Referral, Utilisation and Intensive Case Management

Quality Report

1 Printing House Street
Birmingham
B4 6DF
Tel: 03003000099
Website: www.forwardthinkingbirmingham.org.uk

Date of inspection visit: 14th January 2020
Date of publication: 26/03/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

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

Summary of findings

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

Overall summary

Referral, Utilisation and Intensive Case Management are known as The Access Centre and are a community-based services for people with mental health needs for single point of access activity for children and young people aged 0–25 living in the Birmingham area.

We rated Referral, Utilisation and Case Management as requires improvement:

Our rating of this service went down. We rated it as requires improvement because:

This service was previously rated outstanding overall because it offered the Utilisation and Intensive Case Management part of the service which sought innovative ways to project a continuous cycle of improvement. The Access Centre is no longer contracted to provide this part of the service. The service has dropped two ratings to requires improvement as the safe, responsive and well led domains during this inspection have been rated requires improvement.

- The service did not always have sufficient staff to manage the number of patient referrals on the services caseload, patients referrals were clinically screened within four hours. However, the queue to be triaged for patients screened as requiring routine care were not always triaged in a timely manner. At the time of the last inspection 87% of non-crisis referrals were triaged within 72 hours, but the year to date figures running up to this inspection 47% of non-crisis referrals were triaged within 72 hours. However, data provided by the service for January 2020 highlighted 70% of routine referrals were triaged within 72 hours.
- The caseload volume caused delay in routine triage and delayed referral on to further treatment. However, the service was easy to access.
- Staff did not routinely receive mandatory training in the Mental Health Act and the Mental Health Code of Practice.
- The provider did not have a clear strategy to ensure robust local management levels.
- Staff we interviewed did not have a clear understanding of the providers vision and values.

However:

- Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff referred to a range of treatments suitable to the needs of the patient, Staff assessed and referred patients on who required urgent care promptly.
- The teams included or had access to the range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.

Summary of findings

Contents

Requires improvement

Referral, Utilisation and Intensive Case Management

Services we looked at
Specialist community mental health services for children and young people;

Summary of this inspection

Background to Referral, Utilisation and Intensive Case Management

Referral, Utilisation and Intensive Case Management is provided by Operose Health Limited. The service is subcontracted by a local hospital trust as part of Forward-Thinking Birmingham's services for children and young people aged 0 to 25 years.

The service has been in operation since 1 April 2016. The service was known as The Access Centre, offering a single point of contact for referral to the children's and young people's community mental health services in Birmingham. The service operates between 09:00 and 17:00 Monday to Friday. The staff team within The Access Centre included nurses, social workers and assistant psychologists alongside administration staff. Staff reviewed the referrals made to the service and offered either a triage assessment or signpost to a more appropriate service.

We last inspected this service in June 2018 when it received an overall rating of outstanding. At that time the service was registered under another provider. At the previous inspection the service offered Utilisation and Intensive Case Management, However, they are no longer commissioned to provide this part of the service.

The service was registered to provide: transport services, triage and medical advice provided remotely, treatment of disease, disorder or injury.

The Access Centre did not currently have a registered manager but were in the process of recruitment.

Our inspection team

The team that inspected the service comprised of a CQC inspector, a CQC inspection manager, a CQC assistant inspector and a specialist nurse advisor with expertise in governance.

Why we carried out this inspection

This was an unannounced inspection based on information we had received following a review of intelligence.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited The Access Centre and observed how they handled contacts, access requests, sign posted and triaged calls
- spoke with two patients who were using the service

Summary of this inspection

- listened to telephone discussions between staff and patients
- spoke with The Access Centre manager, the interim operations manager and the clinical Director of Psychological Services and had a telephone discussion with the Operose Health Head of Compliance and Quality Assurance
- spoke with nine other staff members; including a nurse, six assistant psychologists and two administrators
- attended and observed a Gateway two panel meeting (multidisciplinary team meeting with lead provider for community mental health services for children and young people within the area)
- looked at six care and treatment records of patients using the service
- reviewed the providers guidebook including process pathways.

What people who use the service say

As part of the inspection we spoke to two patients, who stated that they felt their calls were dealt with appropriately and the staff were kind, listened and were understanding.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Our rating of this service went down. We rated it as requires improvement because:

- The service did not always have sufficient staff to manage the number of referrals that they were receiving. The number of patients on the services' caseload was too high. The service after clinically screening the patients could not always manage the triage queue well, and patients who required routine care were not always triaged in a timely manner.
- Some staff did not have access to the incident reporting system. Managers investigated incidents however, we were not assured that a lesson learnt was shared with the whole team or actioned.

However,

- Staff assessed and managed risks to patients. Staff re-assessed patients on the triage queue to detect and respond to increases in level of risk if patients re-accessed the service.
- 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. The partnership had a named nurse for child safeguarding and the teams had a safeguarding lead.
- Staff kept detailed records of patients care. Records were clear, up to date and easily available to all staff providing care.
- When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good

Our rating of this service stayed the same. We rated it as good because:

- Staff assessed the mental health needs of all patients.
- Staff could refer to a range of treatment and care for the patients based on national guidance and best practice.
- The teams included or had access to the range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision. Managers provided an induction programme for new staff.

Summary of this inspection

- Staff we spoke to understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence. Staff took advice on competence when they needed it.

However

- Staff we spoke to did not always understand the principles of Gillick Competence as they applied to people under 16.

Are services caring?

Good

Our rating of this service went down. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients.
- Staff involved patients in planning their care and risk assessment. They encouraged use of local advocates when needed.
- When appropriate, staff involved families and carers in assessment and planning their referral outcome.

Are services responsive?

Requires improvement

Our rating of this service went down. We rated it as requires improvement because:

- Patients who had been clinically screened as not requiring urgent care waited too long for an assessment, the longest wait until triage was 41 days, with approximately 1000 patient referrals on the waiting list.
- The service did not always treat concerns and complaints seriously and we were not assured staff complaints were investigated thoroughly and lessons learnt.
- The service did not always treat concerns and complaints seriously and we were not assured staff complaints were investigated thoroughly and lessons learnt.

However,

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly.

Summary of this inspection

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

Are services well-led?

Requires improvement

Our rating of this service went down. We rated it as requires improvement because:

- Staff did not always know and understand the provider's vision and values and how they were applied in the work of their team.
- Staff could not always raise concerns. The new electronic incident system was only accessible to a limited group of managers, a whistleblowing event highlighted staff concerns that incidents raised had not been formally actioned.
- Teams had intermittent access to the information they needed to provide safe and effective care as the patient software system frequently lost connectivity, and we were told the responsiveness of the partnering organisations Information technology team to resolve the issues had been slow.
- The service did not always have systems in place to ensure patient referrals were assessed in a timely manner. The key performance indicators around the length of time after clinical screening until triage for priority 6 routine referrals was three to five working days, however, at the time of inspection the longest wait was 41 days.
- The services during the three months prior to inspection had significant turnover of local management and senior clinicians.
- Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

However:

- Local Leaders had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued by local leaders. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.
- Staff collected analysed data about outcomes, performance and engaged actively in local quality improvement activities.
- Managers worked closely with other local healthcare services and organisations (including service providers, local authority,

Summary of this inspection

voluntary and independent sector) to ensure that there was an integrated local system that met the needs of patients and their carers living in the area. There were local protocols for joint working between agencies involved in the care of patients.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received and kept up-to-date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards and had a good understanding of the five principles.

As of January 2020, 100% of the workforce in this service had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

Staff we spoke with showed a competent understanding of Mental Capacity Act as applied to patients in their service. However, staff did not always have a clear understanding of Gillick competence, staff we spoke to told us if they lacked any understanding they would ask a senior clinician for advice.

We saw examples of capacity assessments in care records.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Specialist community mental health services for children and young people

Requires improvement

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Are specialist community mental health services for children and young people safe?

Requires improvement

Safe and clean environment

Staff were based in an office environment at the registered location. Staff did not see patients on the premises. All areas were clean, well maintained, well-furnished and fit for purpose.

The Access Centre had appropriate equipment for answering and making calls and recording information.

Safe staffing

The service did not always have sufficient staff to manage the number of patient referrals on the services caseload, patients referrals were clinically screened within four hours, however, the queue to be triaged for patients screened as requiring routine care were not always triaged in a timely manner, at the time of the last inspection 87% of non-crisis referrals were triaged within 72 hours, but the year to date figures running up to this inspection 47% of non-crisis referrals were triaged within 72 hours. However, data provided by the service for January 2020 highlighted 70% of routine referrals were triaged within 72 hours.

The service reported a staff vacancy rate of 14% as of December 2019, and a turnover rate of 45% between June and December 2019. Management cited the reason for the turnover rate of staff was that the role offered limited clinical development. Staff often left to pursue face to face clinical roles. The service had always reported a high turnover rate as many of the roles were Assistant Psychologists, who as part of their development, move to different roles to gain experience.

Staff sickness was 3.9% between April and December 2019. Vacancy, turnover and sickness rates have all significantly increased since the last inspection in June 2018.

At the last inspection in June 2018, the service offered the utilisation and intensive case management element of the service, meaning they had higher staffing figures and staff could work between both areas, giving clinicians more experience and opportunities to work with patients face to face. This also offered greater resilience within the workplace.

The service managed low staffing levels by utilising staff and managers flexibly, to ensure all roles were covered. However, due to a prolonged shortage of senior clinicians, managers were relied upon to cover this role alongside their full-time responsibilities. Managers made arrangements to cover staff sickness and absence using assistant psychologists to support call handling administrative staff, and clinical managers to cover senior clinicians, and they also utilised agency clinicians.

Since December 2019 managers had utilised nurse and social worker agency staff to cover senior clinicians staff turnover. Over this period they had 1.8 whole time equivalent agency staff working with them. Managers made sure all agency staff had a full induction and appropriate training and understood the service before working independently.

Medical staff

The service did not need medical cover.

Specialist community mental health services for children and young people

Requires improvement

Mandatory training

Staff had completed and kept up to date with mandatory training. The compliance for mandatory and statutory training courses at 14th January 2020 was 99%.

The mandatory training programme mostly met the needs of the patients and staff. However, it did not cover the Mental Health Act and Mental Health Code of Practice.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients well. Staff responded promptly to sudden deterioration in a patient's health if a further referral was received for a patient on the waiting list.

Assessment of patient risk

Staff screened each referral and prioritised urgent cases based on information provided at referral stage. Referrals were then allocated to a clinician who triaged the assessments with the patient or carer via telephone. Assessments were detailed and followed a comprehensive structure including risk assessment.

Staff could recognise when to respond to patients' immediate risks to self or others. Staff responded appropriately by contacting emergency services or responded within 4 hours to non-emergency response crisis calls. It the clinician could not contact a potential crisis patient prior to the end of the working day they referred the patient to the out of hours crisis team to contact. If the patient had recently been in an inpatient unit, they referred the patient directly to the home treatment team.

Management of patient risk

Patients who were clinically screened as priority one to five were triaged within 72 hours, however, patients who were risk assessed as priority six went onto a queue, which at the time of inspection stood at approximately 1000 calls with up to 41 days until triage.

Staff responded promptly to further referrals from healthcare professions or the patient or family member regarding any sudden deterioration in health of a patient on the waiting list. If staff were unclear on the best route for a patient, they could discuss the referral at the gateway two panel, (a multi-disciplinary panel, working with their partnering organisation) for review. When patients did not respond to calls or letters, staff informed the referrer.

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. The partnering organisation had a named nurse for child safeguarding and the team had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. One hundred percent of appropriate staff had completed level three safeguarding children and adults training. Staff kept up-to-date with their safeguarding training.

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 recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff made 26 safeguarding referrals between July 2019 to January 2020.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patients notes were comprehensive, and records were stored securely.

Staff used the same patient software and records as partnering providers and patient records were shared as appropriate. However, the patient software system frequently lost connectivity, we were told the responsiveness of the partnering organisations information technology team to resolve the issues had been slow. This is on the services risk register and was discussed with the

Specialist community mental health services for children and young people

Requires improvement

partnering organisation at Operations and Quality Meetings and Contract review meetings. This delayed the clinician from triaging patients over the periods of loss of connectivity adding to waiting list times.

Medicines management

No medicines were prescribed via this service or held on the premises.

Track record on safety

The service had a good track record on safety. There were no serious incidents reported by this service in the six months prior to inspection.

Reporting incidents and learning from when things go wrong

The service did not always manage incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents however lessons learnt were not always shared 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 raised concerns and reported incidents and near misses in line with provider policy. However, the provider has recently moved to a new electronic incident reporting system, and there was a very limited number of management staff who could add notes to and view notes on the new system. Management had shared a process with the staff around highlighting incidents, but staff had to pass incident details to limited selected managers to add the notes, meaning the process of passing this information risked misinterpretation of the incident, or there was concern raised in a whistleblowing that not all incidents had been recorded, and there was concerns about raising an incident with a manager that the manager may have been involved in.

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. We were given an example of this happening.

Staff did not always receive feedback from investigation of incidents both internal and external to the service and there was not always evidence that changes had always been made as a result of all investigations. After a whistleblowing incident was reported to the CQC, there was no evidence that a system had been implemented to ensure the situation could not happen again in the future. We saw examples of team meeting minutes where incidents had been shared, however, lessons learnt had not been documented.

Are specialist community mental health services for children and young people effective?

(for example, treatment is effective)

Good

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 an appropriate referral route and updated them as needed.

Staff during triage completed a mental health assessment of each patient. We reviewed six patient care records, which included referrals from GP's and self-referral forms, the notes captured the triage discussion, and were clear on actions to follow. The service did not complete care plans.

Staff were aware of the physical healthcare needs of patients, staff recorded and considered factors around physical healthcare during assessment and throughout coordination of care.

Triage staff could refer patient records to the Gateway Two Panel (multidisciplinary team meeting with partnering organisations) to review and confirm the best outcome decision for the patient.

Best practice in treatment and care

Staff had a range of treatment and care options to signpost patients towards. Staff used rating scales to assess and record severity and prioritise accordingly. They participated in clinical audit.

Staff assessed the patients and referred to partnering services who were able to offer a range of care and treatment suitable for the patients' needs.

Specialist community mental health services for children and young people

Requires improvement

Staff used rating scales as part of the initial assessment to assess and record the severity of patient conditions to support in prioritising the care and treatment outcomes.

Staff took part in clinical audits including; bi-monthly clinical documentation audit, quarterly clinical supervision audit and annual infection control audit. The information was shared with the partnering organisations in the monthly Operations and Quality Meetings, and locally in weekly team huddles and newsletters. Managers reviewed the results from audits to support staff training and quality improvement.

Skilled staff to deliver care

The teams included or had access to the range of specialists required to meet the needs of patients they were assessing. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, Managers did not always make sure that staff had the range of skills needed to provide high quality care.

The service had access to a range of specialists to meet the needs of the patients, including nurses, social workers and assistant psychologists.

Managers made sure staff had the right qualifications and experience to meet the needs of the patients in their care, including agency staff on recruitment. However, staff were not routinely updated on the Mental Health Act and the Mental Health Act Code of Practice.

Managers gave each new member of staff including agency clinicians and administration staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. Appraisal compliance for last year was recorded in December 2019 at 90%.

Staff peer reviewed two telephone calls and two patient notes bi-monthly for each clinician, to provide quality assurance and learning feedback.

At the time of inspection there was no clinicians under performance management.

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 team had a functional working relationship with other relevant teams within the organisation and with relevant services outside the organisation.

Managers took part twice a week in Gateway Two Panel meetings (second line referral discussion with a multidisciplinary team with their partner agency that provided community interventions). Staff were invited to and offered the opportunity to contribute to these meetings. This was a new initiative as partnering organisations had concerns that the referrals to the community teams were not always correct. After initial concerns around referrals being re-triaged and a whistleblowing from team members, staff told us the Gateway two panel had supported in building a better reflective practice model.

Staff had functional working relationships with other teams in the organisation. Staff had effective working relationships with external teams and organisations and routinely met with service providers to review referrals and ensure the referral pathway was streamlined.

Staff made sure they clearly shared information with patients around the pathways they were being referred to and what would happen next, Staff ensured letters were sent following triage to explain the follow up of care.

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 did not receive training on the Mental Health Act and the Mental Health Act Code of Practice. However, staff we spoke to could describe the Code of Practice guiding principles and had a good knowledge of the principles of the Mental Health Act. Staff did not complete Mental Health Act assessments in relation to patients care as this was not part of their remit for service delivery.

The service obtained consent from patients at the referral stage. For online referrals, the service advised how personal data would be used and requested consent to treatment before proceeding to the referral.

Specialist community mental health services for children and young people

Requires improvement

Staff promoted local advocacy services to speak on the patient's behalf, and this was further highlighted in all letters to patients.

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 applied to patients aged 16 and 17. However, staff did not always understand the principles of Gillick competence as they applied to people under 16.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

As of January 2020, 100% of the workforce in this service had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

Staff we spoke with showed a highly competent understanding of the Mental Capacity Act. However, some staff we spoke to did not fully understand Gillick Competence as applied to patients in their service but stated they would always take advice if they were unclear. We saw examples of capacity assessments and Gillick competence principles in care records.

Are specialist community mental health services for children and young people caring?

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 the pathway they were being referred on to.

As part of the inspection we listened to staff in the access centre speaking to patients. Staff were discreet, respectful, and responsive when triaging patients. Staff gave patients help, emotional support and advice when they needed it.

One patient told me that they felt The Access Centre team member was the first person who understood him, and his issues and he felt optimistic he was going to receive the care he needed.

We spoke to two patients who said staff treated them well and behaved kindly. Staff understood and respected the individual needs of each patient.

Staff followed the providers policy to keep patient's information confidential.

Involvement in care

Staff involved patients in discussions around the outcome of triage and risk assessment. Staff informed and involved families and carers appropriately.

Involvement of patients

Staff made sure patients understood the type of care and treatment that they were referring them to and found ways to communicate with patients who had communication difficulties including use of language line. Staff promoted local advocacy services to speak on the patient's behalf and confirmed this option in letters sent to patients with the outcome of their triage.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Involvement of families and carers

Staff supported, informed and involved families or carers when appropriate, and ensured that families and carers understood who to contact if the patient deteriorated. Staff could support families to give feedback on the service via a feedback form.

Are specialist community mental health services for children and young people responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and waiting times

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and triaged patients who required

Specialist community mental health services for children and young people

Requires improvement

urgent care promptly, however, patients who did not require urgent care after clinical screening could be in the queue for up to 41 days for their referral to be triaged, the key performance indicator for routine triage is between 3 to 5 working days.

The service was easy to access and accepted online, telephone and email referrals and communications. Patients could self-refer, or a referral could be accepted from a healthcare professional. The service had clear criteria to describe which patients they would offer services to and patients they could not, they had a comprehensive signposting process.

The service met the organisations top five priority triage times targets, Priority One-Crisis that requires an emergency response, Priority Two- Crisis, Priority Three-Urgent, Priority Four-Early Intervention, Eating Disorders and perinatal, Priority Five-Routine but requires triage within 3-5 working days. However, Priority Six-Routine requiring triage within 3 to 5 working days, longest wait at the time of inspection was 41 days and there were approximately 1000 patients waiting to be triaged and referred for treatment. At the time of inspection, the service had received on average 1402 referrals a month and had triaged 1453 contacts a month, as on average only 51 calls were triaged a month more than were received within the month, this meant that the routine waiting list would only reduce very slowly.

The service is currently receiving 43% more referrals than it was contracted to handle and does not get any additional finance to handle this. At the time of the previous inspection in June 2018 the service was receiving a 28% higher referral rate than they had been contracted to handle showing a growth of 15% over the period between inspections.

During the previous inspection in June 2018 the service was triaging 87% of its non-crisis calls within 72 hours, however, the service reported that in the year to date The Access Centre triaged only 47% of non-urgent referrals within 72 hours, However, data provided by the service for January 2020 highlighted 70% of routine referrals were triaged within 72 hours. However, data provided by the service for January 2020 highlighted 70% of routine referrals were triaged within 72 hours.

The facilities promote comfort, dignity and privacy

The service did not see patients face to face.

Patients' engagement with the wider community

Staff have a comprehensive list of local services that they can signpost patients to.

Staff signposted patients to other services and supported them to access these services if they needed help. Staff had clear process from receipt of the referral, at the call handling stage, and at the stage when patients and their carers was either signposted to another service, or passed for triage, they had multiple services and options they could offer the patient. More complex referrals go to the Gateway two panel to get a multidisciplinary team perspective of the best service outcome that could be offered to the patient.

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 promoted local advocacy services to speak on behalf of patients who use the service.

The service could arrange translation of letters into different languages. Managers made sure staff and patients could access language line for triage discussion with patients when needed.

Listening to and learning from concerns and complaints

The service made sure patients could access information on treatment, local service, their rights and how to complain via the website or by telephone request.

In November 2019 the service received three formal patient complaints and two compliments. When patients wished to make a complaint, they were directed to the partnering organisations Hospital Patient Liaison Service (PALS) as per their policy. Minutes we reviewed confirmed complaints were investigated and shared with the team, however, outcome and lessons learnt were not always shared.

Specialist community mental health services for children and young people

Requires improvement

Are specialist community mental health services for children and young people well-led?

Requires improvement

Leadership

Leaders did not always have the skills and abilities to run the service. However, the local management were visible in the service and supported staff to develop their skills and take on more senior roles.

Local leaders understood the issues, priorities and challenges the service faced, however, strategy around local management was not always managed well. In the three months prior to the inspection several managers and senior clinicians had left the service. The local leadership of the service at the time of inspection was a full-time access centre manager, and full-time interim operations manager whose contracts were due to end. There was two or three days support a week from the Operose Clinical Director of Psychological Services. The Registered Manager had left the provider in November 2019 and the service had no registered manager at the time of the inspection.

Operose Health were recruiting into these positions, however, there was limited resilience in the local management model. Clinical management was needed to cover senior clinician roles to ensure continuity of safe process and procedures within the service alongside their full-time role. There was little strategy or certainty over the next few months local management plan.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy.

Staff we spoke to had limited knowledge of the services vision or strategy, the organisation vision and values were not displayed.

At the time of the inspection Operose Health had put in a detailed service improvement plan in line with its partner organisations, However, the local team where not always consulted in devising the plans.

Culture

Staff told us they felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. However, did not always feel they could raise concerns.

Staff we spoke to at the time of the inspection felt respected, supported and valued by the local leadership. However, we had received whistleblowing reports about concerns that incidents passed to management had not always been appropriately actioned and investigated. There was no system for staff to express concerns without going to management.

Local management had been required to cover additional roles working long hours over a prolonged period of time without the additional support required to make this resilient, there did not appear to be a clear strategy to resolve this situation in a timely manner.

Local managers were visible and accessible and adapted to the needs of the service. We saw collaborative and responsive working between managers and staff throughout our inspection. Managers offered encouragement and support to staff working on the front line. Staff we spoke told us they were supported by their managers. However, staff did not always know who the senior managers were within the organisation and told us they were not visible.

Staff told us they were given opportunities to develop and progress within the organisation if they wanted to.

Governance

Leaders did not always ensure there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had robust and effective governance systems and appropriately qualified staff to carry out their roles. Appropriate checks were in place to monitor professional registration for qualified staff. Staff had access to a range of training and development opportunities.

Specialist community mental health services for children and young people

Requires improvement

The service had good processes in place to monitor the safeguarding of patients. Staff knew how to recognise, and report safeguarding concerns and took appropriate action.

Management and team representatives met at governance meetings monthly, this linked to the partner organisations governance structure.

The service did not always learn from incidents. We saw examples where managers had investigated incidents and complaints and shared learning throughout the service. However, we are aware of an incident where no actions had been taken as an outcome of an investigation.

Staff did not routinely receive training in the Mental Health Act, the Mental Health Code of Practice.

Some staff did not have access to the incident reporting system. CQC had received a whistleblowing concern around staff raising incidents and as an outcome had discussed with management around ensuring a robust number of team members could add incidents to their system as there were concerns that they were not being entered, this had not been effectively actioned.

The patient software system frequently lost connectivity, we were told the responsiveness of the partnering organisations information technology team to resolve the issues had been slow. Management tell us they had queried this and have been told it is a capacity issue and they need to not run certain reports in the morning, The management are monitoring this, it is highlighted with their partner who are wholly responsible for the system via the services Risk Register and at Operations and Quality Meetings and Contract review meetings.

Staff reached out to external organisations and services in order to maintain and improve the directory of services available to patients.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level.

The service used clear pathways agreed and reviewed with other service providers and their partners, and utilised inhouse tools to manage clinical risk. The service used key performance indicators and data systems to measure effectiveness of the service, however, there were no key performance indicators in place around length of time priority six routine referrals should be triaged within.

Operose Health had currently implemented a service improvement plan in line with the service partners. The service improvement plan recognised the risks to the service and outlines actions required to manage the risk. The service presents its top risks from its risk register to the partnering organisations monthly integrated governance meeting.

Information Management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

The service routinely provides their partners with comprehensive analytics about their service.

Managers worked closely with other local healthcare services, local authority, voluntary and other independent sector organisations to ensure that there was an integrated local system that met the needs of patients living in the area. There were local protocols and information sharing agreements for joint working between their partners and healthcare services involved in the care of the patients.

Engagement

The service engaged well with patients, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

The service routinely meets with their partners and also other service providers to support in improving access to services. The week prior to inspection they had met with local learning disability services to review their referral arrangements with them.

The service with their partners has recently introduced a twice weekly Gateway two Panel meeting, which as a multidisciplinary team allows them to review specific referrals as a team, to ensure the best pathway for patients and to support in learning for the team, The Access Centre management attend these meetings and staff are invited to come along.

Specialist community mental health services for children and young people

Requires improvement

Learning, continuous improvement and innovation

All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation.

The assistant psychologists team often worked within this role as a learning opportunity before going onto further clinical training.

Management undertook routine audit of the clinicians and call handling staff within the service and shared the outcomes with their partnering organisation to support in quality improvement.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients receive routine triage that is appropriate to their risk and needs and in line with clearly defined targets. **Regulation 12(1)(2a) HSCA (RA) Regulations 2014**
- The provider must ensure a robust incident/ complaints system where an appropriate level of staff can add or view records.**Regulation 16(2) HSCA (RA) Regulations 2014**

Action the provider SHOULD take to improve

- The provider should ensure staff receive training on The Mental Health Act, The Mental Health Act Code of Practice.

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider must ensure that patients receive routine triage that is appropriate to their risk and needs and in line with clearly defined targets.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider must ensure a robust incident/complaints system where an appropriate level of staff can add or view records.**