

**Good**

# 5 Boroughs Partnership NHS Foundation Trust

# Specialist community mental health services for children and young people

## Quality Report

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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RTV06	5 Boroughs Partnership NHS Foundation Trust	The Warrington and Halton Community Team St Helens and Knowsley Community Team	WA7 5HQ L36 7TA

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs Partnership NHS Foundation 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 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership NHS Foundation Trust.

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

### Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

### **Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

# Summary of findings

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# Summary of findings

## Overall summary

We rated the specialist community mental health services for children and young people as **good** because:

Staff had received safeguarding training and had a clear understanding of safeguarding and their responsibilities in relation to identifying and reporting allegations of abuse. They followed the lone working policy and when they carried out home visits they kept other staff informed of their whereabouts.

Information about any adverse events had been cascaded to staff within the trust. This was done through the trust intranet, which all staff had access to. Incident recording and reporting was effective and embedded across all services. Staffing levels within both teams we visited was up to the level they were commissioned for. At the children and adolescence mental health services (CAMHS) we looked at the design, layout and cleanliness of all the areas where young people were cared for and found the environments were safe and suitable.

Staff worked in a multi-disciplinary and collaborative approach to care and treatment. This meant they worked with other professionals including social workers, a general practitioner, occupational therapist and a psychologist. Supervision was completed monthly. Several staff told us this was booked in advance and it was expected that staff attended. Staff were appropriately qualified and competent at the right level to carry out their work.

The CAMHS services were developing and implementing person centred pathways of care that detailed locally agreed evidenced based clinical standards for a defined care group. These pathways adhered to national institute for health and care excellence guidelines.

The team manager reviewed referrals and risk assessed them daily. During the assessment, a clinician would work with the young person and/or family to think about their difficulties and what might help them.

All information needed to deliver care was stored securely and available to staff when they needed it and this was in an accessible form.

Each service had collected feedback from young people, their parents and carers. The trust provided us with young peoples' and their carers' feedback, which was collected in each of the waiting rooms using a computer.

There was a participation group called 'shout' that was open to current patients, former patients and other young people who wanted to make a difference to mental health services. There were six 'shout' groups in the trust and young people involved were able to log volunteer hours, do training and receive personal references.

Staff involved patients and their families as partners in their care and in making decisions. The patients' agreement was sought throughout. Family were involved as appropriate and according to the patient's wishes and, where appropriate, information was shared with families.

Staff listened to the concerns and complaints of patient's and families. We saw evidence of the information available to patients and their families on how to make a complaint and other agencies such as the patient advice and liaison service that supported people with complaints.

Staff considered the patients and their families' spiritual, ethnic and cultural needs and their care and treatment was planned and delivered to reflect these needs, as appropriate. At the two services we visited, we looked at the design and layout of all the areas where patient's were cared for and found the environments promoted dignity and confidentiality.

Any child or young person who presented with self-harm at accident and emergency (A&E) were seen by the children's and adolescent response team on the day of admission. This service was a 24 hour response team. Referrals to the service were made by other professionals, such as GPs, teachers and social workers. These were reviewed each day and prioritised by a member of each CAMHS team.

The 5 Boroughs CAMHS was accredited with excellence in February 2014 by the quality network for community CAMHS. Key performance indicators were used to monitor progress and quality. Management held regular quality performance meetings.

# Summary of findings

Staff described strong leadership at team level and said they felt respected, valued and supported. Monthly team meetings were held, where information was shared with staff. The management structure was clear and understood by staff.

We saw evidence that staff had clinical and managerial supervision in the CAMHS service. Staff were aware of the

trusts vision and values. Despite staff concerns about resources they were motivated and dedicated to give the best care and treatment they could to young people and children.

However:

At the St Helens and Knowsley office, it had been recognised that the décor needed updating. This was in the process of being addressed.

# Summary of findings

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

### Are services safe?

#### We rated safe as good because

- Staff had received safeguarding training and had a clear understanding of safeguarding and their responsibilities in relation to identifying and reporting allegations of abuse.
- Staff said they followed the lone working policy and when they carried out home visits they kept other staff informed of their whereabouts.
- Information about any adverse events had been cascaded to staff within the trust. This was done through the trust intranet, which all staff had access to.
- Incident recording and reporting was effective and embedded across all services. people ar
- At the CAMHS services we looked at the design, layout and cleanliness of all the areas where young people were cared for and found the environments were safe and suitable.
- Staffing levels in both teams we visited was up to the level they were commissioned for.

Good



### Are services effective?

#### We rated effective as good because

- Staff adopted a multi-disciplinary and collaborative approach to care and treatment.
- Supervision was completed monthly. Several staff told us this was booked in advance and it was expected that staff attended.
- Staff were appropriately qualified and competent at the right level to carry out their work.
- The CAMHS service was developing and implementing person centred pathways of care that detailed locally agreed evidenced based clinical standards for a defined care group. These adhered to national institute for health and care excellence.
- All referrals were reviewed and risk assessed by the team leader daily.
- In the assessment, a clinician would work with the young person or family to think about their difficulties and what might help them.

Good



# Summary of findings

- All information to deliver care was stored securely and available to staff when they needed it and this was in an accessible form.

## Are services caring?

### We rated caring as good because:

- Each service had collected feedback from young people, their parents and carers. The trust provided us with young peoples and their carers' feedback, which was collected in each of the waiting rooms using a computer.
- The service had a young persons participation group called 'shout' that was open to current patients, former patients and other young people who wanted to make a difference to mental health services. There were six 'shout' groups in the trust and young people involved were able to log volunteer hours, do training and receive personal references.
- Staff involved patients and their families as partners in their care and in making decisions. The patient's agreement was sought throughout. Families were involved as appropriate and according to the patient's wishes and where appropriate information was shared with families.

Good



## Are services responsive to people's needs?

### We rated responsive as good because:

- Staff listened to the concerns and complaints of patients and families. We saw evidence of the information available to patients and their families on how to complain and other agencies such as patient advice and liaison service that supported people with complaints.
- Patients' and their families' spiritual, ethnic and cultural needs were considered and their care and treatment was planned and delivered to reflect these needs, as appropriate.
- At the two services we visited we looked at the design and layout of all the areas where patients were cared for and found the environments promoted dignity and confidentiality.
- Any child or young person who presented with self-harm at accident and emergency were seen by the children and adolescent response team on the day of admission. This service was a 24 hour response team.
- Referrals were made by other professionals, such as GPs, teachers and social workers. These were reviewed each day and prioritised by a member of each CAMHS team.

Good



# Summary of findings

However, at the St Helens and Knowsley office, it had been recognised that the décor needed updating. This was in the process of being addressed.

## Are services well-led?

### We rated well-led as good because

- The 5 Boroughs CAMHS had been accredited with excellence in February 2014 by the quality network for community CAMHS.
- Key performance indicators were used to monitor progress and quality. Management held regular quality performance meetings.
- Staff described strong leadership at team level and said they felt respected, valued and supported.
- Monthly team meetings were held, where information was shared with staff.
- The management structure was clear and understood by staff.
- We saw evidence that staff had clinical and managerial supervision in the CAMHS service.
- Staff were aware of the trusts vision and values.
- Staff were motivated and dedicated to give the best care and treatment they could to patients.

Good





# Summary of findings

## Information about the service

5 Boroughs Partnership NHS Foundation Trust was established in 2010 and provides mental health, community health and learning disabilities services across Halton, Knowsley, St Helens, Warrington and Wigan.

The trust provides child and adolescent mental health services (CAMHS) across the 5 Boroughs in line with a four-tier strategic framework that is nationally accepted as the basis for planning, commissioning and delivering services. This report is relevant to tier 3 services.

Tier 3 consists of a community mental health team, clinic or child psychiatry outpatient service, providing specialised services for children and young people with more severe, complex and persistent disorders.

We visited two community teams: the Warrington and Halton team and the St Helens & Knowsley team.

The CAMHS community service has not been inspected by the CQC previously.

## Our inspection team

Our inspection team was led by:

**Chair:** Kevin Cleary, medical director and director for quality and performance, East London NHS Foundation Trust

**Head of Inspection** – Nicholas Smith, Care Quality Commission

**Team leaders:** Sarah Dunnett, inspection manager, Care Quality Commission

Patti Boden, inspection manager, Care Quality Commission

## Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients via focus groups.

During the inspection visit, the inspection team:

- Visited two community teams and looked at the quality of the office environment and observed how staff were caring for patients.
- Spoke with nine patients who were using the service.
- Spoke with the managers for each community team.
- Spoke with 21 other staff members including doctors, nurses and social workers
- Attended and observed five therapy sessions with carers and patients.
- Looked at 14 treatment records of patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service

# Summary of findings

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

Patients told us the staff were okay and they could contact their worker by text or phone if they needed extra support. They also told us they had had a key worker since the service started. One patient told us staff had been flexible over meeting times and venues and they had found this approach more supportive. We were told staff had been really helpful.

Carers told us that staff always listened to them and they could suggest ideas. They told us that staff were interested in their welfare as well as that of their child. They said the service they received was tailored to their requirements and everyone was helped.

Parents confirmed that they had received information about other services available whilst they were waiting for their first appointment. They also told us that they had a first assessment known as a choice assessment and then they had to wait three months before they received their the service. They found the delay frustrating but complimented the service once it had started.

## Areas for improvement

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

- The provider should review the plan to improve the décor at the St Helens and Knowsley office as it had been recognised that the décor needed updating.

# 5 Boroughs Partnership NHS Foundation 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
The Warrington and Halton Community Team St Helens and Knowsley Community Team	5 Boroughs Partnership NHS Foundation Trust

#### Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

At our inspection we were told that no current patients were subject to a community treatment order.

#### Mental Capacity Act and Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) do not apply to people under the age of 18 years. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. These would include the existing powers of the court, particularly those under s25 of the Children Act, or use of the Mental Health Act.

The Mental Capacity Act (MCA) act does not apply to young people aged 16 or under. For children under the age of 16, the young persons' decision making ability is governed by Gillick competence. The concept of Gillick competence

recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the patients where possible in the decision making regarding their care.

The Mental Capacity Act does apply to young people aged 16 and 17 and mental capacity assessments should be carried out to make sure the patient has the capacity to give consent.

# Detailed findings

Treatment was agreed with the young person and their families. Where the young person had decided they did not want their families to be involved, staff said Fraser competence was used and an assessment of risk was carried out to ensure the safety of the young person.

# Are services safe?

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

\* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

## Our findings

### Safe and clean environment

At the CAMHS services we looked at the design, layout and cleanliness of all the areas where young people were cared for and found the environments were safe and suitable.

Each team had a clinic room and these were found to be clean and appropriate for their use.

### Safe staffing

Staffing at both teams we visited was up to the level they were commissioned for. The Warrington and Halton team had two vacancies and these were for a band 7 and band 6 nurse. Recruitment was under way for the band 6 post. There were no vacancies at the St Helens and Knowsley team. The managers told us there was a minimum of four clinicians which included senior nurse practitioners, advanced mental health practitioners and a family therapist on duty Monday to Friday 8am till 5pm. This was in addition to the consultant psychiatrists and psychologists. Across the 5 Boroughs there were five consultant psychiatrists as well as three consultant psychotherapists and an assistant psychotherapist.

Both teams operated a duty call system during the week. Someone was always available for telephone consultations and face to face emergency calls. There were weekly dedicated slots for the consultant psychiatrist on a Wednesday so that any calls received over the weekend could be booked in. Emergency calls on a weekend were dealt with by the child and adolescent response team. They responded to emergencies within 24 hours although there was a protocol with the local accident and emergency departments that they would respond within a 12 hour period. Staff then completed a follow up assessment within 72 hours. If the patient was known to the service, they were seen by a worker known to them within the 72 hour window. If, after assessment, a referral was deemed not to need the level of support offered by the CAMHS units, they were sign posted to other support services within the community.

Staff told us they were supported by their managers to access training to meet the needs of young people. Most staff had completed mandatory training and met the trust's

target of 85%; those staff who had not attained this level were either new starters, on sick leave or were booked in to complete the training. Completion of mandatory training was linked to increments in staff pay and covered topics that included safeguarding, management of violence and aggression and basic life support.

### Assessing and managing risk to patients and staff

The CAMHS teams had a duty system. The duty staff triaged the referrals, reviewed the information and prioritised the referrals according to potential risks. They also signposted young people to other services or made appointments for assessments where necessary. When a young person was admitted to an A&E department, staff attended and carried out an initial assessment of their needs, within a 12 hour timescale.

Staff undertook a risk assessment of every young person on their initial visit. These were reviewed if the young person's needs changed and before discharge. Records we checked showed these had been carried out promptly.

Safeguarding vulnerable adults, children and young people was a priority; appropriate systems were embedded. Each team had a safeguarding lead. Safeguarding supervision was offered to staff where children were involved in child protection issues.

Staff monitored and followed up when children did not attend appointments. Staff contacted the family and/or patient by phone, text or letter. Information about other services they could access was included in any letters sent. If they didn't get a response, they contacted the referrer and informed them of the situation. This meant other professionals were aware of the situation.

Safeguarding concerns were also reviewed as part of the group and individual supervision.

Staff had received safeguarding training and had a clear understanding of safeguarding and their responsibilities in relation to identifying and reporting allegations of abuse.

Staff we spoke with knew who was the safeguarding lead for their area and felt able to contact them for advice when needed. Information provided by the trust showed CAMHS staff had completed safeguarding training.

# Are services safe?

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

Staff followed the lone working policy and kept other staff informed of their whereabouts when they carried out home visits. Alarms were not readily available in the clinic rooms at either community setting. Wigan and Knowsley had installed pin point alarms for staff but these had not been activated at the time of our visit.

## Track record on safety

Information provided by the trust prior to the inspection indicated that the CAMHS services had one serious incident in the period 1 May 2014 to 3 April 2015.

CAMHS teams did not store or administer medicines. They telephoned the emergency services if someone required immediate physical assistance.

The managers were able to demonstrate where lessons had been learnt and practices changed. Following an incident in 2014, it had been identified that there was no formal process when transferring care between the CART and CAMHS consultant psychiatrists. As a result of this learning, a protocol had been put in place.

## Reporting incidents and learning from when things go wrong

Incident recording and reporting was effective and embedded across all services. Team managers reviewed all incidents which were forwarded to the trust's quality assurance team, who maintained an oversight.

Information about any adverse events had been cascaded to staff within the trust. This was done through the trust intranet which all staff had access to. Incidents were also discussed in team meetings and discussions were minuted so that staff not present could keep themselves informed.

Staff were able to tell us about feedback they had received following incidents and the changes that had been made. Staff were provided time to talk about how any incidents had affected them and look at what would improve their experience if it happened again.

# Are services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Our findings

### Assessment of needs and planning of care

We looked at the care records of 14 young people and found they were personalised, holistic and recovery focused. Recovery based means being focused on helping patients to be in control of their lives and build their resilience so that they can stay in the community and avoid admission to hospital wherever possible. A comprehensive and timely assessment had been completed for each person at the initial assessment. Young people's plans of care were shared with the young person, their families and their GP.

Staff we spoke with said that they would often consult or co-work with colleagues. We found that clinicians had a range of professional skills, including psychiatrists, clinical psychologists, specialist doctors, occupational therapist, specialist nurses and social workers.

For young people who had complex needs, staff sought information and participation from schools and other agencies involved with the young person and their family and this was included in the planning of their treatment and care.

All information to deliver care was stored securely and was available to staff when they needed it and was in an accessible form.

### Best practice in treatment and care

The CAMHS services were developing and implementing person centred pathways of care that detailed locally agreed evidenced based clinical standards for a defined care group. This adhered to national institute for health and care excellence (NICE). These aimed to improve the experience and outcome of young people who used the services. Pathways being developed included; self-harm, anxiety, emerging borderline personality disorder, attachment based interventions, and behaviours that challenge. The trust ran a CAMHS NICE forum where updates and new guidelines were identified and discussed.

The experiences of young people, children and families (outcomes) were monitored to evidence whether people improved following treatment and care. However; this was mostly where clinical staff had completed intensity workers or psychological wellbeing practitioners training. An audit of psychosis and schizophrenia, in line with NICE guidance, had just been completed.

All patients had a health of the nation outcome scales child and adolescents' mental health check at the start of their treatment. Staff re-checked these scores at the end of their treatment to determine if their health overall had improved.

The team managers reported there was a monthly quality performance review meeting which was attended by all the managers. We saw the records for three meetings and they looked at staffing levels, patient referrals, and training needs. Quality was also considered in supervision for staff as managers discussed their case load. This was to ensure that patients were getting the support they required and so could move to discharge from the service.

Patients had access to psychological therapies as part of their treatment and psychologists were part of the multidisciplinary team. The service offered a range of groups and specialist clinics

to meet peoples needs, such as incredible years, eating disorders and learning disabilities.

### Skilled staff to deliver care

Based on the information provided by the trust and what staff told us, we concluded staff were appropriately qualified and competent at the right level to carry out their work. For example, staff were trained as high intensity workers or psychological wellbeing practitioners. The training improved access for young people and families to psychological therapies.

Through supervision, staff were expected to identify their own training needs. Staff had received other training including but not exclusive to eating disorders, dialectic behaviour therapy (this looks at how patients can change their patterns of behaviour) and learning disabilities.

Supervision was completed monthly. Several staff told us it was booked in advance and it was expected that staff attended. Staff understood what supervision was and told us that the manager monitored that it was happening. If anyone missed three sessions of supervision then the team manager looked at why. Staff also had access to reflective practice meetings and these were led by one of the psychologists.

# 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.

## Multi-disciplinary and inter-agency team work

A multi-disciplinary team meeting (MDT) is a group of health care and social care professionals who provide different services for people in a coordinated way. Members of the team was varied and dependant on the peoples needs and the condition or disease being treated.

Staff described a multi-disciplinary and collaborative approach to care and treatment. Staff said they would discuss cases at both individual and group supervision and care planning meetings. They sought out and asked advice from the specialists in the team. The teams included consultant psychiatrists, consultant psychologists, specialist doctors, social workers, specialist nurses and occupational therapists. The CAMHS teams had an MDT meeting at least weekly.

We saw evidence that meetings were taking place with local social services to look at how working together could be improved. There was a clear action plan of how the adult social care and CAMHS could gain an understanding of how they each worked and how they could work together. This was especially important for those patients approaching 18 years of age.

In patients notes, we saw examples of referral and discharge letters that informed the receiver about the patients care and their changing needs. Staff reported the MDT had good links with GPs and schools, and considered young people's housing and social needs and any police involvement. We also saw examples of where patients would not engage with the CAMHS but did have good support in school. CAMHS staff provided support and advice to the worker who the patient was engaging with.

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

The service did not have any young people subject to a community treatment order (CTO) at the time of our inspection. Staff had completed training in the Mental Health Act 2005 and understood their responsibilities in relation to patients on a community treatment order.

## Good practice in applying the Mental Capacity Act

The Deprivation of Liberty Safeguards (DoLS) does not apply to people under the age of 18 years. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. These would include the existing powers of the court, particularly those under s25 of the Children Act, or use of the Mental Health Act.

The Mental Capacity Act does apply to young people aged 16 and 17 and mental capacity assessments should be carried out to make sure the patient has the capacity to give consent.

For children under the age of 16, decision making ability is governed by the Gillick competence. This concept of competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. As a consequence, when working with children, staff should be assessing whether a child has a sufficient level of understanding to make decisions regarding their care.

Treatment was agreed with the young people and their families. Where a young person had decided they did not want their family to be involved, staff said the Gillick competence would be used and an assessment of risk carried out to ensure the safety of the young person.



# Are services caring?

Good 

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

## Our findings

### Kindness, dignity, respect and support

Feedback from patients and their families was positive about the staff; all said they were helpful and approachable. They were treated with kindness and respect and they valued their support. Staff returned phone calls in a timely manner and patients could telephone if they needed extra support.

When appointments were cancelled they were always offered an alternative. Parents and/or carers told us that staff listened to their suggestions and comments about the support they felt they needed. Feedback indicated that staff were interested supporting the family unit and staff recognised if they could support the family as well as the patient the outcomes were more positive. Patients told us that staff listened to them and staff were flexible about appointments. This flexibility included changing times and meeting venues for the benefit of the patient. Patients told us they could get in touch with their workers easily and used a variety of methods such as text, email and phoning.

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

Each service had collected feedback from patients, their parents and carers. The trust provided us with feedback from patients and their carers, which was collected in each of the waiting rooms using a computer.

The results of the surveys were printed and displayed each month. At Warrington and Halton for May 2015, 100% of the responses were positive about the service. We saw similar feedback at the St Helens and Knowsley office. Comments were also included in the feedback included “the amazing standards would make me recommend to a friend” and “thank you so much for your wonderful support”. We also saw the response for April and only 37% of the responses were positive and one comment left was “I would not recommend CAMHS as the rooms are really depressing and

need decorating urgently”. The service responded to the surveys and this was displayed as a “you said we did”. The response to the comment about the décor was “we are going to ask the young people in our ‘Shout’ group to look at how we can improve the decorations of our therapy rooms.” ‘Shout’ is a young person participation group and it is open to current patients, former patients and other young people who want to make a difference to mental health services. There are six Shout groups in the trust and young people involved are able to log volunteer hours, do training and receive personal references.

Patients could access an internet page called ‘kouth’ and they were able to ask questions, receive information and support around their illness and identify other agencies that may be able to help.

Staff involved patients and their families as partners in their care and in making decisions. The patient’s agreement was sought throughout. Families were involved as appropriate and according to the patient’s wishes and where appropriate information was shared with families.

Patients and families told us information was shared with them about their care and treatment and decisions were made in partnership with the trust. Verbal and written information that enabled patients to understand their care was available in large print, pictorial, audio and interpreting services dependent on their individual need.

CAMHS patients who self-harmed could access the skin camouflage clinic as part of their treatment. We observed a treatment session and saw the patient was treated in a sensitive way. Staff explained exactly what was going to happen and about the different creams used. At the end of the session the patient left with an information leaflet about the treatment they had received. Staff told us they witnessed a real positive change in patient’s and how they saw themselves after a session and they felt it was beneficial to the patients’ overall well-being.

# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

The team manager reviewed all the referrals and risk assessed them on a daily basis. Referrals were put in to three categories. Urgent cases were seen within 24 hours; those with less risk were offered an appointment for an assessment of risk, needs and planning of care within 10 to 12 weeks. Referrals deemed to be of the lowest risk were informed by letter that they had been placed on a waiting list. They were given information about how they could contact the service if their situation changed and were also provided with information about other community services that may help. This meant people were able to access other means of support if they needed to until they were admitted to the service.

In the assessment, a clinician would work with the young person or family to think about their difficulties and what might help them. The number of appointments agreed was dependent on the needs of the young person. Those with specific needs were referred from the assessment to individual or family therapy, group sessions or specialist clinics such as eating disorder or learning disability. Specialist services for autism or attention deficit disorder (ADHD) were provided by the local acute trust. The multi-disciplinary team reviewed any cases which were very complex.

Any child or young person who presented with self-harm at accident and emergency (A&E) was seen by the child and adolescent response team (CART) team on the day of admission. This service was a 24 hour response team. There was a local protocol with the local A&E departments that the CART team responded within a 12 hour slot. The patient was assessed and the CART team provided the initial treatment and support. After 72 hours there was a review of the situation and if necessary the patient was then referred to the CAMHS teams. If the patient was already known to the CAMHS teams, their known worker saw them within the first 72 hours.

Currently referrals to the service were made by other professionals, such as GPs, teachers and social workers. It was planned that patients and/or their families could self-refer to the service. A 'choice' assessment was carried out by the CART on all referrals. Those deemed to be an emergency had a target to be seen of 24 hours the actual trust mean was 0.4 days; anything deemed to be urgent

had a trust target of three working days with an actual response time of 1.4 days. All routine assessments had to be completed within the trust target of 10 working days; the actual time taken was 9.5 days. The CART team indicated whether patients referred would benefit from tier 2 or tier 3 services. Information provided by the trust prior to the inspection indicated that patients could wait anywhere from 3.7 weeks to 11 weeks for access to treatment. This meant some patients could have to wait for over three months for treatment. The managers of the services told us that non-urgent patients could in reality have to wait between 16 -18 weeks to access treatment. This meant those patients waited up to 20 weeks from referral to treatment. The managers could not give us detail of how many patients this affected. Those patients deemed to be at low risk were contacted and provided with information of other community services available that may have been able to help at that time. They were also provided with contact information for the CART team if their situation deteriorated.

The CAMHS senior management were aware of the long waiting times. Staff carried up to 45 cases on their portfolio. Update of guidance on workforce capacity and functions of CAMHS in the UK in a Royal College of Psychiatrist's report dated November 2013 advised that '40 is the recommended average caseload across a team but that individual clinicians may have more or less than this according to their role and work'. To manage this, staff were expected to carry out at least 11 face to face visits/ assessments every week and keep to appointment times. If a patient was waiting for more than 15 minutes, the administration staff informed the manager who explained why there was a delay to their appointment. The management team had put the high waiting lists and caseloads on the trust's risk register. They had also put together a paper to the trust board outlining the issues and had received a one-off budget payment of £150,000 to use to address the issues of waiting times. This money was not available after March 2016. The service managers monitored caseloads and how staff were managing them through supervision. They identified patients who were approaching 17 and a half so that they could plan their transition to adult services. One manager told us they often kept patients beyond their 18th birthday if the pathway had not been identified or if a placement wasn't available.

Carers told us they had received information about other services available whilst they were waiting for their first

# Are services responsive to people's needs?

Good 

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

appointment. They also told us that they had a first assessment known as a 'choice assessment' and then they had waited three months for their service to start. They found the delay frustrating but complimented the service once it had started.

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

At the two services we visited we looked at the design and layout of all the areas where patients were cared for and found the environments promoted dignity and confidentiality. Information was available in the reception areas informing patients and their carers about CAMHS services. There was information about local voluntary and charitable services that they could also access.

At the St Helens and Knowsley office, it had been recognised that the décor needed updating. This was in the process of being addressed.

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

Patients and their families' spiritual, ethnic and cultural needs were considered and their care and treatment was planned and delivered to reflect these needs as appropriate. Examples of this included the use of interpreters' for the assessment and at care programme approach meetings, and using large print or pictorial information with the care plans so that patients could be fully involved in their care.

Staff told us interpreters were available. Staff worked with the local social services regarding travelling communities. We found there were different therapies to meet the different needs of individuals; for example, play therapy, family therapy, specialist clinics and incredible years.

Services could be accessed by patients and their carers who had issues with their mobility and there were toilet facilities they could access.

The trust website had detailed information about the location of the services and how young people and their families could access them. In addition, it had a section called "I am CAMHS" that linked to a series of short videos on 'YouTube' that were made by patients, their families and staff to inform others about the CAMHS services. The short

videos included patients explaining how they felt and how they had been helped, staff explained their roles and parents talked about the impact mental health had on their family. Information on how young people and their families could make their own video to include on the YouTube site was available on the trusts' web page.

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

Staff listened to the concerns and complaints of patients and families. We saw evidence of the information available to patients and their families on how to complain and other agencies such as patient advice and liaison service that supported people with complaints.

Patients and families we spoke with told us they were aware of how to make a complaint and one relative told us they were satisfied with the way their complaint had been resolved.

The trust had a complaints procedure; the guidance was summarised and advertised in receptions and was available on their website. Staff said they received few complaints and most concerns were resolved locally at service level. Once a complaint had been received an investigation officer was identified. A report and response were formulated and, where appropriate, failings identified and an action plan formed. A series of quality checks were made to ensure the complaint had been fully investigated. The business manager and assistant director for CAMHS were part of the checking process. The modern matron for the service was then asked to respond to the complainant with their findings. Monthly updates about complaints were provided to the board.

The CAMHS community services had received 10 complaints in the last year according to information provided by the trust. Six of these complaints had been upheld. The complaints were primarily about waiting times.

Team managers and staff understood their responsibility in relation to the 'duty of candour'. Duty of candour requires NHS and foundation trusts to notify the relevant person of a suspected or actual reportable patient incident, it focuses on transparency and openness.

# Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Our findings

### Vision and values

Staff were aware of the trust's vision and values. The vision and values were on computer home screens. Despite staff concerns about resources, they were motivated and dedicated to giving the best care and treatment they could to young people and children.

The staff were aware of who the senior management were. Several said they had not seen them in their team office but felt they would be accessible if necessary. Staff accessed the trust intranet and were encouraged to send the chair of the trust questions. We saw recent blogs in which the chair had responded to the questions staff asked. Staff received a monthly e-bulletin with information such as new policies, updated NICE guidance and news from within the trust.

### Good governance

The management structure was clear and understood by staff. There were opportunities for staff to raise issues and risks to their immediate manager who would escalate these to the trust risk register if required. Most staff reported that they liked working within the trust. The trust had carried out a reorganisation of the CAMHS service at which time they looked at the access to services patients had through the local A&E departments. They identified that patients could not access CAMHS services outside of usual office hours and in response to this, they had implemented the CART service to meet their needs.

Supervision was carried out in both teams. We saw evidence that staff had clinical and managerial supervision in the CAMHS service. Staff told us they could approach the manager at any time if they were struggling or needed further advice. Young people and their family needs were put first in all the teams.

The trust were carrying out a review of the CAMHS services and staff had been invited to events looking at specific parts of the service. Staff were engaged in all of the project teams.

### Leadership, morale and staff engagement

Staff described strong leadership at team level and said they felt respected, valued and supported. Staff told us they worked in flexible and supportive teams. They worked together to ensure patients' needs were met.

The managers from both services had been on a coaching and leadership course. Managers told us that this course had helped them look at how they spoke to staff. They told us they had changed their approach from what could be seen as challenging to an approach that was inclusive of staff. This was reflected in feedback from staff who told us the managers were more open to discussion and more supportive.

Monthly team meetings were held, where information was shared with staff. Managers attended a monthly business meeting and clinical governance meetings where the over-arching business of the CAMHS service was discussed.

### Commitment to quality improvement and innovation

Key performance indicators were used to monitor progress and quality. Regular quality performance meetings were held by management where incidents and patient harm, staff attendance at training, the position on vacancies, delayed discharges, patients who did not attend and flexible working were discussed. Information from these meetings was disseminated to the trust board and to staff.

Staff were completing the improving access to psychological therapies training that meant that staff had commenced monitoring young people's and families experience of their care.

5 Boroughs CAMHS was accredited with excellence in February 2014 by the Royal College of Psychiatrists' quality network for community CAMHS. This was an in-depth self-review, followed by a peer to peer review to check compliance against the quality network standards.