Tees, Esk and Wear Valleys NHS Foundation Trust

Specialist community mental health services for children and young people

Inspection report

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Date of inspection visit: 6-7 July 2022
Date of publication: 15/09/2022

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**

Our findings

Specialist community mental health services for children and young people

Requires Improvement 

We carried out this unannounced focused inspection to see whether improvements had been made since our last inspection in June 2021. On that inspection, we issued a warning notice under Section 29A of the Health and Social Care Act.

On this inspection, we checked whether improvements had been made to address the concerns identified. These included, ensuring there were enough staff to meet the demands of the service, staff were appropriately trained, waiting lists were managed, there was clear oversight of any patient risks, the service could be accessed promptly and any issues were promptly addressed by senior management. This is in line with our published guidance to follow up inadequate ratings and section 29A warning notices.

The service provides specialist community mental health services for children and young people. We inspected the following teams:

- Easington Community Team
- CAMHS North Durham
- CYPS Getting More Help Stockton
- CYPS Getting More Help Middlesbrough
- CYPS Scarborough
- CAMHS York East and West

We provided 24 hours' notice of the inspection to ensure someone would be available at each of the team bases. We inspected on 6-7 July 2022. This was a focused inspection looking at the safe key question only. Our rating of this core service improved. We rated them as requires improvement because:

- Although improvements had been made since the previous inspection, there were still not enough staff in every team to meet the demands of the service. Some teams still had a high number of vacancies and high caseloads.
- Not all staff were appropriately trained in the mandatory skills required to fulfil their roles.
- Despite improvements made, some children and young people were still waiting a long time for treatment.
- The majority of children and young people had safety plans in place but where safety plans hadn't been created, there wasn't always justification recorded for this.
- Staff did not have access to personal alarms at North Durham and not all rooms at Middlesbrough and York were sound proofed.

However:

- The service was achieving its targets of maintaining contact with children and young people on waiting lists.

Our findings

- The premises were clean, well maintained and well furnished.
- We found the trust senior management team had responded promptly to address issues identified at the previous inspection and in the section 29A warning notice. However, this work was ongoing and had not been fully embedded in the service.

How we carried out the inspection

On this inspection, we assessed whether the service had made improvements in response to the concerns we identified during our last inspection. We therefore only looked at the safe key question.

Before the inspection visit, we reviewed information that we held about the service. During the inspection visit, the inspection team:

- visited six team bases;
- reviewed the quality and safety of the environment;
- attended six meetings;
- spoke with 48 members of staff, including team managers;
- reviewed 47 care records;
- spoke with one young person and 19 parents or carers;
- looked at a range of audits, policies, procedures and other documents relating to the running of the service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We spoke with one young person and 19 parents or carers.

Everyone we spoke with told us staff treated them with respect and spoke with them in a way they could understand. They told us they always saw the same member of staff and clinicians could be accessed quickly when needed.

Most of the parents, carers and young people we spoke with told us they did not have to wait long for treatment. Four told us they waited longer than two months.

Parents, carers and young people told us the facilities were clean and comfortable.

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Our findings

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Risk assessments were up to date and regularly reviewed. These included fire, lone working and risks from the environment such as potential points of ligature and other hazards. Where risks were identified, actions were put in place to reduce the risk.

Not all interview rooms had alarms. Where rooms did not have fixed alarms, portable personal alarms were available in reception for staff to use. The exception was North Durham, where staff did not have access to alarms. This had been identified in a recent audit as an issue for consideration. However, staff managed risks appropriately and where there was an identified risk, rooms in the reception area were used for appointments. Staff were available in the adjoining room next door to respond to any incident should they arise. There had been no recorded incidents of physical violence at the service.

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

All areas were clean, well maintained and well furnished. Patient participation groups took place, which gave children and young people the opportunity to feedback on the environment and suggest improvements to the décor.

Not all rooms at Middlesbrough and York were sound proofed.

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

Staff always followed infection control guidelines, including handwashing. There were appropriate hand hygiene facilities available in each location visited.

Staff made sure equipment was well maintained, clean and in working order.

Safe staffing

The service did not always have enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was too high in some of the teams. This did not prevent staff from giving each patient the time they needed.

Nursing staff

Although staffing levels, caseloads and waiting times for treatment had improved since the last inspection, the service did not always have enough nursing and support staff to keep patients safe.

Vacancy rates varied by team. The overall vacancy rate for the service had improved from 11% at the previous inspection to 7% at this inspection. The vacancy rate in the Durham and Tees Valley locality was 3% however in the North Yorkshire, York and Selby locality it was 21%. The York East, York West and Scarborough teams all had vacancy rates of 25% or more.

The trust told us they were introducing a recruitment and retention programme, with bespoke campaigns to specifically attract the right staff. Agency staff were being used in the interim and allocated to teams in most need.

Our findings

Caseload sizes had reduced across the community teams. Most of the staff told us there had been significant improvements to caseload sizes and caseloads were more manageable. Only two of the staff we spoke with raised concerns about staffing levels and caseload sizes.

The trust had introduced a number of systems and processes that had resulted in improvements to caseload sizes. These included the introduction of a single point of contact team, that had improved the way referrals were made to the service and reduced the number of inappropriate referrals. Staff were receiving regular caseload supervisions and thorough reviews of caseloads had taken place in some of the teams. Where this work had been completed, there had been significant improvements in caseload sizes. For example in Stockton, managers reported caseloads of 40-95 at the last inspection. At this inspection, the average caseload size had reduced to 23.

Staff in the Scarborough ADHD team reported high caseloads of over 100. They told us there had been an increase in new referrals and 400 patients had been transferred from an acute setting, all requiring consultant review and appointments.

Caseload sizes continued to be large in the York East (72) and York West (69) community teams. This was in part due to the staff vacancies in these teams. The provider had employed two new matrons, due to commence in post in August 2022. These staff will prioritise demand and capacity work with these teams and review all caseloads.

Staff turnover rates varied by team. The North Yorkshire, York and Selby locality had the highest turnover rate at 19.79%. The North Durham team had the highest turnover rate at the last inspection however this had reduced from 25.96% to 11.90%.

Managers supported staff who needed time off for ill health. Staff reported managers were supportive and prioritised their wellbeing.

Levels of sickness were low. Overall sickness rate for the service was 4%.

Medical staff

The service had enough medical staff. Staff, children and young people, and carers reported no issues with accessing medical staff.

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.

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

Mandatory training

Not all staff had completed and kept up-to-date with their mandatory training. Training compliance in the Durham and Tees Valley locality was 91.31%, slightly below the trust target of 92%. In the North Yorkshire, York and Selby locality, overall compliance was 82.77%. Compliance had been impacted due to the turnover in staff and not all new staff had completed all their training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Our findings

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 and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop safety plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each child or young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 47 care records. Risk assessments were present in 45 of the records, only two of these had not been reviewed in the last 12 months.

Staff used a recognised risk assessment tool.

Staff could recognise when to develop and use safety plans and advanced decisions according to patient need. The majority of children and young people had safety plans in place but where they hadn't been created, there wasn't always justification recorded for this.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Children and young people's health was reviewed at every appointment.

Staff continually monitored patients on waiting lists for treatment and responded to any changes in the level of risk. The trust was achieving 100% compliance with keeping in touch (KIT) targets for children and young people waiting for treatment. KIT targets were rated red, amber or green (RAG), depending on risk. A child or young person assessed as being high risk was contacted at least weekly. A child or young person assessed as being medium risk was contacted at least monthly. A child or young person assessed as being low risk was contacted at least every three months.

Waiting times for treatment had improved but varied across the teams. Average waiting times were now 104 days (using the national standard of two contacts with the service) or 176 days (using the trust's internal definition of the wait for a relevant treatment), compared to 371 days at the previous inspection. Using the trust's internal definition, the longest average wait for treatment was 360 days in the Darlington community team. The trust told us they had introduced their own internal definition to provide a more robust and transparent indicator of true waiting times for treatment for children and young people.

A weekly report of children and young people on waiting lists was produced by the trust's corporate performance team to provide oversight and assurance of the children and young people waiting for assessment and treatment and the progress being made to address any children who had been waiting for a long period of time. The report on 4 July 2022 showed the number of children and young people waiting over 12 months for treatment was 275, a reduction of 731 compared to 12 months ago.

We spoke with one young person and 19 parents or carers. Most told us they did not have to wait long for treatment. Four told us they waited longer than two months.

Our findings

Waiting times were skewed if a child or young person was initially referred for a neuro assessment then later referred to the community teams as their clinical presentation had changed. This is because their wait time is calculated from their initial referral.

The trust was achieving their target of 28 days for the average wait from referral to assessment. However, 112 children and young people were waiting over two months.

Managers and staff spoke positively about the introduction of the iThrive framework. iThrive is a nationally recommended operational framework which aims to improve outcomes for children and young people's mental health and wellbeing. Elements include effectively signposting children and young people to the appropriate service.

Staff followed clear personal safety protocols, including for lone working. There was a lone worker policy in place and risk assessments were up to date. Staff told us they felt safe in their role.

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. Training levels for some teams fell below the trust target. The provider had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role.

Not all staff had kept up-to-date with their safeguarding training. Training compliance in the Durham and Tees Valley locality was above the trust target of 92%. In the North Yorkshire, York and Selby locality, overall compliance was below the trust target for safeguarding level 1 (85.71%) and safeguarding level 3 (87.22%).

Staff could give clear 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. We reviewed 47 care records. Safeguarding referrals were appropriately made however in one case, a care record stated a safeguarding referral should be made but there was no evidence of this in the records. A staff member agreed this referral should have been made and would action it.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Care records were easily accessible to all staff. A new electronic care records system was due to be implemented later in 2022.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Our findings

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. The service did not store or administer medicines. Medicines that were prescribed were clearly documented.

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

Staff followed national practice to check patients had the correct medicines.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff told us therapy was always the first option and medicines were used as a last resort.

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.

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

Staff reported serious incidents clearly and in line with trust policy. There had been five serious incidents reported in the previous 12 months. All had been appropriately actioned.

The service had no never events.

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

Managers debriefed and supported staff after any serious incident.

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. Feedback and learning from incidents was provided at team meetings, team huddles, case discussions and through reflective practice.

There was evidence that changes had been made as a result of feedback. Staff could describe specific incidents and what had been learned from those incidents.

Our findings

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that there are enough staff in each team to meet the demands of the service. (Regulation 18(1)(2)(a)).
- The trust must ensure that all staff are appropriately trained in the mandatory skills required to fulfil their roles. (Regulation 18(1)(2)(a)).
- The trust must continue to review waiting times and ensure that children and young people receive treatment in a timely manner. (Regulation 9(1)).

Action the trust Should take to improve:

- The trust should ensure that all children and young people who require safety plans have them in place.
- The trust should ensure all staff have access to personal alarms.
- The trust should ensure all rooms where appointments take place are adequately sound proofed.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, three specialist advisors and one expert by experience.

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 9 HSCA (RA) Regulations 2014 Person-centred care

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