Care Quality Commission

North Staffordshire Combined Healthcare NHS Trust

Specialist community mental health services for children and young people

Quality Report

Trust Headquarters
Lawton House
Bellringer Road
Trentham
Stoke on Trent
ST4 8HH
Tel:0300 123 1535
Website: www.combined.nhs.uk

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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)
RLY00	Trust Headquarters	CAMHS North Stoke Team	ST6 5JJ
RLY00	Trust Headquarters	CAMHS South Stoke Team	ST3 3BS
RLY00	Trust Headquarters	CAMHS North Staffordshire Team	ST5 7HL
RLY00	Trust Headquarters	CAMHS ASD Assessment Team	ST5 7HL
RLY00	Trust Headquarters	CAMHS Disability Team	ST5 7HL
RYL00	Trust Headquarters	Central Referral Hub and Priority Team	ST1 4ND

Summary of findings

This report describes our judgement of the quality of care provided within this core service by North Staffordshire Combined Healthcare NHS 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 North Staffordshire Combined Healthcare NHS Trust and these are brought together to inform our overall judgement of North Staffordshire Combined Healthcare NHS 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	Requires improvement	
Are services safe?	**Requires improvement**	
Are services effective?	**Good**	
Are services caring?	**Good**	
Are services responsive?	**Requires improvement**	
Are services well-led?	**Requires improvement**	

Mental Health Act responsibilities and Mental Capacity Act / 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 have changed the overall rating from inadequate to requires improvement because:

- During the September 2015 inspection, we found that not all young people had an up to date risk assessment and not all of the care plans we looked at involved the young person in their care or had been reviewed. During this inspection, we found that risk assessments and care plans were comprehensive, up to date and involved the young person and their family in their care.
- During the September 2015 inspection, we found outcome measures were not being used consistently. We saw in records during this inspection that showed there was good use of routine outcome measures being used to assess the severity and effectiveness of the treatments used.
- During the previous inspections, we found that waiting lists were long. There were still long waiting lists from initial assessment to treatment. At the time of the inspection, managers were unable to assure us that the service was monitoring and reviewing the young peoples' mental health and risk while they were waiting for treatment.
- There was not always an identified responsible clinician or case holder allocated to the young people on the waiting lists.
- The service managers told us they did not have access to sufficient and accurate data in order to be able to do their job effectively, including; number of referrals received per team, number of young people who do not attend their appointments and number of discharges.
- All of the staff were now trained in safeguarding children level 3 and had a good understanding of how and when to report a safeguarding incident or concern.

However;

- The bases were all well maintained and recently decorated.
- The staff were all kind and caring and demonstrated a good understanding of the young people's mental health and their families' needs.
- The hub and priority team responded effectively to routine and urgent phone calls and referrals.
- The staff spoke positively about the leadership of the service managers.

Summary of findings

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

Are services safe?

Requires improvement

We have changed safe from inadequate to requires improvement because;

- We found long waiting lists from initial assessment to treatment during the previous inspections and although some work had been completed to try and reduce the waits, at the time of the inspection, there were 212 young people on the waiting list for initial treatment. The young people did not have an allocated care co-ordinator and it was not clear how the service was monitoring young people's mental health and risk while they were waiting. The longest wait was from January 2014.
- There was not always an allocated responsible clinician for the young people on the waiting lists from initial assessment to treatment.
- Letters sent to children and young people who were waiting for treatment were sporadic; the inspection team observed several files that contained no letters or an inconsistency in them being sent. This was contrary to the trust policy, which stated that service users should be written to on a monthly basis. The blanket letter sent out placed emphasis on the young people and their families to contact the service if they were concerned as opposed to staff contacting the service user directly to check upon their well-being.

However:

- During the previous inspections, not all young people had an up to date risk assessment. We saw work had been done to rectify this and all of the records we looked at showed risk assessments had been completed and reviewed regularly.
- During the previous inspections, we did not see evidence the staff were aware of the lone working policy and we did not see good personal safety protocols across all bases. During this inspection, the staff were able to explain to us how they adhered to the safety protocols the lone working policy.
- All of the staff were now trained in level 3 safeguarding children and had a good understanding of how and when to raise a concern.
- The bases were visibly clean and well maintained.
- There was sufficient equipment for a CAMHS service. We saw records to show all of the equipment had been safety tested.

Summary of findings

- All of the staff we spoke with knew how to report an incident and what to report. The staff were able to explain duty of candour and told us they informed young people and their families when something went wrong.
- Staff told us they received feedback from investigation of incidents both internal and external to the service, via MDT meetings, email and the monthly bulletin.

Are services effective?

We have changed effective from inadequate to good because;

Good

- All of the records that we looked at of young people receiving treatment contained up to date, personalised, holistic, recovery-oriented care plans. The care plans in the learning disability service were not always written clearly in a way the family would understand and were not available in an easier read format for the young person dependent on their level of learning disability.
- Progress had been made from the previous inspection to ensure care plans and risk assessments were accessible from any trust base. There was a mix of electronic and paper records but all of the new referrals only had electronic records, with a plan to having all electronic records in the spring of 2017. All of the care plans were available electronically so staff could access them from any trust location.
- We saw the medics and the nurse prescriber followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication.
- During the previous inspection, staff were not using outcome measures consistently. During this inspection, we saw records showed staff used a range of outcome measures to monitor the severity of the difficulties and the effectiveness of the treatment.
- In September 2015, it was not clear if staff had received supervision and appraisal. At the time of this inspection, we saw records showed staff received regular supervision and appraisals.
- All of the staff had received an appropriate corporate and local induction.
- We saw training records showed 90% of staff had received training in the Mental Capacity Act and the Mental Health Act. The staff that we spoke with had a good understanding of both.

Are services caring?

We rated caring as good because:

Good

Summary of findings

- We observed two clinical appointments and the staff were caring, warm and responsive towards the young person and their family and listened to the young person's views.
- We observed two multi-disciplinary team meetings and the staff discussed the young people and their families' cases in a caring and respectful way.
- We spoke to 24 young people and their families' and they all reported staff were kind and had a good understanding of their needs.
- There was a high level of participation from young people and their families' in the development and delivery of the service at all levels. There was a young people's council who gather feedback from the young people who use the service and reports to the trust board.

Are services responsive to people's needs?

We have changed responsive from inadequate to requires improvement because;

Requires improvement

- Waiting lists for access to CAMHS remained extremely long at the time of our inspection with 133 young people waiting more than 18 weeks to be assessed. However, the team did recognise that waiting times had reduced since the previous inspection and that work was ongoing with commissioners to continue to address the issue.
- During the previous inspections, there was not a clear duty worker system to respond to emergency and urgent referrals. The development of the priority team meant that urgent and emergency referrals within working hours were seen within two days and if necessary on the same day.
- The joint triaging of referrals by CAMHS priority team and younger minds (tier 2 service) ensured young people, who do not meet the criteria for tier 3 CAMHS, were signposted to another service more appropriate to their needs or were seen by younger minds.

However;

- The service saw young people in a variety of venues in order to support their engagement with CAMHS services.
- All of the bases were comfortable and appropriately decorated and they had disabled access.
- There was a range of information and leaflets in all of the waiting rooms describing treatments, and local support groups.
- Not all of the young people and families we spoke to were aware of the complaints procedure.

Summary of findings

Are services well-led?

Requires improvement

We have changed well led from inadequate to requires improvement because;

- The staff we met with said, since the previous inspections they felt morale and job satisfaction was improving and all of the staff spoke highly about the new service managers.
- The trust acknowledged that they needed to improve the monitoring of waiting lists but failed to evidence when we asked them at the time of inspection how the risk and mental health of the young people on the waiting lists were being monitored and reviewed and how the board were addressing the issue. We were advised that a monthly letter was being sent out to young people on the waiting list but the files we looked in during the inspection did not show that the letter was being sent out consistently every month. The trust put plans in place following the inspection to rectify this.
- We saw the service uses key performance indicators to gauge the performance of the team regarding training and supervision, which had improved since the last inspections. The measures were in an accessible format but we were told the figures were often inaccurate and had names on of clinicians in different teams.
- The service managers felt they had sufficient authority for the day to day running of the service but felt they needed more autonomy and ownership of data to be able to do their job effectively and plan how to reduce the waits.

However:

- The sickness rate for CAMHS was low and below the trust average.
- There were no reports of bullying or harassment and no open cases at the time of inspection.
- All of the staff we spoke to knew how to use the whistle blowing process and felt able to raise concerns without fear of victimisation.

Summary of findings

Information about the service

CAMHS describe the levels of intervention required by each young person and family as tiers:

- Tier 1 describes universal services that are accessible to all; GPs, school nurses, health visitors.
- Tier 2 describes more targeted services around general well-being and mental health. These would usually be accessed via referral from a universal service and include tier 3 services offering training and consultation to tier 2 and 1 services.
- Tier 3 is specialist outpatient mental health intervention, which includes specialised assessment, and treatment of complex and comorbid mental health difficulties in children less than 18 years of age.
- Tier 4 is inpatient mental health.

North Staffordshire Combined Healthcare NHS Trust Community CAMHS service includes;

- Tier 3 specialist community mental health services to children and young people up to 18 years old and their families throughout North Staffordshire. Their hours are Monday to Friday 0900 to 1700.
- A CAMHS Autistic Spectrum Service that provides assessment for pre-school and school age children. Their hours are Monday to Friday 0900 to 1700.
- A CAMHS disability service for children and young people with a learning disability, developmental delay, or physical disability including those who have complex health needs. Their hours are Monday to Friday 0900 to 1700.
- A paediatric psychology service that provides psychological assessments and interventions to children and young people who have experienced acute or chronic illness or a traumatic injury. Their hours are Monday to Friday 0900 to 1700.
- The SUSTAIN service who work directly with carers and children and young people who are looked after or adopted. SUSTAIN also offer consultation to professionals who work with this group of young people. Their hours are Monday to Friday 0900 to 1700.
- Yellow house is a new social care approach where family therapists from CAMHS have been supporting social workers in the local authority to develop a new approach to working with children and families. Their hours are Monday to Friday 0900 to 1700.
- A single point of referral hub with Tier 2 input. Their role is to triage all of the referrals and ensure the young persons are signposted to the most appropriate service to meet their needs. Their hours are Monday to Friday 0900 to 1700.
- A priority team who are based at the hub and respond to all emergency and urgent referrals. Their hours are Monday to Friday 0900 to 1700.

The service is part of the national Children and Young People's Improving Access to Psychological Therapies transformation programme (CYP-IAPT). This means that the service will offer evidence based interventions, use outcome measures to show the treatments used are effective and use the data collected to change the intervention if it is not working and involve children and young people in the development and delivery of their service.

The trust had recently employed a company who works with healthcare providers to improve performance and productivity whilst achieving savings. The company is working with the service around identifying the right skill mix and measuring capacity and demand to ensure the service can plan effectively.

The CQC inspected the service in September 2015 and issued compliance actions to ensure the trust made improvements to CAMHS. These focussed on care planning, risk assessment, audit, quality assurance, supervision and appraisal, infection control and safe staffing. CQC made an unannounced visit to the service on 27th April 2016 and found that the actions described in the trusts plan to improve those areas were in place and progress was being made, resulting in the warning notice being lifted.

Our inspection team

The comprehensive inspection was led by;

Summary of findings

Chair: Beatrice Fraenkel, Chair, Mersey Care NHS Foundation Trust

Head of Inspection: James Mullins, Care Quality Commission (CQC)

Team leader: Kathryn Mason, Inspection Manager, Care Quality Commission

The sub team inspecting the CAMHS service consisted of a CQC inspector and four specialist advisors; a psychiatrist, a mental health nurse, a social worker and a psychologist.

Why we carried out this inspection

We undertook this inspection to find out whether North Staffordshire Combined Healthcare NHS Trust had made improvements to its community child and adolescent mental health service since our last comprehensive inspection of the trust on 7-10 September 2015 and the unannounced follow up inspection on 27-28 April 2016.

Following the comprehensive inspection, we rated the community child and adolescent mental health service as inadequate overall. We rated the core service as inadequate for safe, inadequate for effective, inadequate for responsive, inadequate for well-led and good for caring.

Following the comprehensive inspection, we told the trust that it must take the following actions:

- The provider must ensure that there are sufficient numbers of staff employed in CAMHS community services.

The provider must ensure that all staff who provide care and treatment are suitably skilled and experienced for their role.

- The provider must ensure that weighing scales are calibrated regularly.
- The provider must ensure that staff are able to access a psychiatrist at all times.
- The provider must ensure that all children and young people have a risk assessment. When risks are identified, they must have a risk management or safety plan. Risk assessment forms must be appropriate for CAMHS community services.
- The provider must ensure that CAMHS CONNECT and First Steps services operate an effective duty worker system. The system must ensure that a duty worker is available to deal with urgent matters.
- The provider must ensure that all staff in CAMHS community services have safeguarding children training. Staff providing care or treatment must have level three safeguarding children training.
- The provider must ensure that all young people have a care plan. Care plans must be specific, detailed and personalised. They must address all of the young person’s needs and record the views of young people and/or their carers.
- The provider must ensure that young people have one set of clinical records. These records must be comprehensive and complete. Clinical records must always be available to staff who need them.
- The provider must ensure that outcome measures are used consistently so that the effectiveness of services can be assessed.
- The provider must ensure that a psychiatrist provides dedicated input into all services (with the exception of paediatric psychology).
- The provider must ensure that all young people are able to have an assessment and access to diagnostic or treatment interventions, in a timely manner.
- The provider must ensure that concerns from young people and carers are monitored to identify themes and trends.
- The provider must ensure that all buildings operating CAMHS services are suitable for their use.
- The provider must ensure they operate effective governance systems to ensure the quality and safety of services. These systems should incorporate clinical standards and guidance. The systems must include risks relating to the service, environment and infection control.

We also told the trust it should take the following actions to improve;

Summary of findings

- The provider should ensure that there is an effective system in place to assess the risks to young people whilst they are waiting for assessment or treatment.
- The provider should ensure that there is a record of the date and content of staff supervision in the CAMHS ASD service.
- The provider should ensure that all appraisals record staff members' progress, development and performance. A detailed development plan should be recorded. The provider should ensure that CONNECT CAMHS and First Steps services communicate regularly with young people's general practitioners.
- The provider should ensure that young people's capacity to consent to care and treatment is recorded in clinical records. Where parental or carer consent is provided this should be clearly documented.
- The provider should ensure that feedback from young people and carers, in all services, is coordinated and ongoing.
- The provider should review the management capacity required to drive quality and service improvements in CAMHS community services.

We issued the trust with the following requirement notices;

- Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.
- Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014. Premises.

We issued the trust with the following enforcement actions;

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care.
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.
- Regulation 17 HSCA (RA) Regulations 2014 Good governance.
- Regulation 18 HSCA (RA) Regulations 2014 Staffing.

Following the comprehensive inspection, the trust took several actions and held events for staff in response to their regulation breaches. These focused on care planning, risk assessment, audit, quality assurance, supervision and appraisal, infection control and safe staffing. The trust sent CQC a report that said what action they were going to take to meet the requirements of the regulations.

The inspection in April 2016 found the actions described in the trusts action plan were in place though the effectiveness of the outcomes varied.

Following the unannounced inspection we told the trust it should take the following actions to improve:

- The provider should continue to monitor and progress its staff recruitment strategy.
- The provider should ensure all services and teams have operational policies.
- The provider should ensure caseload levels and complexity are manageable allowing staff to complete relevant paperwork.
- The provider should ensure the risk assessments used within services are informed by expert Child and Adolescent Mental Health Services (CAMHS) clinicians to assess the needs of the range of patients presenting for CAMHS.
- The provider should ensure all care plans are holistic, recovery focused, and involve the patient.
- The provider should develop structures to promote staff engagement in change in practices and services.

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 this service and sought feedback from patients at two focus groups.

During the inspection visit, the inspection team:

- Visited four clinic bases and looked at the health and safety of the environment.

Summary of findings

- Spoke with 24 young people and their families who were using the service.
- Spoke with the service managers for North Stoke team, South Stoke team, North Staffordshire team and the Hub and Priority team.
- Spoke with 30 other staff members; including doctors, nurses, art therapist, psychologists, parent practitioners and social workers.
- Spoke with the clinical director and service director with responsibility for the services.
- Attended and observed two staff meetings and two clinic appointments.
- Looked at 31 treatment records of patients.
- Looked at 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 to 24 young people and/or their parents. The young people and their families were very positive about their experience of CAMHS once they were receiving treatment. They all said there had been long waits for treatment and felt this could have had a negative impact on their mental health. The young people and their families felt listened to and thought their clinician had a good understanding of their needs. They said the appointment times were flexible within working hours and the clinician tried to arrange appointments at a time to suit the young person.

The families that we spoke to who were on the waiting lists, felt forgotten and unsupported. Some of the parents we spoke to often did not know what to do and were worried their child's mental health and behaviour was getting worse while they waited. None of the families we spoke to knew the complaints procedure but they said they would not have complained about the service anyway as they felt sorry for CAMHS and the NHS in general as they knew there had been cuts.

Good practice

The service had run a CAMHS in schools project with special schools for the past 11 years. They had developed a pilot to introduce the model into mainstream schools. At the time of inspection, work was taking place in one primary school, three special schools and with an independent provider funded by the Local Authority. The schools contributed financially for this service. The model was designed to ensure that the project was responsive to the needs of the school, staff and children and the intensity of support could vary as need increased and decreased.

CAMHS deliver a range of services to pupils, parents and staff in school. This includes consultation, teaching, training, group and individual work. CAMHS found that being located in the school and working as part of the staff team, enabled them to work more effectively with the whole school to promote good mental health and provide support for pupils having trouble at the earliest opportunity. For example, when staff noticed a change in behaviour or presentation they were able to discuss with CAMHS and think together about the best way forward.

The art therapist developed a CAMHS tool kit to aide communication when talking about difficulties and concerns.

The service had photographed and displayed young people's artwork on the walls within the North Staffordshire base.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that their waiting list targets from referral to treatment continue to improve.
- The provider must ensure their process of sending out monthly letters to the young people on the waiting list from initial assessment to treatment is adhered to and the letter copied to the referrer.

Summary of findings

- The service must continue to work towards seeing young people within 18 weeks from the point of referral.

Action the provider SHOULD take to improve

- The provider should ensure the young people and families are aware of the complaints procedure and there are leaflets in the waiting areas explaining the complaints process.
- The service should ensure care plans for the learning disability service are written clearly in a way the family will understand and available in an easy read format for the young person dependent on their level of learning disability.

North Staffordshire Combined Healthcare 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
North Stoke CAMHS	HQ
South Stoke CAMHS	HQ
<North Staffordshire CAMHS including ASD and LD team.	HQ
The Hub and Priority Team	HQ

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.

There were no young people receiving treatment under the Mental Health Act at the time of inspection. Staff told us it would be unusual for a young person to be discharged on a community treatment order.

Training records showed 90% of staff had completed Mental Health Act training and the staff that we spoke with had a good understanding of the Act and were familiar with the guiding principles.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Training records showed 90% of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards training.

The staff we spoke with had a good understanding of the difference between capacity and competence. We saw evidence in clinical notes and letters that mental capacity was assessed for their patients aged 16 years and above. For patients less than 16 years old we saw competency was thought about and the staff we spoke with were able to give us definitions and examples of Gillick competence. (This is a term used to decide whether a child under 16 years old is able to consent to treatment without the need for parental consent or knowledge.) However, this information was difficult to find so the service planned to include a capacity section in their electronic assessment form that all staff would have access to. We saw an example of the form being used by the Hub team.

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

- North Stoke CAMHS was based in a once purpose built building that is now too small for the needs of the service. There was a buzzer entry on the door and only CAMHS patients could enter the building. South Stoke CAMHS was based within a health centre and GP practice. CAMHS patients shared an entrance with other patients including adults but there was an identified waiting area and reception. It did not pose a risk for the young people. North Staffordshire CAMHS base shared the building with other trust services too but they had their own reception and waiting room that was separated from the rest of the building and could only be accessed via a door buzzer system. The hub and priority team shared the building with older adult services but had a separate waiting area. All of the bases were bright, welcoming, well maintained and decorated appropriately for CAMHS services.

- North Stoke base had alarms fitted in the therapy rooms and staff in the other bases all carried personal alarms when they saw patients.
- None of the bases had specific clinic rooms for physical examination but there was a height and weight measure in the majority of the therapy rooms and some blood pressure machines to use as needed. All of the equipment was well maintained and safety tested.
- All areas were clean and well maintained. Cleaning records showed staff cleaned toys regularly between uses.
- We saw posters reminding staff to adhere to infection control principles.

Safe staffing

- The service managers that we spoke with acknowledged that recruiting staff had been difficult. As of 12th December 2016, the vacancy rate was 4% and there were 72 whole time equivalent staff in post with 3 vacancies across CAMHS.
- The turnover rate for the 12 months prior to inspection was 13.8%.
- At the time of inspection, the sickness rate was 2.6%.
- The average caseload was 25-30 cases per clinician. There was not a recognised case management tool used in order to determine safe caseloads but the service managers met with the staff each month to review caseloads.
- At the time of the inspection, there were 212 young people on the waiting list for treatment awaiting allocation of a care co-ordinator.
- Service managers met monthly with each staff member and reviewed their caseloads. We saw records evidencing that risk and discharge planning were discussed. The service managers felt that their role would be more effective if they had easy access to the data required. For example; training figures, number of referrals, number of discharges, and number of young people who did not attend their appointment. We were told this data was not readily available and the service managers needed to contact performance management team to request data.
- Service managers were able to arrange cover for sickness and leave to ensure patient safety in an emergency but patients told us that when their clinician was on leave or off sick they did not always have cover for any routine concerns. Agency staff were used when required.
- There was rapid access to a psychiatrist when required. There was a duty rota for CAMHS psychiatrists during working hours. The adult service covered out of hours and the CAMHS staff spoke highly of this service but we heard from two young people who said they had struggled to get support out of hours. All of the young people we spoke to said they were able to access support quickly within normal working hours.

- Mandatory training included CPR, safeguarding children level three, safeguarding adults and infection control. At the time of inspection, the figures showed CAMHS was 90% compliant which met the trust mandatory training target.

Assessing and managing risk to patients and staff

- We looked at 10 clinical records of young people receiving treatment and 21 clinical records of young people on the waiting lists. We saw evidence to show staff undertook a risk assessment of every patient at

initial assessment and updated this regularly for the young people receiving treatment. This tool had been reviewed by the trust to ensure it was suitable for use with young people. For the young people who had received an initial assessment but were on the waiting list, they had a risk assessment completed at the time of assessment but this was not reviewed regularly.

- All of the records, with the exception of one, showed a good use of crisis and safety plans where appropriate. They included phone numbers of the adult out of hour's service and coping strategies the young person may find helpful. The young people we spoke with confirmed this.
- The hub and the priority team were created to respond promptly to a sudden deterioration in a young person's mental health and this was being achieved as the team were able to see young people in an emergency on the same day or the next working day and for urgent referrals they were being seen within a week.
- The staff could not tell us if there was a single process for proactive monitoring of risk and mental health while young people were on the waiting list. We found the notes of the Listening in Action event stated that a letter was supposed to have been sent out monthly from February 2016, asking the young person or their parents to get in touch if they had concerns. We saw from the 21 records we looked at that 10 had a letter sent out at the beginning of September 2016 to inform families they were still on the waiting list and if there were any concerns, they should phone the Hub, but there had been no correspondence prior to that. Eight had no contact at all following their initial assessment and the remaining three had had one contact since their initial assessment.
- All staff were trained in safeguarding children and knew how to make a safeguarding alert and they done this when appropriate. There were two social workers seconded to work within CAMHS and the staff spoke highly of the benefit of having these professionals embedded within the service and felt that it improved safeguarding practice.
- There were good personal safety protocols including lone working practice across all bases.

Track record on safety

- There were no serious incidents reported for CAMHS Community services between 15th January 2016 and 12th March 2016.

Reporting incidents and learning from when things go wrong

- All of the staff we spoke with knew how to report an incident and what to report.
- Staff told us they were open and transparent and explained to patients face to face or in writing if and when something goes wrong. The example we saw was when a letter had been addressed to the wrong young person. The service informed the young person affected.
- Staff told us they received feedback from investigation of incidents both internal and external to the service, via MDT meetings, email and the trust monthly bulletin. Feedback from incidents was discussed in MDT meetings and we saw that it was a standing item on the agenda.
- Staff told us their colleagues or managers de-briefed and supported them after a serious incident, both formally and informally.

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

- We looked at 31 clinical records. All of the files contained assessments completed to varying standards. The majority of the files contained up to date, personalised, holistic, recovery-oriented care plans. It was more difficult to identify the care plans in the learning disability records, as they were all paper files and clinicians had written updates and changes to the care plan over the original care plan. This made it difficult to determine the most up to date plan. We could find no evidence of easy read care plans for the children with learning disabilities.
- There was a mix of electronic and paper records, all of the new referrals only had electronic records. The trust planned to use only electronic records by the spring of 2017. All information needed to deliver care was stored securely and was available to staff when they needed it. All risk assessments and care plans were available electronically so staff could access the records from any base and adult services could access the assessments out of hours.

Best practice in treatment and care

- We saw that the doctors and the nurse prescriber followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. These included; Depression in children and young people: identification and management (CG28); Autism Spectrum Disorder in under 19s: support and management (CG170); Anti-social behaviour and conduct disorders in children and young people (QS59) and Attention Deficit Hyperactivity Disorder: diagnosis and management (CG72).
- We saw in the records that staff had considered any physical healthcare needs where appropriate.
- There was a good use of routine outcome measures during assessment and treatment. These tools measure and monitor the severity and frequency of difficulties and how effective the treatment is for the young person. These included; the strengths and difficulties questionnaire and the revised children's anxiety and depression scale.
- There was a range of audits completed regularly including monitoring the use of risk assessments and care plans. The service had recently taken part in an ADHD audit to improve compliance with the standards set by the prescribing observatory for mental health and the trust came first out of 49 trusts as complying with standard four, which was to record height and weight on growth charts every six months.
- The service was able to offer a range of psychological therapies, recommended by National Institute for Health and Care Excellence (NICE), and, as part of the CYP-IAPT transformation programme (Children and young peoples improved access to psychological therapies). These included; cognitive behavioural therapy and dialectical behavioural therapy. The lead for psychological interventions had completed a review in September 2016 of the psychological therapies offered within the children's directorate, which had identified a number of key points to improve services. These included; reduce demand to reduce waits, reduce waits to initial assessment, increase efficiency of assessment and reduce waits from initial assessment to treatment. One of the points described how the waits were going to be reduced from initial assessment to treatment with an immediate establishment of four post assessment treatment offers for new and existing waiters; these were an additional three appointments to complete assessment and/or treatment if a brief intervention was appropriate. These could be; evidence based group work, evidence based workshops or an online parenting course. We did not see records showing these brief interventions were being routinely offered except for the work done around identifying those on the waiting list in need of an ADHD assessment. We were told the outcome of the ADHD workshop showed good uptake, good customer feedback and clinical outcomes will be collected once the assessments are completed. Approximately 37 families out of 50 invited attended the workshop.
- We saw examples of psychological therapy programmes that were having a positive impact on children and young people and achieving good outcomes. These included a 'friends for life' programme which was aimed at service users experiencing anxiety and a dialectical behavioural therapy programme which focussed on those with a history of hospital admission with the aim of reducing re-admissions.

Skilled staff to deliver care

- The CAMHS teams had a range of mental health disciplines, including psychiatrists, nurses,

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.

psychologists, social workers, art therapists, parent practitioners and care coordinators. There were some staff who were very experienced and qualified and some staff with less experience.

- All staff received regular supervision and appraisals in line with trust policy.
- All staff received an appropriate corporate and local induction, which included shadowing staff across the CAMHS service.
- All of the medical staff had revalidated at the time of inspection.
- Some of the staff had accessed specialist training through the children's and young peoples improved access to psychological therapies transformation programme.
- The service managers all felt confident they were able to address poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

- We observed two weekly multi-disciplinary meetings; one at North Stoke and one at the South Stoke base. The meetings included a business section and a clinical section where cases were discussed. Most of the staff attended regularly except at South Stoke CAMHS.
- There was effective handover and good communication between the CAMHS priority team and the younger minds tier 2 service that formed part of the hub. They shared an office and as the referrals were received, the staff triaged the referrals together. There were other tier 2 services the hub often signposted to and at times can worked alongside. All of the staff we spoke to felt the communication between CAMHS teams was effective. There was a transition policy for moving from CAMHS to adult services and the staff felt this worked well when the criteria for the adult mental service was met.
- There were good working links with the schools participating in the schools project and the hub had good links with local support groups and organisations, including police, safeguarding boards and the local authority.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- There were no young people at the time of inspection receiving care in the community under the Mental Health Act.
- Figures at the time of inspection showed that 90% of staff were trained in the Mental Health Act and the Code of Practice and they had a good knowledge of the Mental Health Act and its guiding principles.
- Administrative support and legal advice on implementation of the Mental Health Act and the Code of Practice was available from a central team if required.

Good practice in applying the Mental Capacity Act

- The trust had a policy on the Mental Capacity Act which staff were aware of and could refer to.
- CAMHS staff were 90% compliant with the trust training on the Mental Capacity Act. The staff that we spoke with had a good understanding of the difference between capacity and competence. We saw evidence in clinical notes and letters that staff assessed mental capacity for their patients aged 16 years and above.
- For young people less than 16 years old, we saw that staff thought about competency and the staff we spoke with were able to give us definitions and examples of Gillick competence (This is a term used to decide whether a child under 16 years old is able to consent to treatment without the need for parental consent or knowledge). However, this information was difficult to find within the electronic care records so the service planned to include a capacity section in their electronic assessment form that all staff would have access to. The hub team were the only service using the electronic form at the time of inspection.

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

- The inspection team observed two clinical appointments and we saw that the staff were caring, warm and responsive towards the young people and their families. Staff provided appropriate practical and emotional support during the appointment and listened to the young person's views.
- We also observed two MDT meetings and the staff discussed the young people and their families' cases in a caring and respectful way.
- We spoke to 24 young people and their families; all reported staff were kind and listened to their views. The young people said they felt supported by their clinician but when they were on leave or off sick, it was difficult to speak to another clinician around non-urgent concerns.
- Staff demonstrated a good understanding of their patients' needs and the young people we spoke with agreed and stated that they felt understood.
- We saw evidence that confidentiality is maintained by not leaving records on desks and the concerns clinicians had raised around confidentiality when in the therapy rooms was being addressed by estates.

The involvement of people in the care they receive

- There was active involvement of the young people and the families' in their care planning. We saw that care plans had been signed by the young people and were written in their own words. In the learning disability team, we saw involvement from other professionals but they lacked the young person's or the families' point of view.
- There was a young person's council made up of current and former service users. The council were involved in gathering feedback from patients in a number of different ways; comment cards in the waiting room, regular face-to-face groups in each of the bases run by the council. Council representatives attended board meetings and took part in recruitment of staff. The council representative we spoke to said they felt listened to as when they were on a recent recruitment panel their scores held as much weight as the other staff members. The council have helped to improve the waiting areas; for example, the addition of the water machine in South Stoke CAMHS base.
- The service planned to develop a parent group in order to offer support to parents and contribute to the development of the service.
- There was a good range of information and leaflets appropriate to a CAMHS service user available in all of the waiting rooms, including how to access advocacy.

Are services responsive to people's needs?

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

Our findings

Access and discharge

The service accepted referrals from any professional who is concerned about a young person's mental health or it accepts self-referrals from young people or via their parents. The majority of referrals come from GP or school.

- The service managers told us the commissioners set them a target to see all young people referred within 18 weeks. As of 8th September 2016 there were 133 young people who had been waiting more than 18 weeks for an initial assessment. There were 140 young people who had been seen within 10-18 weeks and 178 who had been seen in less than nine weeks. This was an improvement since the unannounced inspection that CQC carried out in April 2016. However, the waiting times from initial assessment to treatment had increased. At the time of inspection, there were 448 children and young people waiting for treatment. Of these; There were 116 children and young people waiting for an assessment for Attention Deficit Hyperactivity Disorder or Autism Spectrum Disorder, 69 were receiving on going treatment and waiting for further intervention, 42 had completed their treatment but were waiting for a different intervention, 9 had been discharged and 212 were waiting for their first treatment following assessment.
- The staff we spoke with all expressed concern about the lengths of the wait for treatment and they said they discussed the waiting lists at every MDT and we observed them doing this at both of the MDTs we joined.
- The development of the priority team meant that urgent and emergency referrals were seen within 48 hours during normal working hours. Out of hours, young people are supported by the trust wide services including the RAID and Access teams and the on call psychiatrist. If the young person had self-harmed or if their mental health had deteriorated very quickly, they were also able to access the local accident and emergency department where a member of the CAMHS priority team would be able to assess them the next working day.
- The Hub team responded promptly and adequately when young people or their families' phoned in to discuss routine and urgent concerns.
- The development of the Hub had increased consistency around the referral criteria for tier 3 CAMHS. However, we were told prior to the hub the criteria were slightly different so there were people on the waiting lists that may not meet the criteria now. Young people who were referred since the development of the hub, who do not meet the criteria for tier 3 CAMHS, were seen by Younger Minds or referred to another service more appropriate to their needs.
- The service generally operated Monday to Friday 0900 to 1700 but the staff told us they would see young people a bit later if required. The service arranged appointments for young people in a variety of venues in order to support their engagement with CAMHS services and to provide flexibility.
- The staff we spoke to were aware of the DNA policy but treated each case individually and said they would phone or speak to another professional involved the case to determine what the barrier was for the young person not attending appointments.
- Staff told us appointments were only cancelled when necessary and when they were, the young people would receive an explanation and were given help to access treatment as soon as possible. The inspection team did not see any appointments being cancelled and none of the young people or parents we spoke to raise a concern around appointments being cancelled.
- During the inspection period we observed appointments running on time except for one occasion, we saw a mother and a daughter about to walk out as they had been waiting for 20 minutes. A member of staff spoke with the family and dealt with the situation effectively as the young person agreed to stay.

The facilities promote recovery, comfort, dignity and confidentiality

- All of the bases were bright and decorated appropriately for a CAMHS service. The rooms contained the furniture required and were in good condition. The walls in the bases had been recently painted and artwork, some produced by the young people using the service.
- There was a full range of rooms and equipment to support treatment and care. In North Stoke base, staff told us it can be difficult accessing rooms as there were not enough.

Are services responsive to people's needs?

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

- The majority of the rooms at the bases were all adequately sound proofed although two of rooms that were not, had been raised as an issue and planning was in place to rectify this.
- There was good provision of accessible information on treatments, local services, patients' rights and how to complain in all of the bases.

Meeting the needs of all people who use the service

- All of the bases were accessible for people requiring disabled access.
- Information leaflets were age appropriate and available in languages other than English upon request.
- There was easy access to interpreters and/or signers, however, on one occasion; the assessment of a young person was delayed by two weeks because of difficulty in finding an interpreter. This did not put the young person at risk as staff were visiting regularly and had contact with the young person's mother.

Listening to and learning from concerns and complaints

- The service had received seven complaints over a 12 month period from April 2015 to March 2016. CAMHS ASD and North Stoke CAMHS received the highest for the service with three each; clinical issues were the reason recorded for half of these.
- The service received 3 compliments in the 12 month period, two for CAMHS ASD and one for North Stoke CAMHS
- The young people and the parents we spoke to said they did not know the complaints procedure but would phone the service if they were concerned. The feedback from the parents we spoke with whose children were waiting for treatment was they would be reluctant to make a complaint as they know the services had been cut and they feel sorry for CAMHS staff.
- The staff knew how to handle complaints appropriately. They had received feedback on the outcome of investigation of complaints in their MDT meetings and via email and acted on the findings as required.

Are services well-led?

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

- The staff we spoke with knew and agreed with the trusts values. The service managers explained they were in the process of planning team away days in order to create specific team objectives, which would reflect the trusts values and objectives. The service managers recognised individual clinicians' achievements and in South Stoke team, they had a whiteboard with a 'sparkle' section so that compliments could be recorded.
- Staff knew who the clinical director and service director of the children's directorate were and said they visited the team. They knew who the chief executive was but did not know the rest of the senior managers. The service managers knew who most of the senior managers were.

Good governance

- The staff that we spoke with all knew how to raise any concerns or risks in multidisciplinary team meetings. The service manager explained these concerns were then taken to operational meetings which fed into the risk register.
- The rates of mandatory training and supervision were good. Staff had a good understanding of safeguarding and how to report and recognise a concern. There appeared to be a gap between clinical leadership and operational leadership. We were told that, on occasions, requests would be made for certain staff groups to do specialist training without any regard for the remaining staff left to run the service on reduced numbers. The service managers felt hopeful this was changing, as recently they had been able to decide whether they could release staff for training.
- The level of participation was good and there was lots of provision in place for patient feedback and we saw evidence it was listened to and acted upon.
- There was learning from incidents across the trust and these were shared in team meetings and via email.
- The clinical director, the senior managers, and the trust board were aware there were high numbers of young people having lengthy waits from initial assessment to treatment. We were told by the performance team they produced reports on a monthly basis and send the data to the teams and commissioners. The reports were then shared with the board through the quality committee. The CCG had also been sent the data on the CAMHS waiting lists and they began an investigation in August 2016 to explore the waiting lists and how these were being tackled and were working collaboratively with the Trust in progressing this issue including the provision of recurrent funding to increase staffing and address increased demand for services. We were advised by the clinical director there was a monthly, blanket letter that goes out to all young people on the waiting list explaining they were still on the waiting list and if they had concerns to contact the hub. We did not see evidence in the files that the monthly letter was being consistently sent out to everyone on the waiting list every month. The senior leadership team acknowledged they needed to do better and immediately following the inspection, they produced an action plan describing how they were going to monitor the waiting lists.
- The hub staff told us that the electronic patient system was unable to identify the numbers of young people and parents who had phoned in while waiting for treatment. We saw the staff had started handwritten records of how many young people and parents on the waiting list phone the hub.
- There was a Listening in Action Event held for CAMHS staff. This event was to give staff the opportunity to express concerns and ask questions about the development of the service. One of the outcomes of the event highlighted that clinicians had raised lack of case management for children on the waiting lists as a concern. The response was that since the start of February 2016, a monthly letter had been sent out to the young people waiting for treatment. This letter explained the young people or their parents could contact the service if they had concerns about their mental health. The service managers were concerned about the length of wait and amount of young people on the waiting list for treatment but they felt they were unable to proactively manage the lists without access to sufficient, reliable data. They said they needed data regarding the number of referrals received, the number of young people who do not attend, the number of discharges, the number of available sessions per clinician, the number of initial assessments; routine and urgent. They told us they had raised this issue and had meetings with the clinical director and a member of the performance team. The service mangers felt it was unusual they did not have ownership of this information

and have had previous experience in other organisations of feeding the data up to management rather than the management team sending it down to them. The service managers often felt the data they received was inaccurate and not a true reflection of the performance of their team, they said they have raised this issue with the performance team but the issue remains unsolved

- Staff had the ability to inform the service managers about any concerns that may need to be submitted to the risk register. We saw the children's directorate risk register and waiting lists was third behind ligature risk and confidentiality. It appeared from the risk register that the waiting lists identified were the ones where young people were waiting more than 18 weeks from referral to initial assessment. The inspection team were curious about this as we thought that the level of unknown risk and the amount of young people on the waiting list from initial assessment to treatment indicated a higher risk. We raised this with the clinical director and she was unable to give us an explanation.
- The service uses Key Performance Indicators gauge the performance of the team regarding training and supervision. The measures were in an accessible format but we were told the figures were often inaccurate and had names on of clinicians in different teams.
- The service managers felt they had sufficient authority about day to day running of the service but felt they needed more autonomy and ownership of figures and data to be able to do their job effectively. They felt they had enough administration support but said they did not directly line manage the administration staff but this had not caused any issues or difficulties they were aware of.
- Monthly directorate management meetings were chaired by the clinical director and the attendance included a representative from finance, risk management, the governance lead, patient experience lead, HR advisor from senior clinicians', service managers' and the youth council. We looked at the minutes from the meeting in August and saw staff discussed waiting time initiatives and identified a clinician to take this forward; however, this appeared to be for those waiting more than 18 weeks from referral to assessment rather than from initial assessment to treatment.

Leadership, morale and staff engagement

- The sickness rate for CAMHS was low at 2.3%.
- There were no reports of bullying or harassment and no open cases at the time of inspection.
- All of the staff we spoke to knew how to use the whistle blowing process and felt able to raise concerns without fear of victimisation.
- The staff said morale; job satisfaction was improving since the last CQC inspection. All of the staff spoke very highly about the service managers' leadership and they hoped for some stability within their teams after a year of significant change.
- The staff said they all work as a team and offer mutual support. They felt listened to by their service managers and their colleagues.
- Staff were offered the opportunity to give feedback on services and input into service development at a recent open day but the staff felt the way forward had already been decided to a certain extent by senior managers.
- A CAMHS Listening in Action event had taken place at the beginning of the summer and the feedback from staff was that they found it useful as they felt they could have their say. As part of the listening in action event staff fedback they felt the service followed systems rather than following the needs of young people who use the service. The response from the management team was they were working with the digital team and the youth council in order to address this issue.

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 Regulation 17 HSCA (RA) Regulations 2014 Safe Care and Treatment • Young people's mental health and risk were not being regularly reviewed and monitored on the waiting lists from initial assessment to treatment for North Stoke CAMHS, South Stoke CAMHS, North Staffordshire CAMHS, Autistic Spectrum Disorder assessment team and the CAMHS Learning Disability team. • We did not see evidence to support the service statement that since February 2016 all young people on the waiting lists have a monthly letter asking them to contact the service if there are concerns. This was a breach of Regulation 17 (1) (2) (a) (b) (c)

This section is primarily information for the provider

Enforcement actions

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.