West London NHS Trust

Community-based mental health services of adults of working age

Inspection report

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Date of inspection visit: 31 October 2023 and 1, 6, 7 & 8 November 2023
Date of publication: 05/02/2024

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Community-based mental health services of adults of working age

Inspected but not rated

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.

During this inspection we visited 3 Mental Health Integrated Network Teams (MINTs) which were part of the trust's Community and Recovery Mental Health Services. There are 9 MINT teams across the 3 boroughs, with 3 MINT teams in each borough. Each MINT is aligned to 1 to 3 primary care networks, which are made up of a cluster of general practitioner surgeries.

The MINT teams were set up in 2020 and were developed to reflect NHS England's long-term plan and the Community Mental Healthcare Framework. 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 supports adults 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.

CQC previously inspected this core service in April 2022 and we issued an overall rating of requires improvement, with an inadequate rating for the safe key question. During this inspection, we did not re-rate the core service as it was not proportionate to do so. This was because it was a focused inspection of 3 MINT Teams (Ealing Acton, Hammersmith and Fulham South and Hounslow East), where we looked at the safe and well-led key questions in full, and part of the responsive key question. This was due to intelligence we had received prior to the inspection. We also followed up the concerns found in the last inspection. We did not inspect or report on the key questions effective and caring.

Since the last inspection in April 2022, the MINT teams that we inspected had made some improvements, with improvements made particularly to staffing, staff morale, staff engagement, and data quality and oversight of performance. However, the service still had work to do and was engaged in an improvement process. The service needed time to see the positive effect of recent improvements in staffing, to embed learning and new processes, and to deliver a number of planned work streams. The teams were still working with 2 electronic patient records systems, which caused the same frustrations as the last inspection. There was strong leadership in place across the MINT teams, including at senior level. Leaders were mostly aware of the issues we had identified during the inspection process and were working hard to make the necessary improvements.

The main concerns identified during the inspection were:

- In Ealing Acton MINT team, the assessment rooms where staff saw patients did not have working panic alarms or effective mitigation plans in place while they waited for them to be repaired. This put staff and patient safety at risk.
- Some patients did not have risk assessments and their risks were being recorded in their progress notes instead. This meant that risk and risk management plans were not always easy to access on the electronic patient record system. However, staff in all 3 teams had good understanding of patient risk and the issue related to the recording of risk correctly in records.

Our findings

- Most staff had received training in safeguarding. However, in Ealing Acton MINT team, 50% of staff had not completed the required safeguarding children and adults level 2 training. This meant that these staff may not know how to recognise and / or take necessary safeguarding actions to protect individuals. Safeguarding training had been booked for 19 November 2023 for all of the Ealing Acton MINT team to attend.
- Similarly to the last inspection in April 2022, staff continued to use 2 electronic patient record systems. This meant staff had to review entries on both systems, this caused frustration for staff. We found that staff in Hounslow East MINT team were not regularly reviewing the waiting list for referrals on 1 of the electronic systems. Senior leaders were regularly reviewing the risk of using 2 electronic systems, and had a migration timeline in place to move towards 1 electronic system in April 2024.
- Despite the service working hard to reduce waiting times for appointments. The MINT teams still did not meet trust target times for seeing patients from referral to assessment and assessment to treatment. However, compared to the last inspection, there had been a recent improvement in staffing and managers told us this should allow staff to work through a backlog of assessments. New staff also needed time to undergo their trust induction and local training. The issue continued to be monitored on the risk register.

However:

- The service had made good improvements to staffing since the last inspection. There were low vacancy rates, with most vacancies covered by agency. The trust had active recruitment plans in place to fill vacant posts. Staff told us they felt that they had enough staff to safely meet the needs of patients. However, due to the high number of new recruits in teams, staff told us it may take time for new staff to make an impact on the day to day work as they undergo induction and learn new trust systems and processes.
- Staff followed good lone working practices. This was an improvement from the last inspection, where teams did not consistently use effective lone working systems.
- Apart from low safeguarding training in Ealing Acton MINT team, there had been improvements in mandatory training since the last inspection. Most staff had received basic training to keep them safe from avoidable harm. All 3 teams had received training in breakaway training and promoting safe and therapeutic services, these training modules had low compliance at the time of the last inspection.
- 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. However, not all staff were aware of the trust medicine's policy around the re-use of long-acting depots.
- 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.
- 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.
- 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. They recognised that the teams still had work to do, and there were good plans in place to achieve this work.
- Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Our findings

- Senior leaders were dedicated to improving the MINT service and had partnered with an independent healthcare innovation company to improve areas of identified challenges with access into the service. This included a workstream to improve the triage process.

What people who use the service say

Overall, feedback from patients was very positive about the care and treatment they received from staff. Patients told us that they did not have to wait a long for their first appointment. Patients said they felt involved in their care and listened to by staff. One person told us their named worker knew them really well and listened to what was important to them. All patients told us they were able to access support when needed and understood their crisis plan. All patients said staff treated them with dignity and respect. Most patients said they had enough time with staff to meet their needs.

Is the service safe?

Inspected but not rated

Safe and clean environment

Most clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. However, Ealing Acton MINT did not have working panic alarms, and did not have an up to date environmental risk assessment.

Staff had completed thorough risk assessments of all areas, however, for Ealing Acton MINT team, the risk assessment was out of date. It was last updated in September 2021, and stated it was due to be updated in September 2022. It contained information relating to staff having to wear mandatory face coverings on public transport, which were now not relevant. We raised this with managers following the inspection, who informed us that all MINT team had updated the environmental risk assessments following the inspection.

At the last inspection in April 2023, the Hounslow East MINT did not have alarms present in assessment rooms. At this inspection, this issue was resolved and assessment rooms had alarms. However, the alarms in the assessment rooms in Ealing Acton MINT had been broken for a week. Managers told us that the issue had been reported to trust security, but we were not aware when the alarms would be fixed. The team had put mitigations in place, for example, ensuring service users of concern attending the building were considered for joint clinical appointments, that colleagues were vigilant to calls for support and that the panic button on the electronic patient record system could be used to seek support. However, some staff told us that the mitigations in place while waiting for the panic alarms to be repaired did not feel effective. The interview rooms at Hammersmith and Fulham MINT had alarms in working order.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations.

All areas were clean, well maintained, well-furnished and fit for purpose. At the last inspection in April 2022, the Ealing Acton MINT assessment rooms had broken window latches that had been broken for over a year, and some areas appeared untidy and unorganised. At the inspection, this was not the case. The premises were tidy and well-maintained. The clinical premises was an item on the team's improvement action log, this was to ensure the building was fit for purpose and identified works were completed in a timely manner.

Staff made sure cleaning records were up-to-date and the premises were clean.

Our findings

Staff followed infection control guidelines, including handwashing.

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.

Safe staffing

The service had enough staff, who knew the patients and most staff had received basic training to keep them safe from avoidable harm.

Nursing staff

At the last inspection in April 2022, the service had significant staffing issues across the teams. Overall vacancy rates in the MINT teams ranged from 25% to 35%. At this inspection, we found that staffing had improved and there were low vacancy rates, with most vacancies covered by agency. The trust had active recruitment plans in place to fill any remaining vacancies. Staff told us they felt that they had enough staff now to safely meet the needs of patients. However, due to the high number of new recruits in teams staff told us it may take time for new staff to make an impact on their day to day workload as they were currently undergoing induction and learning new trust systems and processes.

In Ealing Acton MINT team there was 1 peer support worker vacancy, and 1 band 7 senior mental health practitioner vacancy. The band 7 post was covered by a long-term band 7 agency worker.

In Hammersmith and Fulham MINT team there was 1 band 7 senior mental health practitioner vacancy, which was covered by a long-term band 7 agency worker, and there was a mental health practitioner vacancy.

In Hounslow East MINT, there was a mental health practitioner vacancy that was covered by a long-term agency worker. There was also a band 6 social worker vacancy. The team had a full-time band 5 social worker that was being trained for a band 6 role. There was 1 clinical psychologist band 8a vacancy. There was another band 8a full-time clinical psychologist and an assistant psychologist in post to support with this vacancy.

Staffing remained on the service risk register and senior leaders continued working hard on recruitment and retention.

The staff sickness rate varied across the 3 teams we visited, over the last 12-months sickness generally reducing. In September 2023, Ealing Acton had the highest sickness rate at 9%, Hammersmith and Fulham South's rate was 7% and Hounslow East's rate was 3%. Some of the teams had staff members who were on long-term sickness. Managers supported staff who needed time off for ill health.

The teams inspected had low turnover rates. Between November 2022 and October 2023, 6 staff members had left Ealing Acton MINT, with 1 staff member relocating, 4 staff members stating work life balance being the reason for leaving, and another stating there being a lack of opportunities to progress as their reason for leaving.

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 or bank staff. Mangers sought to employ bank and agency staff who were familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Our findings

The trust had determined staffing levels for MINT teams by calculating the number and grade of members of the MDT required. This was constantly being reviewed by senior leaders, who had identified the actual demand for the service was in some areas higher than the current staffing resource could meet and they were looking at how they could better resource these teams.

The number and grade of staff matched the provider's staffing plan mostly. However, in Ealing Acton MINT, managers had struggled to recruit into their band 6 posts, so they had overrecruited band 5 healthcare professionals with the aim to develop them into band 6 posts. The band 7 staff told us that this had put increased pressure on them.

The MINT caseloads were high. Managers assessed the size of caseloads of individual staff regularly and helped staff manage the size of their caseload.

The Ealing Acton MINT caseload was 2495, which was the highest across all 9 MINT teams. This was due to a higher proportion of referrals per capita. Referral demand for Ealing Acton MINT had been escalated within the Ealing Borough Based Partnership meeting with the Integrated Care Board and Primary Care colleagues. The Hammersmith and Fulham South MINT caseload was 946 and Hounslow East MINT had a caseload of 1079. Managers told us that work was underway to determine how resources might be distributed across the 9 MINT teams to better match capacity to demand.

Each profession held their own waiting lists. Managers relied on each profession to keep them up to date on these waiting lists. Waiting lists for each profession varied across the 3 boroughs. For example, in Ealing Acton MINT, there was a 6 to 12 months wait for one to one occupational therapy support, however, there was no wait time for occupational therapy groups in Ealing Acton MINT. In Hounslow East, there was no wait for one-to-one occupational therapy, and an 8 week wait in Hammersmith and Fulham South MINT.

For psychological input, waiting times varied across the 3 boroughs. The wait time was highest in Hammersmith and Fulham, with a wait time for individual therapy of up to 12 months, with 50 patients waiting for this service. We were told that patients on this waiting list would be receiving care and treatment from other members of the MDT in the meantime. The wait time for one-to-one psychological therapy in Ealing was 6 months, and 5.5 months in Hounslow. The psychology department offered a range of psychological groups to patients such as managing emotions and a post traumatic stress disorder group.

In Ealing Acton MINT, there were 97 patients waiting for a medical appointment (average wait of 13 weeks wait), 47 in Hounslow East MINT (average of 1-2 weeks wait), and 51 in Hammersmith and Fulham (average of 8 weeks wait).

Medical staff

The 3 MINT teams inspected had enough medical staff.

In Hammersmith and Fulham South MINT, although medical staffing was fully established at the time of inspection, staff had told us that there had previously been some challenges with consistent medical cover. The long-term lead consultant psychiatrist had recently left, and 1 of the speciality doctors went on long-term leave. These absences were covered by 2 locum psychiatrists. Staff had told us that this had led to inconsistencies in patient care. This also led to an increased wait for medical appointments.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

Managers made sure all locum staff had a full induction and understood the service.

Our findings

The service could get support from a psychiatrist quickly when they needed to.

Mandatory training

We found improvements in mandatory training since the last inspection. All 3 teams had received training in breakaway training, promoting safe and therapeutic services, which were low in the last inspection. Overall, most modules were above 75%, and most staff were trained. However, in Ealing Acton MINT 50% of staff members had not completed safeguarding children and adults level 2. Staff with outstanding safeguarding training had been booked to complete this in November 2023 and the team had identified safeguarding champions to support safeguarding discussions. However, at the time of the inspection, there was a risk that some staff had not received the trust's required safeguarding training

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff now followed good personal safety protocols.

Assessment of patient risk

At the last inspection in April 2022, 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. At this inspection, this was still an issue. Some patient records had detailed risk assessments that covered identified risks. However, some patients did not have risk assessments and their risks were recorded in their progress notes instead. Managers were aware that teams were not consistently recording risks in the trust risk assessment template. Managers told us that teams were knowledgeable about patient risk, but were not always recording it in the right places, this meant that risk management plans were not easy to access on the electronic patient record system. We found that staff in all 3 teams had good understanding of patient risk and the issue related to the recording of risk correctly in records. We saw that this issue was discussed in the latest clinical improvement group meeting at Ealing Acton, where staff were encouraged to complete risk assessments rather than progress notes.

At the time of the inspection, the service was working on an improvement project to ensure patients deemed complex or risky could be easily 'flagged' and prioritised on the electronic record system. The goal was to ensure that those who were currently experiencing a significant worsening of mental, physical or social health were able to access a range of support and interventions rapidly from the MDT. This work planned to be complete by April 2024, in line with the migration over to 1 electronic care record system.

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

Staff responded promptly to any sudden deterioration in a patient's health. In each team, members of staff were assigned to the 'unplanned care' team. The teams operated a rota to allocate staff to this role. Staff in the unplanned care team answered calls to the service. If they received a call that indicated risk, they escalated the matter to the daily zoning meeting. Staff responded to risks by contacting the patient or increasing the frequency of visits to the patient, speaking to their carer's concerns and staff could complete an MDT review.

If the patient continued to present as 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.

Our findings

Staff mostly monitored patients on waiting lists to detect and respond to increases in level of risk. However, at Hounslow East MINT, we found that staff were only regularly reviewing 1 of the 2 electronic patient record systems where patients were referred into the service. On the day of inspection, there were 42 people on 1 of the referral waiting lists. We found that 1 person on the waiting list had been referred to the team 105 days previously and had received no contact by the team. We found other examples where patients were receiving a service from the team or where a patient had been appropriately discharged, however these people were incorrectly still on the waiting list. This demonstrated that the waiting list was not accurate and some people referred into the team were not being contacted. This was raised with managers during the inspection, who assured us that staff were reviewing the waiting list and made contact with patients where necessary for an appointment. The other 2 teams inspected had monitored both waiting lists for referrals into the teams safely.

At the last inspection in April 2022, staff did not follow clear personal safety protocols, including lone working. Most teams we visited did not have a strong culture of personal safety. At this inspection, this was no longer the case. The 3 teams inspected were using different lone working systems, but all staff we spoke with said they were following and were satisfied with their lone working process.

Managers had local plans in place to embed the lone working systems for their teams, but these were relatively new, and needed time to embed to ensure staff used the systems as required. Lone working was identified on the service risk register which helped to ensure oversight at a senior level.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it. However, only 50% of staff had completed the required safeguarding children and adults level 2 training.

Most staff received training on how to recognise and report abuse, appropriate for their role. However, in Ealing Acton MINT 50% of staff members had not completed safeguarding children and adults level 2. This meant that these staff may not know how to recognise and or take necessary safeguarding actions to protect individuals. Safeguarding training had been booked for 19 November 2023 for all staff at Ealing Acton MINT to attend.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them**.** For example, at Hammersmith and Fulham South MINT, staff referred a patient to perinatal services where concerns were identified in regard to their mental health and pregnancy.

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 safeguarding lead if they were concerned about safeguarding. Safeguarding concerns were discussed during the daily zoning meetings.

Managers took part in serious case reviews and made changes based on the outcomes. In Hammersmith and Fulham MINT, there had been four deaths in the community, which had been reviewed by the trust's mortality review group, and recommendations made for the team to action.

Our findings

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.

At the last inspection in April 2022, staff within the MINT teams were using two electronic patient record systems. In some cases, staff had to review entries on both systems which was time consuming, over-complicated and caused frustration for staff. At this inspection, this was still the case. Most patient notes were comprehensive, but staff were still using the same 2 electronic patient record systems and staff reported the same frustrations and risks with using 2 systems. In Hounslow East MINT, we found that the referral waiting list on 1 of the electronic patient record systems was not being regularly monitored. Senior leaders were sighted on the risks associated with using 2 electronic systems. Since the last inspection, the trust expected to move to 1 electronic care system by April 2024. It had a two-step migration timeline, which detailed how complex patients would be transferred over to the system. There was operational and senior leader oversight of the risk, while the trust moved towards 1 electronic system in April 2024. The issue was held on the local and service wide risk registers .There was a digital program board considering a range of solutions and mitigations, and a task and finish group underway to ensure patients awaiting care were booked into planned care and those who no longer needed care were discharged.

Most patient records that we reviewed were detailed. All records had sufficient information about patients' care and treatment in the progress notes. However, staff did not always capture information in the risk assessments, as indicated by trust policy. This meant that staff could not access it quickly. Managers were aware of this and were working with staff to improve record keeping.

Records were stored securely. Staff were required to ensure a username and password 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. However, not all staff were aware of the trust medicine's policy around the re-use of long-acting depots.

Staff mostly followed systems and processes to prescribe and administer medicines safely. In Hounslow East MINT, we found that staff were reusing certain medicines that had been labelled for other patients. It is trust policy that these specific medicines can be re-labelled to avoid a significant cost burden to the trust that would be involved in wasting these medicines. Although the pharmacist was aware of the reasons for re-using these medicines, they were not aware of the trust's medicine's policy regarding this process. The trust's medicine's policy stated that this process was managed by pharmacy, and therefore an expectation that pharmacy and other relevant staff were aware of the policy.

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 6 patients at Ealing Acton and 4 patients in Hammersmith and Fulham South. All records were clearly documented and contained all the information required.

Staff stored and managed all medicines and prescribing documents safely. At the last inspection in April 2022, not all patients who were subject to a community treatment order had the correct certificates stored alongside their medicine administration charts. At this inspection, this was no longer an issue. Community treatment order certificates were attached to medicine records where appropriate in all 3 teams inspected.

Our findings

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

In the last 12 months, the service reported 31 serious incidents (SIs) for the 3 teams we inspected. They reported 12 serious incidents for Ealing Action MINT, 7 serious incidents for Hammersmith and Fulham South MINT, and 12 serious incidents for Hounslow East MINT. The majority of these SIs were patient deaths.. The trust investigated deaths appropriately.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. Staff said they knew how to report incidents on the electronic incident reporting system.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy.

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. In Hammersmith and Fulham South MINT, managers debriefed and supported staff following a recent cluster of patient deaths, which had understandably been an upsetting time for the team.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example, following incidents where patients had become 'lost' on waiting lists, the service carried out a targeted piece of work to review all MINT waiting lists to identify patients who may have been 'lost' and to offer them an appointment if still appropriate or to discharge them. During our inspection, we spoke to staff who were actively involved in leading this work within their teams.

Is the service responsive?

Inspected but not rated

Our findings

Access and waiting times

The service's 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 had to sometimes wait long periods for their first assessment or to start treatment. Staff followed up patients who missed appointments.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. The MINT teams supported adults aged 18+ who needed a non-emergency response with a wide range of mental health difficulties. MINT operated between 9am and 5pm, Monday to Friday. All emergency and out-of-hours requests for mental health support over weekends were directed to the trust's Single Point of Access (SPA).

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 trust's target for referral to triage was 7 days. The trust reported that all 3 teams were meeting this target. At Ealing Acton and Hammersmith and Fulham South MINTs, patients waited on average 5 days from referral to triage, and at Hounslow East MINT, patients waited on average 1 day from referral to triage. New referrals were reviewed during daily triage meetings. Triage meetings were attended by members of the MDT. During these meetings staff would decide which profession would best meet the patient's needs. Some MINT teams booked a patient's future appointment in triage meetings, whereas other MINT teams relied on practitioners to book a patient's future appointment after the triage meeting. The trust had identified that the triage process needed to improve due to an inconsistent approach to referral and triage across the teams, which had sometimes led to patients being lost to follow up. During our inspection, some MINT teams were piloting a new referral and triage process where all patients were booked an appointment within the triage meeting. The trust's plan was to replicate this across all 9 MINT teams.

At the last inspection in April 2022, the MINT teams 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. Staff also told us that staff vacancies had also led to delays. 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. At this inspection, the service had completed work to try and reduce waiting times for first and second appointments, but patients were still waiting an unacceptable time for first appointments and treatments and were not meeting the trust target of 28 days for seeing patients from referral to assessment and assessment to treatment. At Ealing Acton, the average wait from referral to the first appointment was 150 days, and Hounslow East, it was 100 days and Hammersmith and Fulham South it was 175 days. The average wait time from assessment to treatment for Hammersmith and Fulham South MINT was 250 days, 175 days in Ealing Acton MINT, and 175 days in Hounslow East MINT. Leaders told us that caseload cleansing and some staff not validating patient appointments in clinician's diaries was skewing the data. Improvements were expected in early 2024 when caseload cleansing was due to be completed. Staff were hopeful that wait times would reduce due to the recent improvement in staffing which would allow them to start working through a backlog of assessments. This issue continued to be monitored on the service risk register.

Data quality in relation to waiting times had improved since the last inspection. Managers had better oversight of people waiting for a service and a better understanding of how the data quality might have been affected. A head of performance role had recently been introduced to support the MINT teams. They were closely monitoring the waiting list

performance, and supported managers to understand the data, and understand why there may be pressures on waiting times. For example, due to the recent work contacting patients who had been 'lost' on waiting lists, this had caused a recent spike in the number of patients waiting for a first appointment. The teams were also in the process of working through 'long waiters' which may also have skewed waiting times.

Due to the large numbers of patients referred to the MINT teams, which resulted in large number of patients on waiting lists, the trust had partnered with an independent healthcare innovation company to look at ways to improve access into the service. Work streams specifically looked at the triage process and how to identify complex and risky presentations. These workstreams were underway during our inspection process with mapped out timelines.

Despite staff not being able to offer appointments to non-urgent referrals within trust target times, staff were able to see urgent referrals quickly, and these were prioritised during daily triage meetings. The team's 'unplanned care' team were able to respond promptly and adequately when patients telephoned the service or turned up at the premises.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Managers had a good understanding of the different populations they served across the 3 boroughs, and spoke about different ways, such as visiting football grounds, to engage with people reluctant to seek support from the MINT teams.

The service employed staff in GP practices so patients did not have to make a separate journey to access mental health support.

Staff tried to contact and offer support to people who did not attend appointments. Patient records we reviewed demonstrated staff making repeat attempts to contact patients who had failed to attend appointments. Staff would telephone them and visit their homes if they were hard to engage.

Patients had some flexibility and choice in the appointment times available.

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.

Appointments ran on time and staff informed patients when they did not.

Staff supported patients when they were referred, transferred between services, or needed physical health care. For example, in Hounslow East MINT, we saw an example where staff supported the transfer of a patient into the team from forensic services.

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 they knew how to make a complaint.

Staff understood the policy on complaints and knew how to handle them.

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

Our findings

Between November 2022 and November 2023, the 3 MINT teams inspected received 18 formal complaints, Ealing Acton MINT had 7, Hammersmith and Fulham South had 5, and Hounslow East had 6 formal complaints. Of these complaints, 1 was upheld, 7 were partially upheld, 8 were not upheld, and 2 were currently still being investigated. Managers investigated complaints and identified themes. Themes in the last 12 months related to requests for a change of care coordinator, staff communication and difficulties with booking an appointment.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, in Ealing Acton MINT, patients had complained that staff did not answer the telephones when they called into the service. In response to these complaints, the team had recently piloted a new telephone system. The new system had a queue feature so people knew how long they may have to wait, and there was also a callback feature. Managers told us there had been no complaints regarding contacting the service since the pilot had been introduced and the telephony issue had been added to the local risk register.

Is the service well-led?

Inspected but not rated

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.

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a very good understanding of the services they managed. They could clearly explain how the teams were working to provide high quality care. Leaders told us that the MINT teams had made steady improvements since the last inspection, but recognised there was still work to be done and had plans in place to achieve this work.

Leaders were visible in the service and approachable for staff and patients. Staff told us they found managers to be supportive. Staff in Ealing Acton MINT told us that the management of their team had greatly improved since the last inspection.

Leadership development opportunities were available, including opportunities for staff below team manager level. For example, in Ealing Acton MINT, a staff member had started off as a healthcare assistant in the team and had been supported to complete their nursing qualification and had since progressed to a senior band 7 practitioner.

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 the 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.

Our findings

Staff and managers recognised that the new MINT model had created many challenges for staff, including having to use 2 electronic patient record systems, high demand for the service and recruitment challenges. However, we found that most staff had a good understanding of the reasons for implementing the model and spoke positively about the new ways of working.

Senior leaders 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 challenges encountered during the transformation, and it had been challenging implementing it during the covid pandemic.

Despite the challenges encountered, 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.

Staff had the opportunity to contribute to discussions about the MINT strategy during the transformation. The clinical director of the MINT teams held monthly all staff MINT events whereby staff could drop in and provide feedback regarding the MINT transformation. Managers completed a 'discovery' exercise with staff recently to gather feedback on the MINT transformation process. This exercise focused on what had worked well, what were their frustrations, what they wanted introduced and what they did not want. Managers provided feedback on how they were addressing their frustrations. For example, staff mentioned frustrations with the triage process, and managers had subsequently started a workstream on improving the triage process. Staff were invited to get involved in the different workstreams.

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 were overwhelmingly positive about the support they received from colleagues within their multidisciplinary teams. At the last inspection in April 2022, some staff told us that the morale within their team was low. At this inspection, staff said the morale had improved and they felt valued and respected working for the trust and their team. Staff told us they felt able to raise concerns with managers without fear of retribution. 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.

Managers dealt with poor staff performance when needed.

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. Hounslow East MINT had recently had their away day.

Staff had access to support for their own physical and emotional needs through an occupational health service. As part of the trust's recruitment and retention action plan, the trust prioritised delivering wellbeing activities to help reduce staff absence. This included flexible working and implementing employee health passports to ensure reasonable adjustments were made for those with disabilities and long-term conditions.

The provider recognised staff success within the service. For example, in Hounslow East MINT, a mental health practitioner had recently won the trust's patient choice award, whereby the patient stated this staff member had helped them through challenging times.

Our findings

Governance

Our findings from the safe key question and part of the responsive key question demonstrated that governance processes had improved since our last inspection. Senior leaders and team managers had better oversight of the performance at team level. Senior leaders were continuing to work to improve the safety of the service.

Since the last inspection in April 2022, the service had made some good improvements, staffing had increased, data quality had improved, and staff were following lone working practices. However, senior leaders recognised that improvements still needed to be made in the following areas: risks identified with using 2 electronic patient record systems, staff not completing the trust risk assessment document, teams still not meeting the 28 target from referral taking place to a service user starting treatment, and not all staff had received safeguarding training. Senior leaders had plans in place to deliver this work. The service needed time to embed new processes and to deliver workstreams that were in progress at the time of our inspection.

There was a clear framework of what must be discussed at a team or service level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Senior leaders attended regular senior management meetings where topics such as workforce and recruitment, governance and safeguarding were discussed.

Senior leaders from each borough attended regular service level clinical improvement groups. Topics such as referral to assessment/treatment waits, complaints, supervision and training performance were discussed.

The Business Information team produced regular reports for senior leaders on key performance indicators, such as number of referrals received, discharge rates, attended patient contacts, and waiting times for referral to assessment and treatment. This was an improvement since the last inspection, and the head of performance was able to support the MINT managers to understand their performance data.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Staff undertook or participated in clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. This included medicines management audits, safeguarding adults board multi agency audit and caseload audits.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff maintained and had easy access to the risk register at team and service line level and could escalate concerns when required. The risks recorded reflected those we found during the inspection and reported to us by staff. At the time of the inspection, the main risks on the risk register were the challenges due to the MINT transformation, for example, the 2 electronic patient record systems.

Senior leaders were taking steps to address areas of risk and to ensure good oversight of these areas. For example, when leaders identified that specific MINT teams needed targeted support, they supported these teams with improvement action plans. At the time of the inspection, Ealing Acton MINT had an active improvement plan in place. The action plan

addressed points such as safely supporting new staff joining the team with induction and supervision, caseload reviews of each profession, reviewing the data around the 3 primary care networks and associated caseload sizes, and ensuring the clinically lost to follow up work was completed. All actions were regularly reviewed and had an action owner to ensure accountability.

Hammersmith and Fulham South MINT team also had an improvement action plan in place at the time of the inspection. The action plan included risks we identified during the inspection, such as the impact of medical staff being on sick leave and ensuring all cancelled appointments were rebooked.

The trust had a recruitment and retention action plan to improve workforce data quality and increase recruitment activity to fill workforce gaps.

Information management

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

At the last inspection in April 2022, leaders did not have accurate oversight of outcomes and performance of each team, and the quality of data was an ongoing piece of work for the trust. At this inspection, managers had improved oversight of team performance and there had been improvement in the service's data quality. The trust had recently recruited a Head of Performance for MINT to support teams with data and performance. However, during the inspection, staff told us that data quality was still being affected by different factors such as staff not always outcoming appointments. Senior leaders had plans in place to improve this.

Team managers had access to information to support them with their management role. Team managers had performance dashboards to support oversight of team performance. Each team manager also received weekly reports on the performance on their team.

The issues relating to the MINT teams using 2 electronic patient record systems remained since the previous inspection in April 2022. There was a plan in place for the MINT teams to move to 1 system in April 2024.

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

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. Managers from the service participated actively in the work of the local transforming care partnership.

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. The clinical director for the service held monthly MINT all staff event meetings where updates on priorities were shared and it had a listening you said / we did section in each call.

Senior leaders said they were due to provide patients and carers with an update on where the service was currently at with the MINT transformation.

The service had a recruitment and retention action in place, which had objectives to deliver interventions to improve staff experience, which included, video newsletters to update staff on what is happening across the service line.

Our findings

Engagement with other health and social care providers was fundamental to the delivery of the MINT services.

The service had a vision for strong links with voluntary community and social enterprises to work holistically together and deliver better care, but leaders acknowledged that work needed to be done to improve these links.

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 drug and alcohol services, attended patient meetings. Link workers actively supported patients to engage with other services providing support in the community.

Patients and carers had opportunities to give feedback on the services they received.

Learning, continuous improvement and innovation

The trust was 1 of 12 early implementers of the MINT model undergoing a complete transformation of the community mental health services for adults of working age. As a result, it was in a position of constant learning, continuous improvement and innovation and it shared the learning with other organisations. Senior leaders were open and transparent with where improvements needed to be made and were proactive in taking action to make improvements.

In particular, the service had identified that access into the service needed to improve. The service had partnered with an independent healthcare innovation company to improve areas of identified challenge with access into the service. Workstreams included flagging patient risk on care records, clinical lost to follow up patients on waiting lists and the triage process.

Staff used quality improvement (QI) methods and knew how to apply them. In Hounslow East MINT, staff had identified that often there was not sufficient information contained within GP referrals, which caused extra work to gather the necessary information. Staff were carrying out a QI project to improve the referral form to improve the quality of data captured in referral forms.

Staff participated in national audits relevant to the service. Recent audits included re-admission audits, post-discharge service user medicines information audit and monitoring of patients prescribed lithium. Learning from audits was shared through team meetings.

Our findings

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure that 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 follow trust policy when recording patient risk and mitigation plans in patient records. Regulation 12
- The trust must ensure that staff are trained in safeguarding so that staff know how to recognise and take necessary safeguarding actions to protect individuals. Regulation 13
- The trust must ensure that premises where patients are seen provide the necessary security arrangements to ensure people are safe. Regulation 15
- The trust must ensure that the electronic patient record systems allow staff to safely and accurately record information without risk to the safety of people who use the service. Regulation 17

Action the trust SHOULD take to improve:

- The trust should ensure that staff are aware and follow their trust medicine's policy around the re-use of long-acting depots.

Our inspection team

The 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 1 CQC inspector, 1 CQC senior specialist, 2 specialist advisors who were registered mental health nurses, and 1 expert by experience who contacted patients 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 3 services and looked at the quality of the environment
- Spoke with 9 patients and 2 carers
- Spoke with 3 team managers, the 3 service managers, the associate director for the service, the clinical director for the service, the head of performance for the service
- Spoke with 23 other staff members including a community matron, consultant psychiatrist, registered mental health nurses, clinical psychologists, social workers, occupational therapists, peer support workers
- Attended and observed 2 meetings which included a zoning meeting and a meeting with local primary care leaders
- Reviewed 6 care and treatment records
- Reviewed medicines management
- Looked at a range of policies, procedures and other documents relating to the running of the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

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