

Oxleas NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RPGAG	Memorial Hospital	Bromley East locality team	BR6 0JB
RPGAG	Memorial Hospital	Bromley early intervention in psychosis	BR6 0JB
RPGAG	Memorial Hospital	Bexley locality team	DA8 3EE
RPGAG	Memorial Hospital	Bexley early intervention in psychosis	DA8 3EE
RPGAG	Memorial Hospital	Greenwich East locality team	SE18 6PZ
RPGAG	Memorial Hospital	Greenwich West locality team	SE7 8JH

Summary of findings

RPGAG

Memorial Hospital

Greenwich early intervention in
psychosis

SE18 6PZ

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

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Summary of findings

Overall summary

We rated the community based mental health services for adults of working age as **good** because:

- The services had effective systems for managing risk. Staff reviewed risks to patients at meetings that were held several times a week. Patients had risk assessments and clear risk management plans in place.
- Most teams had few vacancies. Staff and patients had access to a psychiatrist when they needed one. Managers monitored and adjusted the caseloads of staff so that they could provide safe care and treatment to patients. Teams were piloting a case load weighting tool aimed at ensuring staff caseloads were balanced.
- Complaints and serious incidents were investigated. The lessons learned were identified and shared with staff in the community teams. Staff made improvements in systems and care to help reduce the chances of the same type of incident or complaint happening again.
- Teams worked effectively with other trust services such as home treatment teams, child and adolescent mental health teams and employment advisors. Staff worked in partnership with local voluntary sector organisations to provide social inclusion programmes which supported patients' recovery. The teams were establishing good working relationships with local GPs.
- Most staff were up to date with mandatory training, received an annual performance appraisal and had regular clinical and managerial supervision.
- Staff provided care and treatment that was evidence based and in accordance with national guidance. Managers in the early intervention service had been proactive in making sure that staff had the skills to deliver family interventions. Psychologists and psychotherapists were integrated into the teams, which helped improve patient access to therapies.

- Staff provided caring and compassionate care to patients and carers. They understood the needs of individual patients. Patients were positive about the care and treatment they received.
- Clear systems of governance supported the teams to learn from incidents and complaints and make improvements in care and treatment. Managers had instant access to key performance information, which helped them monitor and improve the effectiveness of the service, as well as ensuring staff training, supervision and appraisal were up to date.

However:

- Although the trust provided guidance to staff on issues of patient confidentiality it was not clear that all staff followed the guidance and understood the boundaries. There was a risk that staff were not always maintaining confidentiality and could compromise patients' privacy, particularly when leaving telephone messages.
- Waiting times for assessment had improved since the introduction of the re-designed model of care for working age adults in the community. However, the primary care plus teams were inconsistent in terms of how promptly they were able to assess urgent and routine or non-urgent referrals. For example, some teams had assessed over 80% of urgent referrals on the same day and 100% within two weeks. Whereas another team had assessed no urgent patients on the same day and 68% within two weeks in the same time period.
- Staff did not routinely attend training in the Mental Health Act, this was not mandatory. Some staff said they had limited understanding of the Act and associated code of practice.

Summary of findings

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

Are services safe?

We rated safe as **good** because:

- Staff saw patients in premises that were visibly clean and well-maintained.
- Most teams were almost fully staffed and where there were vacancies these were being recruited to. Long term locum staff covered vacancies in the interim.
- Caseloads were weighted so that staff were able to provide safe care and treatment to each patient. Teams were piloting a caseload weighting tool.
- Patients and staff had good access to a psychiatrist when they needed one.
- Patients had up to date risk assessments. Staff reviewed risk on a regular basis. Teams held zoning meetings several times a week where patient risks were reviewed thoroughly and rated.
- Managers investigated serious incidents. Lessons learned were identified and acted upon.
- Staff understood their responsibilities under the duty of candour and apologised to patients when things went wrong.

Good



Are services effective?

We rated effective as **good** because:

- Staff provided care and treatment that was evidence based and in accordance with national guidance.
- Teams worked effectively with other services such as home treatment teams, child and adolescent mental health teams, GPs and employment advisors.
- Staff worked in partnership with local voluntary sector organisations to provide social inclusion programmes which supported patients' recovery.
- Staff received regular supervision and an annual appraisal.
- Managers in the early intervention service had been proactive in making sure that staff had the skills to deliver family interventions.
- Most patient care plans were holistic and person-centred.

However:

- Not all staff had received recent training in the Mental Health Act and the recently revised code of practice. Some staff told us they did not have detailed understanding of the Act.

Good



Are services caring?

We rated caring as **good** because:

Good



Summary of findings

- Staff provided caring and compassionate care to patients and carers. They understood the needs of individual patients.
- Patients were positive about the care and treatment they received and said staff were respectful.
- Patients gave feedback to staff about the care they received. Staff collected information about the patient experience every month in order to learn from it and make improvements in the service.
- Some patients had received training to prepare them to apply for lived experience practitioner posts within the trust.

However:

- Although the trust provided guidance to staff on issues of patient confidentiality it was not clear that all staff followed the guidance and fully understood the boundaries. There was a risk that staff were not always maintaining confidentiality and could compromise patients' privacy, particularly in relation to leaving telephone messages and when working with carers.

Are services responsive to people's needs?

We rated responsive as **good** because:

- Staff responded quickly to urgent referrals.
- Psychologists and psychotherapists were integrated into the teams, which helped improve patient access to therapies. Most patients referred to a psychologist were seen within 18 weeks.
- Staff had a good understanding of complaints management. Staff reflected on complaints and made changes to improve care. Information on how to make a complaint was on display in patient waiting rooms and receptions.
- The primary care plus telephone triage operated extended hours from 9am until 8pm.

However:

- Waiting times for assessment had improved since the introduction of the re-designed model of care for working age adults in the community. However, the primary care plus teams were inconsistent in terms of how promptly they were able to assess urgent and routine or non-urgent referrals. For example, some teams had assessed over 80% of urgent referrals on the same day and 100% within two weeks. Whereas another team had assessed no urgent patients on the same day and 68% within two weeks in the same time period.

Good



Are services well-led?

We rated well-led as **good** because:

Good



Summary of findings

- Managers had instant access to key performance information, which helped them monitor and improve the safety and effectiveness of the service, as well as ensuring staff training, supervision and appraisal were up to date.
- Staff felt well-supported by managers and colleagues. They were positive about the trust as an employer. They described a no-blame culture.
- Clear systems of governance supported the teams to learn from incidents and complaints and make improvements in care and treatment.

Summary of findings

Information about the service

Oxleas NHS Foundation Trust provides a range of community-based mental health services for people 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 trust introduced a locality based service model in each of the three boroughs, Bromley, Bexley and Greenwich in September 2015. 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.

Early intervention in psychosis teams work with people who are experiencing a first episode of psychosis. They provide specific support and treatment over a two year period in Bromley and Greenwich and to a maximum of three years in Bexley.

We inspected the following services:

Bromley East locality team

Bromley early intervention in psychosis team

Bexley locality team

Bexley early intervention in psychosis team

Greenwich East locality team

Greenwich West locality team

Greenwich early intervention in psychosis team

The community based mental health services for adults of working age have not been inspected before.

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 community mental health services for adults consisted of an inspection manager, one inspector, a senior nurse, a social worker and an expert by experience, a person who cared for relatives who used services. Another inspector joined the team for one day of the inspection.

Why we carried out this inspection

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

Summary of findings

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?

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 five community services for adults of working age including four locality mental health teams and the early intervention in psychosis service;
- Spoke with 31 patients who were using the services, either face to face or on the telephone;
- Spoke with three carers or relatives of patients;

- Collected feedback from 28 patients and carers using CQC comment cards;
- Spoke with the locality managers and managers of the primary care plus, intensive case management for psychosis and ADAPT teams;
- Spoke with the managers of the early intervention in psychosis teams, which covered the three London boroughs of Bromley, Bexley and Greenwich;
- Spoke with 26 other staff members including: consultant psychiatrists, nurses, psychologists, occupational therapists, social workers, support workers and a community resources and employment co-ordinator;
- Observed one home visit and six patient assessments and follow-up meetings;
- Attended and observed seven meetings including: referrals, zoning and multi-disciplinary team meetings.
- Looked at 13 care and treatment records of patients; and
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 33 patients and their relatives either in person or over the telephone. The feedback we received was overwhelmingly positive. Most patients and carers we spoke with said they were confident they would be seen quickly in an emergency. Several patients gave examples of when this had happened. Thirty one patients and carers said they had been treated with respect, kindness and compassion by staff. Staff were described as patient, polite and encouraging. Patients said that staff listened to them and they were made to feel welcome. One patient said the care and treatment was “extraordinary” and another said the service was “brilliant”. A third patient said staff had “worked miracles”. These comments were typical of the feedback we received.

Almost all patients said they had been involved in their care and had been offered a choice in terms of treatment. Three quarters of patients remembered receiving a copy of their care plan. Patients and carers said they had been given a range of helpful information by staff, including

leaflets on mental health problems, medicines and local services. All but three patients and carers said they knew how to make a complaint if they needed to. One person had been provided with information in another language. Five patients mentioned that staff always checked on their physical health at appointments. Some patients said that appointments had been cancelled in the past but that this had improved recently. Two patients complained that they had seen several different psychiatrists over the last three to four years and this was unhelpful.

We received feedback from patients and carers on 28 comment cards, which we collected from comment boxes that had been placed in community team premises prior to the inspection. A total of 34 issues were mentioned in the comment cards. Twenty three comments were positive and 11 were negative. Twelve comments praised

Summary of findings

the treatment patients received from staff and four were positive about the standard of the facilities. Two negative comments related to waiting times, staffing levels and treatment by staff.

Good practice

- Staff worked in partnership with local voluntary sector organisations to provide social inclusion programmes which supported patients' recovery. The early intervention service had developed a partnership with a local football club. Patients were able to join an activity programme once a week, which helped increase their confidence, and improve social relationships as well as their physical fitness. Some patients had gained football coaching qualifications. The group undertook a range of activities including foot golf, fishing and indoor bowls. All early intervention service patients were invited to the group.
- Staff offered support for patients' social needs such as housing, benefits and employment. For example, in Greenwich, employment advisors supported patients to remain in work and to find paid employment or voluntary work. They were working with 35 patients at the time of the inspection. The advisors supported patients to self-advocate in the work place or attended meetings with patients and employers.
- The early intervention service manager had been proactive in sending 17 staff to be trained in family interventions so that the team was better placed to deliver the goal of providing an evidence based package of care to patients within two weeks of assessment.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that all staff fully understand how to maintain patient confidentiality and ensure patient privacy is respected when leaving telephone messages and when meeting with carers and others.
- The provider should ensure that all staff have a good understanding of the Mental Health Act and associated code of practice.
- The provider should ensure that all primary care plus teams are able to respond quickly to urgent referrals.

Oxleas NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Bromley East CMHT	Memorial Hospital
Bromley early intervention in psychosis	Memorial Hospital
Bexley CMHT	Memorial Hospital
Bexley early intervention in psychosis	Memorial Hospital
Greenwich East CMHT	Memorial Hospital
Greenwich West CMHT	Memorial Hospital
Greenwich early intervention in psychosis	Memorial Hospital

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.

- Doctors had received training in the Mental Health Act and nurses received training during their preceptorship period. Approved mental health professionals in the teams had received advanced training. However, the

Mental Health Act was not mandatory training for staff. Most nurses and social workers had detailed knowledge of the Act, whereas some said they had more limited understanding.

- Staff knew where to obtain advice about the Mental Health Act, including contacting the trust Mental Health Act administration office and from approved mental health professionals in their team.

Detailed findings

- Patients had access to independent mental health advocacy services when needed.
- There were very few patients in any of the teams who were on community treatment orders (CTOs). We reviewed one community treatment order and found staff had completed it appropriately.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Almost 100% of all staff had received training in the Mental Capacity Act 2005 (MCA). The trust had a MCA policy and had produced a short and clear summary of the MCA for staff. Some staff were very knowledgeable and spoke confidently about the legislation. However, not all staff we spoke with had a good understanding of the MCA and the implications for their practice.
- Where staff had concerns about a patient's capacity they conducted assessments. These were clearly documented.
- The trust policy for consent to examination or treatment gave detailed guidance to staff on when and how to seek and document consent. Staff were well informed in terms of gaining patients' consent to treatment.

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

- Staff saw patients and carers in interview rooms that were fitted with alarms so that staff could call for help if they needed it. Some rooms, that were located near to reception areas or had two doors, were used when staff were unsure about risk levels or a patient was considered a higher risk.
- Clinic rooms in all services were well equipped. Staff had the equipment they needed to carry out physical health examinations. Most equipment, such as weighing scales and blood pressure monitors, was well-maintained and calibrated annually to ensure measures were accurate. Records of equipment checks and calibration details were kept in a medical devices register.
- Patient waiting areas were visibly clean and well-maintained. A poster in the clinic rooms reminded staff of the safest way to wash their hands and minimise the risk of cross infection. There was hand cleaning gel available in all reception areas.
- Staff cleaned clinic rooms every time they were used, which was usually three times a week. Staff cleaned and decontaminated equipment after use. Cleaning schedules and records were completed. Plastic bins used for the disposal of sharp objects including syringes and needles were not over-filled. They were labelled with the date of first use. Staff disposed of clinical waste safely and appropriately.

Safe staffing

- The teams had few staff vacancies. Where these existed they were being actively recruited to. For example, the Bromley East locality team had a vacancy for a psychologist, which had just been filled. The Bexley intensive case management for psychosis (ICMP) team had three vacancies that were being covered by long term agency staff. The Greenwich West locality team had vacancies for one nurse and two social workers in the ADAPT team. One person had been appointed and interviews were about to take place for the other two

- posts. The Greenwich East locality team had three locum staff covering posts while permanent staff were recruited. All locum staff had been in post for several months and were familiar with how the team worked.
- The early intervention teams had one staff vacancy in administration. An agency nurse was covering a post while an additional manager was recruited to the team. Teams in all three boroughs were multidisciplinary and a senior psychologist covered the three teams.
- Locum bank and agency staff were used to cover vacancies and make sure there were sufficient staff to care for patients. Where possible locum staff were used on longer term contracts in order to maintain continuity of patient care. All agency and locum staff received an induction into the service.
- Caseloads of care co-ordinators in ADAPT and ICMP teams were generally between 25 – 30 patients in all of the localities. Some staff had fewer patients on their caseload particularly if they had additional responsibilities, such as carrying out assessments under the Mental Health Act in their role as an approved mental health professional. Managers were aware of staff caseloads and adjustments were made to take account of the complexity of patients. Some staff told us they thought that caseloads were too high currently and it was a challenge to give good quality care to all patients. Some teams were piloting a caseload management tool to help managers balance patient caseloads across the teams.
- Care co-ordinators in the early intervention teams had about 20 patients on their caseloads. The service aimed to have 15 patients per caseload.
- Patients were allocated promptly to a care co-ordinator when this was needed. The teams did not have waiting lists of patients awaiting allocation.
- Staff and patients could access a psychiatrist when they needed one. Staff in primary care plus met with a consultant psychiatrist regularly to discuss referrals and assessments.
- Staff had completed trust mandatory training. Almost all staff were compliant with mandatory training in the teams we visited. Where training was incomplete staff were booked onto training courses or there were particular reasons for non-completion such as long-term sickness absence. In the Greenwich West and

Are services safe?

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Bexley primary care plus and ADAPT teams 71% of staff had completed breakaway training. Seven staff in the two teams needed to attend the training. In Greenwich West primary care plus and ADAPT team 71% of staff had completed equality and diversity training and basic life support. Two staff still needed to complete the training.

- Staff sickness rates across the locality teams and early intervention in psychosis teams were generally low, at 4% overall. The highest rates of sickness absence were recorded in the Bromley East primary care plus and ADAPT team at 15% and Bromley East ICMP at 7%. The early intervention in psychosis teams had an overall sickness rate of less than 2%. Twelve staff had left the teams we visited since the reconfiguration of the community mental health services in September 2015.

Assessing and managing risk to patients and staff

- We observed good assessment and management of risk in all of the teams we visited. There was a robust risk management system in place that used a traffic light system of red, amber and green to categorise risk. Teams held zoning meetings where the multidisciplinary teams discussed and reviewed the risks affecting individual patients. Zoning meetings for high risk patients, those categorised red and amber, were held several times a week. Red zone patients included those in hospital, those being supported by the home treatment team, pregnant patients and patients in crisis. Staff reviewed lower risk patients at zoning meetings once a week. There were clear plans in place to manage the risks identified and these were updated at each zoning meeting. Staff increased the frequency of patient visits in response to increasing risk.
- Patient records contained crisis plans outlining what patients should do and who they should contact in an emergency. Crisis plans contained information on relapse indicators and warning signs.
- Staff were trained in safeguarding and knew how to make an alert. All staff in the early intervention service had completed safeguarding adults training. Ninety five per cent of staff had completed safeguarding children level three training. All staff in the primary care plus, ADAPT and ICMP teams had completed safeguarding adults training. Ninety three per cent of staff had completed safeguarding children level three training. There were safeguarding leads for adults and for children in each team. They provided advice to colleagues on safeguarding matters. We saw several examples of safeguarding alerts raised by staff in response to concerns. Several staff had been trained as safeguarding adults managers and inquiry officers. Staff considered and made safeguarding referrals in multidisciplinary team discussions we attended. Managers attended local multi-agency risk assessment conferences where women at high risk of domestic violence and abuse were discussed. Staff had good understanding of their responsibilities in respect of protecting children.
- Patients taking certain medicines had their blood checked regularly to ensure they maintained therapeutic levels of the medicine and to detect any signs of serious side-effects. Staff ran a clozapine clinic in each team for these patients. The trust had introduced point of care haematology (PocHi) testing for clozapine. Some staff had undertaken additional training that allowed them to carry out blood testing on site. A blood analyser machine was used in the clinic to enable a patient's blood to be tested on site and the result transmitted directly to the clozaril patient monitoring service. This had significant benefits for patients as it provided a 'one-stop service' and reduced the number of times they needed to visit the service. Seventy eight patients attended the PocHi in Bexley. Similar numbers attended the clinics in Bromley and Greenwich.
- Medicines were stored securely and managed safely. Medicines were transported in secure containers when staff needed to take them off the premises. Staff in the Bromley East locality team did not record the medicines fridge temperatures consistently. This meant there was a risk that medicines requiring cold storage were not stored at the right temperature. Recording was better and more complete in the other teams we visited.
- We reviewed several medicine administration records in three of the teams we visited. All records were completed and signed appropriately. Pharmacists attended meetings with patients to discuss concerns about medicines.
- Staff in the Bromley East locality team raised concerns about the high temperatures affecting the clinic room in the service in the summer months. The free standing air conditioner was ineffective. They said they had raised

Are services safe?

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concerns about how this was affecting the safe storage but the issue had not yet been resolved. If this continued there was a risk that medicines stored at an inappropriate temperature would be ineffective.

- The trust had a lone working policy in place to support staff working alone in the community and ensure their safety. Staff had code words and sentences to use to alert colleagues if they needed assistance. These were on display in team offices so that all staff were familiar with them. Staff explained the precautions they took to ensure that home visits were safe; this included two members of staff going together to assess patients not known to the service.

Track record on safety

- The trust reported that there had been 19 serious incidents involving locality team patients since September 2015. Thirteen of the incidents were unexpected deaths of patients. There were eight serious incidents in the Bromley locality team, seven of which were unexpected deaths of patients. In the Greenwich locality teams three of the seven serious incidents reported were unexpected deaths and one was an alleged homicide by a patient. In the Bexley locality team there had been four serious incidents. Three of these were unexpected deaths, including one patient who had been the victim of an alleged homicide.
- There had been an unexpected patient death in the early intervention in psychosis service shortly before our inspection visit. The death was being investigated.

Reporting incidents and learning from when things go wrong

- Staff knew what type of incidents they should report and how to report them. Managers described an open reporting culture. Staff said they were encouraged to report incidents.
- Staff described serious incidents that had occurred in the teams since September 2015. The incidents had been investigated or were under investigation at the time of our visit. The investigations were aimed at identifying and learning lessons from the incidents. Incidents were investigated by a team of managers from a different borough.
- Incidents were presented and discussed at monthly review meetings, which were attended by locality managers, team managers, modern matrons and ward

representatives. Lessons learned were shared with staff in quality meetings that were held with teams every month. Quality meeting minutes confirmed that learning from serious incidents was discussed.

- The trust used the adult mental health (AMH) quality newsletter to share information about learning from incidents with staff in all services. For example, the AMH quality newsletter from March 2016 identified learning from the death of a patient in the community. Learning included the need for patients to have a crisis plan in place, the importance of reviewing and updating patient risk assessments and direct liaison with other agencies working with the patient.
- Staff made improvements to the service in response to learning from incidents in order to reduce the risk of the same type of incident happening again. The trust had produced a report called 'preventing suicide in the community re-audit' in February 2016. The aim of the audit was to review the trusts compliance with national standards on suicide awareness and assessment of risk for community patients in comparison with results of a similar audit in 2013. The report showed that there had been learning from the recommendations of the 2013 audit. There had been improvements or similar scores in all but three standards. There had been marked improvements in some areas such as risk assessment reviews in CPA meetings, the number of non-CPA patients whose care plan had been communicated to their GP, evidence of physical health assessment, records of social circumstances and on-going monitoring of patients' thoughts on suicide. However, the audit highlighted poor compliance and lower scores compared with the 2013 audit in respect of whether the clinician had checked the patient's family history of suicide and failure of patient care plans to specify action to be taken if a patient was non-compliant with the terms of a community treatment order or failed to attend appointments. The results of the audit had been communicated to all staff through the AMH quality newsletter. There was an action plan in place to address recommendations from the 2016 audit report. Actions were due for completion by September 2016.
- Staff were given support after incidents. This included a de-brief and support within the team. Staff discussed incidents at team meetings and were given time to reflect on practice issues.

Duty of candour

Are services safe?

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

- Staff were aware of and understood their responsibilities under the duty of candour. The duty of candour means that providers must operate with openness, transparency and candour, and if a patient is harmed they are informed of the fact and offered an appropriate remedy. Staff described incidents where patients were informed when things went wrong, apologised to and offered the opportunity to make a complaint. The trust had provided an information leaflet for staff explaining the duty of candour.

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

- Staff carried out comprehensive assessments of patients' needs. Most records we reviewed confirmed these had been completed. A few assessments were less detailed. Some staff had received suicide prevention and self-harm mitigation training, which focused on developing the skills needed to help a person at risk of suicide or self-harm to stay safe.
- We reviewed the care records of 13 patients in the four locality teams and early intervention service. Where particular needs had been identified there were care plans in place to address these. Patients' physical as well as mental health needs were addressed. Care records contained up to date information about patients. Most care plans were detailed, person centred and holistic. Three care plans were less detailed and did not address patients' wider social needs. This was brought to the attention of senior staff in the service.
- In the early intervention teams over 95% of patients had received a six month review of their care and treatment.
- Staff stored patient care records electronically. The information was secure. Staff needed a card and password to access the system. Staff in other teams, such as the home treatment teams, could access patient records when they needed to in order to treat patients out of hours.

Best practice in treatment and care

- Staff considered national institute for health and care excellence (NICE) guidelines when making treatment decisions. Staff were able to access NICE prescribing guidelines on the trust website. The early intervention in psychosis teams offered NICE compliant packages of care to patients within two weeks of their referral to the service. Staff offered a range of evidence based therapeutic interventions including cognitive behavioural therapy for psychosis, family interventions, family therapy and multi-family groups. ADAPT team staff used cognitive behavioural therapy to treat social anxiety in line with NICE guidelines. New staff had been given copies of NICE guidelines when they started work in the ADAPT team in Bexley, such as guidelines for anxiety, depression and post-traumatic stress disorder.
- Patients in all three boroughs had access to psychological therapies. Psychologists and

psychotherapists were integrated into the teams. Patients referred to a psychologist were generally seen within 18 weeks. However, there were three breaches of this time limit in Greenwich East ADAPT team and 15 breaches in the Greenwich West ADAPT team at the time of our visit. When primary care plus staff identified, at tele triage, that a patient was likely to require a psychology referral this was highlighted and the patient was assessed by a psychologist in the ADAPT or ICMP team where possible. This reduced the need for the patient to be assessed twice, for example, an initial assessment by any staff member and then an assessment by a psychologist. Similarly if a patient's needs were identified at tele-triage as primarily social they were assessed by a social worker in the appropriate team.

- Staff offered support for patients' social needs such as housing, benefits and employment. For example, in Greenwich, employment advisors supported patients to remain in work and to find paid employment or voluntary work. They were working with 35 patients at the time of the inspection. The advisors supported patients to self-advocate in the work place or attended meetings with patients and employers.
- Staff provided therapeutic groups that supported patients' recovery. These included hearing voices groups, family consultation, anxiety and recovery groups. In Bromley a group for patients with personality disorder was facilitated by patients with the same diagnosis. Staff in Greenwich and Bexley early interventions team offered acceptance and commitment therapy groups. Art therapists offered group and individual art therapy across the three boroughs. In Greenwich East an occupational therapist in the ICMP team co-facilitated a problem solving brief intervention group over several weeks. Staff worked in partnership with local voluntary sector organisations to provide social inclusion programmes which supported patients' recovery.
- ADAPT teams provided a range of workshops for patients including ones on sleep, managing depression, relationship issues for personality disorder, mentalisation for personality disorder, mindfulness, and anxiety management.
- Most patient records showed that staff monitored and considered patients' physical health needs. However, three of the 13 care records we reviewed did not contain information about patients' physical health. Staff carried

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.

out regular physical health checks on patients. There was a commissioning for quality and innovation target that 80% of patients on CPA should have an annual health check, including checks on their blood sugar, body mass index, smoking and alcohol intake. The trust had achieved this target in 2015-2016. For 2016-2017 the target had risen to 90% of patients on CPA and 60% of patients receiving standard care. Managers were planning how they would achieve this. Staff in the clozapine clinics checked and recorded the weight, blood pressure, pulse and body mass index of patients each time they attended the clinic. Staff in the clinics were aware of patients' on-going physical health problems such as diabetes and patients received an electrocardiogram at least once a year to monitor their heart function. Staff asked patients about their physical health in assessments and other meetings with them.

- In the early intervention teams all patients on CPA had received annual physical health checks.
- Clozapine clinic staff assessed the side effects of medicines experienced by patients at each visit. Staff used the Glasgow anti-psychotic side-effects scale every six months to assess the effects on patients. Staff were able to compare medication changes with any increase or decrease in side-effects.
- Staff used a range of tools to measure outcomes for patients using the services. These included positive and negative symptom scales, Warwick-Edinburgh mental wellbeing scale, psychotic symptom rating scale, beliefs about voices questionnaire and target complaint scales. These helped measure the effectiveness of the treatments offered. Some teams were piloting the use of clinical outcomes in routine evaluation, a short measure of psychological distress for routine use in psychological therapies.
- Staff actively participated in clinical audit. For example, an audit of learning from suicides in the community. Recommendations from the audit had been identified and an action plan was in place to address these. Teams had carried out audits of care and treatment records. Where shortfalls were identified these were addressed through individual supervision and in team meetings. Staff discussed audits in team meetings and devised action plans where needed to improve the way the service was provided.
- Consultants were involved in research in collaboration with other institutions. The re-designed community mental health service model was being evaluated

during its first year of implementation in conjunction with Oxford Brookes University. This would enable learning and identify any improvements needed in the model and pathways.

Skilled staff to deliver care

- Staff in all teams had completed an annual appraisal in the last 12 months. Supervision was carried out at least every six weeks. Most staff received regular supervision in line with trust expectations. Team managers were able to monitor this through an electronic system. In some teams care co-ordinators had peer supervision with a psychologist. Occupational therapists received professional supervision from a senior occupational therapist.
- Staff were able to undertake further training to equip them for their role and develop their knowledge and skills. The early intervention teams had responded to the introduction of new standards for early intervention teams in April 2016. The service manager had been proactive in sending 17 staff to be trained in family interventions so that the team was better placed to deliver the goal of providing a NICE compliant package of care to patients within two weeks of assessment. Psychologists had completed or were completing training in advanced cognitive therapy for psychosis. Several staff were undertaking Masters level courses, including an MSc in Leadership course. Staff in ADAPT teams had received additional training in motivational interviewing and solution focussed therapies.
- Employment advisors in the Greenwich West locality team had attended a job retention management course and had achieved NVQ level 4 in advice and guidance. They attended monthly peer support meetings.
- All new staff including locum staff received an induction to their area of work and responsibilities. Permanent staff received a three day corporate induction when they started. One new staff member we spoke with told us their induction had been the best they had ever experienced.
- A social worker in the Bexley ICMP specialised in working with people with autistic spectrum disorders and was able to provide a more tailored and informed service to patients.

Multi-disciplinary and inter-agency team work

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.

- Teams were multidisciplinary and made up of a range of disciplines including nurses, occupational therapists, doctors, social workers, psychologists, psychotherapists and health care support workers
- Multidisciplinary teams met several times a week. Staff shared information and worked effectively. We attended a range of multidisciplinary team meetings and saw how well the different disciplines worked together. For example, in the Bexley ADAPT team post assessment meeting staff from different disciplines worked very well together to devise treatment plans. Each team member contributed their professional knowledge and experience to the meeting. This helped achieve a holistic approach to addressing patients' needs. In many teams there was a blending of roles between disciplines, which many staff told us was very positive.
- The teams worked closely with the home treatment teams to prevent patients being admitted to hospital if they could be supported more intensively at home. Managers attended meetings with community child and adolescent mental health service (CAMHS) teams to identify young people about to transfer to adult teams, which enabled them to provide support to the young person and facilitated information sharing. Similarly the early intervention teams worked closely with CAMHS teams. Managers attended regular meetings with improving access to psychological therapies teams, that frequently referred patients to primary care plus.
- Managers in Bromley East attended a monthly maternity safeguarding meeting which supported and strengthened the team's work with pregnant and perinatal women.
- Primary care plus staff in particular liaised with GPs to inform them about the service and offered support when patients were discharged back to the care of their GP. This work was more developed in Bromley and Greenwich, which were better resourced in terms of funding of the services. The Greenwich West team were targeting the top five referring GPs to discuss referrals. A consultant in the Bexley locality team had visited the local GP forum to explain the role of primary care plus and the new pathways of care. Managers in all teams recognised the need to continue to develop relationships with GPs if the re-designed model of care was to be fully effective.
- The early intervention service linked in with the gang unit, working with local police and partners to address gang related issues, in the boroughs of Bromley and

Greenwich and staff attended monthly meetings with partners. The Greenwich locality teams had leads for perinatal care and good relationships locally with health visitors and midwives. This helped referrals and effective, joined up working with services working with pregnant women.

- Most teams worked effectively with local drug and alcohol services. Staff recognised high levels of drug and alcohol use amongst patients and the need for additional support in this area.
- Primary care plus staff had visited local psychiatric liaison teams based in general hospitals to talk about the new teams and their roles. This led to an improvement in the quality of referrals the team received.

Adherence to the MHA and the MHA Code of Practice

- Doctors had received training in the Mental Health Act and nurses received training during their preceptorship period. Approved mental health professionals in the teams had received advanced training. However, the Mental Health Act was not mandatory training for staff. Managers encouraged staff to undertake additional MHA training where indicated by incident feedback or specific performance management issues identified in supervision. Most nurses and social workers had detailed knowledge of the Act, whereas a few said they had more limited understanding. All teams had staff that had trained as approved mental health professionals and had detailed knowledge of the Act, which they shared with colleagues. Staff knew where to obtain advice on the Mental Health Act.
- Most staff said they had a good understanding of their responsibilities under the Mental Health Act, although a few were less confident. Staff knew where to obtain advice about the Mental Health Act, including contacting the trust Mental Health Act administration office and from approved mental health professionals in their team. Most staff did not have patients on community treatment orders on their caseload.
- Patients had access to independent mental health advocacy services when needed.
- There were very few patients in any of the teams who were on community treatment orders (CTOs). Staff told us the number of patients had been reduced considerably following a national audit on the effectiveness of CTOs. Staff had reviewed patients to see

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how they could work with them in the least restrictive way. Work with patients had become more collaborative. Patients were provided with more information about their diagnosis, care and treatment and encouraged to take responsibility for themselves.

- We reviewed one community treatment order and found staff had completed it appropriately.

Good practice in applying the MCA

- Almost 100% of all staff had received training in the Mental Capacity Act 2005 (MCA). The trust had produced a short and clear summary of the MCA for staff and we saw the statutory principles displayed in staff offices. The trust had a MCA policy which had been reviewed in February 2016. Some staff were very knowledgeable and spoke confidently about the legislation. However, this

varied and not all staff we spoke with had a good understanding of the MCA and the implications for their practice. All staff presumed that patients had capacity unless they had concerns that this was not the case. Staff carried out capacity assessments when they had concerns about a patient's capacity to give informed consent.

- Mental capacity assessments were not carried out routinely. Where there was concern about a patient's capacity staff conducted assessments. These were clearly documented.
- Staff understood the importance of gaining the informed consent of patients. The trust policy for consent to examination or treatment was dated February 2016. The policy gave detailed guidance to staff on when and how to seek and document consent.

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

- We observed staff speaking respectfully about their patients and showing kindness, compassion and concern for them during a home visit, interactions with patients in clinics and a care programme approach meeting. Staff treated patients with kindness and respect. They actively listened to their opinions and wishes. Staff communicated clearly in assessments without using unnecessary jargon. Therapists were skilful and used gentle questioning to gain an understanding of the patient, explained things well, and answered patient questions fully. In one assessment a consultant psychiatrist reviewed literature on medicines in order to meet a patient's preference for as few tablets as possible to make up the correct amount of their prescription. Staff listened actively to patients, were non-judgemental and checked that patients understood the information given to them.
- During telephone assessments staff demonstrated caring and concern through their tone of voice.
- Most patients we spoke with or received feedback from were positive about the care and treatment they had received from the community mental health teams. Patients described community staff as friendly, kind, helpful, respectful and polite.
- Reports of patient feedback questionnaires in March 2016 showed that 94% of patients using the community mental health services considered they were treated with dignity and respect by staff. Forty eight per cent said their quality of life had improved as a result of the care and treatment they had received and 40% were not sure whether it had or not. In terms of the provision of information, 94% of patients agreed they had received enough information about their care and treatment either definitely or to some extent.
- Staff had a good understanding of the needs of individual patients. Staff were committed to patient care and care was patient centred. Staff were responsive to patients' needs.
- Most staff were clear about the boundaries of patient confidentiality and sharing information about patients. Patient records indicated where patients had consented for staff to share information with family members and others. In Greenwich West primary care plus the consultant psychiatrist had produced a brief guide for

staff that gave clear advice on how to protect patient confidentiality during telephone triage. This included making sure staff were speaking to the correct person and how and when to leave a voicemail message. However, not all staff we spoke with were clear about the process or were consistent about the way they left messages and shared information with others. For example, we observed primary care plus staff in one team trying to contact a new referral regarding an assessment. The patient was not at home so the staff member left a message with a close relative asking the patient to contact the service. Although the staff did not say why they were calling, the relative may have realised from the name of the service what the call was about. Staff at that stage had not been able to establish whether the patient consented to the sharing of information with the relative. There was therefore a risk to the privacy of the patient. In addition we observed a staff member, from a different team, meeting with a patient's relative. The relative had brought a family friend with them to act as an interpreter. The patient's records showed that they had consented for information to be shared with others on a need to know basis. However, it was not clear that the patient had consented to personal information being discussed in front of a family friend. Although the trust provided guidance to staff on issues of patient confidentiality it was not clear that all staff understood the boundaries. They risked breaking confidentiality and not respecting patients' privacy.

- The trust's confidentiality code of conduct contained guidance for staff on how to protect and maintain the confidentiality of patient information in a range of ways, including when using email or fax. It did not specifically mention when and how to leave a telephone message for patients.

The involvement of people in the care they receive

- Most patients and carers felt listened to and included in their care. They felt they were offered choices in relation to their care and treatment.
- In the early intervention teams staff used the recovery star to help involve patients in their own care and treatment. Care plans included the patient voice, were person centred and holistic.
- We observed in assessments that staff enabled patients to make their own decisions about their care, and

Are services caring?

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offered support and information about who to contact in the event of a crisis. In one meeting staff from three different disciplines met with the patient and together they created an individual management plan.

- Patients and carers were encouraged to give feedback about their care and treatment via a survey.

Questionnaires were given to patients after care programme approach meetings. Feedback from patients and carers was collated every month, analysed and provided in a report so that staff could use the information to make changes and improvements in the service. Patient feedback about services submitted via questionnaires was mostly very positive. In March 2016 67% of patients said they were extremely likely or likely to recommend the service to their friends or family.

- Staff had placed suggestions boxes in reception areas where patients and carers could post suggestions for improvements to the service and other feedback.
- All staff understood the importance of including families in the care of patients with their consent. Staff offered support to families and carers and we saw meetings taking place during our visits to the teams. The early intervention service ran a welcome to services group for families.
- Staff offered carers assessments to carers. The number of carers assessments carried out was monitored. Staff provided carers groups.
- We spoke with patients who told us they had been involved in recruitment panels for staff.

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

- There were clear care pathways. Primary care plus provided the single point of access to trust community mental health services. All referrals coming into primary care plus on a particular day were reviewed by a consultant psychiatrist to see if the person was known to the service and identify whether any routine referrals should be reclassified as urgent. Staff told us that referrals categorised as urgent by GPs were always treated as urgent. Staff tried to contact urgent referrals on the same day or within 24 hours.
- Information provided by the trust showed significant variation between the teams in respect of how quickly staff were able to assess urgent referrals. Between October 2015 and the end of March 2016 Bromley East primary care plus team had received 11 urgent referrals and Greenwich West primary care plus team 21 urgent referrals. Both teams had assessed over 80% of the urgent referrals on the same day the referral was received and 100% were assessed within two weeks. However, Bexley primary care plus had received 122 urgent referrals in the same time period and had assessed 25% of these on the same day and 92% within two weeks. Greenwich East primary care plus had received nine urgent referrals and assessed none of these patients on the same day the referral was received. They had assessed 68% of urgent referrals within two weeks.
- Routine or non-urgent referrals were contacted for telephone triage within two weeks. The trust provided performance information from the beginning of October 2015 to the end of March 2016. This showed that Greenwich East and West primary care plus teams assessed 74% of patients within two weeks of referral. The two teams assessed 92% and 98% of non-urgent referrals, respectively, within four weeks. The Bexley East primary care plus team had assessed 65% of non-urgent referrals within two weeks and 98% of referrals within six weeks. Bexley primary care plus had assessed 16% of referrals within two weeks and 94% within eight weeks. Bexley primary care plus had performed less well than the other borough teams and it was taking longer to see non-urgent referrals, although the team performed better in terms of how long it took to assess urgent referrals, 92% of whom were seen within two weeks.
- Patients were directed from primary care plus to the appropriate pathway, usually either to the ADAPT team (for patients with anxiety, depression, affective disorder, personality disorder or affected by trauma) or to the intensive case management for psychosis (ICMP) team or early intervention service for a full assessment and treatment. Some patients were referred to a brief interventions clinic if short term treatment was considered most appropriate. The teams had clear criteria describing the type of patients they would offer a service to.
- Managers reported that waiting times for community mental health services for adults had improved considerably since the introduction of the re-designed pathway model in September 2015. Before the changes patients waited, on average, 30 or more days from referral to assessment. The number of complaints from GPs about waiting times had decreased.
- In the early intervention teams there was a requirement to assess and allocate 50% of new patients within two weeks. Teams were meeting this target and trying to improve their accessibility. Patients were allocated for a face to face assessment within a day of receipt of the referral. Managers had good systems in place to track the progress of referrals.
- Upper age limits in the early intervention service had recently been removed in response to national guidance. The service accepted patients of any age who were experiencing a first episode psychosis.
- Patients did not wait for more than a few days while a care co-ordinator was allocated. For example, the Bromley East ICMP had seven patients waiting to be allocated.
- The target for patients who did not attend appointments (DNAs) was set at 10% or lower. In the three months from January to March 2016 the DNA rates in the ICMP and ADAPT teams ranged from 6% in the Bromley East locality team to 11% in the Bexley and Greenwich teams. In the early intervention in psychosis service the DNA rate was below 10% in all of the borough teams over the same time period. The teams reminded patients about appointments via the telephone or text message.
- Staff made determined efforts to keep in contact with patients who were reluctant to engage with the team. For example, a nurse in the Greenwich West locality had

Are services responsive to people's needs?

Good 

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

persisted in visiting a patient at home, left messages and written to them. The nurse said they would not give up on this patient and would continue attempting to make contact.

- The new care pathway model included a greater focus on discharging patients as soon as they no longer required a service. Patients could return to the service if their needs changed. In the ADAPT teams the aim was to support and treat patients for an average of three to four months before discharging them back to their GP. Patients using the ICMP teams were expected to need support for longer periods of time but there was still an emphasis on discharge back to primary care as soon as possible. Primary care plus staff offered support to GPs to enable them to accept and provide care to patients discharged from the teams.
- The early intervention teams aimed to discharge 50% of patients to primary care. In Bromley 60% of patients were discharged to primary care in the last year. In Greenwich the figure was 57%.
- Teams worked closely with local voluntary sector organisations to provide additional support and social inclusion programmes for patients in the community.
- The re-designed service model had cut down on the number of times a new patient was assessed.
- Patient appointments were sometimes cancelled at short notice if a staff member was absent unexpectedly or there was an emergency. Otherwise staff tried to cover for absent colleagues.
- The early intervention teams offered clinics in the evening to enable patients who worked during the day to attend. Family interventions were also delivered in evening sessions. Primary care plus worked extended hours until 8pm during weekdays, which made it easier to contact people who worked and carry out a telephone assessment.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff displayed information leaflets on a range of relevant topics for patients and carers in patient waiting areas. These supported people to make decisions about their care and treatment.
- Waiting areas were welcoming. They were bright and well-lit. There were interview rooms available at all the team premises. They were adequately furnished. Waiting areas were equipped with a water dispenser so that people waiting could have a drink. People had

access to toilet facilities. Greenwich West facilities were in need of improvement, the team hoped to upgrade the facilities to provide more a pleasant environment for patients and staff.

Meeting the needs of all people who use the service

- Patients with mobility concerns, including wheelchair users, could access all of the services. Consultation rooms were generally located on the ground floor. Primary care plus sometimes carried out home visits to complete assessments if the patient was unable to come to the team base.
- Information leaflets were available in different languages. Patients who had difficulties understanding English confirmed they had been offered these. Staff could print information in different languages for patients. If information was not available in a particular language staff could request this. Staff teams were diverse and spoke a range of different languages between them. However, in the Greenwich locality teams there was no information in other languages on display in the waiting rooms although the local areas were very diverse and many different languages spoken.
- Teams tried to honour patient requests to work with staff of a particular gender.
- The Bexley primary care plus received a number of referrals of patients who did not speak English well. When this occurred staff immediately offered the patient a face to face interview with an interpreter present rather than try to use an interpreter during a telephone assessment.
- Staff were aware of community groups who could offer support to patients from diverse backgrounds.
- The trust had set up a lived experience network for staff who had experience of using mental health services themselves.
- Staff referred patients to specialist services when this was appropriate. For example, staff considered a specialist referral to a gender identity clinic for patients who were transitioning.

Listening to and learning from concerns and complaints

- Information about how to complain was on display in patient waiting rooms in the services we visited. All but three of the 34 patients and carers we spoke with knew how to complain.

Are services responsive to people's needs?

Good 

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

- The community mental health services for working age adults had received 33 complaints from patients and carers in the last six months, prior to the inspection. Eight complaints were upheld and four were partly upheld. The issues patients and carers complained about most were clinical care and communication. Of the eight complaints that were upheld three were from carers, two concerned clinical care, two concerned communication and one related to the attitude and behaviour of staff.
- Staff described complaints that had been received about the services and outlined the action that had been taken to address the concerns and make improvements to the service. For example, staff had responded to a patient's concerns at having to share a waiting room with another service. Complaints were discussed in team meetings and in management and governance meetings to make sure learning was identified and acted upon.

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 knew and understood the values of the organisation. These were: having a user focus, excellence, learning, being responsive, partnership and safety.
- Staff knew who senior managers in the trust were and said they were visible. Senior managers and trust board members had visited the teams and sent reports of their visits back to teams.

Good governance

- Clear governance structures supported the delivery of safe and effective care and supported the flow of communication from the teams to senior management and trust board and vice versa.
- Managers had access to real time information about the training and supervision of staff in their teams. They also received monthly reports of mandatory training, which highlighted when staff needed to renew or complete training. This supported the high levels of compliance with mandatory training, supervision and annual appraisals that we found during the inspection.
- Managers and staff met to discuss summaries of learning from incidents and complaints related to the service, reviewed monthly patient experience reports and considered team performance data.
- Managers escalated risks related to the service via their line managers and in regular performance meetings. A risk register was not held at team or service level. However, a directorate wide risk register highlighted the specific risks affecting the adult community mental health teams. These included the steady growth in referrals and the risk that referrals may outstrip the services' capacity to respond; and the risk that staff did not fully understand the requirements of the Care Act.
- Staff were trained in safeguarding adults and children, understood trust procedures and made appropriate safeguarding referrals.

Leadership, morale and staff engagement

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

- Managers told us there were opportunities for leadership training and development in the trust. Several managers had completed, or were completing, leadership and management learning modules.
- Staff were overwhelmingly positive about the trust as an employer. They described a trust that looked after staff, let teams move forward and had a no-blame culture.
- Sickness absence rates in the teams were generally low with an overall rate of 4%.
- Staff felt supported by line managers and colleagues. The trust provided nursing forums where nurses could obtain peer support. Staff said they could obtain support when they needed it. Some staff told us they felt valued and were supported to undertake further training and development. There was good team work.
- The trust had consulted with staff about the significant changes in the service model. The majority of staff were positive about the consultation process. However, several staff felt that they had not been consulted and the changes had been imposed by the trust.
- Staff were open and transparent and explained to patients when things went wrong.

Commitment to quality improvement and innovation

- The early intervention service had developed a partnership with a local football club. Patients were able to join an activity programme once a week, increase their confidence, and improve social relationships as well as their physical fitness. Some patients had gained football coaching qualifications. The group undertook a range of activities including footgolf, fishing and indoor bowls. All early intervention service patients were invited to the group.
- Early intervention team staff were members of the London early intervention reference group and were working with others to deliver new standards of care and treatment introduced in April 2016.
- Consultants were involved in research in collaboration with other institutions. The re-designed community mental health service model was being evaluated during its first year of implementation in conjunction with Oxford Brookes University. This would enable learning and identify any improvements needed in the model and pathways.