Requires improvement

Sussex Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Trust Headquarters
Swandean
Arundel Road
Worthing
West Sussex
BN13 3EP
Tel: 01903 843000
Website: www.sussexpartnership.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX219	Trust Headquarters	Chichester CAMHS	PO19 8QJ
		Worthing CAMHS	BN11 2DH
		Eastbourne CAMHS	BN27 3DY
		Brighton and Hove Community Team	BN3 4AG
		Horsham CAMHS	RN12 1RJ
		Hasting CAMHS community team	TN37 7PT
		Folkestone Community Team	CT18 8AN
		Eastleigh CAMHS Community Team	SO50 9DB
		East Kent Hub	CT2 8JY
			GU11 1AY

Summary of findings

Aldershot Community Team

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

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

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

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

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

Summary of findings

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Overall summary

We rated specialist community mental health services for children and young people as requires improvement because:

- Staff had failed to consistently assess and document risk for young people in the carenotes system. There was poor reporting of lower level incidents within the service.This meant that not all incidents involving young people were escalated accordingly. Care Quality Commission had taken enforcement action through the issuing of a warning notice due to the failings in the recording of risk assessment.
- Some of the sites were not clean. Toys were not regularly cleaned.
- There were extensive waiting times for young people needing to access therapies in some geographical areas. These waits were outside of the target set by commissioners and impacted on you people needing to access vital services.
- Care plans were not always completed for young people and some young people had not received a copy of their care plan.
- Whilst staff did say they received supervision, there was poor oversight of supervision which meant that managers could not guarantee that all staff received regular supervision. Appraisal rates were below the target set by the trust.

However:

- On the 7 December 2016 we carried out a focussed inspection to follow up the warning notice. At this inspection we identified that the trust had responded positively to the findings in the warning notice and significant improvements had been made. The trust had developed an action plan to ensure compliance with the trust target of 95% of risk screens completed. We looked at a random selection of 127 care records from 19 teams across Hampshire, Kent and Sussex. Out of the 127 care records we found only 4 risk screenings were missing, this equated to a 97% compliance rate for the care records we viewed. The trust target was 95%. This demonstrated a significant improvement from our findings in September 2016, where we found only 43% of risk screens having been completed.
- There was good investigation into serious incidents that ensured the trust fulfilled its duty of candour. There were robust arrangements for staff to make safeguarding alerts that included strong oversight of the safeguarding process. Staff received mandatory training. Physical monitoring equipment was available.
- There were evidence based care pathways and staff trained in therapies approved by the National Institute for Health and Care Excellence (NICE). Outcomes were recorded in order for staff to improve practice. There were effective relationships with external services.
- Young people were treated with dignity and respect. Efforts were made to include young people in the running of the service. Communities and schools were educated in mental health problems and coping skills. Groups were available to young people and their parents and carers.
- Staff responded to changes in risk through referral to urgent help services. There was a proactive approach to young people that did not attend appointments. Complaints were dealt with effectively.
- There was good morale amongst the staff teams and they were aware of who the senior managers within the trust were. There were robust systems in place to ensure performance was measured.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Staff had failed to assess all young people entering the service for risk. There was evidence of serious incidents that had highlighted a lack of risk assessment in the learning outcomes. There was systemic failure in recording risk assessments in the carenotes system. Care Quality Commission has taken separate enforcement action through the issuing of a warning notice due to the failings in the recording of risk assessment.
- There was culture of not recording lower level incidents such as individual incidents of self-harm. Staff and management said that they should only record serious incidents and trends.
- There was no cleaning rota for the toys at any of the sites. We found that there were several sites with very dirty toys that had not been cleaned for some time. There were toys lying on the floor of the therapy rooms and reception areas.

However:

- On the 7 December 2016 we carried out a focussed inspection to follow up the warning notice. At this inspection we identified that the trust had responded positively to the findings in the warning notice and significant improvements had been made. The trust had developed an action plan to ensure compliance with the trust target of 95% of risk screens completed. At the time of the focussed inspection this was at 97% for the care records we looked at, where four out of 127 were missing a risk assessment.
- There was good management and investigation of serious incidents. The service fulfilled its duty of candour.
- There were robust safeguarding arrangements across all sites. We found staff to be knowledgeable of safeguarding.
- There were urgent help teams across the trust that were available to respond to changes in risk and need. They were able to provide an out of hours service to young people.
- Staff received mandatory training in line with the trusts target completion rate.
- There was physical monitoring equipment available to staff.

Requires improvement 

Are services effective?

We rated effective as good because:

Good 

Summary of findings

- Staff assessed young people and had clearly defined pathways for treatments. There was good evidence of the use of National Institute for Health and Care Excellence (NICE) guidance to inform their practice.
- There was a wide variety of staff trained in various different evidence based therapies. There were medical and therapy appointments available to young people dependant on their presentation and risk.
- There was extensive use of routine outcome measures that staff used to review their practice and to ensure that young people were getting the treatment they needed.
- Staff had access to specialist and management training. Management encouraged professional development amongst the staff.
- There were effective relationships created with external services. Hampshire had worked closely to include services in their setting up of the single point of access.

However:

- Care plans were not always completed for young people accessing the service.

Are services caring?

Good

We rated caring as good because:

- Young people and their parents or carers were treated with dignity and respect. Clinicians involved young people in compiling care plans. Feedback from young people and their parents or carers was consistently positive. Staff went beyond the call of duty.
- Young people were asked what they wanted from the service and their feedback was sought in order to tailor therapy sessions to their needs. The use of outcome measures was a genuine opportunity for staff to move the service forward according to the need of the young people.
- There was a variety of groups, courses and opportunities for engagement for young people, their families and their carer's.
- Participation workers were in post to encourage innovation within the service. There were many examples of how young people had been involved with changes within the service.

Summary of findings

- There was engagement with local schools and communities in order for the service to educate the wider population on mental health problems and coping skills.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- There were extensive waiting times outside of the 18 week target time for young people wishing to access therapies at certain sites within the trust. Young people were at times waiting for several hundred days before starting therapy. This meant that there was a delay for some young people wishing to access treatments.

However:

- Staff responded to changes in risk for young people on their caseload. There were referral pathways to urgent help and A&E liaison teams.
- There was a proactive approach to following up young people who did not attend appointments.
- There was a variety of rooms and information available to staff and young people.
- Complaints were followed up effectively by management and there was good engagement with young people and their parents or carers when complaints were made.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The oversight of risk assessment and care plan completion had failed to guarantee that young people were protected from harm. The failings in the practice and oversight of assessing risk had led to the issuing of a warning notice. However, the trust had responded positively to this and made significant improvements to the risk assessment and planning of young people.
- There was poor oversight of supervision so managers could not guarantee that all staff were supervised regularly. Appraisal rates were below the level required by the trust.

However:

Summary of findings

- Staff knew who senior managers were within the trust. Staff engagement visits had been set up in order for managers to gain feedback from the staff.
- There were robust systems in place to ensure staff were aware of and made alerts to safeguarding. There was good oversight of safeguarding alerts made. Staff received mandatory training and were able to measure outcomes for young people.
- We found examples of change at a local level as a result of the clinical delivery services which were made to devolve decision making from the executive teams.
- The service used key performance indicators to gauge performance. These were fed back to commissioners. Regular audits were undertaken..
- Staff were aware of the whistleblowing process. Staff felt engaged and morale was good.

Summary of findings

Information about the service

Sussex Partnership NHS Foundation Trust child and adolescent mental health services (CAMHS) provide specialist mental health services, care and treatment for children and young people up to the age of 18 years across Hampshire, Kent and Sussex. The service assesses young people with suspected mental health problems before offering treatment and care coordination. The service was previously inspected in January 2015 and rated as outstanding in caring, good in well-led and requires improvement in safe, effective and responsive giving it a rating of requires improvement overall. In the previous inspection we found issues with completion of care plans and risk assessments, extensive waiting lists with the risks of young people not assessed while waiting, a lack of mandatory training and poor physical health monitoring. These issues were subject to requirement notices.

CAMHS community services are delivered in line with a four-tier strategic framework which is nationally accepted as the basis for planning, commissioning and delivering services.

Tier 1 – Consists of practitioners who are not mental health specialists working in universal services; this includes general practitioners (GPs), health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. Practitioners offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development and refer to more specialist services.

Tier 2 – Consists of CAMHS specialists working in both community and primary care settings. Practitioners offer consultations to identify severe or complex needs, which require more specialist interventions and assessments.

Tier 3 – Consists usually of a multi-disciplinary team or service working in the community clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders.

Tier 4 – Consists of specialised service for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and inpatient units.

Our inspection team

Our inspection team was led by:

Chair: James Warner, Consultant Psychiatrist and National Professional Advisor for Old Age Psychiatry

Team Leader: Natasha Sloman, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Louise Phillips, Inspection Manager, mental health hospitals, CQC

The team that inspected this core service comprised two CQC Inspectors, one assistant inspector and five Specialist Advisors with expertise in child and adolescent mental health services.

Why we carried out this inspection

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

Summary of findings

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.

During the inspection visit, the inspection team:

- visited 10 different sites across the child and adolescent mental health service (CAMHS)
- spoke with 12 young people who were using the service
- spoke with 12 parents and carers of young people using the service
- spoke with 10 managers and service managers
- spoke with 49 other staff members, including; doctors, nurses, social workers, therapists, psychologists and primary mental health workers
- observed five appointments with young people
- attended and observed multidisciplinary team meetings and reflective practice meetings
- held a focus group with nursing and therapy staff
- collected feedback from young people and their parents using comment cards
- reviewed 204 treatment records (127 of these were looked at during the focussed follow up inspection) of young people including care plans and risk assessments
- carried out a specific check of the environments
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

Parents and young people at all locations had positive feedback about the service provided. We heard comments such as the service was a 'life saver' and staff did their 'absolute best'. Young people and their parents and carers were very positive about the service offered to them and how friendly the staff were towards them. We heard that they were aware of risks and the care plans and that the families were written to with a care plan and summary of appointments. Parents and carers felt involved in the care of the young people throughout and they stated that staff were very good at giving information, were polite, respectful, and very caring. However, there was negative feedback around waiting times once a referral had been accepted. We heard on numerous occasions that getting an appointment took a very long time.

Good practice

- Hampshire Child and Adolescent Mental Health Service (CAMHS) had employed an innovation worker in order to enhance the delivery of services using innovation and creative ideas. There were several examples of innovation to engage with schools, families and young people using initiatives such as FITFEST, CARE and creating an app for phones and tablets. There were future plans to provide information events to communities. There were participation workers in place throughout the trust who were working directly with young people and their families to change the service using their experience.
- Hampshire had set up a single point of access into the service. The single point of access was a result of recommissioning so that they could provide a single route into the Hampshire service through one phone

Summary of findings

number. This allowed referrers such as GP's to submit electronic referrals and phone up for advice about whether a referral was relevant. The single point of access had developed to include tier two services such as substance misuse and counselling who could pick up referrals not relevant to CAMHS.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the waiting lists are reduced to allow young people treatment within the 18 week target. The waiting list at Eastbourne showed that there was a delay in care being provided to young people accepted into the service. There were delays of up to 610 days for young people needing therapy. The demand on the service was not being met, meaning that there was an increased risk to young people due to the delay in accessing treatment. We spoke with parents and staff who felt that the delay in accessing the service was incredibly stressful for them.
- The trust must ensure that all young people are risk assessed and a risk management plan developed where relevant.

Action the provider SHOULD take to improve

- The trust should ensure that all toys within the CAMHS service are cleaned regularly. The toys at several sites we visited appeared to be dirty and there was no cleaning rota. Inspection staff found dirty toys on the floor in therapy rooms and in reception areas. The provider should ensure that toys are cleaned regularly to prevent any infection control issues.
- The trust should ensure that all incidents are reported. Staff within the service told us that they would only report more serious incidents and trends amongst the young people. This meant that that lower level incidents were not being reported on the system and that trends across the wider service could be missed. For example, staff did not report individual incidents of self-harm among the young people on their caseload.
- The trust should ensure that electrical appliances are safety tested. We found that electrical appliance testing was overdue at the sites we visited.
- The trust should ensure that there is oversight of supervision. There was lack of knowledge amongst the management team about who was up to date with supervision.
- The trust should ensure that staff are properly equipped with alarms in the therapy rooms to ensure they are able to call for assistance.
- The trust should review the appropriateness of the clinic room at the Eastleigh site as the one staff used when we carried out our inspection was not fit for purpose.
- The trust should ensure that the physical monitoring equipment is regularly calibrated at all sites.

Sussex 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
Eastleigh CAMHS Worthing CAMHS Eastbourne CAMHS Hastings CAMHS Aldershot CAMHS Horsham CAMHS Brighton and Hove CAMHS Chichester CAMHS Canterbury CAMHS Folkestone CAMHS	Trust Headquarters

Mental Health Act responsibilities

The trust had a target rate of 65% for Mental Health Act training. The core service had a compliance rate of 62%. Despite this, there was good knowledge of the Mental Health Act amongst the staff and there were approved mental health professionals and medical staff working within the teams that staff could go to for advice.

There was a feeling amongst staff that the provision of S136 place of safety for young people was missing A S136 place of safety is where young people that have been detained by the police are taken to be kept safe and assessed under the Mental Health Act. Local adult places of safety were being used by the CAMHS team who would then ask for support. There had been an incident involving a young person in a S136 place of safety who had remained in there under arrestfor two days without assessment under the Mental Health Act. The young person had not been able to access the children's place of safety at the Chalkhill hospital as it

did not have enough staff as it was needed out of hours. This had been reported as an incident and there had been a meeting with the local authority about this. Learning from this incident was due to be cascaded through the teams shortly after the inspection.

Consent to share information and consent to treatment was sought at the initial choice assessment.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act knowledge varied amongst the staff. Some staff demonstrated a good understanding of the statutory principles of assessing capacity, whereas other staff were not as clear. Mental Capacity Act training was mandatory e-learning with a 67% completion rate amongst the CAMHS staff.

Staff felt that they always obtained consent to treatment, even for routine procedures such as taking blood pressure.

Gillick competency means young people are under the legal age of consent but deemed capable of consenting for themselves The multidisciplinary team discussed risks around competency and agreed an action plan to maintain confidentiality, unless it was not safe for them to do so. For example, if a young person was at risk of harm.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- We inspected ten sites within the trust and found three sites that were co-located with adult services. While the Worthing site had a separate entrance for young people visiting the service, we found that the site at Hastings shared an entrance and reception area with older person's services. Brighton and Hove also shared an entrance with an adult mental health service which meant that people using those services were walking through the CAMHS reception area. There was a residential flat for an adult patient on the first floor and CAMHS staff were unsure whether this was occupied at the time of the inspection. There had been a lack of consideration given to the potential safeguarding implications of the flat being above the CAMHS area. The Horsham site had a co-designed waiting area with adult services, so the rooms and toilets were shared. There were no toys out for the young people accessing the service to play with.
- Reception areas at the other sites were child friendly and there were adaptations to ensure that they were welcoming for young people. Information appropriate to the age group was displayed on walls and there were toys available at most sites. Reception areas appeared clean and the physical environments were safe.
- All services provided private therapy rooms and clinic rooms in order for young people to be seen. Alarms were not in place at all sites inspected. We found that there was not always good visibility into the therapy rooms. This meant that in an emergency it would have been difficult for staff to call for help easily and effectively. There was CCTV into rooms at the Horsham site as well as alarms fitted.
- There was physical monitoring equipment to record height, weight and blood pressure at all sites. We looked at the stickers displayed on the equipment and found that it was not always calibrated. Calibration of equipment ensures that there are accurate results of what is being measured. The clinic room at the Eastleigh site was not suitable as it was within a storage cupboard with very limited space. Staff on site acknowledged that it was not ideal. Copies of the British National Formulary were available to staff.
- The buildings were generally clean, tidy and well maintained. We found that Eastbourne CAMHS had some interview rooms with toys on the floor that appeared to be dirty with the rooms looking tired and not looked after. Cleaning schedules for the sites were displayed on the walls but there was no recording of what had been cleaned. We found that there was no formal cleaning of any of the toys within the core service and there was only one site where staff routinely cleaned toys after they were used. There were no cleaning schedules for any of the reception or therapy room area toys.
- Staff had access to alcohol hand gels and there were places for them to wash their hands. We found that staff were knowledgeable of infection control principles.
- Testing of the electronic equipment was out of date at all sites. Staff were not able to tell us if there was recent testing of the electronic equipment. Stickers showing the previous test date showed that the tests were overdue.

Safe staffing

- Staffing was estimated according to the budget available to the teams. There was close working with finance teams to ensure that the staffing numbers were adequate and reflected the money available from commissioners and the demand on the service. Staffing levels comprised of a variety of nursing, therapy, administrative and management staff across the sites. We found that there was appropriate use of bank and agency staff with few teams having unfilled vacancies. The turnover of staff for the core service was 5%. There was an overall sickness rate of 3%.
- Staff often split their time between sites but teams had a minimum number of staff on site each day to ensure that the service was operating effectively. This included a duty worker who was in place to respond to referrals and to urgent calls into the service. We heard from staff that they felt that staffing levels were not appropriate for

Requires improvement

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the demand on the service at some sites. This was of concern to staff at the Hailsham site and reflected where there were considerably high waiting lists for therapy and medical appointments.

- Caseloads within the service varied from clinician to clinician and were dependant on the role of the worker. We found that the highest caseloads belonged to medical staff and Attention Deficit Hyperactivity Disorder (ADHD) nurses although caseloads were generally over 30 per worker based on full time hours. Young people referred to the service were allocated a care coordinator following their choice assessment. Although the young person may have not been receiving therapy or treatment at the time they had a named person who they could contact while on the waiting list.
- Caseloads were managed and reassessed through supervision and in team meetings. We found that changes in need of young people on the caseloads were able to be addressed through transfer onto other waiting lists for therapies and that people were able to be seen quicker when necessary. There was a duty system in place for staff to respond to urgent calls. The duty worker was also in place to cover sickness and absence of staff to ensure that there was always someone in place for young people to contact.
- Psychiatrists were available throughout the day and night with one on call at all times. Staff informed us that it could often be hard to secure a medical appointment due to the pressure and demand on the service. There had been a loss in the number of whole time equivalent medical staff employed by the trust in West Sussex. This had resulted in increased demand for the service. There were locum doctors in place to bridge the gap between full time employed medical staff.
- Staff received mandatory training in subjects such as infection control, equality and diversity and safeguarding adults and children. There had been a recent shift over to e-learning where staff were expected to undertake their mandatory training on the computer. Mandatory training completion was within the expected completion rate of 75%.

Assessing and managing risk to patients and staff

- Staff undertook a risk screening of each referral into the service to assess how urgent the referral was. We heard that a risk screening was supposed to be done at the first choice appointment to decide which type of risk assessment was needed, a type one or type two assessment. Risk assessment two was a more in depth multi-agency risk assessment. Managers within the service told us that following the risk screening there should be a risk assessment in the electronic system in care notes using the standardised tool. This was then supposed to be updated when there was a change in risk or a change in the care being provided to the young person. However, there was mixed messages from staff about when a routine review of the risk assessment should be undertaken. While the risk assessment policy did not state a routine timeframe for review of the risk assessment it did state that the risk assessment 'must be completed on the electronic Carenotes system'. When we spoke to staff we found them to be risk aware and when we observed complex case meetings, staff were able to cite the risks of young people that were higher risk and needed a higher level of care. There was broad discussion within the team about the risks of young people.
- We reviewed 77 care records across the core service and found variable quality in the completion of risk assessments. Of the 77 care records reviewed, we found that 33 had no risk assessment at all. A further 16 sets of care records had risk assessments that were completed but were not found in the risk assessment section but had information in letters to other healthcare professionals. The remaining 28 risk assessments were completed comprehensively and were found in the risk assessment tab on the carenotes system. We found that the higher risk patients within the service were comprehensively risk assessed. The lack of risk assessment in more routine referrals into the service was raised with the trust who fed-back that the young people without risk assessments were low risk Attention Deficit Hyperactivity Disorder (ADHD) and had neuro development problems. We did however find that there were young people prescribed medications and young people with conditions such as an eating disorder, autistic spectrum condition or depression, without any risk assessment. The lack of risk assessment meant that staff were not guaranteed to consider all risks associated with the young person. For example, we found a record with no risk assessment but with a referral letter within the notes stating that there had been previous suicide attempts by the young person.

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This was highlighted to management at the time of the inspection. When reviewing serious incidents we found that there had been learning identified on more than one occasion, around the regular updating of risk assessments following a change in a young person's presentation. One of these incidents related to an attempted suicide and the other was related to attempted murder. The recording of risks had not changed from the previous inspection where there was a requirement notice for the trust to address this issue. Teams utilising different systems for reporting risk and care planning had been placed on the risk register.

- Furthermore, a case audit by Cherry tree House in December 2015 had identified that there were 82% of open cases within that service that had no risk assessment in their carenotes. A recommendation from this audit was that all open cases should have a risk screening or appropriate risk assessment. Audits conducted for Lenworth House Clinic and Castleside found a similar amount of open cases without risk assessment. At the time of the inspection we were unable to see a re-audit to check for improvement. Care Quality Commission has taken separate enforcement action through the issuing of a warning notice due to the failings in the recording of risk assessment.
- On the 7 December 2016 we returned to carry out a focussed inspection to follow up this Warning Notice. At this inspection we identified that the trust had responded positively to the findings in the Warning Notice and made significant improvements. The trust had developed an action plan to ensure compliance with their target of 95% of risk screens (assessments) completed. We looked at a random selection of 127 care records and level 1 and level 2 risk assessments (when indicated) from 19 teams across Hampshire, Kent and Sussex. Overall the total patient head count for these teams was: 15,376, so we looked at just under 10% of care records. Out of the 127 care records we found that 4 risk screenings were missing, this equated to a 97% compliance rate for the services we looked at. The trust target was 95%. This demonstrated a significant improvement from our findings in September 2016, where we found only 43% of risk screens having been completed. Where risks had been assessed as not requiring a risk management plan, the practitioner had recorded a written rationale for this. We found the quality of the risk documentation was good and some excellent. There were also examples where feedback from parents had been used to further enhance the risk management plans of young people. The care records dashboard had also been improved to flag to practitioners when they logged on which risk assessments (on their caseload) were due to be reviewed and which ones were overdue. This was to ensure that the assessments were reviewed at regular intervals and after each risk incident. The trust policy for reviewing risk assessments was a minimum of annually, however, the review dates we saw were all at a minimum of six months, to ensure compliance.
- There were systems in place to respond to sudden deterioration in mental health. Each site held a duty system to ensure that there was always someone available to respond to a change in need. The duty worker was able to offer telephone support, urgent appointments and urgent assessments. Changes in need were discussed at complex case reviews during the team meetings to ensure that risks were reviewed and thinking shared in order to see if further input could be given to the young people. We found that in Hampshire staff were given an allocated risk appointment so they knew that at that time there was the potential for an urgent case to be seen.
- The urgent help team in Sussex, home treatment team in Kent and the i2i team in Hampshire were able to take referrals from the community teams to provide increased appointments and home treatment support. They were also able to provide follow up appointments for young people discharged from hospital. Staff we spoke with were knowledgeable of the role of these teams and felt that they were able to respond quickly to changes in need of young people. There were A&E liaison teams in place to provide support and access to the service to young people who were admitted to A&E with psychiatric problems.
- Following the initial choice appointment where young people were able to meet with staff to go through options for treatment and to review needs and risks, they were placed on the waiting list for the appropriate treatment or therapy. We found that the waiting lists were monitored for changes in risks of the young people. A waiting list action plan had been implemented to monitor the waiting list for risk. There was proactive engagement with young people on the

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waiting lists where staff phoned the young people and their parents to see how things were. Young people and their parents or carers were given a 'Z Card' which gave prompts on when to be concerned, such as an increase in self harm or cutting or becoming increasingly isolated. The card had out of hour's numbers, advice on what to do in an emergency, useful numbers such as Parentline and the Samaritans. It also had the numbers for the specialist CAMHS services within the trust. This card was developed following an incident where a young person took an overdose in the community and the family did not know how to respond. We found that there were crisis and contingency plans in letters to parents and carers so that they were aware of what to do in a crisis. However, we found that when reviewing the waiting lists at Eastbourne CAMHS that there had been young people on the waiting lists for over 100 days that had not had this card sent out to them.

- The CAMHS community core service submitted 419 safeguarding referrals between 1 April 2015 and 31st March 2016. This made up 84% of the trusts safeguarding referrals. Staff were trained in safeguarding and were knowledgeable on how to make a safeguarding alert to the local authority. Staff stated there was the opportunity to have a 'no names' conversation with the local authority to see if a safeguarding alert needed to be raised. Each area of the trust had a safeguarding lead. All referrals to the local authority went through the safeguarding lead that kept oversight of the process and logged actions and recorded any contact with staff. The safeguarding lead had links with the local safeguarding children's board and was there to provide training and advice to staff. There was a lead safeguarding doctor in place who had valuable expertise in the subject. In Hampshire there was a monthly report to commissioners to feedback levels of alerts made, serious incident updates and contact with staff. Calls to the safeguarding lead in Hampshire had increased by 78% from February 2016. The Safeguarding Digest in Hampshire was sent to staff to update them on local and national issues and to ensure that they were aware of the safeguarding leads presence.
- There was a lone working policy in place for the community teams although staff told us that they rarely visited young people at home. We found that in general staff understood the procedure for lone working.

Track record on safety

- Information submitted prior to the inspection showed that in the previous year there had been 28 serious incidents reported and investigated by the trust.
- Management investigated serious incidents and fed-back learning to staff. Serious incidents were discussed in manager meetings and then learning was discussed at local team meetings. We saw good examples of learning and changes made as a result of serious incidents. For example, in Sussex when there was the transition to the carenotes system, there had been information governance breaches that had meant that letters were being sent to the wrong houses. The trust had implemented a form for staff to check against to ensure that letters were being sent to the correct address. Management told us that following an incident they were free to submit items onto the risk register in order to escalate risks to higher management within the trust. A report was cascaded around staff to highlight lessons learned around serious incidents.

Reporting incidents and learning from when things go wrong

- The trust implemented an electronic incident reporting system. This system allowed incidents to be sent through to the manager to review and grade as to whether it was a serious incident requiring investigation. We heard from management that incidents such as suicide attempts and self-harm within the community should be reported. We spoke to managers who stated that emerging patterns of self-harm were reported rather than individual incidents. During the inspection we reviewed incident reports and found that there was very little reporting of individual self-harm and that staff concentrated on more serious incidents within the service. The inspection team felt that there was a risk that the lower level incidents were therefore getting missed and not considered serious enough to warrant reporting. As a result, trends across the wider service were at risk of being missed.
- Not all staff were aware of the incident reporting system that was in place within the trust. There were examples of nurses not having used the system for over a year and stating that they would only report serious incidents. We spoke with other staff that were not aware of incidents

Requires improvement

Are services safe?

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

within the trust or reported within their team. There was varying knowledge within the service around what might constitute a reportable incident with some staff unable to state what might be classed as an incident.

- Following a serious incident staff engaged well with young people and their families. Families were provided with a written explanation of the investigation and they met with the families following investigation of the incident. This fulfilled the requirement of the duty of candour.

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

- Following referral into the service young people were offered a choice assessment that gave them the opportunity to meet a member of the team to discuss the reasons for being referred to CAMHS and the options for treatment or therapy. The choice assessment focussed around meeting criteria, risk, care planning and what young people wanted. The presentation of the young person influenced which pathway they would follow and which treatment was open to them. This initial assessment was the first step into the service and formed the basis of further on going assessment of need.
- We reviewed 77 care records that included physical health, risk, care planning and consent across the core service. We found practice around care planning to vary greatly across the trust. There was evidence of personalised holistic care plans completed with young people and scanned onto the carenotes system and there were holistic care plans completed in the care plans tab on the system. There was inconsistency around young people being given a copy of their care plans and there were some care plans written in the letters to the GP and to the young people and their families. This made it difficult to find up to date information within the electronic record. Of the 77 records we reviewed 22 had no care plan. Only 20 of the 77 care records were personalised and holistic and focussed on outcomes, strengths and goals. We found 29 of the 77 care plans had not been shared with the young person or their parent or carer. However, young people told us that they felt involved in their care.

Best practice in treatment and care

- Pathways based on National Institute for Health and Care Excellence (NICE) guidance had been created so that there was a clear treatment pathway for young people entering the service. For example, a young person accessing the service for anxiety was offered a stepped model of care from self-help through to Cognitive Behavioural Therapy (CBT) and up to individual specialist intervention and/or medication. Pathways such as this had been created for a number of mental health issues such as eating disorders, trauma, depression and autism. Although there were waiting lists for therapies and medical appointments, staff showed that they were able to offer a combination of the two to young people.
- Staff offered a number of evidence based psychological therapies approved by NICE. These included individual and group forms of therapies such as Cognitive Behavioural Therapy, Dialectical Behaviour Therapy (DBT), Psychology and Family Therapy. There were nurses allocated to work specifically with young people with an eating disorder and Hampshire CAMHS were in the process of recruiting to a specialist eating disorder team. Young people with an eating disorder did not need to go on a waiting list to be seen and there was proactive engagement with young people and their families in initiating a weight restoration programme with meal planning, therapy and weekly weighing. However, staff were required to refer out to a dietician due to there not being one employed within the service.
- On initial assessment into the service young people were allocated a care coordinator as their named contact in the service. This allowed them the opportunity to be supported around financial issues, benefits and housing as well as with mental health problems.
- Nursing and medical staff had good understanding of physical health problems for young people within the service. There were strong links with local services to arrange for blood tests and electrocardiograms (ECG). Staff were able to measure height, weight and blood pressures on site. For young people on the Attention Deficit Hyperactivity Disorder (ADHD) pathway there were six monthly physical health checks in place as per the NICE guidance on attention deficit hyperactive disorder: diagnosis and management. This was due to the medication prescribed for them. An audit had been undertaken in Hampshire CAMHS to assess the levels of physical monitoring and found that while assessment of ADHD was very good, there was poor recording of physical data on the charts. Actions had been put in place prior to a re-audit. There was documented evidence of good monitoring of young people prescribed antipsychotics with regular follow up appointments with the prescribing staff member. A form for recording had been created based on NICE guidance in order for staff to gain prompts around blood.

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- Staff used a wide range of routine outcome measures (ROMS) in order to evaluate young people's progress in both the short and long term. The strength and difficulties questionnaire (SDQ) was used every six months by parents and young people to assess and measure personal strengths and difficulties. The revised children's anxiety and depression rating scale (RCADS) was sent out to young people prior to their first appointment. Staff then entered the information onto carenotes to aid discussion around young people's experience of depression and anxiety. Outcome rating scales (ORS) were used at the start and end of sessions to gauge a young person's progress. The results from this could then be plotted on a graph to see change over time. The child session rating scale was completed after every session to act as feedback and allow young people to reflect on how good they found the sessions to be. This then allowed clinicians to alter the session for next time if needed. The experience of service questionnaire (CHI ESQ) was completed at the last appointment prior to discharge so that feedback about the running and effectiveness of the service could be sought. Staff had made changes within the service due to the feedback collected from this such as a change in the look of waiting rooms and having staff pictures up on the wall. The outcomes of the CHI ESQ were fed back in business meetings monthly in order for potential changes to be discussed within the team.
- Staff completed a ROMS audit called 'delivering with and delivering well'. This looked at the SDQ and RCADS rating scales. The report found that around 54% of cases within the service had at least one outcome questionnaire completed. Around 50% of cases had an RCADS completed that showed clinical concern with depression and anxiety. An action plan around improving the use of these outcome measures and embedding them within practice was yet to be implemented at the time of the inspection. A quality improvement plan had been put in place which measured the service against the CQC key lines of enquiry. This audited the service and rated areas according to risk and completion. This was geared towards getting the service to fulfil the trusts '2020 vision' of safe, effective, quality care.

Skilled staff to deliver care

- The service employed staff from a range of backgrounds that included nurses, consultant psychiatrists, primary mental health liaison workers, psychologists, art and drama therapists, family therapists and CBT therapists.
- Staff were checked against the disclosure and barring service to ensure that they were suitable to practice in CAMHS. Staff employed to the service underwent a generic trust induction. There was an individual role specific induction delivered by the service where they would spend time with each team member and go on visits to get a feel of how the service worked. Localised induction process checklists were in place for new starters. There was a strong preceptorship programme to support newly qualified nurses.
- It was widely acknowledged by staff within the trust that there was access to specialist courses for professional development. Staff were given the opportunity to access a range of therapy courses relevant to their roles. For example, we found that there was access to CBT courses for nurses and there was systemic therapy training for staff working with young people with an eating disorder. Management in Hampshire CAMHS were proactive in engaging their staff with further specialist training. Staff were able to plan professional development opportunities through the appraisal process.
- Appraisal rates within the core service were reported at the time of the inspection. The trusts target for appraisal rates was 80%. However there was an overall completion rate of 60%. Staff were supervised in clinical and management supervision sessions, however, we found that the recording of this was not consistent between sites and found that not all staff were able to provide supervision records. Management had no oversight of supervision levels in their staff team and it was the responsibility of staff to keep a record. This was a concern that meant there was a risk of staff not receiving regular one to one supervision. Team meetings occurred regularly within each team. We found there to be group supervision on offer and reflective practice sessions for staff.

Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary meetings within teams. We found that there were meetings to discuss complex cases. This was so that the multidisciplinary

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team could discuss treatment possibilities for young people who were particularly unwell in the community or who may be in hospital. We found these discussions to be broad and staff were risk aware and able to get different views from a range of professionals. There were opportunities to discuss referrals and assessment for autism, which allowed shared thinking about reaching a diagnosis.

- There were effective relationships with organisations outside of the service.We heard examples of staff working closely with other health and social care providers relevant to young people on their caseload. Staff were knowledgeable about services that they could refer onto should they feel the young person would be more suited to those. We found that referral meetings were used to signpost young people on to different services such as substance misuse, social services or specialist parenting workers. The Early Help Hub in Hampshire was a multidisciplinary meeting with CAMHS, police, health visitors, substance misuse services and social services. This provided a multidisciplinary approach to care to ensure that the necessary services were in place. We found primary mental health workers who linked in with schools to provide mental health support to pupils and provide training to primary and secondary school teachers. The worker also built links with school nurses in order to have a referral route or advice line to the service. The primary mental health workers were also able to provide short-term interventions.
- Within the service there were a number of teams such as urgent help, i2i, TAPA, looked after and adopted children (LAAC). Staff could refer to these services when support for young people needed to be more specific. The youth emotional support service was a tier two service paid for by the trust to create more capacity within the service. There was effective working with these workers who sat on the referral panels to allow them to pick up the appropriate referrals. We heard from staff that there was an easy referral process into the urgent help services for young people in general hospital or who needed more intensive support. Staff reported that the teams were responsive to changes in risk.
- Hampshire had set up a single point of access into the service. The single point of access was a result of recommissioning so that they could provide a single route into the Hampshire service through one phone number. This allowed referrers such as GP's to submit electronic referrals and phone up for advice about whether a referral was relevant. The single point of access had developed to include tier two services such as substance misuse and counselling who could pick up referrals not relevant to CAMHS.
- There was a consultation phone line open to external agencies such as schools and social services to contact. The duty worker staffed this service and allowed professionals worried about a young person's mental health to gain advice about treatment or referral options.

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

- The trust had a target rate of 65% for Mental Health Act training. The core service had a compliance rate of 62%. Despite this, there was good knowledge of the Mental Health Act amongst the staff and there were approved mental health professionals and medical staff working within the teams that staff could go to for advice.
- There was a feeling amongst staff that the provision of S136 place of safety for young people was missing A S136 place of safety is where young people that have been detained by the police are taken to be kept safe and assessed under the Mental Health Act. Local adult places of safety were being used by the CAMHS team who would then ask for support. There had been an incident involving a young person in a S136 place of safety who had remained in there under arrest for two days without assessment under the Mental Health Act. The young person had not been able to access the children's place of safety at the Chalkhill hospital as it did not have enough staff as it was needed out of hours. This had been reported as an incident and there had been a meeting with the local authority about this. Learning from this incident was due to be cascaded through the teams shortly after the inspection.
- Consent to share information and consent to treatment was sought at the initial choice assessment.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act knowledge varied amongst the staff. Some staff demonstrated a good understanding of the

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statutory principles of assessing capacity, whereas other staff were not as clear. Mental Capacity Act training was mandatory e-learning with a 67% completion rate amongst the CAMHS staff.

- Staff felt that they always obtained consent to treatment, even for routine procedures such as taking blood pressure. Gillick competency means young people are under the legal age of consent but deemed capable of consenting for themselves The multidisciplinary team discussed risks around competency and agreed an action plan to maintain confidentiality, unless it was not safe for them to do so. For example, if a young person was at risk of harm.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed episodes of care undertaken by clinicians working with the young people. We found that young people were treated with kindness and respect. Clinicians were knowledgeable of risks and treatment plans. They were able to review physical health as well as mental health and included families in the appointment where relevant. Feedback from the inspection team was that there was a genuinely caring attitude from workers in all of the sessions that we observed and found that staff gave practical and emotional support to young people and their parents or carers.
- All locations had positive feedback around the service provided. We heard comments such as the service was a 'life saver' and staff did their 'absolute best'. Young people and their parents and carers were very positive about the service offered to them and how friendly the staff were towards them. We heard that staff were aware of risks and the care plans of young people .Families were written to with a summary of appointments. Parents and carers felt involved in the care of the young people throughout and stated that staff were very good at giving information, were polite, respectful and very caring. However, there was negative feedback around waiting times once a referral had been accepted. We heard on numerous occasions that getting an appointment took a very long time.
- Staff used an opt-in form for sharing information outside of the service; they consulted parents in this process but were aware of the need to assess a young person's ability to understand the need for consent around this area. Young people, parents and carers reported that they were always aware of the need to escalate concerns should risk increase and they were aware of the reasons for this. From observing appointments, we found that consent to share and confidentiality were very clearly explained.

The involvement of people in the care that they receive

- Young people and their carers told us that they were aware of the plan for their care. Young people engaged in therapy knew the length of the therapy and the aims. Young people were given the opportunity to feedback to staff about how helpful sessions had been. Staff used this information in order to improve the service and tailor the next session towards the needs of the young person. As part of the initial choice appointment young people were asked what they wanted from the service rather than being told specifically what the treatment was.
- There were families and carers groups and information days for parents and carers to come into the service to meet and ask staff questions about treatment. Staff at Hastings CAMHS had set up the Kinship Carers group – a therapeutic group to support kinship carers who were looking after children and young people who were not living with their birth parents. There were autistic parents groups and drop-ins for parents and carers to come into the service and discuss issues and to identify topics that they were interested in learning about or needed help with.
- Participation workers were in place to support young people to feedback on the service and make changes and suggestions to how the service was run. We found excellent examples of participation in interviews, in designing waiting areas and in designing the way separate letters were written to young people and their parents and carers. The service had gained feedback from young people about the wait for the first appointment and that there was a lack of information given to them. They therefore created the 'getting to know you' book that was an opportunity for the young person to read about what happens when they come into the service. It was designed for the young person to complete to get their views across by writing in the areas that they felt they needed to comment on for example experience of school, where they lived and sleep patterns. This had been a success for the young people under the age of 12 so the service was consulting young people on creating a book for over 12's.
- The Advice Consult Experience (ACE) project had been set up to allow young people, parents and carers to get involved in how the service was delivered. This included helping out with staff interviews and recruitment. There was a buddy system for parents and carers to support one another. Each team had an ACE champion. Hampshire CAMHS had set up FITFEST through external funding. This was to go into schools to offer workshops

Good

Are services caring?

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on mental wellbeing, physical wellbeing, arts and crafts. It was made fun and creative to reduce the stigma around mental health. The workshops had an evidence base in Cognitive Behavioural Therapy (CBT) techniques and outcome measures had been developed by a psychologist in order to assess effectiveness. Previous FITFEST's had shown an upward trend in their success and effectiveness. CARE workshops had been created for younger people who were not suitable for FITFEST. This provided workshops on self-esteem, healthy eating, recognising emotions and coping strategies. There was a plan to train teachers in CARE.

- An app had been created for Hampshire CAMHS which gave local information to young people about where they could get help as well as advice on mental health problems.
- The participation group in East Sussex had gained feedback from young people about mental health in schools. They therefore created the turn your frown upside down blog page and posted films made by the young people. Staff had facilitated a play for the young people that had been performed in three schools in order to open up mental health discussions. The youth cabinet had been set up for a two day meeting with young people to create a teachers pack for schools in order to develop top 10 tips for supporting young people's mental health.
- Following learning from an incident where a young person had taken an overdose where their parents did not know how to respond the service had developed the 'z-card'. A card made in conjunction with young people and families that provided numbers to phone and symptoms to look out for should the young person be in crisis. This was handed to all people entering the service.
- Staff had set up the recovery college where they offered young people and their carers groups and courses to attend. Courses included drama, music, art and woodland workshops.
- Advocacy was provided through the patient advice and liaison service.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- Referral into the service was handled differently by each area within the trust. While Hampshire had made the single point of access, West Sussex had centralised their referral process in order to create capacity within teams. We found that duty workers and managers in East Sussex triaged the referrals. There was a system in place for staff to signpost onto external services should they feel that CAMHS was not appropriate for the referral. This gatekeeping of the service ensured that only appropriate referrals came through to the choice assessment.
- Staff were consistent in their reports of how they dealt with urgent referrals into the service. Urgent help teams and A&E liaison teams were available to provide immediate support and were available during evenings and weekends. Duty workers were able to respond to a change in risk and were able to offer appointments and support short-term face-to-face and over the phone. The teams aimed to see urgent referrals within seven days with slots made free specifically for urgent referrals.
- The service was commissioned to see young people for assessment within four weeks and to start treatment within 18 weeks following assessment. The longest wait times were in Eastbourne CAMHS teams. This service held the waiting list for three sites and had a total of 302 young people waiting for treatment. There were a total of 150 young people waiting over the 18 week target time.
- During the inspection we reviewed the waiting lists and found that in Eastbourne alone there was a longest wait of 610 days for family systemic therapy, 491 days for creative therapy, 484 days for individual therapy, 588 days for psychotherapy and 493 days for CBT. There was a longest wait of 283 days for psychiatric assessment. Eastbourne had secured funding to employ a worker on a fixed term contract to work on reducing the waiting list. Staff cited the waiting list as the biggest challenge for the service. Families we spoke with during the inspection felt that it was difficult to get into the service and became frustrated with the waiting times.
- The service adopted pathways for young people in the service in order to give a clear criteria of who they would accept. These pathways were evidence based using National Institute for Health and Care Excellence guidance and were aimed at treating mental health issues. There was also a pathway for autistic spectrum conditions.
- Staff followed up young people that did not attend an appointment. We found that there was a proactive approach to re-engaging young people and their families following missed appointments and that staff were sending letters and making phone calls. Staff engaged with schools and contacted the GP and demonstrated that they had attempted to re-engage before discharging after two missed appointments depending on the risk of the young person. Staff were able to offer late clinics to maximise engagement and there was the option of seeing young people in their homes. We found that appointments ran on time and staff said they were rarely cancelled unless absolutely necessary, for example, as a result of staff sickness.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff had a variety of rooms available to them at the sites including spaces to take weight, height and blood pressure. Therapy rooms including spaces for family therapy and art therapy. However, we found some areas with untidy rooms and toys on the floor that appeared to be dirty.
- Interview rooms were found to be sound proofed effectively to ensure that confidentiality was maintained throughout appointments.
- There was a variety of information available to young people in leaflet and in poster form. Reception areas advertised groups and other services. We found a range of leaflets about mental health problems, internal and external services.

Meeting the needs of all people who use the service

- Each building had disabled access and adapted bathrooms.

Are services responsive to people's needs?

Requires improvement

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

- We did not see the full range of information leaflets available in languages spoken by people who used the service, but staff confirmed that these were easily accessible through the trust website.
- Staff confirmed that there was easy access to interpreters and/or signers through a local contractor. Information in braille and easy read leaflets could be accessed quickly.

Listening to and learning from concerns and complaints

- Information provided prior to the inspection showed that in the 12 month period up to April 2016 there had been a total of 233 complaints received. Of these, 91 were upheld or partially upheld. The service in Highmore had received the largest amount of complaints with 23 during the year. Inadequate overall care or treatment received the highest number of complaints at 83, while delays or difficulties in accessing treatment totalled 45. Staff told us that most complaints they received they attempted to deal with at a local level and that the majority were around waiting times into the service. Complaints that needed to be escalated were entered onto the electronic incident recording system before being sent to the patient advice and liaison service.
- Information was displayed around the building and leaflets were available advising people on how to make a complaint. We spoke with parents who had complained about the waiting lists and the delay in treatment and found that they felt listened to and that their complaints were taken seriously.
- Following complaints and compliments managers gave staff feedback through supervision and through team meetings. Team managers kept a log an electronic record of compliments and complaints.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- The trusts visions and values were displayed around the buildings and on screen savers. Staff stated that they were aware of the values of the trust and that they were now a part of working within the organisation. Staff had appraisals based on these values and felt that they were values that represented working within the trust.
- Staff were aware of the senior managers and executive team at the trust. The executive team tried to visit each site and many staff stated they had met the chief executive in person. Staff engagement visits had been set up in order for staff to speak freely with managers. There was a senior team mailbox that allowed staff to send in comments and questions to the senior leadership team.

Good governance

- There were systems in place to ensure that staff received mandatory training appropriate to their role. We found that management encouraged access to specialist training in order for staff to continue their professional development. There was robust training around safeguarding and processes were in place for staff to raise safeguarding alerts and to gain support in safeguarding young people from abuse.
- Appraisal rates were below the percentage required by the trust and the lack of oversight of supervision by team management meant that they could not guarantee that supervision was happening regularly. There was no central log of supervision which would have ensured that managers were able to check on the regularity of supervision for staff.
- There was excellent recording of outcome measures that were used to help service improvements. Routine Outcome Measures reports were conducted to allow staff to see the percentage of outcome measures used and there were robust processes to ensure that every young person who attended choice appointment received a copy of the outcome measure they were asked to complete.
- While we found a robust system in place for recognising and reporting serious incidents that were fully investigated, we found that there was a culture of not reporting lower level incidents. Staff were not encouraged to report lower level incidents and were instead encouraged to look for trends and report them. This meant that the team management were not informed of all the risks of the young people and staff using the service. There was however a strong response to complaints made by young people and their parents or carers.
- There was change at local levels due to the commencement of the clinical delivery services that were set up in order to devolve decision making from executive level to local level. For example due to the demand on the capacity of the CAMHS services, there had been a change in the reviewing of the referrals into the service. This change took pressure away from staff in order for them to concentrate on direct care activities. Hampshire CAMHS were in the process of developing their own brand.
- The service used key performance indicators related to referrals into the service, discharge, waiting times and routine outcome measures in order to gauge performance. These were reported to commissioners monthly.
- There was regular auditing by a trust lead for audits. These audits captured rates that patients did not attend appointments, file audits and fundamental standards of care. However, while there had been audits of risk assessments and care plans, the service failed to ensure that all young people were assessed for risk. The systemic failure of the service to document risk meant that young people were not guaranteed to be protected from risk. Staff had failed to adhere to the policy of risk assessing young people while auditing had failed in its job to address the issues. The lack of documentation around this had been placed on the services risk register in order to come up with a plan to improve staff practice. Team managers were free to submit items to the trust risk register. However, when we returned on the 7 December 2016 to follow up the warning notice we found that the trust had responded positively to the findings from the September 2016 inspection and significant improvements had been made to ensure that 97% of risk assessments had been carried out and risk management plans in place.
- Management had oversight of the waiting list and had come up with an active plan to monitor and reduce it.

Are services well-led?

Requires improvement

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Eastbourne CAMHS, who had the longest waiting list, had secured money from commissioners to reduce the waiting list using fixed term contract workers just for this reason.

Leadership, morale and staff engagement

- Sickness and absence rates were generally around the trust average. There were contingency plans in place to cover staff in the event of absence or sickness.
- Staff reported that they did not feel bullied or harassed while working in the service. We spoke with senior managers who felt that there was not a culture of bullying and harassment, although they had to deal with the odd isolated case by investigating as per trust policy.
- Staff knew how to use the trusts whistleblowing policy and said that they would feel comfortable doing so. We heard that staff felt supported by their management team and that they were comfortable in raising concerns without fear of victimisation.
- Staff we spoke with were consistent in their positivity about working within the service. While there was high pressure due to the demands of the service, we found teams to have good morale and were satisfied with their job. There was eagerness and passion for working with young people and staff appeared motivated in their work. There was good team working and staff were supportive of each other. However, they felt that the demands on the service and the waiting lists meant they were under pressure.
- There was good opportunity for further development within the service through professional and leadership development opportunities. Senior managers told us that the development of staff was a priority.
- The service fulfilled its duty of candour and wrote letters and met with young people and their families when things went wrong in order to explain what had happened. There was a transparency around serious incidents and complaints and examples where the service had engaged with families around these.
- Staff were asked their opinions and views about the service and further development by meeting with management in engagement days and through team meetings. In Hampshire there was regular visits by the commissioners to gain insight from the staff. We found that staff were encouraged to promote innovation through the creation of groups and new ideas to engage families and carers.

Commitment to quality improvement and innovation

- The service had worked with the Quality Network for Inpatient CAMHS (QNIC) and there had been accreditation awarded to Worthing CAMHS. Eastleigh CAMHS was going for QNIC accreditation shortly after the inspection.
- Hampshire CAMHS had employed an innovation worker in order to enhance the delivery of services using innovation and creative ideas. There were several examples of innovation engaging with schools, families and young people using initiatives such as FITFEST, CARE and creating an app for phones and tablets. There were initiatives in development in order to provide information events to the communities. There were participation workers in place throughout the trust who were working directly with young people and their families to change the service using their experience.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Care and treatment must be provided in a safe way for service users. Where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of service users. • The waiting list at Eastbourne showed that there was a delay in care being provided to young people accepted into the service. There were delays of up to 610 days for young people needing therapy. The demand on the service was not being met meaning that there was an increased risk to young people due to the delay in accessing treatment. We spoke with parents and staff who felt that the delay in accessing the service was incredibly stressful for them. • Risk assessment and risk management plans had not been undertaken for all young people receiving the service. **This is a breach of Regulation 12(1),(2)(a)(b)**