Good

Somerset Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Somerset Partnership NHS Foundation Trust
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH5AA	Mallard Court	East CAMHS	BA20 2BX
RH5AA	Mallard court	Outreach/Home Treatment	TA6 5LY
RH5AA	Mallard Court	South CAMHS	BA5 1TH
RH5AA	Mallard Court	West Camhs + NDCAMHS	TA2 7PQ

This report describes our judgement of the quality of care provided within this core service by Somerset Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Where applicable, we have reported on each core service provided by Somerset Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Somerset Partnership NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated specialised community mental health services for children and young adults as **good** because:

- Staff received mandatory training, risk assessments were being completed on first assessment and crisis plans were completed when relevant, waiting lists were monitored.
- There was good knowledge of safeguarding procedures, lone working protocols were implemented.
- Assessments were completed for referrals within the required six week target. Care plans were present for young people. There was a range of treatments available including therapies and medicines. Physical health assessments were completed. There was positive feedback of the weight restoration programme on the eating disorders pathway. Audits were completed against NICE guidelines. The service monitored outcomes for young people. Staff were supplied with specialist training.
- Staff were supportive, respectful and knowledgeable about the young people under their care. Staff included external agencies, for example, schools. Parents were included in their child's care. There was participation group for young people to make changes and suggestions for the service. There was a participation information session for newly referred young people and their familes as an introduction to CAMHS.
- The service operated a self harm rota in order for them to see young people in general hospital who had self harmed. Staff followed up young people who did not attend appointments. Two of the sites were accredited young people friendly. Staff were able to adapt to the different needs of patients through training.
- The risk register was being used appropriately. The service monitored key performance indicators and outcomes. Morale was good and there was good local leadership.

However:

- There were safety concerns about the kitchen at Mendip where there were clear fire risks.There was a lack of cleaning rotas for the services toys. There was a lack of rooms available to staff at West CAMHS.
- Risk assessments were not being updated routinely. There was vital risk information missing in the care records. Incidents were not always reported in a timely manner. There was no culture of shared learning across the service.
- Care plans were not always holistic in nature and were not always given to the young person.
- There was no specialist eating disorder training despite the service being provided. Appraisal rates at Mendip were only 54% complete.
- There was very little evidence of capacity assessment or consent being sought.
- Staff were not clear on who provided the advocacy service. Care plans were not always written from the young persons point of view.
- There was a three to four month wait for therapy. There was little support from specialist CAMHS staff for young people in general hospital at weekends and out of hours. There were transition difficulties into the adult service. The Mendip environment was not young people friendly.
- There was little confidence in the senior management of the trust and staff felt they were not being listened to.
- Despite performance being monitored, effective action plans were not in place where issues had been identified.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- There were safety concerns about the kitchen at Mendip. There were clear fire risks. Electric (portable appliance testing) testing was six months out of date.
- There was a lack of cleaning rotas for the services toys across the service.
- Risk assessments were not being updated routinely.
- There was vital risk information missing in the care records.
- Incidents were not always reported in a timely manner. There was no culture of shared learning across the service.

However:

- There was a wide range of equipment available to monitor physical health.
- Staff received mandatory training.
- Risk assessments were being completed on first assessment and crisis plans were completed when relevant.
- Waiting lists were monitored.
- There was good knowledge of safeguarding procedures.
- Lone working protocols were implemented.

Are services effective?

Good

We rated effective as **good** because:

- Assessments were completed for referrals within the required six week target.
- Care plans were present for young people.
- There was a range of treatment available including therapies and medicines.
- Physical health assessments were completed.
- There was positive feedback of the weight restoration programme.
- Audits were completed against NICE guidelines.

Summary of findings

- The service monitored outcomes for young people.
- Staff were supplied with specialist training.

However:

- Care plans were not always holistic in nature and were not always given to the young person.
- There was no specialist eating disorder training despite the service being provided.
- Appraisal rates at Mendip were only 54% complete.
- There was very little evidence of capacity assessment or consent being sought.

Are services caring?

Good

We rated caring as **good** because:

- Staff were supportive, respectful and knowledgable about the young people under their care.
- Staff included external agencies such as schools.
- Parents were included in their childs care.
- There was a group for young people to make changes and suggestions for the service.
- There was an information session for young people and their familes as an introduction to CAMHS.

However:

- Staff were not clear on who provided the advocacy service.
- Care plans were not always written from the young persons point of view.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- The service was meeting referral to assessment targets.
- The service operated a self harm rota in order for them to see young people in general hospital who had self harmed.
- Staff followed up young people who did not attend appointments.
- Teams worked flexibly to meet young people`s needs, for example, meeting young people at a venue of their choice, or undertaking additional training.

Summary of findings

- Two of the sites were accredited young people friendly environments.

However:

- There was a three to four month wait for therapy.
- There was little support from specialist CAMHS staff for young people in general hospital at weekends and out of hours.
- There were transition difficulties into the adult service.
- The Mendip environment was not young people friendly.
- There was a lack of rooms available to staff
- There was little learning from complaints.

Are services well-led?

Good

We rated well-led as **good** because:

- Staff received mandatory and specialist training specific to their role.
- Staff received regular supervision and appraisels.
- There was auditing of the waiting list to ensure that staff were aware of the risks of patients awaiting treatment.
- Systems were in place to report safeguarding concerns.
- The risk register was being used appropriately.
- The service monitored key performance indicators and outcomes.
- Morale was good and there was good local leadership.

However:

- There was little confidence in the senior management of the trust and staff felt they were not being listened to.
- There was a lack of incident reporting.
- Despite performance being monitored, effective action plans were not in place where issues had been identified.

Summary of findings

Information about the service

The child and adolescent mental health service (CAMHS) in Somerset provides specialist mental health care across the county in a community setting. The service operates from four different locations at Taunton (West CAMHS), Mendip (East CAMHS), Balidon in Yeovil (south CAMHS) and the Outreach and Home Treatment service is located at the inpatient unit Wessex House in Bridgwater. The National Deaf service (NDCAMHS) is located at Taunton and provides a service across the south west of the country. The service, commissioned through the Somerset Clinical Commissioning Group, provides therapeutic interventions for youne people suffering from a range of different mental health problems. There is also an integrated learning disability service.

Our inspection team

Our inspection team was led by:

Chair: Kevan Taylor, Chief Executive Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Karen Bennett-Wilson, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The team that inspected this core services comprised : a CQC inspector, a CQC inspection manager, a Mental Health Act reviewer and two specialist advisors with experience in child and adolescent mental health services.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

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 these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- Visited four locations that community bases that CAMHS worked from.
- Spoke with five service users.
- Interviewed 39 members of staff including doctors, nurses and therapists.
- Interviewed four managers.
- Spoke with nine family members and carers.
- Spoke with two external stakeholders.
- Held a focus group with staff.
- Observed five episodes of care.
- Attended three meetings.

We also:

- collected feedback from patients using comment cards.
- Reviewed 22 care records.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

We spoke with parents and carers as well as the young people who used the service. Parents and carers were very positive of the service they received, they felt that they had been given the opportunity to be part of their childs care and were thankful for the input. We heard that the interventions offered by the service had prevented hospital admissions. When a young person had been admitted to hospital, the teams offered support with discharge planning.

Good practice

- The deaf service introduced DVDs with letters and care plans translated into British sign language to help people understand them fully.
- There was a group for the young people coming into the service. This was run with a young person using the service and a psychologist. Young people referred to the service were told about what CAMHS was and were given the opportunity to ask questions and play a game.
- We found excellent examples of family involvement. A CAMHS information session for parents and carers took place. Parents were invited to the one off information session explaining how CAMHS worked and what it did. An overview of different therapy models was given and the process of therapy. There was an interactive psychoeducational session to get attendees to think about how they may be able to help. There was information on useful apps, websites and leaflets.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that the fire risk at Mendip is addressed and that the service adheres to the fire risk assessment that was completed. There were distinct fire risks in the staff kitchen.
- The provider must ensure that there is a cleaning rota for the toys in the service to ensure there is effective infection control precautions in place.
- The provider must ensure that risk assessments are updated timely and ensure that when risks are identified there is clear information available.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- Where relevant in the community service consent is both sought and documented.
- The provider should ensure that all incidents are reported in a timely manner.
- The provider should ensure the environment at Mendip is suitable for young people

Somerset Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
East CAMHS	Mendip CAMHS
Outreach/Home Treatment	Wessex House
South CAMHS	Balidon Centre
West Camhs + NDCAMHS	Fountain House Taunton

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- We spoke with staff about the Mental Health Act and Code of Practice. We found knowledge to be good around the different sections of the Mental Health Act. However, Mental Health Act was not part of the mandatory training programme. There was no recorded evidence available of Mental Health Act training undertaken by staff in CAMHS, we were not assured that staff would be kept up to date with changes in legislation.
- Local adult places of safety were being used by the CAMHS team and they could not guarantee getting specialist CAMHS staff in for such admissions. Any admission into adult places of safety of flagged up as a serious incident. There had been four admissions in the previous 12 months.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act knowledge varied amongst the staff. Some staf were able to recite the statutory principles of assessing capacity, whereas others were not as clear and felt that they did not need to know. We found that Mental Capacity Act training did not form part of the mandatory training programme provided by the trust.
- Staff told us that they always obtained consent to treatment, even for routine procedures such as taking blood pressure. Where patients were gillick competent, which means they are under legal the age of consent but deemed capable of consenting for themselves, the multidisciplinary team discussed risks and agreed an action plan to maintain confidentiality and not discuss treatment with the young person`s parents, unless it was not safe for them to do so. For example, if a young person was at risk of harm.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The services had alarms on each of the four sites, that were tested regularly. However, at West CAMHS the service used personal alarms, there were none available in the building. These were signed out to staff if there was judged to be a risk with the appointment.There was no system in place if an incident occurred and staff were not wearing an alarm, for example, if a young person unexpectantly became aggressive.
- We had concerns about the safety of the small staff galley kitchen in Mendip CAMHS. There was a very large gas boiler with pipes and valves exposed. Staff were using a toaster under the boiler. Next to this was a large electric cooker with numerous plastic dishes stacked on the electric hobs.There was a hot water boiler next to this which still had the power connected despite not working.The room was very cramped and had a large fridge freezer, dishwasher and water cooler. The kitchen fire door was propped open with a wooden door wedge. Young people were using adjacent rooms for therapy.We reviewed the fire risk assessment for the site and found that toasters were not allowed and door wedges should not be used. We raised our concerns with the senior management team.
- Toys were available in the reception areas of the services so that children could be occupied whilst waiting for appointments. We found that there was only a cleaning rota in place for the toys at the Balidon Centre service.
- There was a range of equipment available to staff to monitor the physical health of service users. We found that the scales at West CAMHS were in a corridor that frequently had staff and service users passing through. The inspection team were concerned that this impacted on the privacy and dignity of service users getting weighed.
- We found that electrical testing at Mendip CAMHS was six months out of date. The service was responsible for maintenance and the upkeep of it's equipment.

Safe staffing

- Vacancy rates differed across the services. There was no reported formal assessment to estimate the number of nurses and we heard there was a standard complement. It was reported by the managers that the demand on the service was increasing and the capacity to respond to this demand was challenged. There were vacancies for nurses in the Balidon Centre. These posts were currently filled by agency nurses, the trust were actively recruiting into these posts. There were vacancies for additional cognitive behavioural therapists therapists and a practitioner for the eating disorder service. There was a full complement of nurses at the West CAMHS site with one vacancy for a psychologist. There was one nurse for learning disabilities allocated to the whole of the West area. There trust reported issues with recruitment of nurses across a number of services.
- There had been 12 substantive staff leavers over the 12 months leading up to the inspection. This made a turnover rate of 9.5%. There was an average sickness rate of 3.2%, below the national average. The outreach team had the highest percentage of vacancies but this was a very small team that was needing to recruit an extra nurse.
- Service users were allocated to clinicians based upon an assessment of the needs of the young person, whilst taking into account the sizes of the caseloads of each staff member. We found caseloads varied, with the highest caseloads attributed to the assessment team who were responsible for monitoring service users who were waiting for treatment. The individual assessment team caseloads were over 100. The general working caseload for staff was around 30 young people.
- The National Deaf CAMHS service had seen a significant increase in its referrals. Between April 2014 to March 2015 it had completed 28 new assessments. Between April and August 2015 the service had already completed 18 new assessments. Staff in the service believed this was due to the service being more established andimproved understanding of the referral criteria. The service maintained a two week assessment target for new cases. This was caused pressure on the 1.8 wte nurses in the team who conducted them, due to

Requires improvement

Are services safe?

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the complexity of the assessment process and the timescales. There had been no additional staffing to address the increase in demand. The service sometimes had difficulty in booking translators due to a lack of availability. Although all staff were being trained in British Sign Language (BSL) it was necessary to have translators at times to ensure full understanding, and also for team meetings and communication with team members who themselves were deaf.

- West CAMHS reported that there was a lack of care coordinators available, as a result there were psychologists holding a care coordinating caseload. It was reported that this did not infringe on their ability to provide the required levels of therapy.
- A qualified nurse or manager was always available within working hours. A duty system was set up across the sites so that there was a nurse that could be contactable for advice and to offer support to service users and other professionals.
- Psychiatrist appointments were available throughout the week and the service had capacity to provide routine and urgent appointments. There was an on call system for out of hours psychiatric support for the trust. This covered both the community teams and the inpatient wards. This meant that there would be medical response to an emergency if clinically required.
- Staff received mandatory training from the trust and training records showed that the teams were 91% compliant against a trust target of 90%.

Assessing and managing risk to patients and staff

- Risk assessments were completed on the first assessment. A risk screening tool on the electronic records system, Rio, was scored using a risk rating system. A score above two indicated a high risk, this score then directed staff to complete a risk management plan. However, we found that risk assessments were not always updated regularly and according to a change in risk. There was a minimum review period of one year for risk assessments. A service user who had been in the service for 21 months, had not had an updated risk assessment since initial assessment despite still being in the service. A service user who had presented to hospital in a crisis had not had their risk assessment updated. We found that a young person who had left the service and had then been re-assessed and accepted had not had an updated risk assessment for the new episode of care with the previous risk assessment completed in November 2013.
- We found that while risk assessments were completed for the patients in the Mendip service there was a lack of information in the 'risk information' part of the notes. A service user with a deliberate self harm risk identified in the assessment had no further information on this within the risk information part of the notes. Another patient with a significant risk identified around abuse and neglect had no further information regarding this in 'risk information'.
- Crisis plans were completed when needed, we found that these directed people to services such as out of hours telephone support at the local inpatient unit, NHS Direct support and accident and emergency departments.
- We saw very effective risk assessments and development of crisis plans in NDCAMHS. Due to the regional nature of the service they could not provide emergency crisis support. To ensure the risks were safely managed the team liaised with local services in the young persons home area. There was effective information sharing, which meant there were, clear plans for families and young people to follow. The crisis plans always included the details of the local CAMHS, GP and emergency department. The team would then always pick up any issues on the next working day.
- Risks were monitored through working directly with the young people and liasing with external agencies such as schools. Increase in risks were discussed in team meetings which enabled the contributions of the multidisciplinary team.
- Waiting lists were audited monthly by the managers and results sent to the commisoners to monitor demand. Those on the waiting list had a named professional that they could contact. There was pro-active waiting list management with everyone was telephoned every six weeks. Changes in risk could then be responded to. The waiting list for the service had been placed on the risk register due to the service not being able to meet the current demands.
- There was good knowledge of safeguarding procedures amongst staff, all knew how to recognise safeguarding

Requires improvement

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issues and what to report. There was a lead safeguarding nurse for the trust that staff could liaise with for advice. Staff contacted the local authority to discuss safeguarding concerns where appropriate. Safeguarding issues were discussed in the monthly multidisciplinary team meeting. Monthly audits were completed on safeguarding referrals.

- A lone working protocol was in place across the sites. Files were kept with staff pictures and their contact details. There was a buddy system for workers to ensure other team members were aware of their whereabouts. Around one third of appointments occurred in the home of the young person.There was a policy in place for staff not to visit the home alone on the first visit.

Track record on safety

- West CAMHS had recorded one serious incident that related to the inappropriate placement and care of a young person on an adult ward who needed to be transferred to an inpatient CAMHS ward. The team had appropriately flagged this up as a serious incident and reported it to the Local Authority Designated Officer (LADO). This was still being investigated at the time of our inspection so no learning had been fed back.

Reporting incidents and learning from when things go wrong

- Datix, an electronic incident recording system, was in place across the service. Staff were required to report incidents on this system within 48 hours of an incident occurring. We found that staff were not always recording incidents timely on the system. For example, one incident occured two days before the inspection, this had still not been recorded. There was low reporting of incidents in Mendip CAMHS, as a result there was no record of trends kept around areas of concern within the service.
- We saw that there was learning from incidents and use of the incident reporting system in NDCAMHS. For example, an incident where a letter had gone to a wrong address in error had been followed up by communication and discussion between the staff team and checking systems put into place.
- Staff received support through supervision and team meetings regarding local incidents, however, there was no shared culture of learning across the service as a whole.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- An assessment team undertook most assessments, however, all staff were expected to have assessment slots available where possible. There was limited assessment capacity for the learning disability (LD) service, one nurse was provided for the whole of each area, they had the maximum capacity to undertake two assessments per month. The LD assessment was a joint assessment conducted with a paediatric care team. Young people with a learning disability only received input if there was behaviours that challenge, associated with an Autistic Spectrum Disorder.
- Assessments were recorded on the electronic record system Rio. The assessment of needs covered the history of the problem, reason for referral to the service, what theyoung people expected from the service and the families view. When the presentation was clear they were then able to signpost into therapy groups, doctors appointments, care coordination, individual and family therapy. Young people who were more complex in their presentation were discussed at multidisciplinary team meetings before referring to treatment.
- NDCAMHS provided comprehensive initial assessments of young people and their needs. This assessment included a two hour clinic appointment, a home visit and a school visit within two weeks of referral. These assessments were conducted by nurses within the team and then more specialist assessments and interventions were provided as required.
- We reviewed 22 care plans across the service. Care plans were present for the young people that we reviewed. Two were not up to date and 10 of the 22 were not personalised. There was a lack of young person's and carer's views in 10 of the 22. Care plans were not consistently holistic with a full range of problems considered in 10 of the 22. There was a lack of focussing on outcomes, strengths and goals for the young person in 13 of the 22 care plans. We found 12 of the 22 care plans were not given to the young people and their carers. However, in the observations of care we witnessed good involvement of young people that clearly considered their views and the views of the family.
- The primary care link worker who provided short term intervention for young people who had not met the eligibility criteria for specialist secondary care CAMHS treatment, set care plans out on letters to the young people. These included practical goals for the young person based on their interests and steps to alleviate symptoms in illnesses such as depression and anxiety.

Best practice in treatment and care

- The service provided a wide range of therapeutic interventions for young people including cognitive behavioural therapy (CBT), art therapy, psychology, dialectical behaviour therapy (DBT), family therapy, solution focussed therapy and brief intervention therapy. Eye movement desensitisation and reprocessing (EMDR) therapy was available, as were group interventions.
- Medicines were prescribed according to nice guidelines on depression, psychosis and attention deficit hyperactivity disorder (ADHD). Fluoxetine was used as the first medicine in depression.
- There was consideration of physical health monitoring in the progress notes.
- NDCAMHS had a particular focus on physical health needs as part of their assessment and intervention process due to the complexities that can sometimes occur due to the hearing difficulties of the young person or their parents.
- The eating disorder service provided a weekly weight restoration clinic that provided regular therapeutic support and physical monitoring. We received positive feedback from carers and young people regarding the weight restoration clinic, particularly due to the support for the whole family rather than just the young person. There were plans in place to develop a separate eating disorders service due to increased numbers of referrals. The eating disorders pathway was recently completed and based on Maudsley Hospital guidelines. Staff were being provided with specialist training for eating disorders via systemic family practitioner training if it was specific to their role, although staff had not completed this training at the time of inspection
- The service created an ADHD medication monitoring checklist based on NICE guidleines to ensure they monitored physical health effectively for the treatment.

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This was developed following the outcome of their Prescribing Observatory for Mental Health (POMH) Audit, which showed that physical health checks should be carried out when prescribing. The nurses and psychiatrist monitored young people for potential side effects from medication .

- NDCAMHS operated a quarterly academic group. This group reviewed current best practice and linked in with the local CAMHS governance events. They were also involved in a national care pathway group with the other national deaf CAMHS services that looked at NICE guidance, due to the often need to adapt it to serve people who were deaf.
- An audit of anxiety was completed using the NICE guidelines as reference to ensure that they were using up to date evidence based practice. The service undertook a number of audits to monitor quality and safety. For example, safeguarding and waiting lists.
- The service monitored outcomes using the strengths and difficulties questionnaire (SDQ), which is a a brief behavioural screening for young people. The revised children`s depression and anxiety scale (R-cads) was used to help monitor progress around depression and anxiety.
- NDCAMHS used a variety of assessment tools to measure the effectiveness of their interventions. Commissioners required them to use the health of the nation outcome scales for children and adolescents (HONOSCA).

Skilled staff to deliver care

- The service employed staff from a range of backgrounds including nurses, consultant psychiatrists, primary mental health liason workers, pyshologists, art therapists, family therapists, CBT therapists, child and family support workers and social workers. The outreach team, although small, had a dedicated consultant, nurse and support worker. There was adequate administration support across the whole service.
- Appropriate employment checks were undertaken to ensure staff were suitable to practice in CAMHS. Staff employed to the service underwent a generic trust induction. There was an individual role specific induction developed by the service, where new staff members would spend time with each team member and go on visits to get an understanding of how the service worked.
- Staff were being provided with specialist training for eating disorders via systemic family practitioner training if it was specific to their role although staff had not completed this training at the time of inspection. They had taken part in the children and young persons improving access to psychological therapies (CYPIAPT) by training practitioners. There was training available in the Webster Stratton Model parenting programme.
- Data supplied by the trust showed appraisal rates to be complete at 100% in all areas other than Mendip who were at 54% and West CAMHs who were at 85% completion rates. Clinical supervision was provided once monthly to reflect and review practice and discuss cases in depth to support the staff working with the young person. Management supervision was provided once monthly to address performance and set goals and objectives. However, there were concerns over the effectiveness of the supervision supplied due to the areas of concern we found in the lack of holistic care planning and the incomplete risk assessments.

Multi-disciplinary and inter-agency team work

- A range of team meetings occurred across the service. These included a business section, to communicate about the coporate side of the work and the opportunity case discussion amongst the team. There was a referral meeting daily to review received referrals and agree a plan. Monthly forums for eating disorder patients and young people with ADHD to review cases and discuss progress amongst the team. These meetings were attended by a range of professionals.. There was an individual solution focussed therapy supervision group and a monthly reflective practice group at West CAMHS. Mendip CAMHS held a fortnightly complex case clinic where they met as a team to discuss their challenges of working with some young people.
- The consultant psychiatrist informed the young person`s GP by letter if any medication was prescribed. The letter also explained whether the service would

Are services effective?

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continue prescribing or request the GP take over prescribing as part of a shared care agreement. There was liaison with the GP to complete blood tests for young people with an eating disorder.

- Social workers attended the first meeting with foster carers for young people under a care order. This ensured that the service was able to gain as much information as possible about the young person. There was liaison to gain consent for a treatment plan.
- The teams were able to refer to the outreach team based at the inpatient unit Wessex House. The outreach team provided home treatment, intensive support and helped to facilitate the early discharge of young people back into the community. Out of hours telephone support was available from Wessex House.
- Staff maintained contact with the young person when they were admitted to an inpatient ward. They were also able to attend care programme approach reviews (CPA) prior to discharge. This meant they could liaise with the ward about the young person`s care and provide follow up support post discharge. One parent we spoke with, confirmed that there had been appropriate support when their child was discharged from hospital.
- We saw that the NDCAMHS had very good working relationships with other teams and agencies across a wide geographical area. Senior staff at two schools with specialist provision for young people who were deaf, were praised service and its responsiveness. One headteacher stated that the adapted approaches the service uses with deaf children was something they could learn from.

Adherence to the MHA and the MHA Code of Practice

- We spoke with staff about the Mental Health Act and Code of Practice. We found knowledge to be good around the different sections of the Mental Health Act. However, there was no recorded evidence available of Mental Health Act training undertaken by staff in CAMHS, and it does not form part of the trust mandatory training programme. We were not assured that staff would be kept up to date with changes in legislation.
- Local adult places of safety were being used by the CAMHS team and they could not guarantee getting specialist CAMHS staff in for such admissions. Any admission into adult places of safety of flagged up as a serious incident. There had been four admissions in the previous 12 months.

Good practice in applying the MCA

- Mental Capacity Act knowledge varied amongst the staff. Some staff demonstrated a good understanding of the statutory principles of assessing capacity, whereas other staff were not as clear. Mental Capacity Act training provided by the trust was not mandatory.
- Staff felt that they always obtained consent to treatment, even for routine procedures such as taking blood pressure. Where patients were gillick competent, which means they are under the legal age of consent but deemed capable of consenting for themselves, the multidisciplinary team discussed risks and agreed an action plan to maintain confidentiality and not discuss treatment with the young person`s parents, unless it was not safe for them to do so. For example, if a young person was at risk of harm.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- We observed five episodes of care provided to children in their home and at the locations of the service. Staff appeared supportive and clearly cared about the outcomes for the young people. Staff were respectful of the young people coming into the service and demonstrated a good understanding of the young person`s needs and treatment plan. Staff were supportive and encouraging towards the young person throughout the sessions we observed.
- Staff considered the involvement of services such as school and school nursing.
- Parents were given the opportunity to feedback to the staff about their own observations of their childs progress and what had worked well.
- Parents and carers we spoke with stated that the services had prevented hospital admissions and that the therapy involving whole families had played a key role in keeping the family together. We heard that when hospital admissions were not preventable there was a plan to support discharge and that follow up care was arranged.
- Parents of young people using NDCAMHS we spoke with reported a kind and caring team who treated them with respect. Parents confirmed that the team were easily contacted and provided additional support when they needed it. We saw one example of a staff member visiting a family every day for three weeks to encourage a child to leave their house and go to school with success.

The involvement of people in the care they receive

- Care plans were reviewed with the young people and related to how it helped improve their mood. There was a focus on elements of lifestyle, what had worked and what hadn't rather than solely on symptoms of illness. Young people were allowed to go at their own pace in the appointment and were not hurried, they were given time to think about their responses to questions. Risk was reviewed in conjunction with the patient and this was scored using a risk rating scale. However, some care records we reviewed reflected that patients were not always provided with a copy of their care plan. We found that some care plans were written in letter form and sent out to the family home. These were often not written from the young persons point of view.
- Staff were unclear on who provided the advocacy service due to a recent change in the advocacy provision.
- We found excellent examples of family involvement. A CAMHS information session for parents and carers took place. Parents were invited to an information session explaining how CAMHS worked and what it did. An overview of different therapy models was given and the process of therapy. There was an interactive psychoeducational session to get attendees to think about how they may be able to help. There was information on useful applications available on electronic devices, websites and leaflets.
- There was a group for the young people coming into the service. This was run with a young person using the service and a psychologist. Young people referred to the service were told about what CAMHS was, were given the opportunity to ask questions and play a game.
- Young people were involved in the design of the building at Balidon CAMHS and West CAMHS.
- The service had a Patient Participation Group gave existing service users the opportunity to feedback on the service, they were also able to join interview panels for new staff. We found some excellent responses to patient feedback. Young people found sensitive leaflets being on display prevented them from being taken so responded by placing them in magazines. This way young people coming into the service with parents or carers were able to take sensitive information more discreetly. However, outcomes such as this were not shared across the service.
- The friends and family test was used across the service to provide young people the opportunity to feedback.
- NDCAMHS had a comprehensive strategy document that had been updated in July 2015 detailing their participation strategy at three distinct levels. These were of individual patient's participation in their own care, service level participation and how they would engage

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with trust systems and senior management. The strategy had clear objectives and desired outcomes. We saw that young people had recently been involved in the recruitment of the NDCAMHS psychiatrist.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- Access to the service was through GP referral. From receipt of the intial referral to assessment time there was a set target time of six weeks. The service was meeting this target set by commissioners, and had been recently adjusted due to the demand on the service making it difficult for staff to meet assessment targets.
- Staff stated that there was no formal target time following the initial assessment to starting treatment, although the aim was to see everyone within 18 weeks. Waiting lists for therapy were present in all services. Staff reported there was a wait of three to four months for therapy. However, we found that a young person had waited since February 2015 for a place on the caseload of the learning disabilities service in West CAMHS.
- The service operated a self harm rota, which gave clinicians the responsibility of revieweing young people admitted to general hospital because of over dose or self harm. This ensured that young people were given CAMHS contact and received an assessment within a day of being admitted to hospital. The service had a self-harm assessment protocol which covered Musgrove Park Hospital, Yeovil District Hospital and Somerset Minor Injury Units. Assessments were completed between 9 am and 5 pm, Monday – Friday. There was weekend input if there was a risk issue or if the young person refused to stay in hospital for an assessment on Monday. This meant that young people admitted to the general hospitals on a Friday afternoon would have to stay in hospital until Monday for an assessment or treatment by CAMHS.
- The service had capacity and systems to respond to urgent referrals within seven days of referral and emergency assessments within 24 hours. The allocated duty worked arranged emergency assessments when required. The duty clinician responded to young people that telephoned into the service.
- There was a rota in place for assessment into the service. Allocated referrals and assessment workers performed four assessments per week. Clinicians, such as nurses, were provided two assessment slots per month.
- There was a `did not attend appointment` (DNA) policy. Staff were proactive in re-engaging young people that they felt presented a risk. A DNA was if a young person cancelled within four hours of their appointment time. If the young person did not attend, staff would look at risk and prioritise, for example, if it was a deliberate self harm seven day follow up. If staff were not concerned about risk they telephoned, or wrote a letter, asking the young person to phone for another appointment. If the young person did not contact then another letter was sent saying they would close the referral if there was no reply within 10 days. A letter would also be sent to the GP.
- Hard to engage patients were seen at a venue of their choice in the community, if needed such as at school or with the GP.
- Changes to funding and availability for tier two CAMHS services had impacted on the service. Tier two services work with children, young people and their families, where the young person is experiencing mild to moderate mental health difficulties. Staff reported an increase in referrals for this client group within their teams.
- Staff identified that there were transition difficulties into the adult service. Whilst potential transitions were flagged up and referred around six months prior to the young persons 18th birthday there was not always timely transition. We found that young people who were over 18 still had a CAMHS psychiatrist as their first point of contact.

The facilties promote recovery, comfort, dignity and confidentiality

- We were concerned at the environment at Mendip CAMHS. In stark contrast to the welcoming environment in the other two settings where young people had been involved in the decoration and furnishings, Mendip CAMHS was a bleak environment in poor decor.There were no age appropriate decorations on the walls. The waiting area was small and unwelcoming with no age appropriate information available, there were no toys other than an empty dolls house. The team member`s photographs were on display at reception but no other appropriate decoration was present.The other two CAMHS sites had both been awarded young people's

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friendly accreditation in 2013, which showed they had age appropriate welcoming facilities. At the Mendip service not all of the therapy rooms were sound proofed.

- The facilities provided by the service included therapy and clinic rooms.
- CAMHS West had placed access to appropriate rooms on the risk register. The cost of renting extra rooms was placing strain on their budget.
- NDCAMHS used a variety of settings across the region to see young people, including home visits, school visits and the use of clinical rooms local to the young person and their families.

Meeting the needs of all people who use the service

- Disabled adaptations to the bathrooms were present, there was good acess to the sites for those in wheelchairs.
- There were no information leaflets on display in different languages. However, staff advised that they could access an interpreter through the trust.
- Staff within NDCAMHS all showed a good understanding of the needs of the families they worked with. A new member of staff confirmed that the undertstanding culture within the team had supported them to develop a clear understanding of the cultural needs of the deaf community. All staff within the service received training in British Sign Language (BSL), including the administrative staff. This helped with communication to the families and also for those staff team members who were deaf. The service made innovative use of technology, including facetime and skype. We observed appointments made using text messgaes by the secretaries. The service produced visual care plans for those people who did not have reading skills.
- The NDCAMHS service had identified that not all families and young people could understand the care plans and clinical letters in a traditional written format. We were very impressed that the service had been innovative in addressing this, through getting translators to sign the letters and reports into British Sign Language which the team filmed and sent out as a DVD with the written version.

Listening to and learning from concerns and complaints

- The service had received nine complaints in the past twelve months, of these a total of eight were upheld.
- Information on making complaints was displayed in the reception areas of the service. We found when reviewing complaints logs that young people were supported to make a complaint and that formal complaints were encouraged.
- Whilst we found that the service did respond to formal complaints we found that there was no log of informal complaints in the service. This meant that there was no overview of potential trends.
- We found that there was feedback of complaints in the team meetings. However there was no evidence of learning from complaints across the different sites.
- In the NDCAMHS service, we saw evidence of learning from complaints. For example, a local community team had complained of not being aware of NDCAMHS involvement. The service conducted a full review into the case and provided a detailed response to the local service of what went wrong and detailed changes in practice to ensure it would not occur again. During our inspection we saw that those changes had been implemented and were working.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Staff were aware of the trusts vision and values. However, some staff told us that they felt the trust was more performance driven than compassionate and they only heard from the executive team when something went wrong.
- The staff we spoke with knew who the most senior managers in the organisation were and could tell us who had visited their services, for example, the chief executive. However, one senior member of the trust did not realise there was no individual CAMHS learning disabilities service. This meant that there was not a wider, senior management understanding of the limited resources for this client group within CAMHS.
- Staff were concerned that there was limited understanding of the CAMHS service within the senior management team, particularly since services had been restructured and CAMHS now sat within the community health directorate, rather than mental health.

Good governance

- The service operational policy had not been updated or reviewed since April 2010. A new operating procedure had been written and was due to be implemented in October 2015.
- There were systems in place that ensured staff received mandatory training as well as more role specific training for professional development. The service participated in therapy programmes such as Children and Young Persons Improving Access to Psychologocial Therapies. This was a good example of the service promoting professional development and responding to demand on the service.
- Staff were supervised in line with trust policy. Supervision records showed that issues were addressed with practice as well as reflecting on clinical issues. However, due to risk assessments being out of date and an often lack of holistic approach to care plans we were concerned about the quality and effectiveness of the supervision.
- Appraisal rates varied across the service ranging from 54% at Mendip to 100% at Balidon, Deaf CAMHS and the outreach team.
- There was a low level of incident reporting on Datix, incidents were not always reported timely. We were concerned that although there was a recording system in place it was not getting used effectively to record incidents across the service.
- There was auditing of the waiting list to ensure that the risk of children waiting for treatment was monitored and mitigated. We found that there was the ability for staff to provide support based on increase risk.
- There was auditing across the service using NICE guidelines as the standard to measure against.
- We found that staff adhered to safeguarding procedures appropriately but referrals were not always taken on by the local authority due to a high threshold for taking on cases.
- The risk register across the service was being used effectively to escalate risk. There were plans put in place to mitigate risk where possible, other risks were there to be highlighted highlighted to the trust.
- The service used key performance indicators to monitor performance in areas such as care records having a crisis plan, the six week target time for assessment, DNA rate, mandatory training and annual care plan reviews. Due to care plan reviews not always taking place in the records we reviewed we were concerned that plans were not put in place when there were issues.

Leadership, morale and staff engagement

- The teams were well-led at a local level with positive feeling amongst staff about local management. Staff felt able to raise concerns to their manager. Morale across the service was generally good. Staff felt able to support each other at a local level and felt supported by their immediate manager
- There was a mixed feeling of whistleblowing amongst staff with some staff not feeling confident and that they would not be supported by senior management. Staff told us that they did not feel listened to by senior members of the trust. There was an example where a change in policy had led to concerns about the access of sensitive CAMHS information in other areas of the

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trust. This was raised by staff and they did not receive a response to their concerns. Concerns were shared by staff with the local authority safeguarding team. The CAMHS service staff told us that they had still not had a response from the senior management team at the time of our inspection.

- Sickness was low at a 3.2% average across the service, this was below the national average
- We saw good local leadership evident in NDCAMHS. There were reported some difficulties in the trust supporting and understanding the needs of this specialist service, although they felt that this was improving. For example, the service has staff members who are deaf, and despite the service having the necessary funding, it took two years for the trust to approve smartphones with the ability to make video calls. These were necessary for staff members to be able to communicate with other members of the team through sign language and also to ensure their safety in line with lone working.

Commitment to quality improvement and innovation

- There was a quarterly CAMHS best practice group to enable innovation and define good practice. This was used to check the service against NICE guidelines.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17(2) (c)HSCA 2008 (Regulated activities) Regulations Systems were not in place to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Risk assessments did not always reflect changes in people`s circumstances, and were not always clearly linked to assessment of needs and identified risks. Capacity, consent and information sharing was not always recorded. This meant the information was not easily available or accessible to staff. This was a breach of Regulation17(2) (c)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(d) HSCA 2008 (Regulated activities) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

The ward did not have effective processes for reducing the risks to patients and staff. This included risks in the environment.

We had concerns about the safety of the small staff galley kitchen in Mendip CAMHS.

This was a breach of Regulation 12(2)(d)