

**Requires Improvement**

Worcestershire Health and Care NHS Trust

# Specialist community mental health services for children and young people

## Quality Report

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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)
Trust Headquarters	R1AZ3	South Worcestershire CAMHS, Aconbury North	WR5 1JG
Trust Headquarters	R1AZ3	Wyre Forest CAMHS, Kidderminster Health Centre	DY10 1PG
Trust Headquarters	R1AZ3	Redditch and Bromsgrove CAMHS, The Pear Tree Centre	B97 4BD
Trust Headquarters	R1AZ3	Single Point of Access and Home Treatment Team	WR9 8QU
Trust Headquarters	R1AZ3	Learning Disability CAMHS Service, Seaford Court Lodge	WR14 1EX

# Summary of findings

This report describes our judgement of the quality of care provided within this core service by Worcestershire Health and Care 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 Worcestershire Health and Care NHS Trust and these are brought together to inform our overall judgement of Worcestershire Health and Care 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 Specialist community mental health services for children and young people

Requires Improvement



Are Specialist community mental health services for children and young people safe?

Requires Improvement



Are Specialist community mental health services for children and young people effective?

Good



Are Specialist community mental health services for children and young people caring?

Good



Are Specialist community mental health services for children and young people responsive?

Requires Improvement



Are Specialist community mental health services for children and young people 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 rated the community mental health services for children and adolescents as 'requires improvement' because:

- Staffing vacancies and sickness meant there were long waiting times to receive treatment.
- Staff vacancies had affected the completion of administration tasks.
- Risks were found regarding safety and security in some teams.
- Records were not always held securely and were not easily accessible to frontline staff.
- Record of mental capacity and consent to treatment assessments were not always clearly documented.
- Young people accessing crisis services did not always have an assessment carried out by appropriately skilled staff.
- If required, young people could not be admitted to an in-patient facility locally and were placed out of area.
- Carers and young people were not always aware of the trusts complaints procedure.
- Recording staff supervision and arrangements were not consistent across teams.
- Staff did not feel that the trust were responding effectively to their concerns regarding low staffing levels.
- Several staff expressed low morale and lack of communication from senior managers regarding the actions by the trust to address identified concerns.

- Feedback from people using the service, staff and others was not being used to continuously improve and ensure the sustainability of the service.

Staff received training in safeguarding and demonstrated that they knew how to do this effectively in practice.

Staff were using the nationally recognised 'Choice and Partnership Approach' (CAPA).

Staff provided a range of therapeutic interventions in line with National Institute of Clinical Excellence (NICE) guidelines.

Regular team meetings took place and the staff told us that they felt supported by colleagues.

We found evidence of the trust providing a service to meet young people's diverse needs, including an identified learning disability pathway.

Young people and carers reported they were treated with dignity and respect and gave positive feedback about staff.

Staff showed an understanding of the individual needs of young people.

The LD CAMHS service review showed parents and carers were highly satisfied with the service they received.

# Summary of findings

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

### Are services safe?

We rated the community mental health services for children and adolescents for safety as 'requires improvement' because:

- There is a 23% vacancy rate at Wyre Forest leading to waiting lists.
- We found two environmental safety risks with window restrictors and window blind cord.
- Not all staff had not received training to manage aggression from others. This training is not currently listed in the trust as essential to role.
- Young people on waiting lists had not always been effectively monitored.

Each young person had an individualised risk assessment that had been reviewed by the multi-disciplinary team.

Staff received training in safeguarding and they knew how to do this effectively in practice.

There were opportunities to have complex case reviews with peers for advice on effective assessment and treatment plans.

**Requires Improvement**



### Are services effective?

We rated the community mental health services for children and adolescents as 'good' because:

Staff were using the nationally recognised 'Choice and Partnership Approach' (CAPA).

Assessments took place using nationally recognised assessment tools.

Staff provided a range of therapeutic interventions in line with National Institute of Clinical Excellence (NICE) guidance.

Regular team meetings took place and staff told us that they felt supported by colleagues.

- Records in South Worcestershire and Redditch and Bromsgrove teams were not always held securely.
- When working out of hours there was no access to CAMHS paper records.
- Records of mental capacity and consent to treatment assessments had not always been clearly documented.

**Good**



# Summary of findings

## Are services caring?

We rated the community mental health services for children and adolescents for caring as 'good' because:

Young people and carers reported they were treated with dignity and respect and gave positive feedback about staff.

Staff showed understanding of individual needs of young people.

Young people from the Youth Board had been involved in the clinical service manager interviews and there were plans to involve them in other senior CAMHS appointments.

Young people had been involved in the redesign of team meeting rooms and waiting areas.

- Young people and carers said staff encouraged them to give their views and involved them in their care. The assessment and treatment records seen did not always reflect this.
- A 2013 'Your welcome' report had collated feedback from young people and carers but action taken to address the identified issues was not evident.

Good



## Are services responsive to people's needs?

We rated the community mental health services for children and adolescents for responsiveness as 'requires improvement' because:

- Young people often waited long times for treatment.
- Young people accessing crisis services did not always have an assessment carried out by appropriately skilled staff.
- If required young people could not be admitted to an in-patient facility locally and were placed out of area.
- Carers and young people were not always aware of the trusts complaints procedure.
- The trust complaints staff were not aware of formal complaints that had been made.

The trust had redesigned CAMHS's. This had resulted in the provision of a single point of access team who triage referrals to determine the most appropriate course of action.

We found evidence of the trust providing a service to meet the diverse needs of the local population. This included an identified learning disability pathway.

A 'transition project' with staff champions from CAMHS and adult services helped ensure an easier transition across different trust services.

Requires Improvement



# Summary of findings

## Are services well-led?

We rated the community mental health services for children and adolescents for well led as 'requires improvement' because:

- Staff supervision arrangements and recording were not consistent across teams.
- Staff did not feel that the trust were responding effectively to their concerns regarding low staffing levels.
- Several staff expressed low morale at Wyre Forest.
- Staff reported changes to management across all CAMHS teams in the last three months.
- Several staff reported a lack of communication from senior managers regarding the actions taken to address identified concerns.
- Feedback from people using the service, staff and others was not being used to continuously improve and ensure the sustainability of this trust core service.

Staff knew who the most senior managers in the trust were and gave examples when senior managers have visited teams.

Managers had access to governance systems that enabled them to monitor the quality of services provided and identify potential risks.

Managers had systems for monitoring sickness levels and conducted exit interviews to identify any themes.

An LD CAMHS service review showed parents/carers were highly satisfied with the service they received.

## Requires Improvement





# Summary of findings

## Background to the service

- The trust provides specialist community mental health services for children and young people aged 0 to 18 years.
- Assessment, support, therapeutic interventions and treatments are offered to children and young people with complex and enduring emotional and behavioural difficulties and emerging mental health disorders.
- There are three CAMHS teams based in Redditch, Kidderminster and South Worcester.
- Each has a multi-disciplinary team of psychiatrists, psychologists, psychotherapists, community psychiatric nurses, primary mental health workers and social workers to provide services for young people and their families across Worcestershire.
- This core service is managed under the integrated service delivery unit (SDU) for Children Young People and Families.
- CAMHS teams have not been previously inspected by the Care Quality Commission.

## Our inspection team

Our inspection team was led by:

**Chair: Dr Ros Tolcher, Chief Executive, Harrogate and District NHS Foundation Trust**

**Team Leader: Pauline Carpenter, Head of Hospital Inspection (mental health) CQC**

The team included CQC managers, inspection managers, inspectors, support staff, a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected this service consisted of a CQC inspector, and three specialist professional advisors. A consultant child and adolescent psychiatrist, a senior mental health nurse and a social worker. All of whom had recent mental health service experience.

## Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

## How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and trust:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about Worcestershire Health and Care NHS Trust and asked other organisations to share what they knew.

We carried out an announced visit between 19 and 23 January 2015. Unannounced inspections were also carried out on 28 January 2015.

During the site visits for this core service the inspection team:

# Summary of findings

- Visited three child and adolescent mental health services (CAMHS) teams, the single point of access team and a learning disability CAMHS team.
- Spoke with two young people using the service and six carers.
- Talked with 44 staff.
- Spoke with a professional from a children's external agency.
- Reviewed 37 assessment and treatment records.
- Observed an initial assessment with staff and a young person.
- Observed a psychiatrist's team meeting.
- Interviewed senior clinicians. This included a CAMHS manager, a service lead for psychological interventions, a clinical services manager, a service development unit lead and a clinical director.

- Reviewed a range of policies, procedures and other records relating to the running of this service.
- Observed staff interactions with young people.
- Held focus groups with different staff groups.
- Reviewed information we had asked the trust to provide.
- Collected feedback from young people and their carers using the comment cards provided by the Care Quality Commission.

The team would like to thank all those who met and spoke with the inspectors during the visit and were open and balanced in the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

## What people who use the provider's services say

- We spoke with young people and carers who used these services in focus groups and individual interviews.
- Young people and their carers gave feedback using the comment cards provided by the Care Quality Commission.
- Young people told us that they were treated with dignity and respect and received good care.
- They told us that there were opportunities for involving them and their carers in service improvements.

## Good practice

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

#### Action the trust **MUST** take to improve

- The trust must ensure that administrative tasks are undertaken in a timely manner.
- The trust must review its contingency arrangements for staffing to ensure young people receive assessment and treatment without long delays.
- The trust must review its procedures for assessing and monitoring environmental risks to ensure that young people's health and safety is maintained.
- The trust must review its procedures for maintaining assessment and treatment records, storage and accessibility including out of hours provision.

- The trust must review its provision of crisis services for young people to ensure that young people using crisis services have an assessment by appropriately skilled staff.

#### Action the trust **SHOULD** take to improve

- The trust should review its procedures for ensuring that staff receive regular supervision and that this is recorded.
- The trust should ensure that staff effectively record the mental capacity and consent to treatment assessments of young people.
- The trust should review its procedures with commissioners for admitting young people to out of area in patient services.

# Summary of findings

- The trust should review its procedures for using feedback from people using the service, staff and others to continuously improve.

## Worcestershire Health and Care 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
South Worcestershire CAMHS, Aconbury North	Trust Headquarters
Wyre Forest CAMHS, Kidderminster Health Centre	Trust Headquarters
Redditch and Bromsgrove CAMHS, The Pear Tree Centre	Trust Headquarters
Single Point of Access and Home Treatment Team	Trust Headquarters
Learning Disability CAMHS Service, Seaford Court Lodge	Trust Headquarters

#### 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 Trust.

We did not monitor responsibilities under the Mental Health Act (MHA) within this core service as during our inspection none of the young people were detained.

Staff would contact the Mental Health Act administrative team if they needed any specific guidance about their roles and responsibilities under the Mental Health Act.

When required staff could contact the Approved Mental Health Professionals (AMHP) service to co-ordinate assessments under the Mental Health Act 1983.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

This service caters for people under 18 years of age so the Deprivation of Liberty Safeguards do not apply.

We saw the use of a standardised consent form for recording the consent of children and young people and carers in relation to the Data Protection Act 1998.

We found that the recording of discussions and assessments with young people regarding consent to treatment varied across teams.

# 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

We rated the community mental health services for children and adolescents for safety as 'requires improvement' because:

- There is a 23% vacancy rate at Wyre Forest leading to waiting lists.
- We found two environmental safety risks with window restrictors and window blind cord.
- Staff had not routinely received training in the management of violence and aggression.
- Young people on waiting lists had not always been effectively monitored.

Each young person had an individualised risk assessment that had been reviewed by the multi-disciplinary team.

Staff received training in safeguarding and they knew how to do this effectively in practice.

There were opportunities to have complex case reviews with peers for advice on effective assessment and treatment plans.

- One room had a window blind with a dangling cord. A senior manager told us this should have been removed following a trust issued patient safety alert.
- Wye Forest, Redditch and Bromsgrove teams had access to medical clinical rooms were required.

### Safe staffing

- The trust had identified staffing levels for teams although were not using a recognised tool.
- Nineteen staff across teams reported shortages in staffing and suitable skills mix, particularly for administration staff. Three staff reported that on some days there were no administrative staff available.
- Five staff reported that staffing posed a risk to service delivery.
- We found two incidents where young people did not receive appointment letters in sufficient time.
- Staffing concerns had identified on the risk register and senior managers had developed an action plan dated January 2015 for CAMHS to address staffing vacancies.
- Trust data showed CAMHS staff vacancies of 16%, whole time equivalent of 14.8 (WTE), at Wyre Forest 23% of posts were vacant (4.3 WTE).
- Staff sickness data showed 9% for CAMHS and 26% for Wyre Forest. Long term sickness had increased from 5% in November 2014 to 8 % in December 2014. Short term sickness had reduced over the same period.
- Return to work support plans were in place for individuals. Managers told us that they felt that most staff sickness was not work related and that there were no identifiable themes.
- The duty rotas showed us that bank and agency staff were used and some staff had moved across teams to give support.
- Five agency doctors had been used to provide cover for one post. Some staff expressed concerns that young people lacked consistency of treatment.
- Senior managers told us they had difficulties recruiting some staff posts such as band six nursing posts.
- Trust data showed in an unspecified three month period in 2014, 374 agency shifts were used with 41 not filled. There were difficulties booking external agency staff with the correct skills and knowledge.
- Trust information sent showed 12.7% of the service budget had been spent on cover in 2014.

## Our findings

### South Worcestershire, Wyre Forest, Redditch and Bromsgrove CAMHS, Single Point of Access and Home Treatment Team, Seaford Lodge

#### Safe environment

- Interview rooms did not have alarms in case of an emergency. Staff undertake individual assessment to mitigate this risk.
- Health and safety staff completed risk assessments with local staff as required.
- All staff received mandatory health and safety training.
- Two first floor meeting rooms at Redditch and Bromsgrove had faulty window restrictors and windows could not fully open. Staff told us this had been previously reported.

# Are services safe?

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

## Assessing and managing risk to patients and staff

- A separate individualised risk assessment was not documented but detailed in notes these had been reviewed by the multi-disciplinary team.
- Risk assessments took into account historic risks and identified where additional support was required.
- Staff coordinated multi agency meetings for suicide prevention where there were concerns about risks for young people.
- When appropriate staff created and made use of crisis plans.
- Staff received training in safeguarding and knew how to do this effectively in practice.
- Complex case reviews took place with peers for advice on effective assessment and treatment plans.
- Safeguarding staff attended team meetings for a review of individual cases where appropriate and teams had systems for monitoring the amount of referrals.
- Staff explained electronic record systems for monitoring young people on the waiting list and at team meetings staff discussed risks to young people.
- Staff explained that when a young person did not attend for an initial appointment they would close the case and contact the referrer. If the young person was allocated to a worker and failed to attend an appointment staff would have further contact with them.
- We found an example where this did not take place, indicating monitoring systems were not always robust. We raised this with a manager who took action to address this and report the incident.

- The Wyre Forest team meeting minutes dated December 2014, referred to difficulties with administration staff keeping the 'partnership spreadsheet' updated showing those young people awaiting treatment.
- Staff were aware of lone working procedures.
- Not all staff had received training to manage aggression from others. This training is not currently listed in the trust as essential to role. The overall service figure for completion of MAPA is 36 out of 74 staff (49%).

## Track record on safety

- Staff told us there had been no serious untoward incidents within this service in the last year. Trust data we looked at confirmed there had been no serious incidents.
- CAMHS teams had risk registers at service line and team level with identified actions for waiting times for therapies (CAMHS 10-12 months) and staffing difficulties.

## Reporting incidents and learning from when things go wrong

- Staff knew how to report any incidents on the trust's electronic reporting system.
- Staff received email bulletins with trust updates and alerts following learning from incidents.
- Staff told us incidents were discussed at staff team meetings. Meeting minutes did not always detail this.
- Staff told us that they received feedback about the outcome of incidents and debriefs took place following incidents.

# 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

We rated the community mental health services for children and adolescents as 'good' because:

- Staff were using the 'Choice and Partnership Approach' (CAPA).
- Assessments took place using nationally recognised assessment tools.
- Staff provided a range of therapeutic interventions in line with National Institute of Clinical Excellence (NICE) guidelines.
- Regular team meetings take place and staff told us that they felt supported by colleagues

At South Worcestershire and Redditch and Bromsgrove teams, young people's records were not always held securely.

Out of hours staff had no access to CAMHS paper records.

Staff across teams reported that administrative staff vacancies had impacted the outcome for young people's care.

Records of mental capacity and consent to treatment assessments were not always clearly documented.

- Out of hours staff had no access to CAMHS paper records.
- CAMHS staff were involved in the trust Information technology (IT) project and had requested to trial the new integrated IT record system.

### Best practice in treatment and care

- Assessments took place using nationally recognised assessment tools including the children's global assessment scale (CGAS) which measures children's general functioning and the Galatean risk and safety tool (GRIST) for assessing and managing the risks of suicide, self-harm, harm to others, self-neglect and vulnerability.
- Staff working with young people with a learning disability had led on a national project with the British Psychological Society to identify outcome measures for the service.
- Staff used the 'child outcomes research consortium' (CORC) to rate their service and measure improvements for young people.
- Staff provided a range of therapeutic interventions in line with National Institute of Clinical Excellence (NICE) guidelines such as family therapy, dialectical behavioural therapy (DBT) and cognitive behavioural therapy (CBT). NICE guidance was followed when prescribing medication for individual young people.

### Skilled staff to deliver care

- CAMHS teams included or had access to a full range of mental health disciplines required.
- Systems were in place for new or temporary staff to receive inductions to the trust and the service.
- Staff received supervision opportunities as well as peer supervision and yearly appraisals. Data we saw showed that 96% of staff in the Children, Young people and Families service development received supervision.
- There was no standard for supervision recording. Those seen varied in quality. Some staff kept their own records off site. We were informed there are plans to audit records and develop a standard approach to supervision across CAMHS.
- Staff had opportunities for specialist training for their role and had continuous professional development (CPD) as part of maintaining their professional registration with examples given.

## Our findings

### South Worcestershire, Wyre Forest, Redditch and Bromsgrove CAMHS, Single Point of Access and Home Treatment Team, Seaford Lodge

#### Assessment of needs and planning of care

- CAMHS referrals were made to the Single Point of Access (SPA) team and staff were using the 'Choice and Partnership Approach' (CAPA).
- Assessments and care plans were completed to meet young people's needs with systems for ensuring these were updated as needs changed.
- At South Worcestershire and Redditch and Bromsgrove teams, young people's records were not always held securely. Due to lack of space, files and staff post were held in lockable cabinets in corridors. We found some of these were unlocked, despite guidance issued to staff by managers.



# 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.

- Managers explained supervision and other monitoring systems to ensure staff competence and capability for their work.

## **Multi-disciplinary and inter-agency team work**

- Staff reported effective multi-disciplinary team working and joint working across services.
- Assessment and treatment handovers between teams within the trust such as community crisis team took place.
- Staff liaised with other agencies including in patient units, GP's and acute hospitals.
- Staff reported attending interagency meetings.
- **Adherence to the MHA and the MHA Code of Practice**
- Staff would contact the Mental Health Act administrative team if they needed any specific guidance about their roles and responsibilities under the Mental Health Act 1983/2007.

- Staff could contact the approved mental health professionals (AMHP) service to co-ordinate assessments under the Mental Health Act 1983.
- There were systems to monitor the number of people being assessed under the Mental Health Act 1983 when detained by the police using section 136 powers.

## **Consent**

- Staff told us that they had received training on the Mental Capacity Act 2005.
- We saw use of a standardised consent form for recording the consent of children and young people and carers in relation to the Data Protection Act 1998.
- Trust policy and staff made reference to the need to consider 'Gillick competency and Fraser guidelines' for young people under the age of 16 years.
- We found that the recording of discussions and assessments with young people regarding consent to treatment varied across teams. This included the recording of prescribing "off licence" medication.

# Are services caring?

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

## Summary of findings

We rated the community mental health services for children and adolescents for caring as 'good' because:

- Young people and carers reported they were treated with dignity and respect and gave positive feedback about staff.
- Staff showed understanding of individual needs of young people.
- Young people from the Youth Board had been involved in the clinical service manager interviews and there were plans to involve them in other senior CAMHS appointments.
- Young people had been involved in the redesign of team meeting rooms and waiting areas.

Young people and carers said staff encouraged them to give their views and involved them in their care. However those assessment and treatment records seen did not always reflect this.

2013 'Your welcome' report and CORC outcome measures had collated feedback from young people and carers but action taken to address any issues were not evident.

- Staff spoke about young people in a caring and compassionate manner.
- We observed interactions with staff and young people and carers using the service and found that staff communicated in a calm and professional way.
- Staff showed understanding of individual needs of young people.

### The involvement of people in the care they receive

- Young people and carers said staff encouraged them to give their views and involved them in their care. Records seen did not always capture this.
- Two carers and two staff reported difficulties with changes in staffing affecting consistency of care and reported that they were not always being kept informed.
- 2013 'Your welcome' report and CORC outcome measures had collated feedback from young people and carers but actions taken to address any issues were not evident. We are informed that these would have been discussed at local team meetings.
- The Community Engagement Team set up a 'Youth Board' for young people aged 14-24 years to obtain young peoples' views, recommendations and feedback about services.
- In addition a CAMHS mental health subgroup was set up.
- Young people from the Youth Board had been involved in the clinical service manager interviews and there were plans to involve the board in other senior CAMHS appointments.
- The trust website detailed how young people and carers give feedback and raise queries using social media sites, twitter and facebook.
- Young people had been involved in the redesign of meeting rooms and waiting areas at South Worcestershire.

## Our findings

### South Worcestershire, Wyre Forest, Redditch and Bromsgrove CAMHS, Single Point of Access and Home Treatment Team, Seaford Lodge

#### Kindness, dignity, respect and compassion

- Young people and carers reported they were treated with dignity and respect and gave positive feedback about staff.

# Are services responsive to people's needs?

Requires Improvement 

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

## Summary of findings

We rated the community mental health services for children and adolescents for responsiveness as 'requires improvement' because:

- Young people often waited long times for treatment.
- Young people using out of hours crisis services did not always have an assessment by staff with CAMHS experience and skills.
- If required young people could not be admitted to an in-patient facility locally and were placed out of area.
- Carers and young people were not always aware of the trusts complaints procedure.
- Where formal complaints had been made the trust complaints staff were not always aware of them.

The trust had redesigned CAMHS. This had led to the provision of a single point of access team (SPA)

This team triage referrals to determine the most appropriate course of action.

We found evidence of the trust providing a service to meet the diverse needs of the local population. This included an identified learning disability pathway.

A 'transition project' with staff champions from CAMHS and adult services helped ensure an easier transition across different trust services.

referral to assessment targets (choice appointment). From August to November 2014, the average waiting time was five to eight weeks with two young people waiting over 18 weeks.

- Managers checked data provided by the trust as there were inaccuracies in recording. Guidance had been issued to staff on ensuring accurate recording.
- Following referral through choice and partnership approach (CAPA) we found that data for referral to treatment times from October to December 2014 varied across CAMHS teams from 11 weeks in Wyre Forest (October) to 22 weeks Redditch and Bromsgrove (November). The SDU risk register at South Worcestershire detailed there had been a 10-12 month wait.
- Young people could wait long periods before receiving treatment.
- Five carers and six staff confirmed delays in assessment and treatment and long waiting times.
- Managers reported ways they had tried to reduce waiting times for example, offering short term and group work.
- Two carers reported lack of flexibility in the times of appointments.
- CAMHS teams had a duty system to respond to emergency needs of young people waiting for appointments.
- This service was not commissioned to provide a 24 hour service. Out of hours, the crisis service could be contacted. A consultant CAMHS psychiatrist was available for telephone advice.
- The trust had contributed to the children and young people's multi agency urgent mental health care pathway.
- We found that young people are not assessed in a timely manner by CAMHS professionals. Liaison meeting minutes with the acute trust, detailed that the Mental Health Liaison Team was not always assessing young people out of hours and these young people were sometimes admitted to acute wards.
- A CAMHS out of hour's liaison team provided telephone support for example to nurses and carers who might need support.
- The trust had an identified learning disability pathway and monitored referrals. Fewer referrals were received in

## Our findings

### South Worcestershire, Wyre Forest, Redditch and Bromsgrove CAMHS, Single Point of Access and Home Treatment Team, Seaford Lodge

#### Access, discharge and transfer

- The trust had redesigned CAMHS. The SPA team working on rota triaged referrals to determine the most appropriate course of action.
- There were processes for responding to emergency, urgent and non-urgent referrals within identified time frames.
- Trust monitoring systems for waiting times showed CAMHS were meeting the majority of 18 week from

# Are services responsive to people's needs?

Requires Improvement 

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

the Redditch and Bromsgrove and staff took action to promote the service. Staff had identified a need to work with colleagues in the integrated service for looked after children (ISL).

- A home treatment team was developed to work intensively with young people to prevent hospital admission or to link in with them before and after discharge from out of area hospital placement. A trial of extending the hours of this service to provide support at weekends was agreed however The trust was not commissioned to provide hospital beds for young people when required.
- The records seen demonstrated that young people were referred for in-patient treatment to Manchester or Devon.
- There was an identified referral pathway for requesting hospital admission. Staff reported there could be delays in beds being identified which was detailed on the SDU risk register.
- We found that one young person had waited for 12 days for a bed and an occasion when a young person was admitted to an adult ward.
- There were multi agency meetings, with trust staff in attendance, to monitor and review admissions to in-patient facilities.

## **The facilities promote recovery, dignity and confidentiality**

- Offices and environments varied across the teams visited and none were purpose built.
- Appointments were offered at site premises or other venues as required.
- Wye Forest, Redditch and Bromsgrove teams shared reception areas with other trust services this meant young people shared waiting areas with adults.
- A receptionist was not available until 09:00 hours at Redditch and Bromsgrove, therefore young people and parents had to wait in a downstairs corridor until they could access CAMHS waiting areas.
- Redditch and Bromsgrove CAMHS had offered 'end of day' appointments and out of hours clinics for young people.
- South Worcestershire and Redditch and Bromsgrove had child friendly waiting areas with donated toys and toy cleaning arrangements in place.
- At South Worcestershire, young people had their weight and height taken in the corridor due to lack of space.

- We are informed that at South Worcestershire some consultation rooms were not sound proofed. We raised this with senior managers for their attention.
- A range of leaflets and service information for young people and carers was available across team sites. Self-help guides were available to young people on the trust website.

## **Meeting the needs of all people who use the service**

- Staff told us that alternative appointment and venue arrangements were made for young people or carers using a wheelchair.
- Redditch and Bromsgrove offices and meeting rooms were upstairs with a lift but there were additional steps and therefore this was not accessible by wheelchair.
- A carer with mobility difficulties told us they were not aware of a choice of venue.
- Age appropriate leaflets were available to young people and carers giving information on the service.
- Staff offered young people a choice of the gender of worker they met. A carer told us that due to staffing difficulties this was not always possible.
- Staff showed us systems for arranging interpreters and/or signers to assist with communicating with young people and carers if required.
- A 'transition project' with staff champions from CAMHS, adult services and the youth board has helped to ensure easier transition across teams and services. This involved reviewing the transition protocols and identifying areas for learning, improvement and response.
- CAMHS staff worked with the trust specialist eating disorder service and has staff leads within each team.
- The Umbrella Pathway (Neuro-Developmental Assessment and Care) provided assessment, management and care for young people presenting with neuro-developmental disorders.
- CAMHS were developing 'Improving Access to Psychological Therapies' (IAPT) service and five staff were undertaking training for this.

## **Listening to and learning from concerns and complaints**

- The trust's recently introduced the 'family and friends' test.

# Are services responsive to people's needs?

Requires Improvement



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

- The trust website gave details on how to make a complaint and the actions that the trust had taken as a result of the complaint.
- Patient advisory liaison service (PALS) and advocacy services information was displayed.
- Teams had systems for monitoring complaints relevant to their area.
- Complaints made in 2014 related to the availability of support, waiting times, appointment times and communication. These had been investigated and inspection team were shown examples of this.
- Staff gave examples of advising people of the complaints procedure. Three carers and a young person had not been given information.

# Are services well-led?

**Requires Improvement** 

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

We rated the community mental health services for children and adolescents for well led as 'requires improvement' because:

- Recording staff supervision and arrangements were not consistent across teams.
- Staff did not feel that the trust were responding effectively to their concerns regarding low staffing levels.
- Several staff reported a lack of communication from senior managers regarding the actions taken to address identified concerns.
- Feedback from people using the service, staff and others was not being used to continuously improve and ensure the sustainability of the service.

Staff knew who the most senior managers in the trust were and gave examples when senior managers have visited teams.

Managers had access to governance systems that enabled them to monitor the quality of services provided and identify potential risks.

Managers had systems for monitoring sickness levels and conducted exit interviews to identify any themes.

An LD CAMHS review showed parents/carers were highly satisfied with the service they received.

### Good governance

- Staff described various ways in which they received information from the board and other governance meetings. For example information was discussed at business team meetings.
- Managers had access to governance systems that enabled them to monitor the quality of services provided and identify risks.
- These governance systems included the trust electronic incident reporting system, corporate and national audits and staff training record.
- Team managers had access to trust data such as assessment times and training to gauge the performance of the team and compare against others.
- Managers said information and data from governance meetings such as the Children's' Service Quality and Safety meeting, was given at team meetings which was confirmed by staff. The team meeting minutes seen did not fully capture this.
- Staff confirmed that they received emails from the trust giving updates on corporate developments.
- There were systems for monitoring staff attendance at the trust's mandatory training and 90% had been achieved this is below trust targets of 95%. Staff attendance at training had increased in January 2015.

### Leadership, morale and staff engagement

- Staff said their manager/supervisor was accessible for advice and guidance as required.
- The trust had a system for staff to raise any concerns confidentially.
- We had contact from staff raising concern about staffing level impacting on service delivery.
- Senior managers had identified staffing concern as a risk to the service and explained actions taken to minimise this risk.
- We found a disconnect between risks and issues described by staff and those reported to and understood by senior managers. An example given by staff was they had been told that for two years there was a review of administrative services however they had not been given a timeframe for when it would conclude.
- Staff reported changes to management across all CAMHS teams in the last three months this has effected communication from senior managers.

## Our findings

### South Worcestershire, Wyre Forest, Redditch and Bromsgrove CAMHS, Single Point of Access and Home Treatment Team, Seaford Lodge

#### Vision and values

- Information on the trust vision and values was available across teams.
- Staff knew who the most senior managers in the trust were and gave examples when senior managers had visited teams.
- Teams received a monthly Child, Young Person and Families SDU newsletter with information relevant to the trust and their service such as objectives and priorities.

# Are services well-led?

Requires Improvement 

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.

- Several staff expressed low morale and lack of communication from managers regarding actions taken particularly at Wyre Forest.
- Staff spoke positively about the supportive culture in their teams but said they had little contact with other teams.
- Regular team meetings took place and staff told us they felt supported by colleagues.
- Staff reported opportunities for staff engagement events and away days.
- Managers had systems for monitoring sickness levels and conducted exit interviews to identify any themes.
- Human resources department referred staff to occupational health services where applicable.
- LD CAMHS had reviewed their performance and effectiveness over a 19 month period that identified future actions.
- The commission for health improvements experience of service questionnaire (CHI-ESQ), showed parents/carers were highly satisfied with the service they received. A referrer satisfaction survey was completed and high levels of satisfaction were identified.
- CAMHS staff reported systems to seek feedback from young people and carers.
- The trust had improvement plans to increase training and appraisal rates and was regularly monitoring this. In five out of 10 months for 2014 targets had not been met. In December 2014, 95 % was achieved meeting the trust's target.
- Staff had liaised with The Anna Freud Centre, a charity providing treatment, research and training for professionals, to set up a 'CAMHS web' for young people. The tool enables access from the internet to set goals and complete self-assessment/outcome measurement tools.

## **Commitment to quality improvement and innovation**

- LD CAMHS team won the trust's staff achievement award for, 'Excellence in integrating services'.



# Compliance actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA 2008 (Regulated Activities)

Regulations 2010 Safety and suitability of premises

**The trust must review its procedures for assessing and monitoring the environment for example alarm systems, windows and blinds, to ensure that young people's health and safety is maintained.**

The trust must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of appropriate measures in relation to the security of the premises. Regulation (15)(1)(b).

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

Regulation 20 HSCA 2008 (Regulated Activities)

Regulations 2010 Records

**The trust must review its procedures for maintaining records, storage and accessibility including out of hours.**

The trust must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; and the trust must ensure that the records are kept securely and can be located promptly when required; retained for an appropriate period of time; and securely destroyed when it is appropriate to do so. Regulation (20)(1)(a)(2)(a)(b)(c).

### Regulated activity

### Regulation



# Compliance actions

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation 10 HSCA 2008 (Regulated Activities)  
Regulations 2010 Assessing and monitoring the quality of service provision

**The trust must review its provision of crisis services for young people to ensure that they have an assessment by appropriately skilled staff to a responsive standard.**

The trust must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. Regulation (10)(1)(b).

## Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

## Regulation

Regulation 22 HSCA 2008 (Regulated Activities)  
Regulations 2010 Staffing

**The trust must review its provision of staffing to ensure there is adequate staff to effectively complete administrative tasks.**

In order to safeguard the health, safety and welfare of service users, the trust must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation (22).

## Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

## Regulation

Regulation 9 HSCA 2008 (Regulated Activities)  
Regulations 2010 Care and welfare of people who use services

**The trust must review its contingency arrangements for staffing to ensure young people receive assessment and treatment in a timely manner.**

The trust must take proper steps to ensure that each person is protected against the risks of receiving care or

## Compliance actions

treatment that is inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the person's individual needs, ensure the welfare and safety of the person. Regulation (9)(1)(b)(i)(ii).