Tees, Esk and Wear Valleys NHS Foundation Trust

Trust Headquarters

Inspection report

Tees, Esk and Wear Valleys NHS Foundation Trust
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Overall summary

This inspection was an announced focused inspection carried out on 5 July 2018 to confirm that the provider had carried out their plan to meet the legal requirements in relation to the breach in regulations that we identified in our previous inspection between 10 and 13 July 2017.

The July 2017 comprehensive inspection was carried out in partnership with Her Majesty's Inspectorate of Prisons (HMIP) under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions in accordance with our published methodology. CQC issued one Requirement Notice under Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 to Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). This can be found in Appendix 2 of the joint inspection report. The joint inspection report can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/wp.../Holme-House-Web-2017.pdf

This focused inspection report covers our findings in relation to those aspects detailed in the Requirement Notice dated 5 December 2017 and findings published in the joint report. We do not currently rate services provided in prisons.

Our key findings at this focused inspection were as follows:

• The trust had taken positive action to improve the delivery of mental health services.

• All referrals made to the mental health team were triaged on receipt and allocated to a mental health practitioner within 24 hours. Assessments now took place within a week.

• Care plans were now well developed and showed evidence of patients' involvement in their planned care.

• Clear timescales for continuation of patient care were recorded in care plans; all had been reviewed to ensure follow up assessments; and future appointments were documented.

• Caseload management had improved significantly and was monitored and discussed by staff and managers at both individual and team meetings.

• Managers had made improvements to recording systems and patient information templates to ensure a consistent approach.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
We did not inspect this key question during this focused follow up inspection.

Is the service effective?
We did not inspect this key question during this focused follow up inspection.

Is the service caring?
We did not inspect this key question during this focused follow up inspection.

Is the service responsive?
We did not inspect the responsive key question in full at this inspection. We inspected only the area identified in the Requirement Notice, dated 5 December 2017 and findings in the joint inspection report published by Her Majesty's Inspectorate of Prisons on 5 December 2017.

We found that the areas of concern identified during the inspection in July 2017 had been addressed. Mental health care for patients was responsive and accessible. Improvements had been made to the timeliness of assessments, care planning and caseload management to ensure consistency and that patients' needs were met.

Is the service well-led?
We did not inspect this key question in full during this focused follow up inspection. However, we have reported on relevant service improvements that resulted in better patient care.

Trust Headquarters

Detailed findings

Background to this inspection

Health services at HMP Holme House are commissioned by NHS England. Trust Headquarters is the registered location for community mental health services provided by Tees, Esk and Wear Valleys NHS FT (TEWVs). The contract for the provision of mental health services at HMP Holme House is held by TEWVs.

HMP Holme House is a purpose-built category B prison which was designated as a reform prison in 2016, the change from a local prison commenced in May 2017. During our visit HMP Holme House was holding around 1,200 male prisoners.

CQC inspected this location with HMI Prisons between the 10 and 13 July 2017. We found evidence that fundamental standards were not being met and one Requirement Notice was issued to TEWVs for Regulation 9, Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We subsequently asked the provider to make improvements regarding this breach. We checked this area as part of this focused inspection and found that the provider had addressed the issues identified that fell within their control and remit.

How we carried out this inspection

This focused inspection was carried out by two CQC health and justice inspectors.

During this inspection we reviewed the action plan submitted by TEWVs to demonstrate how they would achieve compliance. Service managers described the improvements and developments that had been made since the last inspection and provided evidence of this. We also reviewed patient clinical records and healthcare complaints. We spoke with the mental health team managers, mental health staff, primary care managers and the prison governor.

Is the service safe?

Our findings

We did not inspect this key question during this focused follow up inspection.

Is the service effective?

Our findings

We did not inspect this key question during this focused follow up inspection.

Is the service caring?

Our findings

We did not inspect this key question during this focused follow up inspection.

Is the service responsive?

Our findings

At our previous joint inspection with HMI Prisons in July 2017 we found the trust did not ensure mental health care was delivered in an appropriate way, which met the needs and reflected the preferences of patients. The team had experienced staffing shortages which had resulted in large caseloads. Caseload management was not taking place which meant there were significant gaps in patient care. One patient had not been seen by the mental health team for over six months following transfer into the prison from a secure mental health hospital. Another had not been reviewed despite apparent deterioration in his mental health.

In 2017 we saw care plans were underdeveloped and patients often had considerable waits to see their allocated mental health worker. They were often not given information about future care or when they would next see their mental health worker. The restricted prison regime had impacted upon the timely delivery of mental health care, for example therapeutic groups could not be run due to lack of prison staff to escort and supervise prisoners.

Responding to and meeting people's needs

During this inspection we found the provider had worked hard to improve the delivery of care and address the issues we had identified. We found the service was now fully staffed and a new manager had been appointed. The mental health team had a wide range of skilled staff and now comprised: a team manager; eight registered mental health nurses; a learning disability nurse; a senior psychological wellbeing practitioner; two trainee psychological wellbeing practitioners; a resettlement officer; a psychologist and higher assistant psychologist, a speech and language therapist, two support workers, two counsellors and two psychiatrists.

Staff told us they felt their caseload numbers were now more manageable. They had reduced from an average of 35 down to 28 with many staff holding fewer patient cases. The manager told us case numbers were now allocated based on the complexity of patients' needs and support required. This meant there was better support for individual patients.

New referrals received into the service were now managed by an administration worker. Referrals were then triaged by experienced, senior mental health workers within 24 hours and allocated to a member of the team for an initial assessment. These initial assessments were completed within a week, which was a significant improvement on the two to three weeks we found in July 2017. Staff discussed new referrals and existing patients at a daily panel meeting. We observed one of these meetings and found staff communicated well and were very knowledgeable about individual patients' needs. Minutes from these meetings were available for staff who had been on leave, and it was a requirement that all staff attended meetings when they were on duty. When additional support for a patient was identified, the team contributed to discussions, identifying new approaches and ways of supporting individuals.

Caseload management dates as well as other important information was clearly recorded and available to managers and staff. The information recorded included planned assessments, care in custody and team work (ACCT is the process used by prison staff to support prisoners at risk of self-harm and suicide) reviews and future medication administration dates. This allowed staff and management to have an 'at a glance' oversight of service delivery and future appointments.

Requests from prison staff for mental health staff to attend the wings to see patients had placed pressure on the team as many of these requests were inappropriate. The manager had introduced a triage assessment of these calls and liaised with prison staff to make them aware of the mental health team's remit, which in turn reduced the inappropriate requests and reduced pressure on the mental health team. This allowed the team to ensure prisoners who were most in need of support received appropriate care.

The service manager acknowledged that our 2017 inspection had highlighted administration and recording errors. The management team had reviewed all caseloads to ensure care plans were up to date and follow up appointments booked according to the person's identified risk and needs. To ensure there were no gaps in the future delivery of care to a patient, caseloads and planned appointments were allocated to another member of staff if any member of the team was absent.

At this inspection we found the care plans we looked at were detailed, up to date and had clear timescales recorded when patients needed to be seen again. We saw evidence that patients had signed their care plans and been offered a copy.

Is the service well-led?

Our findings

We did not inspect this key question during this focused follow up inspection. However, during the inspection the provider shared information with us that demonstrated continual improvements in the service.

Governance arrangements

The trust had introduced a range of monitoring arrangements to ensure that care was meeting patients' needs. Management audited care plans to ensure the quality of records was maintained. Timescales were recorded and caseloads reviewed to ensure that there were no gaps in patient care.

Improvements had been made to standardise patient information templates to ensure all staff were recording essential information in a consistent way.

There had been no complaints about mental health care or access to support in the three months prior to our visit.

Leadership and culture

Since the July 2017 inspection the trust had recruited a new team manager and filled the vacancies within the mental health team. The new manager had prioritised team development and supporting staff. This included reviewing wider team workload and engagement with other health colleagues and prison staff. The team had recently completed an analysis of team strengths, weaknesses, opportunities and threats and had clear direction for improving patient care and the wider support provision for prisoners within HMP Holme House.

The introduction of daily review meetings to monitor caseloads and opportunities to meet together over informal lunches had improved staff morale and contributed to a positive culture to improve care for patients.

Staff reported to us that they found the new manager highly committed and driven, to ensure the team were well supported and promoted an open-door culture. Staff felt confident to raise any concerns with the management team and received regular supervision which gave the opportunity to discuss caseload management with their manager. This ensured that care met the needs of each patient

We observed team members to be highly motivated and there was a strong team spirit, committed to working collaboratively to provide care and support to patients. All staff we spoke with told us they felt the service had improved significantly and they felt well supported by the management team.

During this inspection, we saw that the management team had the skills and experience to deliver responsive and safe care and support the delivery of continued improvement to the service.

Continuous improvement

The team had begun to utilise psychologist support to improve the wider service and was offering training on trauma based care and awareness for prison and wider health staff. There were also planned improvements to the service to introduce wellbeing mentors, a scheme which was being shown to have a positive impact on wider prisoner mental health in other prisons.