Sheffield Children's NHS Foundation Trust

# Specialist community mental health services for children and young people

**Inspection report**

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|
| Are services safe? | **Requires Improvement** |
| Are services effective? | **Good** |
| Are services caring? | **Good** |
| Are services responsive to people's needs? | **Requires Improvement** |
| Are services well-led? | **Good** |

# Our findings

## Specialist community mental health services for children and young people

**Requires Improvement** 

Sheffield Children's Hospital NHS Foundation trust provides specialist mental health services for children and young people across Sheffield and the wider region.

The community child and adolescent mental health service (CAMHS) is made up of nine teams. These include mainstream CAMHS, the specialist eating disorders and treatment team (SEDATT), learning disabilities and mental health, healthy minds, primary mental health, forensic CAMHS and multi-agency psychological support for looked after children. The teams work across different geographical locations. These include Beighton, Centenary House, Albion House, Gibson House, Star House, Amber Lodge and the Acute Hospital site.

The teams provide assessment and treatment for children and young people up to 18 years old with mental health conditions, learning disabilities, autism and/or emotional and behavioural difficulties. The service operates between Monday and Friday 9am until 5pm. Staff work with patients and their carers at a range of locations including schools, homes and in clinic.

The trust also provides a day unit and outreach service for children and young people at the Becton Centre. Amber Lodge is a regional unit and accepts referrals from child and adolescent mental health services throughout South Yorkshire. It provides services for children and young people aged between five and 11 years old who have severe and complex mental health problems.

The trust established the Supportive Treatment and Recovery (STAR) team in 2015. The team operates between 8.30am and 9.30pm seven days per week. This team provides assessment and brief intervention sessions to children and young people who present to the accident and emergency department with concerns for their mental health. The team also provide community intensive treatment. This is commissioned for typically three sessions per week for up to eight weeks.

The trust also established a health based place of safety for young people aged 16 to 17 in 2015. A health based place of safety is a place at a hospital where people are taken by the police or ambulance service for mental health assessment when they have been found by the police to appear to be suffering from a mental disorder and in need of immediate care or control. This must be necessary in the interests of the person or for the protection of others. The health based place of safety is situated at the Becton Centre alongside the child and adolescent mental health wards.

As part of this inspection we visited the following locations;

- Centenary House
- Beighton community centre
- Sheffield Treatment and Recovery (STAR) team at Sheffield Children's Accident and Emergency
- Becton Centre health-based place of safety.

# Our findings

Our rating for this service stayed the same. We rated the service as requires improvement. The reasons for this rating are set out below;

- Children and young people waited a long time to access the service, clinicians had high caseloads which had an impact on their ability to provide safe care.
- The service did not always ensure that children and young people received a physical health check at their initial appointment.
- Staff did not always complete mandatory training.
- The trust did not always ensure that staff were safe in their role because policies, procedures and training in; management of violence and aggression lone working, and incident response were unclear.
- There was not a clear process in place to support young people who were leaving the service and not making a transition to adult services.
- Where there were gaps in delivery the service did not maintain adequate communication with young people, their carers or other agencies.
- Appointments that were cancelled by the service were not always re-appointed.
- Parents told us that they were concerned about the lack of urgent out of hours provision where their option was limited to attending the accident and emergency department.
- There were some areas of good governance which were not entirely effective.

However;

- Staff were described as patient and insightful.
- Parents were grateful for flexibility given in appointment arrangements and the variety of settings in which these could take place.
- The STAR team had expanded their remit to include all mental health presentations which improved access to mental health services for the wider community.
- The risk assessments carried out were comprehensive and also included crisis plans which were shared with all those involved in the care of the child or young person.
- The trust had made a number of improvements to the service and were taking an innovative approach based on continuous improvement.

## Is the service safe?

**Requires Improvement** 

Our rating of safe stayed the same. We rated it as requires improvement.

### Safe and clean environments

**All clinical premises where patients received care were not always safe. They were however clean, well equipped, well furnished, well maintained and fit for purpose.**

# Our findings

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Each of the teams completed environmental and ligature risk assessments for all areas. For young people that attended the acute hospital the Support Treatment and Recovery team had their own waiting area and assessment room separated from the main emergency department. The team carried out risk assessments for the areas that were used for the treatment journey including the ward areas and adjusted where necessary based on clinical judgement. Managers for the teams ensured seasonal decorations in the communal areas were suitable and did not increase the risk of harm.

Interview rooms did not have alarms and did not always have staff available to respond. There was no alarm system in individual rooms however staff were encouraged to carry personal alarms. On activation staff in the area were expected to respond. There was however no system or procedure in place for responding. There was also no assurance that there would be enough staff on site to respond at any given time.

There was an incident where a young person locked a clinician in a room. There were other incidents where staff have been assaulted and had furniture thrown at them with no clear evidence of a response from the wider team. There was no evidence appropriate procedure was taken to mitigate risk.

The service provided a standard operating procedure for lone working which included usage of personal alarms after the inspection.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. The clinic room at Becton Centre had the necessary equipment for monitoring physical health. The electronic equipment was calibrated and within date.

All areas were clean, well maintained, well-furnished and fit for purpose. There was minimal furnishing in the interview rooms, and they were adequately equipped.

Staff made sure cleaning records were up-to-date and the premises were clean. Staff always followed infection control guidelines, including handwashing. The services scored adequately for their most recent environmental audits. Beighton and Centenary scored 83.3% and 91.7% respectively. The target score was 85%.

Staff did not make sure equipment was well maintained or used safely. The emergency grab bag at Centenary house did not have a list of contents attached. The two tongue depressors had expired in 2020. The emergency grab bag at the Becton Centre had face mask sizes 1, 2 and 3 opened from their packaging.

There was a sharps box at Becton Centre that was not stored correctly and had not been labelled in accordance with Health and Safety Regulation.

## Safe staffing

**The service did not have enough staff. The number of patients on the caseload of the teams, and of individual members of staff was high. Staff knew the patients but not all of them received basic training to keep them safe from avoidable harm.**

### Nursing staff

The service did not always have enough staff to meet the needs of young people.

# Our findings

The community teams had an overall vacancy rate of 12.8 %. The rate of vacancies varied across the teams.

Most of the teams had vacancies, some of which showed high vacancy rates. The trust told us some of the teams were a relatively small size which had an impact on percentages. For example, the Healthy Minds team had a vacancy rate of 31.2% but had a relatively small team of five staff. However, the Beighton and Centenary teams were over establishment by 8.8% in June 2022.

The service had low rates of bank and agency staff. Use of bank and agency staff was low among non-medical staff within the previous 12-month period. The wellbeing and mental health team had used the highest among the community teams. The only other team to use bank and agency was Amber Lodge.

Some of the teams had low and / or reducing turnover rates. For example, the learning disabilities team had a turnover rate of 40% in July 2021. This had reduced to 0% in June 2022. The support treatment and recovery team had a turnover of 81.8% for the same period. This had reduced to 6.9%. However, the Beighton and Centenary teams had an increase from a turnover of 16% to 21.4% in June 2022.

Levels of sickness varied across the different teams since July 2021. For example, the community mental health team had a low rate of 0.61% in July 2021. This had peaked to 26.44% in April 2022 and reduced to 2.74% in June 2022. In June 2022 most teams had a sickness rate that was below 10%.

Hybrid working which meant a mixture of working on site and working from home had helped to reduce sickness. Occupational health was able to support with reasonable adjustments.

Managers used a recognised tool to calculate safe staffing levels. The service had completed a capacity and demand analysis to identify staffing needs. The need for more staff was identified in most of the community teams. The exceptions were the eating disorders team as well as the wellbeing and mental health team.

The service had a total caseload of 3209 patients in June 2022. The community mental health team had the highest caseload with 2101 patients. The trust told us that this included young people who were on waiting lists.

The service used a caseload weighting tool to measure individual staff caseloads. Some of the staff we spoke to reported increases in their caseload to up to 106 of mainly children with complex needs. When caseloads were too high staff could use a job plan to request changes such as pausing initial assessments or having patients re-allocated to other clinician's caseloads. There was no evidence of contingency when individual team numbers were low. Some of the feedback from incidents and parents showed that re-allocation was not always performed, and patients were allocated to staff who were not at work or available for long periods. In other cases, changes were not always communicated effectively.

### Medical staff

**The service had enough medical staff.**

They ensured there was always someone on site during working hours. The medical team have a layout with their availability completed a month in advance. This allowed them to identify gaps and make provision for cover in good time. After hours the service had an on-call consultant.

Some of the consultant psychiatrists had been holding cases to mitigate the pressure on people waiting to be seen.

# Our findings

Managers could use locums when they needed additional support or to cover staff sickness or absence. The service used a higher number of bank and agency medical staff compared to non-medical. Of the twelve community teams listed, five of them used bank and agency medical staff. Use was highest in the wellbeing and mental health team.

The service could get support from a psychiatrist quickly when they needed to. All the teams had access to a psychiatrist. Support was reduced out of hours. There was a consultant psychiatrist available on-call.

### Mandatory training

**Not all staff had completed and kept up to date with their mandatory training.**

The mandatory training was broken down into core skills training as well as training essential to role. The average compliance rate for 'essential to role' training was 83%. However six teams in the service were less than 73% compliant with training.

The trust told us that managers monitored mandatory training and alerted staff when they needed to update their training. The service had a training and educator in post who monitored performance. The service also held drop-in sessions to assist staff in undertaking their training.

Following the inspection the service told us their matron and training manager were reviewing the levels of training required for all specialist community child and adolescent mental health services.

### Assessing and managing risk to patients and staff

**Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.**

### Assessment of patient risk

**Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.**

We reviewed 13 care records. All of them had comprehensive risk assessments carried out at the point of referral. These were continually updated throughout the care records. The outcomes from the risk assessments were shared with the young person, their parent or carer as well as relevant agencies. The risk assessments were accompanied by crisis plans. These gave information on actions to be taken when risks escalated. The service were commissioned to ensure that young people were able to access the STAR team in the emergency departments in Sheffield until 9:30pm as part of crisis planning. However families and carers using the service told us that there were limited other out of hours options for support in a crisis.

All referrals were triaged daily by a multi-disciplinary team. One of the team members was a duty clinician. This allowed the more urgent referrals and any identified risks to be actioned.

Staff could recognise when to develop and use crisis plans. Young people had crisis plans as part of their care plans. These were individually updated in response to risk. These were collaborative and included triggers, early warning signs, things the young person found helpful in a crisis, having a safe space. They also covered identified mental and physical health needs. Crisis plans also included generic information on who to contact and where to go in the event of an emergency.

# Our findings

### Management of patient risk

**Staff responded promptly to any sudden deterioration in a patient's health.**

The team had access to doctors and consultants to seek advice. They reported them to be responsive and supportive.

Staff monitored patients on waiting lists for changes in their level of risk and responded when risk increased. The service had a duty team which was citywide and made up of multidisciplinary clinicians from a range of teams. The service triaged and managed risk for new referrals as well as patients on waiting lists for the community services. They operated within core office hours. The service offered referral screening and triaging, consultation calls and rapid response appointments. Consultation calls were calls available to young people on the waiting list for an initial assessment. They were offered where risks or concerns were raised and needed to be explored further. The service's response time for consultation calls is the following day. In most cases however, the consultation service relied on young people or their parent/carer contacting the service.

The service also offered Rapid Response for those with a rapid deterioration in their mental health, increased risk or first episode of psychosis. The waiting time for this was two weeks. If risks were deemed acute or escalated further young people were directed to the Support Treatment and Recovery (STAR) team based in the emergency department of the acute hospital, who were able to see them more urgently. Where necessary the STAR team would continue to see a young person until they were seen by the relevant community team.

Staff also spoke of being able to discuss risk in their daily huddles where a multidisciplinary formulation and plan were then made. Risks were also discussed by individual clinicians in clinical supervision. This was then recorded in the clinical notes. This was in line with the trust's standard operational procedure for risk assessments.

The service did not follow clear personal safety protocols, including for lone working. The service required frontline staff who are lone working to undertake Level 2 Conflict Resolution Training. However, their training record showed that 50% of their staff groups were below 75% compliance. The procedure for lone working involved staff alerting a buddy of their whereabouts. It then relied on the buddy being able to raise the alarm where necessary. The trust's 'Lone Working' policy outlined putting procedures, devices and/or safe systems of work into practice designed to eliminate or reduce the risks associated with working alone. There was no centralised system in place. There was also no arrangement in place to ensure that staff could be traced and located if there were concerns for their safety. The Lone Working policy placed responsibility on divisions within the trust to arrange their own contracts with device operators if this was identified as a need.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

The trust had a named Doctor for safeguarding and a dedicated camhs named nurse.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff received training in safeguarding adults and children. Most of the staff groups had 100% compliance. The service had a dedicated specialist safeguarding team. The service also had an electronic safeguarding dashboard that all staff could access. The safeguarding team were able to support staff with recognising and reporting abuse. Staff received additional training that included Children's Care Act 1989, Capturing the Voice of the Child, Safeguarding up to Level three as well as Child Sexual Exploitation.

# Our findings

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Safeguarding was included in their assessments. Safeguarding was also discussed in the daily multidisciplinary team huddles staff. The service worked closely with other agencies including third sector to provide support around gender, racial, religious and cultural diversity as well as disability. Their public areas had information and leaflets on available support

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff spoke of using effective communication and observation skills to identify harm. Staff within the learning disability team demonstrated an understanding of the wider cultural and social issues that enabled them to recognise concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff were aware of the safeguarding lead and were able to access their support or advice when required. They used various bulletins to deliver messages regarding safeguarding. This included reminders for staff to keep up do date with training and to keep up to date and accurate records. It also encouraged staff to discuss concerns within their multi-disciplinary teams.

Managers took part in serious case reviews and made changes based on the outcomes.

### Staff access to essential information

**Staff working for the service kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

Patient notes were comprehensive, and all staff could access them easily. The service had a universal IT system for recording patient information that all staff could access. This contained information on both their mental and physical health.

Records were stored securely. Staff used password and card protected access.

When patients transferred to a new team, there were no delays in staff accessing their records. Patient's record and information was accessed via the same system.

### Track record on safety

**The service had a good track record on safety.**

The trust undertook clinical harm reviews to establish whether a patient had been harmed as a result of excessive delay to their treatment.

### Reporting incidents and learning from when things go wrong

**The service managed patient safety incidents well. Staff generally recognised incidents and reported them appropriately. Managers investigated incidents and shared the relevant lessons learned with the whole team and the wider service. When things went wrong staff apologised and gave patients honest information and suitable support.**

Staff did not always know what incidents to report and how to report them. Incidents reported included admin, safety, avoidable cancellation as well as failure to attend meetings. In one of the forums for learning from incidents staff were being encouraged to report incidents of violence and aggression towards staff.

# Our findings

The incident records showed that most of the incidents were related to systems, processes and poor communication that affected safe, effective and timely delivery of care. Some of the incidents resulted in increased risk to young people. The service's most recent thematic analysis showed that communication was the most referenced complaint followed by delivery of care. Of the complaints, most of them had referenced both showing a link between the two. The analysis showed the actions taken and lessons learned. In addition the service had identified the need to collate themes from incidents and ensure action plans to address them were in place and delivered.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The incidents recorded showed that staff were responsive and communicated with young people and their families. They were able to apologise and give adequate explanations. In some of the incidents they provided information on how to complain. Senior clinicians and management supported staff by taking the lead where necessary when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff received debriefs and appropriate measures were taken for support. In an incident where a clinician was injured their physical and emotional wellbeing were addressed.

Managers investigated incidents thoroughly. Young people and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. The trust sent out a monthly 'Learning from Incidents' circular. The information in the document sent to us also related to incidents from the acute trust. Significant incidents that were between teams both internal and external were escalated appropriately. Meetings were held between relevant persons and feedback was given to the wider teams.

Staff met to discuss the feedback and look at improvements to patient care. Complex cases were discussed in case study reviews.

There was evidence that changes had been made as a result of feedback. An incident happened where a young person had a long delay in assessment as the clinician was off work long term. The service addressed this by putting in place a standard operational procedure for reviewing ongoing and reallocation of cases. This allowed young people in these cases to be reviewed and reallocated to an appropriate clinician.

## Is the service effective?

**Good** ↑

Our rating of effective improved. We rated it as good.

### Assessment of needs and planning of care

**Staff assessed the mental health needs of all patients. They worked with young people and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented. The care plans did not always reflect how assessment and monitoring of physical health was carried out in all teams.**

# Our findings

Staff completed a comprehensive mental health assessment of each patient. The mental health assessments were comprehensive and considered the wider issues such as family, development educational, support network and social situations.

Staff did not make sure that patients had a full physical health assessment within the mainstream community mental health teams. Seven of the care records we looked at did not have physical health monitoring. One of the records showed a physical health review was held during an appointment with a psychiatrist. In another record a full assessment of the height, weight, blood pressure and pulse were done at every appointment. The physical health assessments were not completed routinely at initial assessment.

The clinic rooms had equipment for basic observations as well as height and weight scales. When the service carried out audits for care records, they checked for evidence of discussions and considerations for physical health and checked that the user/young person had been asked about past physical health. The audits did not monitor for routine physical health checks. They did not have a specific policy around physical health as this was carried out on an individual needs basis. The Royal College of Psychiatrist's Quality Network for Community Child and Adolescent Mental Health Service's Standards recommends conducting physical examinations as part of the initial assessment.

Staff developed a comprehensive care plan for each patient that met their mental health needs. Most of the care plans seen were comprehensive and personalised. They covered domains such as sleep, nightmares, appetite. They included feedback from the parent/carer. All the parents we spoke with reported being included in the care plan and felt the plans addressed the needs of their child.

Staff regularly reviewed and updated care plans when patients' needs changed. The care plans were reviewed at three monthly intervals where there were no concerns. In other cases, they were reviewed at each appointment. This was reflected in the care plan audit that showed a compliance of 95% of care plan reviewing for June across all community teams.

Care plans were personalised, holistic and recovery orientated. They covered a range of psychological and social needs. Although there was no specific prompt the care plans also considered protected characteristics. The care plans included action plans for the young person, their parent/carer and the service to address identified needs.

### Best practice in treatment and care

**Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.**

Staff provided a range of care and treatment suitable for the patients in the service. The service was made up of different teams that set up pathways for different modalities. This included Learning Disabilities and Autism, Forensic, Psychological wellbeing, safeguarding support unit, a Specialist Eating Disorders Assessment and Treatment Team (SEDATT), Supportive Treatment and Recovery (STAR) as well as Early Interventions in Psychosis. For mothers of infants the service provided a Parent and Infant Relationship Service (PAIRS).This supported caregivers to build secure relationships with their babies.

The treatment provided included varied psychological therapies as well as a solutions clinic, speech and language, occupational and art therapy.

# Our findings

Staff delivered care in line with best practice and national guidance. The service was guided by NICE guidance in the delivery of its interventions. They followed both NICE and Maudsley guidance for any required investigations relating to medication or medical conditions.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Children and young people under the SEDATT team had their growth assessed and measured by a Growth and Measurement team. The learning disabilities team worked closely with other agencies in the advocacy and provision of physical health. They highlighted the significance of physical health co-morbidities in this cohort of young people which reduced their life expectancy.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. They were able to work with external agencies for additional support.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes.

Staff used technology to support patients. Staff offered the flexibility of virtual consultations where appropriate. Some of the teams used a Video Integration Service as part of their treatment programme. The Parent Infant Relationship Team used Video Interaction Guidance as part of its range of specialist interventions. Patient information was available to staff via a secure card system.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The service had undergone a peer review from the Quality Network for Community CAMHS under the Royal College of Psychiatrists and were in the process of actioning recommendations. Different clinicians took the lead on aspects for service delivery. For example, an assistant psychologist was driving outcome measures.

### Skilled staff to deliver care

**The service included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. However, trust data did not provide evidence staff regularly accessed appropriate supervision.**

The service had access to a full range of specialists to meet the needs of children and young people. The multidisciplinary teams were made up of a range of professions from the disciplines of psychiatry, psychology, nursing, social workers, an international fellow as well as administration and clerical staff. Within these disciplines the clinicians had expertise and specialisms in a variety of areas such as infant mental health, psychotherapies, safeguarding, perinatal care, eating disorders, forensics and learning disabilities.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care. There was evidence of continued learning among the staff group.

Managers supported staff through regular, constructive appraisals of their work.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work.

# Our findings

The trust told us that staff received monthly clinical supervision. In addition, staff were offered safeguarding supervision, caseload supervision, a six-session supervision forum and therapy-specific clinical supervision. Supervision also took place in the daily huddles and an extended weekly huddle. All job plans include time allocated for monthly clinical supervision to ensure the time is protected.

Psychiatry trainees received clinical supervision every week. Psychotherapy supervision took place fortnightly.

However, the trust's data did not support that staff were receiving clinical, caseload and safeguarding supervision. Data provided by the trust showed that 29% of staff were in receipt of clinical supervision, 26% were in receipt of caseload supervision and 23% were in receipt of safeguarding supervision. The trust said that they were aware that their data collection methods were not accurate.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Teams received feedback in their discussion forums or via email.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had a 'Jam' board where they noted concerns or areas for improvement. Staff fed-back that this offered them a forum to work together to address needs.

Managers made sure staff received any specialist training for their role. Staff spoke of receiving specialist training to carry out their role. The service provided an extensive list of specialist training that included DBT accredited training, Dyadic Developmental Psychotherapy, Theraplay, Outcomes training as well as Post graduate diplomas.

### Multi-disciplinary and interagency teamwork

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation. They did not have effective working relationships with some of the relevant services outside the organisation.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. These took place daily as individual team huddles as well as huddles between different community teams. The teams also held supervision sessions where they discussed individual cases.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. This was done by setting up tasks for other clinicians within their electronic record system. The system also provided alerts which drew clinicians to relevant information they needed to be aware of.

Staff had effective working relationships with other teams in the organisation. Staff were able to liaise with other teams within the organisation through their huddles. Staff also reported feeling comfortable contacting other teams to discuss referrals or for advice. Parents also reported that staff were good at liaising with other teams and gave clear information on pathways for care.

Staff did not have effective working relationships with external teams and organisations. Staff reported having trouble when liaising with social care in trying to get placements for children and young people. The service's incident log showed incidents where safe care had fallen short due to lack of feedback and the ability of staff to follow-up on their referrals. This had on one occasion left a patient being incorrectly discharged. The service provided information following inspection on how their safeguarding team had delivered training and awareness to external agencies.

# Our findings

The service also had difficulty in transitioning young people into adult services. This had resulted in delays in discharge. One of the incidents demonstrated poor communication after a referral appeared to have been verbally agreed but was later formally rejected. The teams were able to refer and signpost to third sector agencies. However, there was no clear process of support in place for young people who turned 18 and felt they needed support but did not meet the remit for adult services.

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

**Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.**

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff reported receiving training. They were not required to apply it frequently due to the nature of community work.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff were able to access this via their intranet.

Patients had easy access to information about independent mental health advocacy. Information was also displayed in reception areas.

### Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. However, staff did not always assess and record consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. 85% of the relevant staff teams were up to date with level two Mental Capacity Act training.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. This was available via their intranet.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff did not always assess and record capacity to consent clearly each time a patient needed to make an important decision. There was no documentation that clearly showed capacity to consent had been considered during the process of decision-making. Most of the staff reported relying on consultants for capacity assessments where necessary.

Staff did not audit how they applied the Mental Capacity Act and were unable to identify or act when they needed to make changes to improve. The care plan audit for April 2022 to June 2022 showed 100% compliance for evidence of consent to treatment. This was not reflected in the care records. The evidence provided showed the audit was not carried out in a way that captured how the Mental Capacity Act was used in practice.

# Our findings

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. Most of the staff demonstrated good knowledge on Gillick competency and how to apply it.

Staff knew how to apply the Mental Capacity Act to patients aged 16 to18 and where to get information and support on this.

## Is the service caring?

**Good**  

Our rating of caring improved. We rated it as good.

### Kindness, privacy, dignity, respect, compassion and support

**Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.**

Staff were discreet, respectful, and responsive when caring for patients. Young people and their parents described the staff listening to them and considering their thoughts and feelings.

Staff were responsive to children's needs. Some of the parents described the staff as going out of their way to accommodate their children. For example, if a young person did not want to engage at an appointment in the hospital, staff would walk around with them in a park which encouraged engagement. Parents also reported that assessments were not rushed and found staff had a kind and considerate attitude towards them.

Another service user reported not having to wait to get better for their treatment for post-natal depression in order to be supported in building a relationship with their child under the PAIRS service. The treatments ran alongside each other which they found very helpful as it improved their response to interventions.

Staff gave patients help, emotional support and advice when they needed it. Staff were responsive when young people were distressed. Feedback from children, young people as well as their parents/carers was mostly positive. Most described the staff as having a significant positive impact to their well-being.

Staff supported patients to understand and manage their own care treatment or condition. The care records showed that young people were included and involved in the planning of their care. Following a session, the young person, their parent or carer as well as the clinician would have an action plan to work on ahead of the next review.

Staff directed patients to other services and supported them to access those services if they needed help. They had information on a diverse range of third sector agencies that offered support such as gender and sexuality, eating disorders, self-harm, education as well as support services for parents and carers.

Patients said staff treated them well and behaved kindly. The results from patient surveys showed most of the respondents felt listened to and understood. Most agreed with the statements 'I was treated well by the people who saw me' and 'it was easy to talk to the people who saw me'. Some of the young people spoken with during the inspection reported most of the time staff considered their thoughts and feelings and that they interacted kindly.

# Our findings

Staff understood and respected the individual needs of each patient. The learning disabilities team spoke of cultural differences in the way people responded to disability. They reported the diversity in the staff group assisted them in understanding how to address the individual needs of each young person.

Staff followed policy to keep patient information confidential. Information was sent via a secure email network. Patient records were only accessible via a secure card system.

### Involvement in care

**Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff informed and involved families and carers appropriately.**

### Involvement of patients

Staff involved patients and gave them access to their care plans. The care records showed that young people were involved in their care plans.

Staff made sure patients understood their care and treatment and found ways to communicate and obtain feedback from patients who had communication difficulties. The service founded a user engagement team which created 'Social Stories' aimed at children and young people with communication difficulties. Through this forum they were able to develop feedback forms to capture their views. The process has allowed them to create service user interview questions for the recruitment of new staff.

Staff involved patients in decisions about the service, when appropriate. As part of the service user engagement strategy the service worked with a local charity to gather feedback from young people. Through this the young people were able to create an engagement pack that staff could use when working with young people. They also created a pronouns guide which was presented to staff in one of their team meetings.

Patients could give feedback on the service and their treatment and staff supported them to do this. The service has several forums for patient feedback. The feedback in the engagement pack was designed into games and activities to suit different levels of ability. Examples of this was painting how they felt. This could be done individually or as a group. They could also use sticky dots or wish trees. Other forums for feedback were feedback cards in waiting rooms, Experience of Service Questionnaires as well as feedback forms. A sample from a 2021 survey found that young people generally had a positive experience of using the service. However, they highlighted long waiting times, staff changes and a lack of continuity when staff were off as some of the areas of concern.

The service also developed a Service User Engagement Team as a way of obtaining and acting on feedback. An example of this was feedback on the environment in the waiting rooms at the community sites. Using the responses and with support from a local charity they were able to create concept images which were shared with clinicians and young people and their families for their opinion. The service applied for funding to improve the environment.

### Involvement of families and carers

Staff supported, informed and involved families or carers. This was evidenced in the care records. A parent reported that after each visit, they were given an action plan for the week and were also informed of the long-term plan. They did however request that information was provided in a written format to avoid misinterpretation.

Staff helped families to give feedback on the service. Families were included in some of the feedback questionnaires. Families also provided written and verbal feedback informally which was recorded by the service and fed back through team meetings and annual reports.

# Our findings

Staff gave carers information on how to find the carer's assessment. They also signposted carers to local services that offered support.

## Is the service responsive?

**Requires Improvement** 

Our rating of responsive stayed the same. We rated it as requires improvement.

### Access and waiting times

**The service was not easy to access. Patients who did not require urgent care had long waits to start treatment. The service did not adequately ensure that patients who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care. Staff followed up patients who missed appointments.**

The staff did not have clear criterion to describe which patients they would offer services to. They did not have a robust plan for those who could not commence treatment under children's services either due to not being deemed suitable, or due to age if they were approaching 18. Feedback from parents was that this was not always clear. They also reported their children being accepted on their insistence following a few rejections. The process was not robust enough for those approaching 18. For example, there was an incident where it was suggested to refer on a young person to adult services to commence therapy to avoid disruption by starting it with the children's service. The young person was however not accepted by adult services. It was unclear what arrangements were in place for young people who were on the waiting list and in the transition phase.

The service did not meet trust target times for seeing patients from referral to assessment and assessment to treatment. Data provided by the trust showed that;

A total of 1027 people were waiting for their first appointment.

Of these 911 were waiting for their first appointment with the community mental health team.

684 people were waiting longer than the recommended 18 weeks for a first appointment.

94 people were waiting more than 52 weeks for their first appointment with the community child and adolescent mental health team which the service considered to be a breach.

Their most current information for internal waiting times showed that

271 people had waited under 40 weeks for therapy

30 had been waiting 41 or more weeks.

The standard set by the Quality Network for Community CAMHS is no more than six weeks between assessment and treatment.

# Our findings

A total of 1145 people are waiting for their second appointment.

Of all the teams under the community services, the community child and adolescent mental health team had the highest number of people waiting for a second appointment. This was a total of 968. 859 people had been waiting more than six weeks.

The shortest wait was for the Psychological Wellbeing Practitioners which stood at 8 weeks. There were 17 people on this list.

The first episode in psychosis and very urgent eating disorders pathways had no people waiting. The routine referrals for eating disorders showed a 100% performance rate for seeing people within 28 days of referral. This was in line with the service's target.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff used non-formal ways of trying to engage with people. They used an engagement pack which provided alternative ways of communication such as art, crafts and games. Staff also saw young people where they felt most comfortable such as schools, parks or in their homes. Parents expressed their gratitude to staff for making this provision.

Staff tried to contact people who did not attend appointments and offer support. They sent out letters inviting them to book an appointment. This would be followed by offers of two appointments. The first appointment would be set three weeks ahead to allow adequate time to make arrangements to attend. If this appointment was not attended a further assessment date would be set another three weeks ahead. If there were no concerns and the person did not need a clinical review, they would be sent a discharge letter with a copy to the referrer.

When patient appointments were cancelled, staff did not always give patients clear explanations and offer new appointments as soon as possible. There were examples where staff were off and needed their caseloads re-allocated. This process was not fully effective as some young people were left without a clinician or appointments for some time. The service's Exception Report showed a higher number of cancelled appointments by the trust that were not re-appointed compared to those cancelled by patients. When we spoke to parents, two of them reported they had appointments cancelled without an explanation.

The service used systems to help them monitor waiting lists/support patients. Waiting times was identified on the trust's risk register. It had cited staff leavers/retiring, reduced capacity as well as an increase in referrals as some of the factors that had impacted on waiting times.

The service used their Patient Tracking List to maintain oversight over their waiting times. This was with the aim of ensuring that those with long waits were regularly reviewed. Waits that were longer than 52 weeks were considered a breach in the service's waiting times and would trigger a root cause analysis to ensure lessons learned were communicated to staff.

The Service also used Activity Performance Meetings to monitor activity against expected delivery and monitor patient flow across teams. This included clinician caseload and activity data. Following this key issues and action points were circulated to the teams.

### Facilities that promote comfort, dignity and privacy

**The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.**

# Our findings

The service had a full range of rooms and equipment to support treatment and care. Within the community teams the physical arrangement of where young people were seen offered privacy. In the emergency department the Sheffield Treatment and Recovery team had their own waiting area separated from the hospital's main one. The area available for the team included consultation rooms.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

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

**The service was able to meet the needs of all patients – including those with a protected characteristic. Staff were able to signpost to external agencies. Staff helped patients with communication, advocacy and cultural and spiritual support. However, staff had difficulties in accessing interpretation services.**

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The service was able to access support through external agencies. The buildings were accessible for disabled people. However, staff reported having trouble accessing language interpretation in time and had had to rely on families during emergencies.

Children and young people seeking support with gender identity and sexuality were referred to the most appropriate service or signposted to a third sector organisation.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Information and leaflets were available in the waiting areas.

The service had information leaflets available in languages spoken by the patients and local community.

### Listening to and learning from concerns and complaints

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Patients, relatives and carers knew how to complain or raise concerns. The parents we spoke to reported knowing how to complain, and for those who had were supported by staff through the process.

Staff understood the policy on complaints and knew how to handle them. Staff reported they would initially engage with the person to understand the concerns and resolve them where possible. If the complaint needed to be escalated people were given information on how to do this formally. They would also follow up this information with a letter.

Managers investigated complaints and identified themes. The service reported received a total of 41 complaints between March 2020 and February 2022. The themes with the highest scores were communication (21) and delivery of care (20). Transition was an area where several complaints referred to a lack of clear communication about the process and a lack of provision for patient information. Waiting times also featured as an area of concern.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Parents we spoke with reported their concerns were fully addressed. They were also kept informed throughout the process.

Managers shared feedback from complaints with staff and learning was used to improve the service.

# Our findings

The service used compliments to learn, celebrate success and improve the quality of care. The trust developed a Greatix system which had a functionality within the trust's incident reporting system Datix. Greatix was used to allow individuals to express thanks to colleagues and record positive feedback and achievements. This was incorporated into team meetings.

## Is the service well-led?

**Good** 

Our rating of well-led improved. We rated it as good.

### Leadership

**Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.**

The management team had come from a variety of backgrounds that included nursing, medical and social care with experience in a variety of settings that included acute care and mental health. The management team participated in integrated care and was involved in groups at a national level. Within the trust managers spent time in areas they represented and attended team meetings. Some of the senior management also worked as clinicians on the frontline. They covered evenings and out of hours where they were able to develop visibility with the staff group and gain an understanding of the of issues faced by the service.

The leaders of the children's mental health services had worked to gain equality and recognition in the trust. Being virtual as a result of the pandemic enabled them to liaise and take part in huddles with the acute trust. When the acute trust had a surge in mental health patients, they were able to find ways to support them. They did this by changing their criteria from only seeing those that attended with self-harm and suicidality to all forms of mental health. The leaders were also able to establish links with the acute trust and felt they were now in a position where they were heard. The leadership team also sat in the board meetings with the Integrated Care Systems to observe.

### Vision and strategy

**Staff knew and understood the provider's vision and values and how they were applied to the work of their team.**

The trust was reviewing their clinical strategy. As a care group they had a 'Plan on a Page' that fed into the trust's process.

The service's care group offered specially designed training that was tailored to the needs prioritised by the Children's Workforce. Multi-agency staff could attend this training. It was designed to support colleagues in responding to challenges in relation to children's mental health.

The child and adolescent community mental health team developed a document specifically to support staff at the acute hospital in managing children and young people with their mental health needs.

The management team was linked in with NHS England and had set up clinical groups for training.

# Our findings

The service established a mental health liaison post that gives bitesize teaching to the acute trust. This training was delivered on the frontline in clinical areas and has been fed back as being a success.

The learning disabilities lead nurse organised training days titled Autism Bus Experience that were shared trust wide.

The Eating Disorders Assessment and Treatment team offered bespoke training for the acute trust.

Some of the senior management team provided training on the standard operating procedure for the care of 16/17 year olds.

The medical team provide training on medication and legal frameworks. They also provide training on referrals for tier four beds and the completion of some of the legal paperwork.

Training is also provided on Recognising and Assessing Medical Problems in Psychiatric Settings. This is a simulation course that uses realistic scenarios based on real life incidents.

### Culture

**Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.**

The service benchmarked culture through service user and staff feedback incidents. They encouraged leavers interviews from staff that left the trust. They also looked at staff survey results. They reported this helped in forming a view of the culture.

The management team reported a shift in culture over the past 10 months. The service had lost several staff and experienced changes in the service. They gained an opportunity to rebuild and felt the culture had improved. Staff reflected this stating things used to be held by the management team and not owned by the team. This had now changed.

The management team reported staff were now emailing the service manager and clinical directors directly. They also had an open-door policy for staff that could not speak up during formal meetings and valued corridor conversations. The managers felt that although they did not always have the answers, these approaches allowed them to work through challenges together. The staff and managers reported that the current culture was that leadership was becoming less centralised with everyone being involved in decision-making.

The four staff members who we spoke with about culture gave positive feedback. They described their teams as brilliant and helpful. They felt respected and valued. They were also happy with management. The frustration for some of the staff came from their struggles to meet demand.

The service developed a ‘You Said We Did’ model for turning recommendations into results. Some of the issues raised were;

- Capacity not meeting demand. In response, the service had completed a capacity and demand review. Following this they requested four whole time equivalent band six staff and one whole time equivalent band seven nurses. They were awaiting feedback for the request at the time of the inspection
- Staff feeling worn out. The service had arranged a wellbeing day. They aimed to introduce further days for the future.

- The challenge in recruiting new staff. To address this, the service developed a recruitment pack to attract new staff. The service also planned to trial recruitment open days and developing band five roles.

The trust provided opportunity for career progression. The management team undertook needs analyses, supervision and appraisals to identify career pathways. The trust offered qualifications in leadership and management. The service also developed a programme called 'Ready to Rise' and 'Stepping Up' for people from black and minority backgrounds. They also provided acting in periods and buddying up to build experience for staff.

The trust identified challenges in the nursing staff leaving their clinical roles. To address this, they incorporated secondment roles.

The trust participated in and supported the NHS Graduate Management Training Scheme and hosted trainees. Some of the staff have gone and taken up operational leadership and management positions following completion of the training scheme.

### Governance

**Our findings from the other key questions demonstrated that some governance processes did not always operate effectively at team level.**

The service had a structure meeting chart and clinical operational group that gave visibility across the service. All the meetings fed into the trust board meeting.

The service also had a mental health clinical operation group. This group assessed quality against the CQC five key questions.

On a team level staff used manager supervision, huddle dashboards and an audit lead to ensure processes operated effectively. Issues flagged up were put into the trust's risk register.

There were some areas of governance which required additional focus from the leadership team to ensure that oversight and action was robust and that improvements made were embedded. This included oversight of physical health, capacity to consent, management of violence and aggression, and lone working.

### Management of risk, issues and performance

**Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Leaders had oversight of risks and were taking action to mitigate them.**

The service had a risk register in place, and items on the risk register matched the concerns of staff within the service. They included:

- Waiting times
- Size of caseloads
- Delay to treatments.

The management team had put into place measures to mitigate risks, examples included;

- The development of 'Waiting Well meetings'. They used these to discuss waiting times for patients and measures they could put in place to mitigate risks.

# Our findings

- Outsourcing some of the assessments and treatments to an external agency. The service was aimed at those waiting for a mental health or autism assessment or those waiting for cognitive behaviour therapy or goal-based intervention. The assessments and treatment were delivered online. Clinical leads for the trust triaged referrals and refer to this external agency. Clinical leads also look at those who are longest on the waiting list and referred where appropriate. The trust reported they maintained oversight and monitored the agency's waiting list and included them in the patient tracker list. The staff from the agency were also included in huddles to discuss those at risk. The data provided by the trust showed that for those referred, the agency consistently met the target set by the trust. This was for children and young people to have their initial assessment and first goal-based intervention within a maximum of 18 weeks. The data sent for the months of May to July 2022 showed the maximum wait time was 11 weeks and the shortest was three.
- Caseload waiting tools.
- Staff activity and performance tracker.

The trust reported that these measures had started to reduce waiting times for routine assessments and treatment leaving capacity for more complex face to face assessments.

### Information management

**Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.**

### Engagement

**Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.**

### Learning, continuous improvement and innovation

The trust had undertaken a number of actions to innovate and continuously improve the service.

- The service had developed an in-reach service for the acute trust during the pandemic. This involved the eating disorders team, a mental health nurse specialist and the supportive treatment and recovery team (STAR).
- The eating disorders team provided review and consultation for patients in the acute trust. They also provided training within the trust as well as externally.
- The mental health nurse specialist provided support and training to colleagues in the acute site. This role included being a point of contact for the surgical and medical wards, working with the head of security around management of risk, working with the wards to develop knowledge and expertise as well as facilitating reflective forums.
- The STAR team initially only saw people that attended with concerns around self-harm and suicidal ideation. They expanded their remit to include all mental health presentations.
- The service had introduced a parent and infant interaction programme which aimed to promote emotional well-being in infants by supporting caregivers to build secure relationships with their babies. This was a newly developed pathway.
- The service had brought in a dialectical behaviour therapy service which was training staff in delivering the therapy. All the staff in the STAR team had received the training and had improved their ability to engage with young people.

# Our findings

- The trust had introduced a 'healthy minds' programme. This aimed to deliver early intervention that is described in the Future in Mind (2015) report. They aimed to work closely with schools and support them in delivering evidence-based interventions to meet identified mental health needs in children and young people.
- The service had launched a '17 ½ pilot' after noticing that a number of young people were reaching the age of 18 whilst still on their waiting list. A clinic was developed offering consultations to those who had or were about to breach the 18-week referral to treatment waiting time. The pilot was ongoing at the time of inspection.
- The service had two peer support workers in post and they were allocated to a supervisor.

# Our findings

## Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the service MUST take to improve:**

- The trust must continue to reduce the length of time patients wait to access treatment. This must include the deployment of sufficient number of staff to ensure caseloads are manageable and safe. (Regulation 12)

**Action the service SHOULD take to improve.**

- The trust should ensure that staff clearly record capacity assessments and that they monitor this.
- The trust should ensure that physical health assessments are undertaken in line with guidance.
- The trust should ensure that systems are in place to ensure safe working environments for staff. This includes that staff are able to safely manage violence and aggression and lone working and have received appropriate training.
- The trust should ensure that there is clear guidance in place for staff to enable them to support young people post 18 who were not transitioning to the care of adult services.
- The trust should ensure that all staff complete mandatory training in line with its targets.
- The trust should ensure that CQC ratings are on display.
- The trust should ensure that emergency grab bags are monitored to ensure they remain in line with trust policy.
- The trust should ensure that governance processes are effective in monitoring and mitigating risk and accurate recording of data.

# Our inspection team

During the inspection the team:

- Toured the environment at Centenary House, Amber Lodge, Becton Centre and the STAR team based at the emergency department and the 136 suite.
- Spoke with 6 parents and three children
- Spoke with 18 staff. This included managers, clinical leads, nurses, consultants, doctors, psychotherapists and senior management.
- Viewed 13 care records
- Observed a multidisciplinary team huddle
- Reviewed a range of other documents, policies and procedures.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |