West London NHS Trust

Community-based mental health services of adults of working age

Inspection report

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Ratings

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

Our findings

Community-based mental health services of adults of working age

Requires Improvement 

West London NHS Trust provides a range of community based mental health services for adults of working age throughout the London boroughs of Ealing, Hammersmith and Fulham and Hounslow. Some adults receiving services may be subject to conditions under the Mental Health Act 1983.

We visited a sample of the locality teams in each borough. We inspected a combination of early intervention services and Mental Health Integrated Network Teams (MINT).

The Early Intervention Service (EIS) provides specific support and treatment for patients experiencing a first episode of psychosis. The EIS teams had been established for some years and subsequently expanded their remit to provide a service to people between the ages of 12 and 65 years, over a three-year period.

The MINT teams had recently been set up. The MINT model focuses on supporting people's mental health, alongside their physical health and social needs, providing joined-up, community-based care tailored for each individual. MINT had been developed to reflect NHS England's Long Term Plan for Mental Health and the Community Mental Health Framework for Adults and Older Adults. MINT supports adults aged 18+ who need a non-emergency response to a mental health issue. The MINT model expands the traditional community mental health model; under MINT, therapeutic intervention and support is accessible to a much wider range of people than was previously the case.

Our rating of the service stayed the same. We rated the service as requires improvement overall but inadequate for safe because:

- The main concerns identified during the inspection were in relation to the MINT service.
- The service had significant staffing issues across the teams. Overall vacancy rates in the MINT teams ranged from 25% to 35%. Staff told us that high vacancies and turnover rates made it difficult to provide a consistent, high quality service. In line with the new MINT model not all patients had or needed a care co-ordinator which may result in a risk of patients not having their needs met due to the high level of demand in the service. In one team a member of staff had left, and the patients who required a care co-ordinator had not been reallocated which meant they might not be appropriately supported. Patients told us they had experienced changes in their care co-ordinator.
- Risk assessments for some patients were brief and did not always explain how a risk was mitigated. There were examples of where new risks had been identified, for example a deterioration in their mental health, but these had not been followed up in a timely manner.
- The MINT did not meet trust target times for seeing patients from referral to assessment and assessment to treatment. Delays to patients accessing treatment were significant. Staff told us that these delays were due to increased demand which was 40% higher than anticipated and staff vacancies. Data produced by the trust was unreliable so it was not always possible to identify how many patients were waiting for specific treatments and how long this was taking.
- Staff in most teams did not follow clear personal safety protocols, including for lone working. There were multiple systems in use for lone working; this meant that the process could be confusing and that staff may record visits on systems that were not being monitored.

Our findings

- Staff within the MINT teams were currently using two electronic patient record systems. In some cases, staff had to make duplicate entries on both systems which was time consuming, over-complicated and caused frustration for staff. At the time of the inspection the quality of data produced by the MINT teams did not facilitate sufficient oversight of outcomes and performance.
- Some clinical premises we visited were not well maintained and one did not have panic alarms fitted.
- Supervision rates for March 2022 in the MINT ranged from 17% to 33%. The supervision rates were better in the EI teams, however, there were still months when rates of supervision were low. There was the potential for staff to feel unsupported as a result.
- Some staff training modules also had a low compliance rate. This reflects the trust's decision to suspend courses which could only be offered through face to face teaching during the last two years of the Covid-19 pandemic, which led to a backlog of compliance. The trust told us that this issue is now being addressed. The courses with the lowest compliance rates were breakaway training, promoting safe and therapeutic services (PSTS). For example, the compliance rate was 43% for all staff for breakaway training. Therefore, there was a risk that staff may not be appropriately trained and may not respond appropriately to incidents.

However:

- The EIS teams which were longer-established were providing a good level of care and were meeting the needs of their patients. Their prompt response to referrals had been confirmed by the National Clinical Audit of Psychosis (NCAP).
- Staff provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. The service provided care and treatment including medication, psychological therapies, psycho-social education and signposting to social opportunities or specialist groups. Compared to the remit of the former recovery teams, the range of needs the MINT teams worked with was very broad.
- The teams included or had access to the full range of specialists including peer support workers who met the needs of the patients. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation. The trust part-funded some local third sector organisations so people could receive support tailored to their specific needs.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Overall, feedback from patients was very positive about the care and treatment they received from staff. Patients said that staff were kind and caring and they felt involved in their care.
- Although areas of concern were identified during the inspection, senior managers were already aware of these issues which had been identified through the governance processes within the trust and were working to make the necessary improvements.

There are nine MINTs across the London boroughs of Ealing, Hammersmith & Fulham and Hounslow. Each MINT is aligned to one to three primary care networks, which are made up of a cluster of general practitioner surgeries. At the time of inspection there were nine MINTs, three teams per borough.

Our findings

CQC previously inspected this core service pre-MINT in September 2018 and issued an overall rating of requires improvement. During this inspection we rated this core service as requires improvement overall and requires improvement for the safe and responsive domains.

This inspection was short notice announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

The CQC inspection team that inspected the service included four CQC inspectors, two inspection managers, one specialist advisor who was a registered mental health nurse and one expert by experience who contacted patients and carers on the telephone. Before the inspection visit, we reviewed information that we held about these services and information requested from the trust. During the inspection visit, the inspection team:

- visited six services and looked at the quality of the environment
- spoke with eight patients and six carers
- spoke with six team managers
- spoke with 44 other staff members including consultant psychiatrists, registered mental health nurses, clinical psychologists, counselling psychologists, mental health associates, occupational therapists and social workers
- attended and observed seven meetings, which included a zoning meeting, triage meeting and a meeting with local primary care leaders
- reviewed 24 care and treatment records
- reviewed medicines management
- looked at a range of policies, procedures and other documents relating to the running of the service

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What people who use the service say

Overall, feedback from patients was very positive about the care and treatment they received from staff. Patients said that staff were kind and caring and that they felt involved in their care. Most patients we spoke to had received services from the trust for a number of years. They felt that there had been a huge improvement since the MINT transformation. The only issue occurred during the transition from the old system to MINT. Most patients told us they were not informed of the change and did not immediately understand the new model. Patients told us that now everything was very clear and positive with effective interventions and good quality of care. However, some patients also fed back that there had been multiple changes to their care-coordinator.

Feedback from carers was positive about the care and treatment family members received. Relatives told us that staff were supportive and they kept them involved in their loved one's care.

Is the service safe?

Inadequate 

Our findings

Our rating of safe went down. We rated it as inadequate.

Safe and clean environment

Most clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Some clinical premises we visited were not well maintained and one did not have panic alarms fitted.

In most services we visited, staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. All areas had completed a Covid-19 risk assessment and made the recommended alterations, such as the addition of perspex screens and floor markings. Staff had conducted recent fire risk assessments at all of the services we visited. Some teams had recently moved premises and, whilst this was largely positive, it meant that some of the new buildings had recently repurposed and the risk assessments did not always fully reflect the new purpose. For example, the annual building risk assessment completed for the Hounslow East MINT did not consider ligature risks. This meant that staff may be unaware of ligature risks within the building. The service manager addressed this immediately. At the time of inspection, the risk of ligature was mitigated by patients always being escorted within the building, however, the toilet area remained unsupervised.

Most interview rooms had alarms and staff available to respond. The rooms at Hounslow East MINT did not have alarms present in assessment rooms but a business case was being made for their installation. The only way staff could summon help in an emergency, other than by shouting, was via a panic button on the electronic patient record system. Staff told us that they used a room at Lakeside Mental Health Unit to see people if distressed behaviour was anticipated.

Most work areas we visited were clean, well maintained, well-furnished and fit for purpose. The Ealing North MINT team had recently moved to a new building, the new building was large and accommodated all of the team comfortably. Staff that we spoke to were very happy with the new building. However, this was not the case for the Hounslow Early Intervention (EI) team who were using space at Lakeside Mental Health Unit. We visited an assessment room as part of the inspection. The assessment room we visited was not a therapeutic environment; rising damp was present in the room. Managers were aware of the environmental concerns and had a detailed estates plan in place. Staff that we spoke with in Hounslow EI team were keen to move premises as the current estate was too small and the assessment rooms were not fit for purpose.

Staff at Ealing Acton MINT said some of the window latches had been broken for over a year, meaning that they were unable to open them. Some areas at Ealing Acton MINT appeared untidy and poorly organised. In some rooms, broken equipment clearly needed to be disposed of.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. New clinic rooms had been set up on some sites that met all the required standards, including those for infection prevention and control.

Staff made sure equipment was well maintained, clean and in working order. For example, portable appliance tests had been completed on electrical items in the kitchens. A contractor visited each service annually to test and calibrate equipment in the clinic rooms.

Staff across the teams expressed their frustrations about parking in the service, some of them could not carry out their duties effectively without a car. Staff told us that there were not enough spaces and finding a space was challenging. For example, staff in the Hounslow EI team had to move their cars multiple times each day to allow others to enter and leave the car park.

Our findings

Staff followed infection control guidelines, including handwashing. At the time of inspection all staff were observed to be wearing appropriate personal protective equipment (PPE). Hand sanitiser stations were located throughout the buildings. Arrangements had been made to meet the additional cleaning requirements that had resulted from the pandemic. Chairs and desks in the service were set apart and the number of occupants for each room was limited to facilitate social distancing.

Safe staffing

The service had significant staff vacancies and the workload of each staff member was high in some teams. Some staff had not received basic training needed to keep people safe from avoidable harm.

The service had significant staffing issues across the teams. Overall vacancy rates in the MINT teams ranged from 25% to 35%. The vacancy rates in the EI teams ranged from 15% to 24%. Staff told us that high vacancy and turnover rates made it difficult to provide a consistent, high quality service. Staff also told us that the vacancies had a negative effect on team morale as there was more pressure on the remaining staff.

Staffing was on the service risk register and senior leaders were aware of these issues and were taking action to try and lower the vacancy rates. The service was finding it challenging to recruit staff despite using both tried and tested and creative recruitment methods. There were continuous advertisements out for nursing staff vacancies. Recruitment events with universities were recommencing and the service had started to recruit international nurses, this had also been paused during the pandemic. A preliminary paper had recently gone to the trust board to try and address the capacity issues within the MINT teams. This paper detailed the ambition of senior leaders to review the staffing models in each team and to look at caseload allocation across disciplines.

The number of patients on the caseload of the EI teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. The EI teams' average caseload per staff member ranged from 10 to 11 patients, however, some members of staff did work with higher numbers. EI staff told us their caseloads were manageable.

In line with the new model, not all patients were assigned a care co-ordinator. The new model was considering alternatives to the care programme approach for patients with a higher profile of need. It meant that staff were care-coordinators for some people on their caseload and not for others who had a lower profile of need. MINT staff commented that caseloads were high and staffing levels were low for the number of patients receiving a service. For example, one nurse said they had a caseload of 45, although they felt this was manageable as the patients did not require weekly contact.

The calculations for MINT staffing levels was based on modelling prior to the launch of the service. The actual demand for the service was in some areas higher than modelled. This meant that the number of staff employed by the service may not be sufficient to meet patients' needs.

In the MINT teams it was hard to confirm exactly how many patients were assigned to each member of staff from the available data. The high caseloads staff told us about were not reflected in the data which showed average caseloads of around 20 patients. This discrepancy may have been caused by the service using two systems for recording casework.

Our findings

In the Ealing Acton MINT data showed that consultant psychiatrists had a caseload of between approximately 100 to 200 patients who they typically met with once or twice a year. These records also showed that other mental health professionals within the team were assigned between five and 25 patients. However, the named mental health professional for a substantial number of patients no longer worked for the team. This meant that no one had responsibility for monitoring and managing the care and treatment of these patients.

To promote community inclusion the MINT model includes non-registered staff covering the duty desk along side registered staff. Non-registered staff said they found that working on the duty desk could be difficult and they had to deal with some distressing situations. However, they said they were well supported by colleagues and could escalate any concerns.

The first cohort of mental health graduates had recently started working in the teams. Managers were positive about the contribution they had made and the potential for further development. Senior leaders acknowledged that in the current staffing model there was a lot of pressure on care-co-ordinators and they were working to try to reduce the workload for them.

Managers made arrangements to cover staff sickness and absence. Where there were unfilled vacancies for registered nurses and other staff, vacancies were filled by agency staff or bank staff. Managers sought to employ bank and agency staff who were familiar with the service. For example, at Ealing Acton MINT, an occupational therapist employed by an agency was engaged on a rolling three month contract. Locum staff received supervision and appraisal in the same way as permanent staff.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. An induction checklist was used to induct all new starters. New staff shadowed more senior staff before patients were allocated to them.

Managers supported staff who needed time off for ill health. Staff said that managers had referred them to occupational health and counselling services when they had needed additional support.

Medical staff

The service had enough medical staff. For example, at Ealing Acton MINT there were three consultant psychiatrists. Teams also employed higher trainees and associate specialists.

Staff could get support from a psychiatrist quickly when they needed to consult one in respect of a patient.

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff received training in risk assessing, basic life support, infection prevention and control and safeguarding children and adults. Staff had completed and kept up-to-date with most elements of their mandatory training. The overall training compliance for the MINT was 77% and 81% for the Early Intervention teams. Training compliance for courses that required face to face elements had been affected due to the Covid-19 pandemic.

The courses with the lowest compliance rates were breakaway training, promoting safe and therapeutic services (PSTS). The compliance rate was 43% for all staff for breakaway training. This reflected the trust's decision to suspend courses

which could only be offered through face to face teaching during the previous two years of the Covid-19 pandemic, which led to a backlog of compliance. The trust was in the process of supporting staff to meet its training compliance target of 90%. In the meantime, there was a risk that staff may not be appropriately trained and may not respond appropriately to incidents.

Managers monitored completion of mandatory training and alerted staff when they needed to update their training. Training compliance was discussed during monthly supervision and during team meetings.

Assessing and managing risk to patients and staff

Staff did not always document risks to patients well and there were examples of where they had not responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff did not follow good personal safety protocols.

Assessment of patient risk

Staff did not always complete risk assessments for each patient following the first clinical contact or following an incident. There was a large variation in the quality of risk assessments across the teams. Some patient records had detailed risk assessments that covered all identified risks, such as risk to others and risk to self, however, other records contained very brief assessments of risk. In the records we reviewed these differences did not correlate with the complexity of patient need, so could not always be explained by some patients having a lower profile of need than others.

There was a dashboard in place that identified if a patient had had a risk assessment in the previous six months or within the last year. This dashboard did not allow managers to review the quality of the risk assessments. Managers told us that auditing the quality of records was an ongoing piece of work and had been delayed due to the transformation work.

Staff did not always place an alert on the electronic patient record to highlight patients presenting a high risk. In April 2022, the absence of a formal risk assessment and insufficient exploration of risk history had been highlighted as immediate learning in an investigation report into a patient's death.

Although some risk documentation was poor, we saw the teams assessed risked regularly during meetings. Members of the multidisciplinary team held a meeting each day to review new referrals. During this meeting, they considered the risks that each patient presented. Where risks were identified, they arranged to see the patient promptly, either urgently or within seven days. Staff updated the risk assessments for some patients during triage meetings. Each team operated a simple system of rating the risk level associated with patients on the team's caseload as either red, amber or green. Teams held daily meetings to review all the patients presenting high risk and also considered whether the risk rating of other patients needed to be adjusted.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. We saw evidence of crisis plans in place for patients. Staff were reminded to update the crisis plans during MDT meetings. Patients that we spoke with said that they were aware of their crisis plans.

Management of patient risk

Our findings

Most staff responded promptly to any sudden deterioration in a patient's health, however, we found some incidences where this was not acted upon. In each team, a member of staff was assigned to the duty desk. The teams operated a rota to allocate staff to this role. Staff on the duty desk answered calls to the service. If they received a call that indicated risk, they escalated the matter to the daily risk management meeting. Staff responded to risks by contacting the patient or increasing the frequency of visits to the patient, listening to their or their carer's concerns and conducting a multidisciplinary review, including a review of their medication.

If the patient continued to present a high risk, staff referred the patient to the crisis team, the police or arranged for the patient to be assessed for admission to hospital under the Mental Health Act. We identified a few incidences where there was no clear follow up when new risks were identified. For example, a dietician raised concerns with a MINT team about a patient because they had said they were depressed and wanting to go to hospital. This information was not acted upon for several weeks until it was identified by our inspection team. Staff then called the patient to ensure they were safe.

Due to the large and increasing numbers of patients referred, there was limited capacity to continuously monitor patients on waiting lists for changes in their level of risk. New referrals were reviewed during daily triage meetings. Triage meetings were attended by members of the multi-disciplinary team (MDT). During these meetings staff would decide which profession or group session would best meet the patient's needs.

The waiting times from referral to triage varied across the MINTs. For example, at Hounslow East MINT most new referrals were triaged the day after referral, however, at Ealing North MINT we were told it may be up to two weeks before a new referral is triaged. To mitigate this, the Ealing North MINT prioritised referrals that had come through the old IT system as these often related to higher risk patients. This was in response to a death of a patient at the service. Staff told us that during the transformation there had been significant delays to the triage process, previously hundreds of referrals were waiting for triage. The delays to triage were much shorter at the time of inspection. Once a referral had been triaged, staff sent an appointment letter to the patient. Each appointment letter included a crisis plan that patients could use if their condition deteriorated before the appointment. This plan involved contacting the duty desk during office hours or contacting the single point of access (24 hour telephone line) at other times. When necessary, MINT teams placed patients on the waiting list in the red zone to ensure they were kept under review, discussed their risks in the multidisciplinary team meetings and accelerated the assessment if required.

Since the transformation there had been several instances of patients going missing within the system. For example, in the Hounslow East MINT referrals for 350 patients had been sent to the inbox of a member of staff who was no longer working in the team. At the time of the inspection staff were reviewing the impact on those patients and taking steps to make sure the referrals were appropriately allocated. A lessons learned meeting was held during our inspection. Senior leaders assured us that processes were now in place that would allow them to quickly identify if this occurred again.

Staff in most teams did not follow clear personal safety protocols, including for lone working. Staff said that if they believed there was a risk to their safety, they would interview patients with another member of staff. However, most teams we visited in the service did not have a strong culture of personal safety. Only one member of staff in the Ealing Acton MINT said they always carried a personal alarm. During interviews, staff appeared complacent about the risk to their personal safety. Staff also told us there were many different systems for recording where staff were working. This included three different diary systems, a movement sheet and electronic messaging services. The different systems in use meant that the process could be confusing and there was some risk of staff using systems that were not being monitored. Senior leaders were aware of this and were continuously working with the teams to improve lone working practices.

Our findings

Staff could arrange Mental Health Act (MHA) assessments without significant delays. Staff told us that it could sometimes take between a week to two weeks for MHA assessments to take place. Staff told us that delays were often due to police availability or delays obtaining a warrant, however, if an urgent assessment was required this could be carried out quickly.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them**.** For example, at Ealing Acton MINT, a patient experiencing self-neglect was referred to the local authority safeguarding team in relation to both themselves and their children who lived with them.

Staff described safeguarding procedures as being clear to follow. For example, a member of staff described a situation where they suspected domestic violence was taking place in a patient's home. They said they had completed a safeguarding form on the electronic patient record and escalated the matter to the safeguarding lead. Staff also said that if they had immediate concerns about the safety of a patient, they would contact the emergency services. There were safeguarding leads in each team, within the Hammersmith and Fulham MINT, the team manager had been assigned the role of safeguarding lead. This role involved giving support and advice to staff on safeguarding matters

Staff were largely up-to-date with their safeguarding training. Staff in the MINT teams had a compliance rate of 81% for all safeguarding training modules. Staff in the EI teams had a compliance rate of 93% for all safeguarding training modules.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff said they would speak to their manager or a senior colleague if they were concerned about safeguarding. Safeguarding concerns were also discussed during the daily zoning meeting.

Managers took part in serious case reviews and made changes based on the outcomes. Staff in Hammersmith and Fulham explained that the safeguarding process had recently changed. Safeguarding investigations were now led by the local authority.

Staff access to essential information

Records were not easily available to all staff providing care. Staff kept detailed records of patients' care and treatment, however the information was stored in multiple places across the teams.

Most patient notes were comprehensive, however, MINT staff could not access them easily. MINT teams operated two patient record systems. The first system, used across the trust, was used to create records for patients with complex mental health needs. For example, it was used for patients who received depot injections, clozapine or had their care managed through the care programme approach. Staff created records for other patients using a system that was shared with primary care services.

Our findings

Staff explained there were some advantages to this arrangement, as it meant they had access to information about patients' medical history on their primary care record, as well as access to information about any mental health inpatient admissions from the trust system. However, it could be difficult to access information about patients quickly. In some cases, staff had to make duplicate entries on both systems which was time consuming, over-complicated and caused frustration for them. Staff said there was a risk of patients' information being lost as a result.

Senior leaders were aware of this issue and were working on ways to increase the interoperability of the two systems. At the time of inspection, staff from other teams within the trust, such as the single point of access or EI teams, could not access the new primary care electronic system. The trust was in the process of rectifying this. Once resolved, this would allow the teams to identify if patients were currently under the care of the MINT teams. The trust said there was an initiative to move to one record system which would likely take two years to complete. Staff told us that the support provided by the IT team during the transformation was responsive and helpful.

Most patient records were detailed. All records we reviewed had sufficient information about patients' care and treatment in the progress notes, however, it was not always available in the risk assessments and care plan sections. This meant staff could not access it quickly. Managers were aware of this and were working with staff to improve record keeping. For example, at Hounslow East MINT, managers were in the process of carrying out case reviews with staff. Case reviews involved care co-ordinators caseloads being discussed and reviewed with a manager. Staff told us that they found this process helpful as they could get advice and support from managers about their caseloads.

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

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. For example, all clinics were run by two members of staff. Staff completed monthly orders for medicines. A pharmacist visited each service once a week.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date. We reviewed the medicine administration records for four patients at Ealing Acton MINT. All records were clearly documented and contained all the information required.

Staff stored and managed all medicines and prescribing documents safely. Prescription pads were stored in locked cabinets. However, the treatment of patients subject to community treatment orders required a certificate confirming consent to treatment or a certificate from a second opinion doctor authorising the medication. At Hammersmith and Fulham South MINT, these certificates were not attached to the medicines administration record. This meant that the doctor was not able to see which medicines and dose had been authorised when they changed the prescription.

Medicine fridge temperatures were monitored closely and kept within the recommended range; staff recorded the fridge temperature daily.

Track record on safety

Our findings

The service had a mixed track record on safety.

Just prior to the publication of this report the trust made CQC aware that they were due to receive two prevention of future deaths report from the coroner, one was in relation to MINT. The trust acknowledged that during the initial phase of the transformation demand for MINT services exceeded the planned capacity. This led to delays to assessment and treatment.

Reporting incidents and learning from when things go wrong

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

In the period from March 2021 to March 2022 there were a total of 15 serious incidents reported on Strategic Executive Information System (STEIS) for the MINT and EIS teams (inclusive of the services that became MINT). To put this into context, the MINT and EIS teams offered over 4,000 appointments per month. Ten of these investigations had been completed and submitted to the clinical commissioning group (CCG). Of the five that remained open, three were under investigation, one was at the action planning stage and one was at the signoff stage. Ten of these incidents were in relation to self-inflicted harm.

Staff knew what incidents to report and how to report them. Staff said they knew how to report incidents on the electronic incident record. A member of staff said that when they did this for the first time, a colleague helped them.

Staff raised concerns and reported incidents and near misses in line with trust policy. For example, staff at Hammersmith and Fulham South MINT had reported two recent incidents that had involved suicide attempts by patients. In both cases, the patients were reviewed by staff after the incident. In one case, the patient was admitted to hospital for a period of inpatient care and treatment. However, at one team, the manager felt staff may have been under-reporting incidents. They were conducting a review of incidents to clarify this.

The service had no never events.

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

Managers debriefed and supported staff after any serious incident. Staff said they found debriefing sessions helpful, providing an opportunity to discuss the learning from incidents. They said these meetings were very supportive. Staff also said that senior managers within their service line facilitated debriefing sessions when there had been a serious incident, such as when a patient had died.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, at Hammersmith and Fulham MINT, staff discussed incidents at clinical governance meetings. This involved a member of staff presenting the incident, a question and answer session and breakout groups in which staff discussed what could have been done differently.

Staff met to discuss feedback received on the service and considered what improvements could be made to patient care. For example, the Clinical Improvement Group (CIG) meeting minutes for Ealing EI contained an agenda item on

Our findings

learning lessons. The manager described learning they had shared with the team about a diabetic patient who was under the care of another team. The learning focused on the importance of physical health checks and how to raise a safeguarding notification if they suspected a patient was being neglected. This took the form of a 90 minute presentation and an accompanying document was shared.

There was evidence that changes had been made as a result of feedback. For example, the trust had received feedback from GPs and patients about delays in progressing referrals to assessment. In response to this the service was in the process of recruiting additional team members to work in GP surgeries to direct referrals to the right place at the right time.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Under the new MINT model, a far greater range of patients were being referred, some for more preventative work, and assessment and care planning was meant to reflect this. Staff completed a comprehensive mental health assessment of each patient in order to help determine the appropriate response. Members of the multidisciplinary team carried out an initial assessment of each patient at a daily triage meeting. For some patients, staff referred them to other services, such as the improving access to psychological therapies (IAPT) service, at the triage meetings. In other cases, staff addressed the referral by giving advice to the GP on adjusting the patient's medication. For other patients, the service arranged an assessment of the patient to find out more details of their mental state and social circumstances. When appropriate, this could include a brief assessment, which took the form of a structured questionnaire designed to be completed by non-registered staff. All brief assessments were reviewed each week by a registered mental health professional.

Occupational therapists completed two comprehensive patient assessments each week. These assessments included discussions about the impact of medication and physical health issues on patients' day to day functioning.

Care plans were meant to vary to reflect the patient's profile of need. In some cases they were appropriately brief. In other cases, staff did not always develop a comprehensive care plan in the relevant part of the patient record that met the individual's mental and physical health needs. For example, at Ealing Acton MINT there was no care plan at all on three of the five records we reviewed. However, the progress notes did include details of the care that was being provided but, without the structure of the relevant section of the electronic patient record, the planned interventions and the discharge goals were not always clear.

Staff did not always regularly review and update care plans when patients' needs changed. The care plans we reviewed in the EI teams were regularly updated and were holistic and person centred. However, the MINT service had gone

through significant transformation work and this had been one of the things that there had not yet been capacity to prioritise. This was a considered approach, not an accident; leaders had prioritised safety, including the assessment of risk and safe discharge over care planning. As a result, MINT managers were just starting the process of auditing the quality of patient care and treatment records.

Best practice in treatment and care

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

Staff in both the MINT and EI teams provided a range of care and treatment suitable for the patients in the service. The services provided care and treatment for patients with mental illness including bi-polar affective disorder, low mood, anxiety and depression, post-traumatic stress disorder and psychosis. The service provided care and treatment including medication, psychological therapies, psycho-social education and signposting to social opportunities or specialist groups. Compared to the remit of the former recovery teams, the range of needs the MINT teams worked with was very broad.

The MINT teams had a combination of patients that required long-term support and others that required short interventions. For example, at Ealing Acton MINT, around 300 patients were considered to have complex mental health needs. These patients were assigned a care co-ordinator who provided long-term support. Such patients had previously received a service from the recovery teams. The team took a 'task focused' approach to the other 1700 patients referred to them, who, typically, had not received a service from recovery teams in the past. MINT teams provided this latter group of patients with assessments, short-term interventions and help to access support through creative and recreational activities in the community. For example, link workers supported patients to participate in art classes, gardening activities and sports groups to reduce isolation and promote positive lifestyle options. Therapeutic groups were also available. For example, the Hammersmith and Fulham South MINT provided a dialectical behavioural therapy group.

Services provided regular clinics for patients who required depot medication and offered physical health monitoring to attendees. Covid-19 had impacted on the service's ability to hold face-to-face clinics. In Ealing, physical health clinics had only recently restarted following the Covid-19 pandemic.

The provision of physical health monitoring varied in line with individual patient needs but staff in at least one team were not clear about where the boundaries lay and there were some variations between teams. In the Ealing Acton MINT team, many staff were uncertain about whether their team was responsible for patients' physical health or whether this was the role of the GP. Most staff in this team said they did not carry out physical health monitoring. Managers were in the process of trying to recruit physical health workers to try and improve the physical health offer. In contrast, the Hounslow EI team provided physical health bags for all relevant staff. The bags contained items such as blood pressure monitoring machines, a set of scales and a pulsometer. Staff in this team told us they carried out regular physical health monitoring of their patients.

MINT teams now had access to the GP record system so they could identify who had not received a physical health check in GP practices, as well as within other parts of the trust. This enabled them to prioritise. Physical health checks undertaken by MINT and EIS teams were recorded and audits were carried out so there was oversight of compliance and

there was evidence of improvement work underway as a result. For example, as of February 2022, only 59% of patients under the care programme approach in the Ealing North MINT had had a full physical health examination in the previous 12 months. In response to this the team were in the process of employing a support worker who would conduct physical health checks and the manager was also setting up a new physical health clinic in the new premises.

Access to the electronic patient record system used in the community also enabled staff to have an overview of other community health services being received by a patient so they could take this into account too. For example, if a patient was receiving treatment for substance misuse issues.

Physical health was prioritised as a topic during the monthly training sessions. Training was being provided on physical and mental health comorbidities, focussing on specific topics such as diabetes, cardiovascular disease, obesity and medication side effects.

Staff encouraged patients to live healthier lives by supporting them to take part in programmes or giving advice. During the case review and formulation meeting at the Ealing EI team a number of different options were discussed for patients. For example, participating in the lifestyle and wellbeing session on offer, encouraging engagement with local community groups, and completing work on body image. Support Time and Recovery (STAR) workers were embedded within the service to encourage patients to engage in activities they may enjoy such as the gym, photography or gardening projects. One patient record reviewed showed connections to an external drug and alcohol service.

Staff used recognised rating scales and other approaches to rate the severity of illness and to monitor outcomes. For example, the Health of the Nation Outcome Scales.

Staff used technology to support patients. Patients were able to access the service remotely; this had been put in place during the Covid-19 pandemic. At the time of inspection, the service was using a hybrid model of face-to-face and remote appointments. Staff were able to work remotely when needed. Extra speakers had been purchased to enable better sound quality during meetings when some staff dialled in remotely and some staff were in the office. This also helped to minimise office over-crowding so social distancing could be maintained.

Peer support workers were employed in each team. The peer support workers had direct experience of living with mental health issues and inspired hope in many of the patients with whom they came into contact. They worked with patients at their own pace on goals that were priorities for the person. One senior peer support worker we spoke with was able to work with another organisation to deliver a popular ‘hearing voices’ group to help people who heard voices to manage them in a way that did not have a detrimental impact on their life.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. For example, staff in the Ealing EI team had been involved in a QI initiative which aimed to improve the quality and experience of the MDT meetings. Staff were able to contribute openly or anonymously to the QI project. Staff reported a marked improvement in these meetings as a result of the project.

Managers used results from audits to make improvements. For example, following a routine risk audit, managers had booked extra training for staff on risk management. The service had a detailed audit schedule, which included evaluating the effects of teletherapy on patient outcomes, analysing the effectiveness of all therapies using outcome measures collected before and after the therapy and an audit of carer and patient factors that influence carer engagement. However, some audits had been delayed due to the transformation work, such as the MINT clinical record audit.

Our findings

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. Managers provided an induction programme for new staff. Supervision rates in the MINT teams were very low.

The service had a full range of specialists to meet the needs of each patient. Each MINT team employed a variety of staff, including nurses, link workers, peer support workers and psychiatrists. EI teams also contained an appropriate range of specialists. Some 'non-traditional' roles had been established. For example, Hammersmith and Fulham South MINT employed staff who were based in GP practices and link workers supported patients to access support in the community.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. There was scope for some staff to develop special interests, for example, one psychiatrist had a special interest in personality disorders and they held a regular, borough-wide, complex case meeting with a clinical psychologist and systemic therapist to discuss specific patients' needs.

Managers gave each new member of staff a full induction to the service before they started work. All new staff at the trust attended a corporate induction lasting three days. New staff were required to complete mandatory online training. There were specific induction programmes for some professions, for example, nurses and occupational therapists. All new staff observed more senior staff for at least their first two weeks. During this period, they spent time in different areas of the service, such as the depot clinic and the duty desk.

Regular supervision was not consistently available in all teams. We visited four MINT teams as part of our inspection. Supervision rates for March 2022 ranged from 17% to 33%. The supervision rates were better in the EI teams, however, there were still months when rates of supervision were low. There was the potential for staff to feel unsupported as a result. However, most staff told us that they felt supported and able to approach managers with any concerns at any time.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff said the trust produced a monthly newsletter showing the training opportunities that were available. They said they could request to do relevant training and that line managers usually approved this. However, at Ealing Acton MINT, very few of the staff were completing any training other than the mandatory requirements. Some staff said access was difficult.

Managers recognised poor performance, could identify the reasons and dealt with these. For example, a manager identified issues with a staff member's performance and spoke with the staff member who disclosed some issues in their personal life. The manager recognised the need for welfare support and referred them to occupational health for counselling.

Multidisciplinary and interagency team work

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

Our findings

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff made sure they shared clear information about patients and any changes in their care with other relevant professions and teams, including during transfers of care.

Staff had effective working relationships with other teams in the organisation. For example, services in Ealing held a 'safe transitions' call twice a week to discuss patients who were moving between different teams. This was attended by Ealing MINTs, the crisis team, the psychiatric liaison service, the rapid discharge teams and managers from the wards.

Changes led by local authorities in both Ealing and Hammersmith and Fulham had led to social workers being withdrawn from the integrated team and as a result staff reported that social workers no longer routinely attended meetings. It also meant that social workers recorded their work on a separate electronic system that staff within the MINT did not have access to. Staff felt that whilst social workers were responsive to requests to work with patients, the social care and healthcare was less integrated than it had been previously and when the emphasis was increasingly on joined up work with community partners.

Staff had effective working relationships with external teams and organisations. For example, at Ealing Acton MINT, organisations providing counselling, drug and alcohol services and services providing access to psychological therapies attended the weekly triage and complex care meetings. A housing officer from the local authority also attended regular meetings. At Hammersmith and Fulham South MINT, staff had invited a patient's probation officer to an assessment.

MINT teams worked closely with GPs. A large part of the transformation from recovery teams to MINT teams was focused on closer work with local GPs in order to provide patients with more joined-up care and treatment. Relationships between GPs and the MINT teams were at various stages of development. In the Ealing North MINT assessments had begun to take place in local GP practices, however, this was not yet happening in Hounslow East MINT. The trust was in the process of recruiting staff members to work within the GP practices to improve relationships between GPs and the MINT teams.

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

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. They knew how to access support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Staff followed clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. For example, when the service believed that a patient required an assessment under the Mental Health Act, they spoke to staff at the crisis team in the first instance. Mental Health Act assessments usually took place within seven to ten days of the referral being made. Patients awaiting a Mental Health Act assessment were placed in the 'red' risk zone. This meant staff increased the frequency of their contact with the patient.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly. For example, at Ealing Acton MINT, we found all statutory documents relating to community treatment orders were stored on the electronic patient record.

Our findings

Good practice in applying the Mental Capacity Act

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

Staff received mandatory training in the Mental Capacity Act. There was a policy on the Mental Capacity Act, which staff knew how to access and they could also describe how to obtain further information.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. For example, at Ealing Acton MINT, a comprehensive assessment of mental capacity was recorded for a patient who was subject to a community treatment order.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff said that if they had concerns about mental capacity, they would discuss this in the multidisciplinary team meeting.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

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

As part of the inspection we spoke to eight patients and five carers and we also reviewed patient surveys. Between March 2021 to March 2022 the service had received feedback from 295 patients or relatives. Most of the patients we spoke with had been in receipt of trust services for a number of years. Patients felt that there had been a huge improvement since the recovery teams had transformed into the MINT teams. Feedback from all patients was positive about how staff treated them. Patients described staff as discreet, responsive, caring and respectful.

Staff directed patients to other services and supported them to access those services if they needed help. Link workers signposted patients to other services in the community such as employment support and gardening programmes. Link workers attended appointments with patients if a patient requested help to engage. For example, they would support people seeking employment to liaise with the local vocational recovery service.

Patients said staff treated them well and behaved kindly. Managers were able to describe situations where their colleagues had provided additional tailored care and support for patients. For example, staff provided extended visits to patients who were coping with emergency situations. Staff also supported a patient with agoraphobia to attend a medical appointment with another provider.

Our findings

Link workers described how they could build relationships with patients through the activities they facilitated. For example, staff said the weekly walking group in Ealing provided an opportunity to get to know patients and, over a number of weeks, patients had grown more open and comfortable about talking to them about their problems.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff. Most staff we spoke to told us that they felt able to raise any concerns with their managers.

Staff followed trust policy to keep patient information confidential.

Involvement in care

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

Involvement of patients

Staff involved patients and gave patients with care plans access to them. Some patients told us that they did not have a care plan. However, all patients told us that they felt involved in their care.

Staff made sure patients understood their care and treatment. One patient's notes said they needed an Arabic interpreter so this was arranged. Staff told us about a patient who was deaf and how they were provided assistance with communication through a consultant at a deaf unit.

Patients could give feedback on the service as a whole as well as their own treatment and staff supported them to do this. The trust facilitated patient forums in each borough.

Staff made sure patients could access advocacy services. Information about patient advocacy was shared with patients when they were assessed by the teams.

Staff informed and involved families and carers appropriately. Although families and carers were not always referenced in patients' care plans there were many entries in patients' progress notes detailing contact and the patients' specific circumstances. We attended multiple meetings throughout the inspection, during these meetings staff showed that they had an extensive knowledge of patients' personal relationships. For example, during a zoning meeting staff decided to contact a patient's mother as a patient was proving hard to engage with.

Involvement of families and carers

We spoke to five family members of people using the service. Everyone we spoke to was positive about the service. All the family members said that the level of support provided by staff was greatly appreciated and they felt well involved in their loved ones' care. The service was able to offer family counselling if required.

Families and carers were provided with opportunities to give feedback on the service. Services encouraged patients to complete 'Friends and Family' questionnaires, asking whether they would recommend the service to people they know. Completed questionnaires were reviewed at Clinical Improvement Group meetings which carers had sometimes attended.

Carer support was one of the seven core interventions of the EI service. There were leaflets on family support and family and friends feedback forms in reception.

Our findings

Staff in all teams supported, informed and involved families or carers in the care of their relative or friend. On occasion, such as when the patient withheld their consent to this and had the capacity to do so, staff recognised this was not appropriate. There was a carers support worker available in each of the three boroughs. We were told the service was the first in the trust to employ someone in this role.

The service's ambition was to routinely involve families and carers in crisis and contingency planning. This was already in place for some people, but not all.

Is the service responsive?

Requires Improvement 

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

Access and waiting times

The services' referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly. However patients who did not require urgent care were sometimes waiting long periods to start treatment. Staff followed up patients who missed appointments.

The MINT teams had clear criteria to describe which patients they provided services to and offered patients a place on waiting lists. All new referrals were assessed by staff from the multidisciplinary team at daily triage meetings. Once a referral had been accepted, the service sent a letter to the patient offering an appointment for an assessment. Within this letter, the service provided details of who to contact if the person's condition deteriorated before the appointment.

The MINT teams were very busy teams; in March 2022 the MINT teams collectively offered 5,269 appointments. To put this into context, Ealing Acton MINT received approximately 70 referrals each week from GPs or the trust's single point of access.

The MINT teams did not meet trust target times for seeing patients from referral to assessment and assessment to treatment. They expect to reliably achieve this by the time the service transformation is completed in March 2024. At the time of inspection managers were not completely confident about how each team was performing in relation to referral to assessment and assessment to treatment times. Senior leaders told us that the quality of data had been negatively affected by the transformation work but a number of 'work arounds' were in place to improve data quality.

From the data provided, in the Ealing Acton MINT 25% of patients were waiting more than two months to be assessed. At Hammersmith and Fulham South MINT, the average time from referral to the first appointment for new referrals was 78 days. Referrals from other mental health teams, such as the crisis team or early intervention service, were, on average, seen after 42 days.

The service used the systems and work arounds that were in place to help them monitor waiting lists. Managers received performance data on waiting times each week and used it to check for backlogs. This was shared with their colleagues at clinical improvement group meetings.

Our findings

Senior leaders were aware of the significant delays to treatment. The Covid-19 pandemic had contributed to a period of increased demand. Staff also told us that staffing vacancies were also affecting their ability to treat patients quickly. In addition, the MINT teams had received a high number of inappropriate or misdirected referrals following the transformation. In response to this, an interactive map had been created and shared with referrers which showed which MINT team covered every address in the three boroughs and the GP practices in each MINT area. Managers told us a link to this map would soon be added to the trust website so patients could also access it.

The EIS teams had recently received the results of their National Clinical Audit of Psychosis (NCAP). NCAP is a five-year improvement programme to increase the quality of care that NHS Mental Health Trusts in England. All three EI teams were top performing nationally for seeing patients within two weeks of referral.

Staff took steps to engage with people who found it difficult, or were reluctant, to seek support from mental health services. They were starting to operate out of some 'non-traditional' settings, such as football grounds. Increasingly the service employed staff in GP practices so patients did not have to make a separate journey to access mental health support. We saw this happening at Hammersmith and Fulham South MINT. Staff always tried to contact people who did not attend appointments and offer support. Patients records we reviewed showed repeat attempts by staff to contact patients who had failed to show up for appointments. Staff also visited patients' homes if they were hard to engage.

Staff considered patient risks and mental capacity. If people chose not to engage with the service and there were no concerns about risks or the patient's mental capacity, staff discharged the patient. If a patient was very unwell and was not engaging, staff would look at a variety of ways to encourage the patient to engage.

Patients had some flexibility in respect of appointment times. Patients told us they had a choice of times to suit their personal lives, however some patients told us it would be helpful to have more sessions with staff.

Staff worked hard to avoid cancelling appointments and when they had to they gave patients clear explanations and offered new appointments as soon as possible.

Staff supported patients when they were referred, transferred between services, or needed physical health care. For example, during the case review and formulation meeting in the Ealing Early Intervention service, staff discussed how they planned to contact a service in the new area the patient was due to move to. They also aimed to involve the patient's mother and obtain views on her expectations in relation to the transfer.

The facilities promote comfort, dignity and privacy

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

The service had a full range of rooms and equipment to support treatment and care. Each service had interview rooms, clinic rooms, office space and meeting rooms.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Meeting the needs of all people who use the service

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

Our findings

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Managers said they expected staff to be comfortable talking about race and sexuality when these issues were important to patients. During triage and complex care meetings, staff considered whether the patient was likely to be experiencing any inequalities or discrimination that had an impact on their mental state and social circumstances.

The MINT model was based on integrated community support and the trust part-funded some local third sector organisations so people could receive support tailored to their specific needs. Staff were aware of other services in the community that provided support for specific groups. For example, Ealing Acton MINT supported a patient to engage with a group providing support to the lesbian, gay, bi-sexual and transgender community.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. At Hounslow East MINT, for example, there were robust arrangements in place to keep information about local services up-to-date. All services had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get hold of interpreters or signers when needed. Care and treatment records we reviewed contained information about whether an interpreter was required.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Patients told us that they knew how to make a complaint. From March 2021 to March 2022 the MINT and EIS teams received 55 formal complaints. The team with the most complaints was Ealing Acton MINT which received 12 complaints.

Staff understood the policy on complaints and knew how to handle them. They protected patients who raised concerns or complaints from discrimination and harassment. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. For example, managers often contacted patients personally to talk through their complaint. In one instance, the patient felt that staff were not listening to them. The manager invited the patient to the clinical improvement group (CIG) to talk to staff about their experiences.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, staff discussed complaints at monthly CIG meetings. The most common complaint themes in the last 12 months were around staff communication, access delays, waiting times and support plans. In response to the access difficulties, senior leaders were in the process of recruiting staff to work in local GP practices to facilitate timely and appropriate referrals.

The service used compliments to learn, celebrate success and improve the quality of care. Team meetings had an agenda item for compliments which were shared with the team. There were displays of thank you cards from patients in the offices we visited.

Is the service well-led?

Requires Improvement

Our findings

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

The senior managers led the service using appropriate skills and knowledge to perform their roles. Most team managers had worked within the trust for a number of years.

Staff said they found managers to be supportive. They recognised that managers were often very busy but were always approachable if staff needed help.

Some long-standing staff said they had seen significant improvements in leadership across the trust as a whole. They spoke positively about the chief executive and described a culture in which they could express their views openly and ask for support.

We found senior leaders had a good knowledge of the strengths and weaknesses of the teams within the service and the systems in place. Both senior leaders and local leaders were open and honest about their successes and challenges.

Vision and strategy

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

The introduction of the mental health integrated network teams (MINT) represented a significant strategic change for West London NHS Trust's community mental health services. Addressing health inequalities was at the core of the model and the way the budget was allocated reflected this. The changes involved the implementation of new ways of working, support to additional patient groups, a broader range of staff roles and better engagement with a wide range of community services. The implementation of these changes was overseen by a steering group in each borough.

Fortunately, the early intervention service (EIS) was longer established, although it had extended its original remit and now worked with a wider age range. EIS represented a mature service which the MINT teams could aspire to.

Staff and managers recognised that the new MINT model had created many challenges for staff, not least having to use two electronic systems for patient records. Staff said that the difficulties in introducing the new model were compounded by increased demand for mental health services, the increasing complexity of patients, recruitment difficulties (in line with the national picture) and high staff turnover. However, despite these challenges, we found most staff had a good understanding of the reasons for implementing the new model and spoke positively about the new ways of working. One member of staff commented that the advantages still outweighed the negatives, particularly in relation to having access to GPs' records.

Senior leaders at the trust were committed to delivering all of the elements of the Community Mental Health Framework for Adults and Older Adults by 2024. They acknowledged that there had been more challenges encountered during the transformation than anticipated. Some of the challenges were the result of external factors which were not within the trust's control, such as delays to the interoperability of the IT systems.

Our findings

We were told the pace of change could not be easily slowed down as this would cause further issues. Despite the challenges, both senior leaders and staff were committed to the vision and wanted to make a real difference to people's lives and tackle health inequalities in the community.

Culture

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

Staff spoke positively about the support they received from colleagues within their multidisciplinary teams. Most staff said they felt valued. Staff felt able to raise concerns without fear of retribution. They said they would feel comfortable in raising any concerns with their colleagues and managers. Most staff felt their views and opinions were listened to and acted on. Staff knew how to use the Freedom to Speak Up process. Posters detailing who to contact if staff needed to speak up were on display in staff areas.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Managers told us they supported staff members to access counselling if that need was identified.

Most staff reported that the trust promoted equality and diversity in its day-to-day work. However staff had mixed views on career development. For example, a link worker in one team said they had been supported to carry out additional training and were now looking to move on to a more senior role but other link workers and peer support workers felt there were insufficient career progression opportunities.

Team members worked well together and when there were difficulties managers dealt with them appropriately. Teams held regular away days to build rapport between team members, some of whom had been appointed during the pandemic so had had relatively little face-to-face contact with their colleagues. Managers told us that the away days were helpful for identifying and discussing any issues that the teams needed to address.

Whilst MINT staff were well-informed about the challenges within the service and how leaders were trying to address them, it was clear staff worked under considerable pressure and some staff said morale within their team was low. Staff described the work as frustrating and stressful because they were not yet able to work in the ways they wanted to. For example, they said they had to field a lot of concerns about waiting times and access to appointments with doctors. Staff shortages meant they felt overwhelmed by the amount of work they had to do. In Ealing Acton MINT, staff were concerned about the number of colleagues who were leaving.

Governance

Significant concerns were identified during the inspection, however the governance processes within the trust had also identified these concerns. Senior leaders were sighted on the concerns and were working to improve the safety of the service.

Although areas of concern were identified during the inspection, senior managers were already aware of these issues which had been identified through the governance processes within the trust. These concerns had been shared with the trust board, regulators and integrated care system partners. Senior leaders were trying to resolve these issues as quickly as possible. Some of the issues, such as delays to assessment and recording of information, were becoming less problematic but progress had sometimes been hampered by the transformation work.

Our findings

The service held a range of meetings at which staff shared issues and concerns, identified actions and monitored progress. Agendas for governance meetings were standardised across the service and covered learning from incidents, complaints and safeguarding cases. This clear framework ensured that essential information was reliably shared and discussed.

Staff were clear about their roles and responsibilities and they understood the management structure within the service.

Management of risk, issues and performance

Teams did not have access to the information they needed to provide safe and effective care

The trust was aware that any service transformation increased risks to patients and staff who were involved with services that were in a state of transition. Therefore, the trust had commissioned a 'deep dive' into the new MINT teams to make sure the risks were fully understood. This took place prior to the inspection and was comprehensive in its analysis.

During the transformation to the MINT model, senior leaders had made the decision to focus on safety, which is why we found there was a good knowledge of the risks associated with the teams, as well as the individual patients, but areas such as care planning and recording were less well developed.

Staff in both EIS and MINT teams maintained and had easy access to the risk register at team and service line level. Staff could escalate concerns when required from team to service line level. The risks recorded reflected those we found during the inspection and reported to us by staff. At the time of inspection, the main risks on the risk register were IT challenges due to transformation and the two electronic patient record systems and high levels of demand coupled with recruitment difficulties.

The Early Intervention Service had comprehensive dashboards that displayed information on team performance so managers could easily identify any areas of strength or concern. MINT managers had more limited oversight of their team performance at the time of inspection, this was due to the lack of IT system interoperability; there was a reliance on spreadsheets rather than dashboards. Extensive work was taking place to improve data quality and presentation.

Leaders within the service were actively working on mitigating risks. For example, there were high levels of demand for community mental health services and reduced capacity due to vacancies and infection prevention and control considerations, challenging the match between demand and capacity. In response to this, workshops on demand and capacity were planned to engage teams in creative solutions to maximise flow through services. Senior leaders were also reviewing the staffing models for each team to try and reduce the workload of care co-ordinators.

Team managers were taking steps to address areas of risk. For example, the manager at Hammersmith and Fulham South MINT was reviewing the team structures around safeguarding and how staff were working across the two IT systems. They were planning further training for staff on care planning and risk assessments.

Information management

Staff engaged actively in local and national quality improvement activities. However, leaders did not have accurate oversight of outcomes and performance of each team. Improving the quality of data was an ongoing piece of work for the trust.

Our findings

The transformation work required that the new MINT teams had access to two electronic patient record systems. For reasons beyond the trust's control, the interoperability of the systems had not been achieved by the start of the transformation as promised and the deadline had kept slipping. This had a significant effect on the data about outcomes and the performance of each team. The EI teams had been largely unaffected by the issue as all their records remained on one system. EI team managers had access to information to support them with their management role.

At the time of the inspection the quality of data produced by the trust did not facilitate oversight of outcomes and performance. For example, referral to assessment and assessment to treatment times were not accurate. The data produced reflected longer periods of delay than what was happening in reality. Managers told us that they were working with the information management team to try and improve this and some 'work arounds' had helped. Managers were frustrated as these issues reduced their oversight of their team's performance and the 'work arounds' were time consuming. Staff found working between two systems to be challenging as well.

The trust had a three-pronged approach to addressing this issue. Firstly, it continued to work with external partners to resolve the interoperability problem. Secondly, it was about to consider a business case for the whole trust to change its electronic patient database which would resolve the matter in the longer term and, thirdly, it was working to pull relevant information from both systems into spreadsheets and dashboards which managers could use to monitor their team's performance and outcomes.

Staff made notifications to external bodies as needed. For example, the teams made safeguarding referrals to the local authority when required.

The EIS teams had recently received the results of their National Clinical Audit of Psychosis (NCAP). NCAP is a five-year improvement programme to increase the quality of care that NHS Mental Health Trusts in England. Hounslow achieved top performing overall when compared nationally. Hammersmith and Fulham received performing well overall and Ealing required improvement overall.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Engagement with other health and social care providers was fundamental to the delivery of MINT and EI services and took place at all levels of the service. The trust was actively funding some local partners to extend or enhance the services they offered, particularly those working with seldom-heard communities.

At a strategic level, there were regular meetings between the trust, borough based partners and the integrated care system (ICS). These meetings included the local authority, social care agencies and Healthwatch.

At an operational level, managers from MINT services regularly met with managers from primary care networks. Staff from other organisations, such as counselling services and drug and alcohol services, attended the teams' complex care meetings. Link workers actively supported patients to engage with other services providing support in the community.

As part of the inspection we attended a local health interface meeting in Hounslow. Leaders from local GP practices, acute hospitals, mental health leads and adult social care leads attended this call. During the call updates were

provided by each participant on the challenges each pathway was facing. For example, arrangements for GP appointments over the bank holiday were discussed. There were plans to hold 'hyper-local' interface meetings to discuss issues specific to each locality. For example, some GPs in Hounslow were not comfortable providing titrations of medication to their patients. Further dialogue was planned so different options could be explored.

Learning, continuous improvement and innovation

The trust was one of 12 early implementers of the MINT model and one of the few which were attempting a complete service transformation. As a result, it was in a position of constant learning, continuous improvement and innovation and it shared the learning it acquired with other organisations. It was involved in the Kings Fund lessons learned for early implementers group. Tools were being continually developed by the teams to ease the challenges of the transformation. For example, a tool had recently been developed to allow staff to type in a patient's NHS number to find the location of notes. This indicated to staff if the patient was already known to the service or partner services and, if so, where their records were stored.

Staff that we spoke to were committed to continuous improvement. Staff talked about a number of initiatives they were introducing such as a social group for patients, pet therapy days for patients and wellbeing days for staff. Face-to-face away days had restarted and staff could suggest quality improvement projects.

There was an extensive audit schedule in place for the service. Between April 2021 and April 2022 25 cross-team audits had taken place or were still being carried out. Fourteen had been completed, eight were at the data collection stage and three were overdue. Recent audits included evaluation of the effects of tele-therapy on patient outcomes across the three EIP Services, assessing the impact of coronavirus pandemic upon patients on clozapine and an audit of carer and patient factors that influence carer engagement. Learning from audits was shared through team meetings.

There were arrangements in place for staff and managers to share learning from incidents, complaints, compliments, audits, training and similar opportunities. Managers facilitated specific sessions when needs were identified. Managers listened and learned from feedback from patients, carers, GPs and other professionals and we saw they had introduced changes as a result, such as additional staff based in GP practices.

MINT managers told us that although the transformation had been challenging it had provided them with opportunities to change and improve the service. For example, teams were improving their relationships with local GPs; some teams had successfully begun seeing patients at local GP practices. Staff told us that this was an important step in reducing the stigma around receiving help about mental health issues.

Our findings

Outstanding practice

We found the following outstanding practice:

- The trust was actively working to address health inequalities. The allocated budgets for the new MINT teams reflected population rather than demand in recognition that some groups had traditionally not received adequate mental health support. Through its engagement work and funding of local groups the service was reaching out to seldom-heard groups in order to redress this. The estates plan had already provided teams with clinical space at two local football grounds making them very accessible and approachable because it placed them at the heart of communities and more developments of this type were planned.
- National Clinical Audit of Psychosis (NCAP) audit results had recently been received for the Early Intervention Service. The Hounslow EI team was a top performer overall nationally.

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that sufficient staff are deployed to safely meet the needs of the patients requiring community mental health services. Regulation 12
- The trust must ensure that robust risk systems are in place to assess and manage patient risk. Regulation 12
- The trust must ensure staff in MINT teams assess and treat patients in a timely manner in line with trust targets. Regulation 12
- The trust must ensure that staff know and follow the lone working policy and revise it if necessary. Regulation 12
- The trust must ensure that all staff have regular supervision at the frequency described in its policy. Regulation 18
- The trust must ensure that electronic patient records systems are not overburdensome for staff and that data generated by each team is accurate and provides oversight of outcomes and performance of each team. Regulation 17
- The trust must ensure that staff complete their mandatory training and this is recorded. Regulation 18

Action the trust SHOULD take to improve:

- The trust should ensure that all premises have an up to date ligature risk assessment.
- The trust should ensure that all premises where patients are seen are fit for use.
- The trust should ensure that patients who are subject to community treatment orders always have the correct certificates stored alongside their medicine administration charts.

Our inspection team

The CQC inspection team that inspected the service included four CQC inspectors, two inspection managers, one specialist advisor who was a registered mental health nurse and one expert by experience who contacted patients and carers on the telephone.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing