers to develop their leadership role. Staff were also provided with leadership opportunities. Most managers had been promoted from within the services.
- Staff worked together to ensure the best outcome for patients and carers. Staff respected each other and their role in the service. Staff provided mutual support to each other irrespective of job or grade. Staff spoke highly of the culture within the services and the directorate.
- All staff were aware of what actions they should take if a mistake could have harmed a patient. Staff were able to describe in detail the process of apologising to patients. There was an open and transparent culture.
- Following the IHTT service reconfiguration, a series of 'test and learn' meetings explored the impact of the changes. Staff were involved in the process and provided input.

Commitment to quality improvement and innovation

- The Bromley memory service had been accredited by the Royal College of Psychiatrists memory service national accreditation programme. There were plans to seek accreditation for the Bexley and Greenwich memory services.
- At Bromley CMHT, the care home project had received a recognition award for their innovative work with care home staff. This award was from the Health Innovation Network and NHS Health Education South London. A pain assessment tool for patients with dementia was being developed. An app for younger patients with dementia was being reviewed for possible use in services.
- The services were involved with five research programmes. Four of these related to dementia, and one to depression. A further research programme was due to start.