Good

Dudley and Walsall Mental Health Partnership NHS Trust

Specialist community mental health services for children and young people

Quality Report

Dudley and Walsall Mental Health Partnership 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)
RYK33	Dudley and Walsall Mental Health Partnership Trust HQ	Walsall Early Intervention in Psychosis service	WS3 3AZ
RYK33	Dudley and Walsall Mental Health Partnership Trust HQ	Walsall CAMHS Community Team	WS3 3AZ
RYK33	Dudley and Walsall Mental Health Partnership Trust HQ	Dudley CAMHS Community Team	B63 2UR

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Dudley and Walsall Mental Health Partnership 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.

Where applicable, we have reported on each core service provided by Dudley and Walsall Mental Health Partnership Trust and these are brought together to inform our overall judgement of Dudley and Walsall Mental Health Partnership 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 Dudley and Walsall Mental Health Partnership NHS Trust as Good because:

- Staffing levels were adequate and vacancy rates were low across the services.
- There were effective safeguarding processes in place. All staff received training in child and adult safeguarding, levels one to three.
- All staff had received training in child specific management and prevention of aggression and violence.
- Patients had access to a wide range of professionals who had additional training in specific psychological therapies, for example, cognitive behaviour therapy, cognitive analytical therapy, eye movement desensitisation reprocessing, family therapy and psychotherapy.
- Staff completed a wide range of clinical audit. For example, caseload audit, deliberate self-harm audit and the national prescribing observatory for mental health.
- Staff were sensitive to the needs of patients and showed good knowledge of the issues they faced.
- Physical health care needs were monitored on a regular basis.

However

- Although child and adolescent mental health services (CAMHS) had introduced initiatives to reduce waiting times and provide a more responsive service, there were still long waiting times for specialist partnership working.
- There were no safety alarms in place at any of the sites across the core services.
- There was no access to a CAMHS psychiatrist outside of normal working hours.
- Risk assessments were not always fully completed, detailed or up to date.
- CAMHS staff used different systems to record care plans and update risk information. This could lead to errors in patient care.
- Confidentiality was compromised at the Dudley service base due to the poor sound proofing in the interview rooms.

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 :

- There were no alarm systems for staff or patients to summon assistance if needed.
- There was no access to CAMHS psychiatrist outside of normal working hours.
- Although all case records we reviewed had initial risk screening, four out of eight full risk assessments we reviewed were incomplete. This meant information had not been recorded accurately and indicators of risk may have been missed.
- Some staff did not use the electronic recording system to document risk assessments and were documenting risk in paper records. These were not always accessible out of hours.
- It was not always clear from the paper or electronic risk assessments that staff had updated the risk assessments.
- Not all staff were clear about the lone working policy and there was confusion about the use of code words.

However

- All the premises were visibly clean and well maintained.
- Staffing levels were good and services had secured funding for further recruitment.
- Caseloads were manageable and audited on a regular basis.
- All services had accessible psychiatrists during working hours.
- All staff across CAMHS had child specific MAPPA training that included breakaway techniques.
- Staff had a good understanding of safeguarding and worked alongside the trust safeguarding team and local authorities.

Are services effective?

Good

We rated effective as good because:

- Patients had access to a wide range of professionals across all services, including occupational therapists, nurses, psychologists and psychotherapists.
- Staff had additional training in cognitive behavioural therapy, dialectical behaviour therapy, family therapy and eye movement reprocessing therapy.
- Staff followed National institute of clinical excellence guidance.
- Physical health care was monitored on a regular basis.
- All services were using clinical outcome measures and rating scales.

Summary of findings

- There were a wide range of clinical audits completed at trust and local level.

However

- Staff did not use a consistent approach to record care plans. This could lead to miscommunication between professionals that could in turn negatively affect patients care.
- Care plans were present but did not always document the patients or carers views.
- Staff did not routinely document Gillick competence.

Are services caring?

Good

We rated caring as good because:

- Staff demonstrated a respectful, caring and compassionate attitude towards patients and their carers.
- Staff were sensitive to the needs of patients and showed good knowledge of issues they faced.
- Staff documented consent to share information and staff understood when and how to breach confidentiality if needed.
- Care and treatment plans demonstrated involvement from people who used services. Plans were individual, reflected views of patients and families

Are services responsive to people's needs?

Good

We rated responsive as good:

- All services had clear criteria for referrals.
- Services offered flexible appointments to meet the needs of patients.
- EIPS and Dudley CAMHS met referral to assessment time targets.
- Walsall CAMHS breached referral to assessment times by one week. However, initiatives were in place to address this.
- Initiatives were in place across teams to reduce waiting times from assessment to treatment.
- Staff were part of a duty rota that was able to respond to patients needing extra support.
- The Walsall CAMHS tier 3.5 service had reduced referrals to inpatient units in the last 12 months.

However

- Confidentiality was compromised at the Dudley service base due to the poor sound proofing in the interview rooms.

Summary of findings

Are services well-led?

Good

We rated well-led as good:

- The services objectives and operational policies reflected the visions and values of the trust.
- All staff received regular clinical and managerial supervision. The trust supported staff with specialist therapeutic skills in accessing specialist clinical supervision from outside of the trust.
- CAMHS services were working with local commissioners to develop services in line with NHS England CAMHS transformation plans.
- All staff we spoke with were motivated and proud of the service they provided.
- Staff felt listened to and supported by service managers.
- Services participated in national research projects and audits.

However

- Some staff were concerned that the CAMHS service manager post across Dudley and Walsall teams was not permanently recruited in to. They felt a permanent position would offer consistency across teams.

Summary of findings

Information about the service

Dudley and Walsall each had a child and adolescent mental health team (CAMHS). Due to commissioning arrangements, there was a variation in service provision. Dudley CAMHS were commissioned to treat patients up until the age of 16 and Walsall CAMHS up to the age of 17. Both teams were commissioned to work with children under the care of the local authority up to the age of 19.

The two CAMHS teams each had their own clinical lead. One service manager had responsibility for both teams. Both teams operated the choice and partnership approach (CAPA). CAPA is a service transformation model that combines collaborative and participatory practice with patients. Patients who met the referral criteria are offered choice appointments. This is a face-to-face appointment aimed at identifying what the patient and /or carer want help with and reaching a shared understanding of the problems. If treatment was indicated, patients were offered partnership appointments. In partnership appointments, the patient and or carers engage therapeutically with the CAMHS clinician. Further specialist partnership appointments were offered if patients and or carers needed specific interventions, for example family therapy. Walsall CAMHS also had a tier 3.5 team. The tier 3.5 staff offered crisis assessment and intensive home treatment interventions to offer an alternative to hospital admission.

The early intervention in psychosis service (EIPS) worked with people experiencing a first episode or possible prodromal phase of psychosis, between the ages of 14 -35. EIPS worked alongside child and adolescent mental health services (CAMHS) in the care of adolescents aged from 14 – 16 in Dudley and 14 -17 in Walsall. Within the EIPS team, there were dedicated CAMHS workers.

Our inspection team

Our inspection team was led by:

Chair: Angela Hillary, Chief Executive, Northamptonshire Combined Healthcare NHS Foundation Trust

Head of Hospital Inspections, CQC: James Mullins

The team that inspected the core service consisted of one CQC inspector and three specialist advisors. These included a consultant child and adolescent psychiatrist, specialist child and adolescent nurse and a social worker.

Why we carried out this inspection

We inspected this core service as part of our on-going 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 we held about these services, asked a range of other organisations for information and sought feedback focus groups.

During the inspection visit, the inspection team:

Summary of findings

- visited Dudley and Walsall child and adolescent community mental health services and Walsall early intervention in psychosis service
- spoke with eight patients who were using the service
- spoke with seven carers
- spoke with the managers for each of the teams
- spoke with 22 other staff members; including doctors, nurses and social workers
- attended and observed one hand-over meeting and one multi-disciplinary meeting
- collected feedback from two patients using comment cards
- attended and observed three choice appointments, one crisis assessment, one family therapy session, one partnership session, two psychiatrists follow ups, one home visit, one appointment with the eating disorder nurse and spent time with the duty worker reviewing how referrals were screened
- looked at 19 patient care records
- reviewed a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with seven carers and eight patients who were using the services. We collected feedback from two comments cards and two CQC share your experience forms.

Most people were happy with the care they received and fed back that staff were kind, respectful and had a good understanding of their needs. Some people were concerned were about waiting times to access specialist therapies.

Good practice

The CAMHS teams held open days for local communities to attend. They invited community groups, general practitioners, schools, patients, friends and families of patients and professionals form other organisations. Staff said the open day was about providing information and increasing awareness of mental health issues amongst children and young people and to try and breakdown stigma attached to mental health services.

Staff had also completed local audits monitoring different areas of their work, for example, an audit of deliberate self-harm trends. This had led to the development of specific groups for young people before exams i.e. anxiety management and anger management groups.

CAMHS services were working with a company to develop a mood diary 'app' for children and young people to use.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The trust must review its procedures for maintaining a safe environment for example, alarm systems to ensure that staff and patients' health and safety is maintaine
- The provider must ensure that all relevant care records contain a fully completed and up to date risk assessment.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should continue to reduce waiting list times for CAMHS.
- The provider should ensure that where toys are available for the use of young people attending services that records of the cleaning process are maintained.

Summary of findings

- The provider should ensure that all staff are aware of the trust lone working policy and adhere to local protocols.
- The provider should ensure that there is a consistent approach to recording care plans.
- The provider should review the soundproofing of interview rooms at the Dudley team base to ensure that confidentiality is not compromised.

Dudley and Walsall Mental Health Partnership NHS 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
Walsall Early Intervention in Psychosis service	Dudley and Walsall Mental Health Partnership NHS Trust
Walsall CAMHS Community Team	Dudley and Walsall Mental Health Partnership NHS Trust
Dudley CAMHS Community Team	Dudley and Walsall Mental Health Partnership NHS Trust

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.

- The teams we inspected did not have any approved mental health professionals. They were able to access these professionals from the local authority as and when needed.
- Consultants and staff grade were section 12 approved. This meant they had extra training and were approved to carry out particular duties under the Mental Health Act (MHA).
- Generic psychiatrists completed out of hours MHA assessments for under 18 year olds as there was no out of hours child and adolescent psychiatrist.
- Staff on the early intervention in psychosis (EIPS) team demonstrated good knowledge and understanding of the (MHA) and the MHA code of practice.
- Staff could contact the trust MHA administrative and legal team if they needed guidance. Not all staff were aware of this.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act 2005 is not applicable to children under the age of 16. Gillick competence, which balances children's rights and wishes with the responsibility to keep children safe from harm, should be used for those under 16.
- Staff we spoke with within Dudley and Walsall CAMHS demonstrated knowledge of Gillick competence. Staff did not routinely document Gillick competence.
- EIPS staff had varied understanding of Gillick competence. Those who lacked understanding said they would seek advice from the EIPS CAMHS nurse or CAMHS team.
- The trust had MCA training but this was not mandatory. Seventy six per cent of staff were up to date with MCA training.

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

- Interview rooms did not have alarms in case of an emergency. At the time of our inspection, staff were unable to show and we saw no evidence of access to personal alarms. This meant staff or patients may be unable to summon assistance if needed. Staff said they undertook individual assessments to reduce this risk. Two staff we spoke with raised the lack of alarms as a concern.
- Walsall child and adolescent mental health service (CAMHS) and early intervention in first psychosis service (EIPS) shared premises. They had access to a clinic room, which was visibly clean and well maintained. The medication cupboard was in good order and kept locked. Blood pressure monitoring machines and scales were available. Records confirmed regular calibration and maintenance of all clinical equipment.
- Dudley CAMHS was a standalone service. It did not have a clinic room. However, there were blood pressure monitors and measuring equipment available. We saw audits that confirmed the equipment was calibrated regularly. There was no medication stored at the Dudley site. Doctors prescriptions were kept locked in the administration office.
- All service premises were visibly clean and well maintained. We were unable to see cleaning records as the cleaning contractors kept these.
- Toys available in the waiting and interview rooms were visibly clean. Dudley CAMHS had audits confirming toys were cleaned on a regular basis. The Walsall services were unable to provide this on request; however, we saw that the toys were visibly clean.
- Staff were aware of infection control principles. Laminated posters were displayed in bathrooms, these demonstrated good hand washing techniques. Seventy-nine per cent of staff were up to date with the trusts mandatory infection control training. Staff within CAMHS had recently completed a hand-washing audit for which they had achieved the pass rate.
- Electrical wall socket covers were present in interview rooms. This would prevent the risk of younger children harming themselves.

Safe staffing

- The trust had estimated staffing levels based on previous service demand and had agreed these with commissioners. Staffing numbers within the CAMHS teams had increased over the last 12 months as part of service development. Walsall CAMHS had secured funding for further recruitment in 2016 to develop their tier 3.5 team.
- The EIPS team were in the process of recruiting extra staff to enable them to meet new service level agreements. From April 2016, the service is increasing its upper age limit from 35 to 65.
- EIPS had no vacant posts at the time of our inspection.
- There were six vacancies out of 74 posts within CAMHS. Locum staff filled vacancies while the service was in the process of recruiting to posts. Locum staff were employed appropriately. For example, Locums were employed to cover staff seconded into the tier 3 .5 team or to cover maternity or sickness leave. This meant the rest of the team would not have to carry other staffs caseload.
- Systems were in place to ensure there were safe levels of staff cover during holiday periods.
- All patients had an allocated care co-ordinator or case holder. The average caseload was 35 patients per clinician in CAMHS and 15 per clinician in EIPS.
- All services had access to a consultant rota during working hours. Staff reported psychiatrists were accessible and there was adequate medical cover. EIPS also had additional access to a staff grade EIPS psychiatrist.
- There was no out of hours CAMHS psychiatrists. General psychiatrists on the trust duty rota dealt with any CAMHS Mental Health Act assessments that were needed.
- Eighty-seven per cent of staff had completed all mandatory training.

Requires improvement

Are services safe?

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

- CAMHS staff had child specific management of aggression and violence training, which included breakaway techniques.

Assessing and managing risk to patients and staff

- CAMHS staff undertook an initial risk screening assessment on all patients at the first choice meeting. Staff would complete an in depth risk assessment if indicated. Staff used the functional analysis in care environments (FACE) risk assessment tool.
- EIPS staff used the FACE tool on initial assessment. They would update an existing FACE tool if the patient had been referred in from another service, for example, from an acute ward.
- Walsall CAMHS 3.5 tier staff completed a FACE risk assessment on all assessments. On inspection we observed two tier 3 .5 assessments and one deliberate self-harm assessment. We observed that staff completed FACE assessments together with the patients and their carers.
- All 19 records we looked at across the teams had risk screens and additional FACE assessments if indicated.
- Four out of eight full risk assessments we reviewed had not been fully completed. This meant information had not been recorded accurately and indicators of risk missed.
- Some staff were not using the electronic system to record risk assessments and documented risk in paper records. These were not always accessible to out of hours staff.
- Staff told us they would reassess risk dependent upon the patients' presentation. It was not always clear from the paper or electronic risk assessments that they had been updated. We found updates on risk recording in a variety of places, for example, within clinic letters or daily contact sheets as opposed to a risk assessment template. This could mean that risk information may be missed or hard to find if it is not recorded consistently in one place.
- Staff told us the doctors did not use the electronic system. Therefore, risk assessments completed by the doctors would be in the paper records. This could lead to miscommunication or difficulty accessing up to date risk assessments.
- EIPS ran a daily morning meeting that all clinical staff attended. The meeting functioned as a hand over and staff discussed high-risk patients. Staff grouped patients into high, medium or low risk. Staff recorded this information on a white board in the staff office. From observing this meeting, we found that staff had a good knowledge of the patients' risks and were able to share reflective practice. Management plans were discussed verbally but we noted this meeting was not documented.
- All services were able to respond to deterioration in a patient's mental health via the duty system or tier 3.5 services in Walsall.
- Staff gave patients and parents/carers service information packs. These included crisis contact numbers and information on other services. For example, out of hours contact numbers and the Samaritans.
- The trust had a dedicated safeguarding team that monitored safeguarding alerts and referrals for people using the service. CAMHS services made 42 child and 3 adult safeguarding referrals during the period of November 2014 – October 2015.
- Ninety-seven per cent of all staff had up to date children and adults safeguarding training, levels one - three. Staff we spoke with were knowledgeable regarding safeguarding issues. Forty-one per cent of staff had completed PREVENT training. This is training to enable staff to identify young people who may be at risk of radicalisation.
- Trust wide lone working policies were in place. All staff had trust mobile phones to use whilst out on community work. Four staff we spoke with expressed some concern with local lone working protocols. They were not sure of the correct 'code word' to use if in difficulty whilst out in the community. EIPS and CAMHS staff said it was the role of the duty worker to follow up on late returning staff.

Track record on safety

- Two SIRI incidents were reported for EIPS between August 2014 – August 2015. One related to an unexpected death. This had been investigated and there

Requires improvement

Are services safe?

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were no concerns raised with regard to care. However, staff were reminded to date, time and sign all amendments to documents in line with the trust clinical recording policy.

- Trust data indicated that no SIRI incidents were reported between August 2014 – August 2015 for CAMHS teams.

Reporting incidents and learning from when things go wrong

- Data provided by the trust pre-inspection indicated that no incidents within the CAMHS services. However, CAMHS staff told us they did use the trusts electronic incident reporting system and were able to show us evidence of incidents reported. Each had an action plan and outcome. We could see that staff had reported a wide range of incidents. Examples we reviewed included, a kitchen fire and a lost mobile phone.
- Staff received information about lessons learned in governance meetings and through email. Learning from incidents also happened within peer supervision, case studies and multi-agency meetings. One member of staff shared a recent incident, which led to a multi-agency professionals meeting. Within this, it was identified that communication amongst all agencies involved with a particular patient group, should be kept informed of all admissions to the paediatric ward.
- Staff said that they could debrief following incidents in in various settings. For example, team handover, meetings and peer supervision. We observed discussion in handover between staff following a difficult home visit. Staff were given time to reflect and discussions between professionals were facilitated by the team leader.
- All staff we spoke with were aware of the duty of candour principles and the importance of being open and transparent in their work.

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

- CAMHS received referrals directly from other agencies. Duty staff screened and prioritised the referrals and allocated initial assessments according to the rating.
- CAMHS services used the Choice and Partnership approach (CAPA). This is a nationally recognised CAMHS service model complete with assessment and care planning tools. All qualified clinical staff completed choice appointments. During choice appointments, a plan of care was agreed and if appropriate partnership appointments offered to begin treatment. CAMHS staff that completed the choice assessment, held the patient on their caseload until the partnership appointment. Staff said they would advise parents or patients to contact CAMHS if there was deterioration in a young persons' mental health whilst on the waiting list. Staff gave information packs were given out at the choice appointments. These contained strategies and self-help guidance that the patient and or carers could use.
- EIPS received referrals from the early access service. All clinical staff completed initial assessments with patients. Staff said that the assessment process was ongoing throughout their work with the patients. Staff used a variety of assessment tools, dependent on their clinical background. For, example the occupational therapist used interest checklists and the psychologist used a cognitive analytical therapy assessment tool.
- The trust had introduced an electronic system to document care records. However, not all staff were using the electronic system. Most staff were using both electronic and paper care records and others were using the paper based care records only. This meant staff would need to look at both sets of notes to access up to date and accurate patient information. The doctors across the services were still using paper records. The electronic system was not set up to document all tools that staff used, for example, psychology formulations and health of nation outcome scales for children and adolescents (HONOSCA). Non-medical staff we spoke to said it would be better if everyone used the same system to record contacts. Often staff would complete a paper based assessment and care plan with the patient and then it would need typing up on to the electronic system. Staff expressed frustration that this was a duplication of work, which often led to the electronic/ paper version not being fully completed. Some staff said the dual use of paper and electronic recording systems was problematic and inconsistent.
- We reviewed 19 patient care records, all of which had care plans present. We looked at both paper and electronic records for each patient. We found the recording of care plans was inconsistent. For example, one set of paper notes had a more detailed care plan compared to the electronic system; another set of notes had a care plan in the paper file but none on the electronic system. This could lead to miss communication between professionals that could in turn affect patients care. Not all-necessary care plan information would be accessible to staff who do not have access to the patient paper records.
- The format used to carry out care planning with patients varied. In some files, care plans were included within a clinic letter, which would then be sent to the child or young person. In others, they were recorded on the goal based outcome recording sheets. Two out of 19 care plans we reviewed were in the child or young persons' own handwriting, using language that was meaningful to them. Fifteen of the care plans were up to date while another four had not been dated. It was not always documented on the care plans that copies had been given to patients. Patients and carers views were not always documented within the care plan, but we found them to be documented elsewhere within the care record.
- Care plans were recovery orientated and focused on what was meaningful to the individual patient and or their carers/ family.
- Paper records were stored securely.

Best practice in treatment and care

- Staff followed National Institute for Health and Clinical Excellence (NICE) guidelines when prescribing medications. For example, in EIPS, guidance was followed when prescribing anti-psychotic medications. Care records evidenced that staff undertook baseline physical investigations and routinely monitored physical

Are services effective?

Good

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health. We also observed when medication was being prescribed above licensed dose, the 'pros and cons' were discussed with the patient and a record of consent made.

- NICE guidelines were followed for the treatment of depression in children and young people. Following assessment, children and young people were offered specific psychological therapy (individual cognitive behaviour therapy, family therapy or psychodynamic therapy) before being considered for anti-depressant medication. Children with attention deficit disorder were offered both medication (if needed) and psychological interventions.
- EIPS supported patients with employment, housing and benefits. We observed staff supporting patients with paperwork. Staff documented work and education goals identified by patients in case records.
- Staff monitored physical health care across all services. EIPS had established a monthly clinic for patients. Staff said they had recently implemented the Lester tool. This assessment tool supports the recommendations relating to the monitoring of physical health in the NICE guidelines on psychosis and schizophrenia in adults and young children. If patients were reluctant to attend the physical health clinic, EIPS staff would take baseline physical observations on home visits or arrange for a general practitioner appointment. Young people under EIPS had physical health checks from the CAMHS consultant.
- Dudley and Walsall CAMHS monitored physical health where appropriate i.e. eating disorders, when prescribing medications. Staff documented this on charts or within contacts in care records.
- Outcome measure tools were being used across services. Staff completed health of the nation outcome scales for both children and adults on assessment, during therapy and on discharge. Patients under EIPS completed the clinical outcomes in routine evaluation questionnaire (CORE-OM). CORE-OM measured change in mental health bought about by psychological therapies. CAMHS staff told us they used the strengths and difficulties questionnaire, children's global outcomes scale and Connors comprehensive behaviour rating scales. Completed outcome measure tools were present in all the care records we reviewed.
- There was evidence of clinical audit across all services and professions. Staff had participated in national audits, for example, the national prescribing observatory for mental health (POMH). Staff had completed trust wide audits such as infection control. Staff had also completed local audits monitoring different areas of their work, for example, audit of deliberate self-harm trends. This had led to the development of specific groups for young people before exams i.e. anxiety management and anger management groups.

Skilled staff to deliver care

- All services had a full range of disciplines. This included psychiatrists, nurses, psychologists, family therapists, psychotherapists, occupational therapists, social work and family support workers.
- Some staff specialised within their service. EIPS had a dedicated CAMHS practitioner, a nurse who took the lead on physical health care and a smoking cessation specialist. CAMHS had staff that specialised in working with looked after children and learning disabilities.
- All the staff we spoke with had received additional training for their roles. Six nurses had completed postgraduate cognitive behavioural therapy courses. Others had completed training in eye movement desensitization reprocessing therapy, dialectical behaviour therapy and family therapy.
- All staff received a minimum two week induction which included shadowing other clinicians, electronic recording system training and receiving laptop and phone for agile working. Two new staff we spoke with confirmed that they had received an induction.
- Records showed individual clinical supervision and managerial supervision took place regularly. The trust paid some therapists to have external clinical supervision, for example, the cognitive analytical therapist, family therapists and psychotherapists had supervision from other practitioners within their field. All staff had access to peer supervision sessions which were not formally recorded. Staff felt the group should not be recorded as it may affect the therapeutic process.
- Staff had yearly appraisals. Data supplied by the trust showed that 89% of staff within the core service had completed an appraisal.

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.

- There were no staff performance management issues. Mangers reported that the human resources department had been supportive with past issues. Mangers had received a full human resource-training package as part of leadership training.
- All EIPS staff were trained in skills based training on risk management (STORM). STORM is an evidenced based training package developed by the University of Manchester to equip staff in assessing and managing risk of suicide and deliberate self-harm.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings took place weekly. We observed one team meeting during inspection. Staff shared information and discussed cases to inform best practice in care and treatment.
- The EIPS team manager attended meetings with home treatment teams, wards and the early access service with the aim to improve communications between services.
- Walsall CAMHS had a GP liaison nurse. They met with GP's weekly to review referrals that had not been accepted and to sign post appropriately.
- Walsall & Dudley CAMHS had a dedicated clinician who worked part time alongside the local authority youth offending service. They provided mental health interventions to young people under these services and participated in multiagency reviews and interventions.
- Specialist behavioural support clinicians worked in partnership with Walsall schools reintegration and exclusion officers. School exclusion within Walsall was above national average. The clinicians targeted interventions towards children who were at risk of exclusion due to the impact of mental health. Staff had audited the service and found it had been helpful in managing schools expectations of CAMHS services. It had also increased awareness of mental health and its impact upon behaviour at school. Staff had provided interventions to those children at risk of exclusion. The outcome of this had led to further funding posts until 2017.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- Seventy six per cent of staff were up to date with MHA training. MHA training and updates were included within the trusts mental capacity act training.
- Staff knew how to access independent mental health advocates if needed. Leaflets promoting advocacy services were available in EIPS welcome pack.
- The teams we inspected did not have any approved mental health professionals.
- Consultant psychiatrist and the staff grade psychiatrist were section 12 approved. This meant they had extra training and that they were approved to carry out particular duties under the Mental Health Act (MHA).
- Out of hours CAMHS MHA assessments were completed by the trusts on call generic psychiatrists, as there was no out of hours CAMHS psychiatrist on call.
- Staff on the EIPS team demonstrated good knowledge and understanding of the MHA, about community treatment orders, the code of practice and the guiding principles.The trust had a central MHA administrative and legal team that could be contacted by staff if guidance was needed. Not all CAMHS staff were aware of this.

Good practice in applying the Mental Capacity Act (MCA)

- The MCA 2005 is not applicable to children under the age of 16. Gillick competence, which balances children's rights and wishes with the responsibility to keep children safe from harm, should be used for those under 16. All staff we spoke to within Dudley and Walsall CAMHS demonstrated knowledge of Gillick competence, but they did not routinely document it.
- EIPS Staff had varied understanding of Gillick competence. Those who lacked understanding said they would seek advice from the EIPS CAMHS nurse or CAMHS team.
- The trust provided MCA training but this was not mandatory. Seventy six per cent of staff were up to date with MCA training.

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

- Observations carried out during inspection showed staff attitudes and behaviours were respectful, responsive and provided appropriate practical and emotional support.
- Staff were sensitive to the needs of different age groups. We observed staff adjusting their language to explain treatment options to younger children.
- On a home visit, we observed staff sensitively tackle a child safeguarding issue with a parent. The staff informed the parent of process and legal requirements at all times. Consent to share and permissions to gather information with others was sought and clearly documented within care records. However, staff understood the criteria for breaching confidentiality to protect children and young people.
- Patients and carers told us staff were kind, thoughtful and respectful; they said they felt listened to and did not feel judged. One young person under child and adolescent mental health services (CAMHS) said that they had every confidence in the staff, believing they would only share risk information with their parents.
- Carers felt they were well informed and able to ask questions when they needed clarification.

The involvement of people in the care they receive

- On one home visit, we observed staff involving patients in decision making about medications, attendance at support groups and developing a personal activity timetable.
- There was evidence in the care records that patients were actively involved in their care plans. This was documented in the choice or partnership documents or within care plans and care programme approach (CPA) reviews. Patients and carers we spoke with said they had been involved in care planning. Records showed within the CAMHS teams; children, young people and their carers usually received a clinic letter rather than a care plan. This detailed the support they would receive, how and why.
- EIPS CPA documentation we reviewed documented patients views and choices for example, goals to enrol at college, discussions about medication options and possible side effects.
- Interactions we observed during a clinical appointment with a psychiatrist and a nurse showed staff negotiating diet plans with young people, encouraging their food likes and dislikes. We observed one doctor getting the children to press the blood pressure monitoring machine button in a way to get them involved and on board with the treatment plan.
- Staff were aware of local advocacy services they could refer on to and advocacy leaflets were available for patients.
- A number of patients had participated in recent staff recruitment joining interviewing teams.
- The Walsall teams waiting area had a 'comments' tree for people to write their comments about the services on. Staff collected and documented the feedback before sending it on to the trusts service experience desk. This process had identified changes patients and carers wanted making to the waiting area, for example, provision of a water dispenser. Feedback and comments from patients and carers were also on display in Dudley CAMHS waiting area.
- Some of the looked after children (LAC) had been involved in developing a service leaflet for the LAC patients. The trust had agreed the leaflet could be printed and used within the service.
- Choice assessments promoted collaborative working and if a patient and or carer chose not to take up a partnership session or it was not appropriate then staff offered alternatives. For example, Staff gave parents behavioural strategies to use with their child or a referral to counselling services was made.
- Walsall CAMHS had run open days for the local community, schools and other agencies. These had provided the service with an opportunity to share information about how they work, reduce stigma and obtain feedback.

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

- Child and adolescent mental health services (CAMHS) took referrals directly from other agencies.
- Referral criteria for both CAMHS teams was clear. Referrals that did not meet the criteria were signposted to other services such as paediatricians or counselling services. CAMHS duty workers screened and rated the referrals on a daily basis. Referrals were rated red, amber or green. Staff told us those rated red were seen within 24 hrs, amber seen within six weeks and green seen within 12 weeks.
- Tier 3.5 staff in Walsall assessed all referrals rated red. Dudley duty staff would assess red referrals.
- Data supplied by the trust indicated the CAMHS average waiting time from referral to treatment was 19 weeks for Walsall CAMHS and eight weeks for Dudley CAMHS.
- The tier 3.5 service in Walsall had been set up as a pilot project in January 2015. Staff worked 8am to 8pm, seven days a week. The average team caseload was 20-25 patients. They provided home treatment and crisis support alongside CAMHS staff. The trust reviewed the service in September 2015 and reported progress to secure further funding from commissioners. The report showed there had been a 70% decrease in the use of inpatient beds. The tier 3.5 staff had freed other CAMHS staff from the deliberate self-harm (DSH) rota so they could carry out more choice assessments and reducing waiting lists. Data supplied by the trust indicates average waiting times from referral to treatment have been steadily reducing since the implementation of the tier 3.5 service. Walsall CAMHS have now secured funding for the service to be permanent and are in negotiation with Dudley commissioners to develop a tier 3.5 service within Dudley CAMHS.
- Waiting times to see specialist practitioners (specialist partnership) for specialist assessment and treatment varied. For example, the longest waiting time to access family therapy was 8 weeks in Dudley and 12 weeks in Walsall.
- EIPS had clear criteria for service provision. Since the introduction of the Early Access service (EAS), referrals to EIPS came through the EAS or direct from in patient wards. EIPS had noticed referrals were taking longer to process through EAS than from when they processed them directly themselves. In order to facilitate quicker access to the EIPS, an EIPS worker triaged referrals alongside the EAS service. The referral to treatment standard for EIPS was two weeks and they were meeting this target.
- Flexible appointment times before 9 am and after 5 pm were offered by all services. Two carers we spoke with confirmed this happened and said that the services were very flexible.
- All services operated a duty system that was staffed by senior clinicians. This operated between 9am to 5pm on weekdays. The role of the duty worker was to screen referrals, triage clinical calls, and listen to parental concerns and co-ordinate crisis response if needed. In addition to this, both CAMHS teams ran a deliberate self-harm rota. Staff on this rota assessed any children or young people that had been admitted to the paediatric ward following deliberate self-harm or because of deterioration in their mental state.
- In order to reduce waiting times, the CAMHS teams had started to run attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorder (ASD) clinics. Data confirmed there was no waiting list for children and young people with ADHD in Dudley or Walsall and the waiting times for children and young people with ASD were significantly reduced.
- All services had a proactive approach to 'did not attend' (DNA) appointments. For example, within CAMHS, if a patient did not attend a priority choice appointment staff would phone or text them as well as contacting the general practitioner. If it was for a choice appointment, an 'opt in' letter was sent out. Within EIPS, patients who did not attend were actively followed up by home visit, phone or letter. We saw evidence of this documented in case records. A DNA audit had highlighted high did not attend rates within family therapy. To tackle this directly, they implemented specific family therapy text reminders and reminder telephone calls.
- The trust had a policy to guide transition of patients from CAMHS to adult mental health services. Staff said they followed these guidelines by identifying those patients in advance and joint working with adult services. Staff said that CAMHS patients would need to meet the adult services referral criteria.
- CAMHS services would work with young people beyond their age criteria if there were a realistic possibility this

Are services responsive to people's needs?

Good

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

would avoid the need for a referral to adult mental health services. This is supported by the National Institute of Clinical Excellence guidelines for the treatment and management of self-harm in over eights: long-term management. We spoke with a carer of an 18 year old was in the process of discharge. They said therapy had continued beyond 17 years of age and their child was going to be discharged to the GP.

The facilities promote recovery, comfort, dignity and confidentiality

- Waiting areas across all services were visibly clean and child friendly. Toys and reading materials were available in the waiting areas. CAMHS services had responded to feedback from children, young people and carers by updated aspects of the waiting area environment. For example, they had purchased new furniture for the waiting area.
- There were information leaflets in different languages at the main receptions. Numerous notice boards were placed around the buildings, sharing information to patients and carers. Information included details about patient's rights, how to complain and support services available.
- A range of clinic rooms were available across all sites. However, a common theme staff reported was there were not enough rooms to access and they needed booking in advance. Staff managed this by seeing patients at school and home visits. Some staff said home and school visits meant they would see fewer patients due to lengthy travel times.
- Within the corridors at the Dudley site, we could hear conversations from the clinic rooms. A carer told us they had also overheard conversations whilst waiting in the corridor. They were concerned this could be anxiety provoking and make people uncomfortable. This would also be breaching confidentiality.

Meeting the needs of all people who use the service

- The Walsall services location was fully accessible to people with physical disabilities. At the Dudley site, the ground floor had clinic rooms and bathrooms that met the needs of people with limited mobility.
- Staff told us it was easy to access interpreters when needed.

Listening to and learning from concerns and complaints

- Between January 2015 – January 2016, CAMHS services received 13 complaints. One went on to the parliamentary health service ombudsmen (PHSO). PHSO closed the complaint with no actions for the trust. Following investigation by the trust, seven complaints had been partially upheld, two upheld, two withdrawn and one closed due to no response from the complainant. A common theme throughout the complaints was poor communication and sharing information with others. In response to concerns over the sharing of information, CAMHS developed a form for carers to sign detailing whom they did not want information shared with.
- EIPS had one complaint during January 2015 – January 2016, this was partially upheld.
- Ten of the carers and patients we spoke with confirmed they knew how to make a complaint.
- Staff we spoke with were knowledgeable and confident when discussing the complaints procedure. Staff received feedback about complaints and lessons learnt within the team governance meetings.

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

- Some staff wore lanyards that had the trusts values and visions printed on. The services own objectives and operational policies reflected those of the trust.
- Staff we spoke with knew who the senior managers within the organisation were.

Good governance

- All services provided regular supervision and yearly appraisals. There were systems in place to monitor one to one supervision.
- Staff received mandatory training as well as financial support towards specific training in therapeutic interventions.
- There were systems for reporting incidents and incident feedback was discussed in monthly governance meetings. Meeting minutes we reviewed confirmed this.
- Where necessary, managers could submit items to the trust risk register. No examples were identified on inspection.
- Staff undertook a wide range of audits as detailed throughout this report.
- CAMHS services were negotiating with commissioners to develop services in line with CAMHS NHS transformation and the department of health document 'Future in mind'. They had successfully received further funding for the year old Walsall tier 3 .5 team and were in negation with Dudley commissioners for a Dudley tier 3.5 posts.
- Teams had responded to complaints from parents about long waiting times for children with ADHD and ASD by setting up bespoke clinics.
- EIPS were in the process of renewing their key performance indicators (KPI's) to meet the new referral to treatment standards and change in service referral criteria.
- CAMHS had key KPI's that were being reviewed with the commissioners due to service developments in line with CAMHS transformation plans.
- We were told key performance indicators for EIPS had been suspended in preparation for the new referral to treatment standards that will start in April 2016.

Leadership, morale and staff engagement

- All staff we spoke with said the teams were well led at a local level. Some staff were concerned however that the CAMHS service manager post for both Dudley and Walsall teams was not permanently recruited in to. They were unsure of the future developments for this post, which caused them some anxiety.
- Staff told us they made a difference and were proud of the work they did. They reported feeling valued and worked in supportive, cohesive teams. They felt that they were listened to at a local level.
- Clinical and administrative staff reported they felt listened to by their local managers.
- Leadership opportunities were available for both clinical and administrative staff.
- Sickness and absence rates were three percent across services.
- Staff we spoke with were aware of the whistle blowing policy and felt able to raise concerns. One member of staff told us they had raised concerns with the new acting chief executive and had felt listened to. The concerns related to a culture of bullying and harassment from director level management.

Commitment to quality improvement and innovation

- CAMHS services were working with local commissioners to develop services in line with NHS England CAMHS transformation plans.
- The EIPS had participated in several research projects with one example being the CIRCLE project. This project focussed on cannabis use reduction and relapse prevention work.
- Services were working alongside the new youth forum in order to empower children and young people to have a say in service developments.
- CAMHS services were working with a company to develop a mood diary 'app' for children and young people to use.

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- CAMHS services had held open days to showcase the work they did. We reviewed comment cards and feedback from people who had attended, all of which were positive

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not maintain accurate, complete and detailed records in respect of each person using the service. Risk assessments for people receiving care were not fully completed or up to date. This was a breach of regulation 12 (2) (a, b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The trust must review its procedures for maintaining a safe environment for example, alarm systems to ensure that staff and patients' health and safety is maintained. Regulation (15) (1)(b).