

Good **Bradford District Care Trust**

Child and adolescent mental health services

Quality Report

BDCT Headquarters

New Mill

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Website: www.bdct.nhs.uk

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
BDCT Headquarters, New Mill	TAD	Hillbrook CAMHS (Airedale, Wharfedale and Craven)	BD20 6LD
BDCT Headquarters, New Mill	TAD	Fieldhead CAMHS (Bradford)	BD7 1LN

This report describes our judgement of the quality of care provided within this core service by Bradford District Care 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 Bradford District Care Trust and these are brought together to inform our overall judgement of Bradford District Care 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 CAMHS

Good 

Are CAMHS safe?

Requires Improvement 

Are CAMHS effective?

Good 

Are CAMHS caring?

Good 

Are CAMHS responsive?

Good 

Are CAMHS 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

There were effective systems in place for reporting patient safety incidents and the service compiled and reviewed safety information from a range of sources. Staff were however unclear about the lone working policy. Risks were not always recorded in the electronic care notes system in an effective way.

There was a system in place for assessing people's needs, however, the service did not have an effective audit programme in place. The service environments were suitable for young people and families. Written information was not always available in appropriate formats.

The different professionals in community services worked well together and made sure that people's needs were met. These staff had access to effective training, managerial and clinical supervision and appraisal.

All of the people that we spoke with were positive about the staff and the care they received. Feedback from young people and their families was however not used effectively.

The team had a range of therapies, collaborations, outreach programmes and specialty roles. There was also a good system in place for managing referrals and waiting lists safely and effectively.

The transition of young people to adult mental health services and concerns and complaints were effectively managed.

Staff felt supported within the team and from service and executive level staff.

Clinical dashboards and safety information was managed effectively at governance level, however systems for ensuring that policies and procedures were up to date were not effective.

Summary of findings

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

Are services safe?

There were effective systems in place for reporting patient safety incidents and for making sure that incidents of potential or actual abuse were reported to the local authority safeguarding teams.

The service compiled and reviewed safety information from a range of sources, including incident trends, safeguarding information and complaints. However, staff were unclear about the lone working policy and were put at unnecessary risk when they visited people alone in the community.

Documents associated with risk were not always uploaded to the electronic care notes system quickly enough or in an effective way. Also, staff were not always kept informed about potential risks as warning signs (risk triggers) were not always recorded.

The inpatient areas located on the male and female adult inpatient wards were well managed and risk was minimised.

Requires Improvement



Are services effective?

There was a system in place for assessing people's needs, which used evidence-based best practice. However, the service did not have an effective audit programme in place and action plans were not monitored. This meant that information from audits was not being used to make improvements to the service. In addition, the system in place for auditing care planning documents was not effective and did not make sure that the documents were accurate and up-to-date.

The team provided services in environments that were suitable for young people and families.

Written information was not always available in formats that were appropriate for children or for young people with a learning disability.

Staff had access to training, managerial and clinical supervision and appraisal, which was monitored effectively.

The different professionals in community services worked well together and made sure that people's needs were met.

Good



Are services caring?

All of the people that we spoke with were positive about the staff and the care they received. They felt staff were kind and treated them with dignity and respect.

Good



Summary of findings

Young people and their families had the opportunity to be involved in the service. However, although there were systems in place for gathering feedback, these were not effectively monitored at a local level.

Are services responsive to people's needs?

The team had a range of therapies, collaborations, outreach programmes and specialty roles that helped them to deliver a prompt and effective service.

There was also a good system in place for managing referrals and waiting lists safely and effectively.

Clinical leads in the CAMHS service were integrated in the team.

The transition of young people to adult mental health services was managed effectively, and there was a dedicated team to make sure that the move was safe and person-centred.

Young people and their families were happy with the way the concerns and complaints handled, which were effectively dealt with.

Good



Are services well-led?

The team compiled and reviewed safety information from a range of sources in a clinical dashboard including incident trends, safeguarding information and complaints. This was coordinated at governance level.

Staff felt supported within the team and from service and executive level staff. Staff told us that they could approach senior management if they had any concerns. Staff were aware of the trust vision and values.

Systems for ensuring that policies and procedures were up to date were not effective.

Good



Summary of findings

Background to the service

Bradford District Care Trust provides community Child and Adolescent Mental Health Services (CAMHS) for young people from pre-school years, up to the age of 16, or up to 18 years of age if still in school.

The service is located over two sites: Hillbrook CAMHS is located in Keighley and covers the areas of Airedale, Wharfedale and Craven. Fieldhead CAMHS located in Bradford and covers the Bradford area.

The service offers family work, individual counselling, parent counselling, group therapy and play therapy. It covers problems such as depression, eating disorders, school refusal, substance misuse, developmental difficulties, psychotic illness, obsessive compulsive disorder and attachment difficulties.

We also visited two inpatient areas. These are designated rooms within Oakburn (male-only) and Ashbrook (female-only) adult mental health wards at Lynfield Mount Hospital. They are used as emergency admission beds for young people, and are a last resort if people cannot be cared for in the community and there are no inpatient beds available. As Bradford District Care Trust does not have provision for inpatient CAMHS, the trust uses out-of-area beds when admission is required. There is a Tier 4 CAMHS specialist eating disorder and intensive home treatment team (known as 'speediht') to support people in the community and to help reduce admissions.

Our inspection team

Our inspection team was led by:

Chair: Angela Greatley, Chair, The Tavistock and Portman NHS Foundation Trust

Team Leader: Jenny Wilkes, Head of Inspection – Hospitals Directorate (Mental Health), Care Quality Commission

The team included: a CQC inspector, a consultant psychiatrist specialist advisor, a nurse specialist advisor and a CAMHS ward manager.

Why we carried out this inspection

We inspected this core service as part of our Wave 2 pilot mental health and community health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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?

We visited the Child and Adolescent Mental Health Services (CAMHS) of Bradford District Care Trust on 17 and 18 June 2014. During the visit, we held focus groups with a range of staff who worked within the service, including nurses, doctors, and therapists. We talked with people who use services, their carers and/or family members. We also observed how people were being

Summary of findings

cared for and reviewed their care or treatment records. We used the information we hold about the service, as well as the information we gathered, to inform our inspection of the service and the questions we asked.

What people who use the provider's services say

We attended initial assessments and family therapy at CAMHS. We also went to two young people's groups, facilitated by Barnados, where we observed group activities and spoke to young people using the CAMHS service. In addition, we spoke with young people using the service and families on the phone and asked them about their experiences of CAMHS.

All of the young people and families that we spoke with were happy with way they were treated by the team. Comments included "I feel 100% listened to", "I'm very happy with the service" and "I've never felt judged."

Most people told us that they had had consistent care workers throughout their time with CAMHS. One person said, "I've had the same worker throughout, which is good because I don't have to explain my story over and over again."

Young people using the service told us that they were involved in their care. Parents and families were also involved if the young person wanted them to be.

Good practice

Area managers gave us examples where the incident reporting system had been used effectively to improve the service.

There was an out-of-hours nursing service in place, which was provided by the speediht team (intensive home treatment and support) with management and consultant cover on-call. This service made sure that young people in crisis had urgent support. It also managed the need for inpatient admission or discharge to the community out-of-hours.

The CAMHS suites, located in the male and female adult inpatient wards, were well managed and risk was minimised when young people needed to be admitted.

The CAMHS team were members of the Quality Network For Community CAMHS (QNCC), a quality network run by the Royal College of Psychiatrists.

A specialist 'post sixteen' pathway had been developed for young people aged 16 and above and the options available to them in CAMHS.

As part of 'agile working', staff were provided with equipment such as tablets and video links. This enabled them to work from multiple locations and gave them better and more regular contact with young people and their families.

Staff could access training in specialty areas such as eating disorders, substance misuse and learning disabilities. They also told us that they were encouraged to specialise within the team and were supported to develop specialist skills.

All of the people that we spoke with were positive about the staff and the care they received. They felt staff were kind and treated them with dignity and respect.

Young people had the opportunity to be involved in the service through the collaborative work with Barnados. For example, young people told us that they had been involved in interviewing CAMHS staff and had input into the design of the waiting areas in CAMHS buildings.

While consent was not always required, staff found training on consenting to treatment for young people useful and helped to involve young people in decision-making.

Summary of findings

The team had a range of therapies, collaborations, outreach programmes and specialty roles that helped them to deliver a prompt and effective service. Therapies offered included: family work, individual counselling, parent counselling, group therapy and play therapy.

There were monthly consultations with a local children's care home to make sure that any mental health needs were met.

Each school had a primary health worker, who carried out joint assessments with the CAMHS team and were the source of all non-urgent referrals to the service.

The transition of young people to adult mental health services was managed effectively, and there was a dedicated team to make sure that the move was safe and person-centred.

The medical director had visited the service and attended meetings specific to CAMHS. There had also been drop-in sessions with executive staff for trust staff to discuss their concerns.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Risks relating to people using the service should be fully documented in the electronic case note system (RIO) after each meeting, to make sure that all information about risk is captured and that this is communicated to all staff.

The RIO system tick box system for recording risk triggers and safeguards, which lets staff know that young people using the service may be vulnerable, should be used consistently and all staff should be made aware of this function.

The lone working policy should be made more accessible and clearly outline measures for staff safety when making community visits. This should be communicated to all staff and adhered to.

An effective audit programme should be implemented and actions monitored record service improvements. This includes local audits of care planning documents, as well as feedback from young people using the service and their families and quality network involvement.

Policies and procedures should be brought up-to-date so that staff follow the trust's current guidelines.

Bradford District Care Trust

Child and adolescent mental health services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
BDCT Headquarters, New Mill	Hillbrook CAMHS (Airedale, Wharfedale and Craven)
BDCT Headquarters, New Mill	Fieldhead CAMHS (Bradford)

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.

Mental Capacity Act and Deprivation of Liberty Safeguards

Not applicable for this service. MCA and DoLS does apply for young people.

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

Summary of findings

There were effective systems in place for reporting patient safety incidents and for making sure that incidents of potential or actual abuse were reported to the local authority safeguarding teams.

The service compiled and reviewed safety information from a range of sources, including incident trends, safeguarding information and complaints. However, staff were unclear about the lone working policy and were put at unnecessary risk when they visited people alone in the community.

Documents associated with risk were not always uploaded to the electronic care notes system quickly enough or in an effective way. Also, staff were not always kept informed about potential risks as warning signs (risk triggers) were not always recorded.

The CAMHS suites located on the male and female adult inpatient wards were well managed and risk was minimised.

series of incidents reported by staff following the loss of the centralised administration team and the introduction of a new administration hub which meant that young people and their families were having difficulty contacting the CAMHS team by phone.

Learning from systems, processes and practices to keep people safe and safeguarded from abuse

There was a system in place to ensure that incidents of potential or actual abuse were reported to the local authority safeguarding teams. The service managers told us that the service monitored the number of safeguarding alerts submitted and progress. All staff told us that they had received level three safeguarding training and most were up to date with refresher training. Those that were not up-to-date had a planned date to attend refresher training. Staff were able to inform us about the system that they used to escalate any safeguarding issues and could identify potential signs of abuse. Staff were given updates on the progress of safeguarding cases through safeguarding best practice group supervision, facilitated by the lead nurse responsible for safeguarding, and which were held every three months.

Assessing and monitoring safety and risk

People using the service were risk assessed using various assessment tools including SDQ (Strengths and Difficulties Questionnaire), CGAS (Children's Global Assessment Scale) and BDS (Beck Depression Scale). The assessment tools captured risks associated with people using the service and identified any safeguards that may need to be put in place to ensure that people using the service were protected from potential abuse.

Young people who were identified as being vulnerable were prioritised and a flexible approach was taken in relation to the prioritisation of high-risk young people. We observed initial assessments of young people using the service and multi-disciplinary meetings where people using the service were discussed. Risks to young people were identified and documented in meetings.

We were told that risks would be uploaded into the electronic case note system called RIO after each meeting to ensure that all risk information was captured. We saw a few examples of where this information was not historically

Our findings

Track record on safety

There was an effective system in place for reporting patient safety incidents. Staff knew about the systems that were in place for reporting incidents and knew about their responsibilities around reporting. Staff were also given information through weekly team meetings, email and intranet bulletins about incident trends, current risks to the service and the measures that they should take to help prevent reoccurrence. Incidents including serious untoward incidents (SUIs) were also discussed by service managers, at monthly CAMHS governance meetings, held within each geographical locality. We saw evidence that any action resulting from SUIs were monitored and any changes in practice were cascaded to staff.

We were given examples by area managers where the incident reporting system had been used effectively to bring about improvements in the service, specifically around the introduction of a new phone system after a

Are services safe?

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

uploaded into the RIO system during out case note tracking exercises. This meant that risks were not always being documented leaving a risk of important information not being documented and communicated.

The RIO system had a tick box system for recording risk triggers and prompts that young people using the service may be vulnerable to. This was not always used by staff to capture individual risk/safeguards. This meant that identified risks may not always be flagged up making risk information more difficult for staff to access. Staff told us that they would look through electronic case notes and written meeting minutes (these were not always typed into the system). This was identified as being a particular concern if staff were covering another caseload or bank and agency staff were used, as they would be unfamiliar with young person's risk factors. In one instance we saw in the electronic case notes that one person was identified as being at risk of sexual exploitation, however there was no associated trigger or risk assessment in place. We asked the service to provide us with assurances that this was reviewed during the inspection visit.

Understanding and management of foreseeable risks

There was an out-of-hours nursing service in place provided by the speedhit team (intensive home treatment and support) with management and consultant cover on-call. This was provided to ensure urgent support was available for young people in crisis and to manage the need for out-of-hours inpatient admission or discharge to the community.

The CAMHS team were unclear about the lone working policy within the trust. We asked to see this, however, it could not be located on the intranet. We were later told that the lone working policy forms is encompassed within the health and safety policy. Staff were unaware what procedures to follow in order to keep them safe when undertaking visits in the community alone. There was an ad hoc system in place to sign in and out of the office base when going on visits, and informing staff members of where visits would take place. However staff did not always check in and out especially for visits at the end of the day. Staff did not know the procedures for raising an alarm if they were at risk in the community. This left staff at risk when undertaking visits on their own in the community.

Inpatient areas

The CAMHS suites located on the male and female adult inpatient wards were well managed and risk was minimised on the occasions that these would need to be used to admit young people. Examples of risk minimisation included using only permanent staff to provide observation to young people using the suites as well as daily input from CAMHS staff and training for staff working in the adult areas around young people and mental health problems. We were told that any admission to the CAMHS suite would be discussed at handover and that care planning documentation was available through the RIO system also used in adult services. We were told that all staff had received safeguarding training specific to young people. The service was aware that these beds were not sustainable in the long term, but a project with monitored timeframes was in place for inpatient provision to be provided within the trust in the future.

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.

Summary of findings

There was a system in place for assessing people's needs, which used evidence-based best practice. However, the service did not have an effective audit programme in place and action plans were not monitored. This meant that information from audits was not being used to make improvements to the service. In addition, the system in place for auditing care planning documents was not effective and did not make sure that the documents were accurate and up-to-date.

The team provided services in environments that were suitable for young people and families.

Written information was not always available in formats that were appropriate for children or for young people with a learning disability.

Staff had access to training, managerial and clinical supervision and appraisal, which was monitored effectively.

The different professionals in community services worked well together and made sure that people's needs were met.

We saw that young people's needs were assessed in line with guidance published by professional and expert bodies. This meant that young people's needs were fully assessed so that they could be met in the most appropriate way by the relevant professionals in the team.

We observed initial assessments of young people using the service as well as family therapy sessions and saw that the relevant assessment tools were followed and used effectively to gather information about young people using the service.

Outcomes for people using services

Performance information was available and reviewed by the CAMHS team and the team engaged in national clinical audit and quality networks. Although we observed some evidence of changes having been implemented as a result of audit, evidence of an audit programme and monitoring of action plans was not in place. This meant that audit was not being used effectively to implement improvements to the service.

The CAMHS Team were members of the Quality Network For Community CAMHS (QNCC), a quality network run by the Royal College of Psychiatrists. The service had been peer reviewed in 2013. There was however no action plan in place to identify how the improvements that had been suggested would be undertaken.

There was a local audit of care planning documentation in place which was undertaken by the area manager on a six-weekly basis as a supervision exercise with staff to ensure that care plan contained the correct and up to date information. We were shown the evidence of this and found that shortfalls identified in care notes were not always being changed and in some cases members of staff had not received supervision to monitor the accuracy of the documentation in their case loads. The system was not effective in ensuring that documentation was accurate and up-to-date.

A specialist 'post sixteen' pathway had been developed for young people above sixteen and the options available to them in CAMHS.

Staff, equipment and facilities

The team worked out of appropriate environments suitable for young people and families with access to therapy rooms when required. As part of 'agile working', a system being

Our findings

Assessment and delivery of care and treatment

There was a system in place for assessing the needs of the people using the service which was based on evidence-based best practice. An initial contact assessment SDQ (strengths and difficulties questionnaire), was used to identify the needs and the young person accessing the service before they had an initial assessment. We were shown a range of tools used such as HoNOSCA (Health of the Nation Outcome Scales for Children and Adolescents), CGAS (Children's Global Assessment Scale) and BDS (Beck Depression Scale), CAF (Child Assessment for young people using the service during assessment and treatment. Staff that we spoke with told us that these assessment tools captured information about the young person and their family effectively and enabled them to plan and deliver a care pathway based on their outcomes. Timescales for re-assessment were clear and we were shown evidence of at least six-monthly assessments, where necessary.

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.

used by the CAMHS to enable staff to work from multiple locations using the latest technology, equipment such as tablets and video links enabled effective and more regular interaction with young people and their families.

Suitable waiting areas with child friendly surrounding were provided at both office locations. There was written information available for professionals and families about the CAMHS services and local community services, however this was not always available in age appropriate formats for children or for young people with a learning disability.

Staff in community services told us that they had regular training relevant to their role which helped them to develop their skills and knowledge. The uptake of training was being effectively managed and service managers were able to provide us with an accurate picture of which staff required updates on their training. Specialist training was available to staff in areas such as eating disorders, substance misuse and learning disabilities. Staff told us that they were encouraged to specialise within the team and supported to develop specialist skills.

There was managerial and clinical supervision and appraisal available for staff which was monitored effectively.

Multidisciplinary team working

We saw that different professionals in the community services worked together to ensure that each person who used the service had their needs met. We saw that relevant information was shared between professionals ensuring

they each knew how to support a person to meet their needs. We observed multidisciplinary team meetings took place, which included strong links within the integrated team providing a range of specialties.

The CAMHS team had integrated specialisms within the team. There were a range of specialist services such as eating disorders, school refusal, substance misuse and learning disability.

Joint assessments were provided with other agencies including a joint autism assessment with Bradford Autistic Society. There were strong links with young people groups such as Barnados who provided support groups for young people.

Mental Health Act (MHA)

We did not monitor responsibilities under the Mental Health Act 1983 at these locations, however we examined the trust's responsibilities under the Mental Health Act at other locations and we have reported this within the overall trust report.

Inpatient areas

There was no direct access to outside space for young people using the inpatient areas. In order to access the inpatient areas it required walking through the adult wards which was not ideal, however, staff explained measures to minimise exposure to other people using the service during admission such as using the side door and encouraging adults not to be in the corridor areas during an admission.

Are services caring?

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

Summary of findings

All of the people that we spoke with were positive about the staff and the care they received. They felt staff were kind and treated them with dignity and respect.

Young people and their families had the opportunity to be involved in the service. However, although there were systems in place for gathering feedback, these were not effectively monitored at a local level.

Our findings

Kindness, dignity and respect

We attended initial assessments and family therapy at CAMHS. We attended two young people's groups facilitated by Barnados where we observed group activities and spoke to young people using the CAMHS service. We spoke with young people using the service and families on the phone and asked them about their experiences of CAMHS.

All of the young people and families that we spoke with were happy with the way they were treated by the team in regards to kindness, dignity and respect. Some comments included "I feel 100% listened to", "I'm very happy with the service" and "I've never felt judged."

Most people told us that they had had consistent care workers throughout their time with CAMHS. One comment included "I've had the same worker throughout which is good because I don't have to explain my story over and over again."

All staff we spoke with were passionate about the job they did and were motivated to ensure that people who used services were cared for. One comment about the staff was "they're very helpful."

People using services involvement

Young people using the service told us that they were involved in their care. Parent and families were also involved at the discretion of the young person.

We observed that staff used appropriate communication, and made adjustments where necessary, to help people to express themselves and their views about the service provided. We observed that staff spent time with people who used the service to explain their care plan and ensured that they agreed with it. We saw that people's relatives, where appropriate, were involved in their care.

Young people had the opportunity to be involved in the service through the collaborative work with Barnados. Young people told us they had been involved in interviewing CAMHS staff as well as having input into the design of the waiting areas in CAMHS buildings.

Specialist training was available around consenting to treatment for young people which staff told us was useful to involve young people around decisions although consent not have always been required.

Emotional support for care and treatment

Young people using the service told us that they were treated with compassion, empathy, kindness and respect through their treatment from CAMHS. We observed that staff provided emotional support to young people using the service. Staff gave young people the opportunity to discuss their care at their own pace and dictate their own care.

Are services responsive to people's needs?

Good 

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

Summary of findings

The team had a range of therapies, collaborations, outreach programmes and specialty roles that helped them to deliver a prompt and effective service.

There was also a good system in place for managing referrals and waiting lists safely and effectively.

Clinical leads in the CAMHS service were integrated in the team.

The transition of young people to adult mental health services was managed effectively, and there was a dedicated team to make sure that the move was safe and person-centred.

Young people and their families were happy with the way the concerns and complaints handled, which were effectively dealt with.

During our visit we spoke with clinical leads in the CAMHS service that were integrated into the team. Clear roles had been identified in leading specialism within the team and clinical supervision was provided by these clinicians to members of the multidisciplinary team.

Transition for young people moving on to adult mental health services was managed effectively with a dedicated team ensuring the transition was safe and person centred.

Staff spoken with had an awareness of how to meet people's religious and cultural needs. Staff showed that they were sensitive to the person's needs, and that of their family, when visiting them in the community. Cultural needs of the young people using the service were met and information was available in different languages as well as access to interpreters. The staff took the cultural needs of young people into consideration throughout their treatment.

Right care at the right time

The referral process was managed effectively and people were seen within 11 weeks. Waiting lists were managed effectively through two weekly Multidisciplinary referral meetings and young people who were at higher risk were prioritised accordingly. We were told that urgent referrals would usually be contacted and assessed within 24 hours. Appointments were given at times to suite young people and took place in appropriate environments. Do not attends (DNAs) were monitored by the team in an effort to reduce reoccurrence.

The speedhit team were a specialised Tier 4 provision team in place looking at intensive home treatment support, effectively supporting young people with higher needs in the community and in out of area inpatient beds. This service was available seven days a week.

Learning from concerns and complaints

Concerns and complaints were dealt with effectively and to the satisfaction of young people using the service and their families. We saw that information about how to make a complaint was displayed and available to people who used the service. People we spoke with told us that they knew how to make a complaint. People said that these would be listened to and action taken to make improvements. Learning from complaints and concerns could, however, not always be evidenced through action planning.

Our findings

Planning and delivering services

There were a range of therapies, collaborations, outreach programmes and specialty roles in the team to ensure that service delivery was effective and timely.

There was a waiting list for some therapies with access to psychological therapies (CBT) and family therapy took from nine to 12 months. A recent review of psychological therapies had taken place which meant that a skills monitoring exercise had taken place and some staffing changes had been made which was affecting the access to these therapies.

Other therapies offered included family work, individual counselling, parent counselling, group therapy and play therapy. There were monthly consultations with a local care home for children to ensure that any mental health needs were met from this community. We were told that there was a primary health worker role in each school who carry out joint assessments with the CAMHS team and are the source of all non-urgent referrals to the service.

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.

Summary of findings

The team compiled and reviewed safety information from a range of sources in a clinical dashboard including incident trends, safeguarding information and complaints. This was coordinated at governance level.

Staff felt supported within the team and from service and executive level staff. Staff told us that they could approach senior management if they had any concerns. Staff were aware of the trust vision and values.

Systems for ensuring that policies and procedures were up to date were not effective.

Our findings

Vision and strategy

Staff told us that they received information about the vision and strategy of the trust and were aware of this and how it impacted on their role. Staff told us that they shared good practice within the trust. Teams were integrated with health professionals and social workers all working together to benefit people who used services.

Responsible governance

We were shown examples about how risk was assessed by the service through governance. There was a risk register in place that encompassed the risks CAMHS services. Risk registers were discussed at the locality governance meetings and were discussed up to board level. Staff were able to tell us about the risks that were currently on the risk register and progress made against these risks.

The team compiled and reviewed safety information from a range of sources in a clinical dashboard including incident trends, safeguarding information and complaints. This was coordinated at governance level by the risk management team and disseminated to the area managers on a monthly basis. We saw evidence that these were discussed at the monthly governance meetings and appropriate actions were taken to learn from this information.

Leadership and culture

Staff felt supported within the team and from service and executive level staff. Staff told us that they could approach senior management if they had any concerns. Staff were aware of the trust vision and values. We were told that the

medical director had visited the service and attended meetings specific to CAMHS. There had also been drop-in sessions with executive staff available to all trust staff where they could discuss their concerns.

Most staff told us that they received regular supervision and appraisals which were focussed and useful to the member of staff in improving their performance.

Engagement

We saw that teams worked together and shared practice with each other and with external providers and networks. This meant that best practice was shared to benefit people who used the service.

There were multiple methods of collecting people's views including a patient satisfaction survey in place. There was a system in place called 'Elephant' which was a kiosk for young people to complete a short questionnaire about the service. Results of the most recent surveys from the last three months were displayed for people to see. There was also a comments box available in the waiting areas. We asked the service manager about how feedback from young people and their families was looked at and how improvements were made based upon people's feedback. We were told that there was no system in place to ensure that the box was emptied on a regular basis and that comments were reviewed or acted upon. During the visit we opened the comments box and found a number of suggestions, however it was unclear as to how long these comments had been in the box as they were not dated. The service manager assured us that a system would be put into place to ensure comments were regularly reviewed and a date was recorded on the comments paper.

Performance improvement

There were some systems in place to ensure that the team looked at the performance and made improvements. The service reviewed itself against recommendations from the Winterbourne report including having a nominated clinician responsible for reviewing people using the service who were placed out of area. Areas for improvement had also been identified looking at specialist autism services from this review.

There were systems in place to gather feedback from young people using the service however these were not always being used effectively and in a timely manner to ensure that views were impacting on the way that the service ran.

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.

We reviewed the policies and procedures in place specific to CAMHS on the intranet and found that most of them had not been reviewed within the set time frame. We spoke to the area manager about this which was attributed to staff

sickness. Systems for ensuring that policies and procedures were up to date were not effective and therefore staff were not aware of the most up to date practice that they should be following.