

Solent NHS 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)
R1CF2	St James Hospital	Portsmouth CAMHS	PO4 8LD
R1CD1	Adelaide Health Centre	Southampton CAMHS	SO16 4XE

This report describes our judgement of the quality of care provided within this core service by Solent NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Solent NHS Trust and these are brought together to inform our overall judgement of Solent NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Requires improvement 

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 specialist community mental health services for children and young people as **good** overall because:

- By the time of this inspection, the services had completed the actions we required it to take following the inspection in June 2016. The specialist community mental health services for children and young people were now meeting Regulations 9, 12 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- Staff understood how to assess and manage the risk to young people. Clinicians in the service had designed a new bespoke risk assessment appropriate to young people's needs. All young people had a risk assessment and staff completed risk management plans if it was appropriate to do so. Managers had made adjustments to manage environmental risks in the team bases. Staff understood how to make safeguarding referrals and felt confident to do so.
- Staff completed care plans to support the safe and effective care of young people on their caseload. Staff had received appropriate training to enable them to assess young people and work with those on their caseload.
- Staff demonstrated empathy, kindness and caring when working with young people. Staff actively

encouraged young people and their carers to be engaged in making plans of care and to provide feedback on the service they received. This included training for young people to interview new staff. Staff were highly motivated and offered care that is kind and promotes young people's independence. We rated caring as outstanding.

- There were robust governance structures in place to ensure the quality and safety of the care young people received. We saw closer working relationships between the teams in Southampton and Portsmouth. This ensured consistency in the delivery of care with teams sharing ideas and training opportunities.

However:

- We found that waiting list times between assessment and receiving treatment were still long. However, the trust had made changes and recruited more staff to reduce these as quickly as possible.
- Staff in Southampton did not routinely record capacity or consent in an easily accessible manner. None of the 20 records in Southampton had it recorded. In Portsmouth, all records had a form that recorded consent and considered Gillick capacity. The trust confirmed that they would implement this form in Southampton when we raised this with them.

Summary of findings

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

Are services safe?

We rated safe as good because :

- The service had addressed the issues that had caused us to rate safe as inadequate following the June 2016 inspection.
- In June 2016, we found that staff in Southampton CAMHS had not consistently completed risk assessments for all young people or risk management plans for young people at moderate to high levels of risk. When we visited in May 2017, we found a completed risk assessment in each of the 28 records we reviewed and risk management plans where appropriate.
- In June 2016, we found that staff had not considered environmental risks to young people. Young people had access to knives in an unlocked kitchen in Southampton CAMHS and access to the photocopying cupboard and doctor's office in Portsmouth CAMHS. When we visited in May 2017, managers had made changes so these areas were now secure and young people could not access them.
- Managers supported staff to manage their caseload to ensure that the care provided to young people was appropriate, timely and kept them safe.
- The service provided an on call telephone service so young people and their carers could access support and advice about any concerns or worries or if the young person's level of risk increased.
- Managers discussed incidents with staff and made sure that they circulated learning from incidents to members of staff within the team.

However:

- Staff completion of mandatory training was inconsistent with only five subjects achieving the trusts compliance rate of 85%. Although we had no concerns about safeguarding practice we were concerned about the low level of training in safeguarding at 56%. Paediatric life support was also low at 54%.
- Staff in Southampton did not follow the trust policy for cleaning toys.
- Not all incidents that resulted in no harm were reported.

Good



Are services effective?

We rated effective as good because:

Good



Summary of findings

- The services had addressed the issues that had caused us to rate effective as requires improvement following the June 2016 inspection.
- In June 2016, we found that 12 of 23 care records we reviewed in Southampton did not contain up to date care plans to support the safe care of young people. When we visited in May 2017, each of the 20 care records we reviewed in Southampton contained an up to date care plan.
- In June 2016, we found that staff had not received training specific to their role and staff in Southampton completed assessments that they had not had sufficient training to do so. When we visited in May 2017, we found that staff had received specialised training to assist them in completing their roles.
- The services had a number of interagency working arrangements with other care providers or stakeholders to provide effective joined up care for young people using the service.
- The service used a range of outcome measures to assess the efficacy of the treatment they provided to young people.
- Clinicians monitored the physical health of young people taking medicine to help with their mental health issues.

However:

- Staff in Southampton did not routinely record capacity or consent in an easily accessible manner. None of the 20 records in Southampton we saw had it recorded anywhere we could find. In Portsmouth, all records had a form that recorded consent and considered Gillick competency. However, when we discussed this, the trust confirmed that they would implement this form in Southampton.
- Appraisal rates for non-medical staff were low at 60%.

Are services caring?

We rated caring as outstanding because:

- Young people and carers were very positive about how they were supported by staff. Carers and young people we spoke to said staff were kind and treated them with kindness, dignity and respect. This was supported by the feedback that the trust collected through feedback on the services.
- Staff were highly motivated and offered care that is kind and promotes young people's independence.

Outstanding



Summary of findings

- We witnessed highly skilled, kind, caring and empathetic interactions between staff, young people and their carers. Staff completed these whilst ensuring they maintained confidentiality unless the young person had given permission to share information with others.
- Staff ensured that young people and their carers were involved in the planning of their care. Young people and their carers were active partners in their care. Young people's views and individual preferences were considered and reflected in how the care was delivered.
- The trust sought feedback and actively engaged with young people, parents and carers to help shape the future of the service. We saw numerous examples of this and young people and carers were positive about how this interaction made them feel about the service they received. For example, young people interviewed new consultant psychiatrists and family members had been involved in the planning of new care pathways.
- Young people were encouraged to provide feedback on the service and managers had arranged training for young people so they could be involved in recruiting new staff.

Are services responsive to people's needs?

We rated responsive as requires improvement because:

- The service had not addressed an issue that had caused us to rate responsive as requires improvement in June 2016.
- In June 2016, we found that the community CAMHS service did not meet all their targets for assessment or treatment in all areas. When we visited in May 2017, we found this was still the case. They met their targets for triaging young people for appointments; however, the team in Southampton had recently breached their target for assessment. There were long waiting lists for young people to receive treatment after assessment. However, the trust had taken action to address this issue.

However:

- In June 2016 we found caseload management was not robust, affecting the capacity for staff to work with young people. When we visited in May 2017, we found that staff were more positive about caseload management and felt that it was more effective.

Requires improvement



Are services well-led?

We rated well-led as good because:

Good



Summary of findings

- The services had addressed the issues that had caused us to rate safe as inadequate and effective as requires improvement following the June 2016 inspection.
- When we visited in June 2016, we found that there was not an effective system to ensure consistency in standards in work processes across the different community CAMHS teams. When we visited in May 2017, we found there was a more consistent approach, with stronger relationships between Southampton and Portsmouth CAMHS staff with more joined up working.
- When we visited in June 2016, we found that governance systems in place to manage a variety of issues were not effective. When we visited in May 2017, we found that there had been improvements in governance systems and they worked more effectively than before.

However:

- Most subjects for staff training had not achieved the trust's compliance target of 85%. However, the majority of these subjects did not directly relate to working with young people.

Summary of findings

Information about the service

St James Hospital and Adelaide Health Centre are the registered locations from where Solent NHS Trust provides its child and adolescent mental health services (CAMHS) for the people residing in the cities of Portsmouth and Southampton. Southampton CAMHS includes the

building resilience and strength (BRS) team that is part of the integrated family assessment and intervention service. Young people also had access to the Jigsaw service which is an integrated health and social care provision for young people with moderate and severe learning disability plus complex family circumstances or

enduring complex health conditions. The CAMHS service is a multi-disciplinary service providing a range of assessments, treatment and support for young people in the community where there are concerns about their mental health. Types of conditions include depression, psychosis, eating disorders, self-harm, obsessive compulsive disorder and neuro-developmental disorders. The two CAMHS services work independently of each other. They have different commissioners and work in different ways. However, there was evidence of changes in practice so that the teams were starting to work together more frequently.

Our inspection team

The team that inspected these services was comprised of Colin Jarratt (lead CQC inspector), a CQC inspection manager, a further CQC inspector and an assistant inspector.

Why we carried out this inspection

We undertook this inspection to find out whether Solent NHS Trust had made improvements to their specialist community mental health services for children and young people since our last comprehensive inspection of the trust in June 2016.

When we last inspected the trust in June 2016, we rated the specialist community mental health services for children and young people as **requires improvement** overall.

We rated the core service as inadequate for safe, requires improvement for effective, responsive and well led and good for caring.

Following the June 2016 inspection, we told the trust that it must take the following actions to improve specialist community mental health services for children and young people:

- The provider must ensure risks assessments are completed for all young people and there is an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.
- The provider must ensure crisis plans are completed for all young people who are assessed as requiring them to keep them safe.
- The provider must ensure care records contain up to date care plans to support staff to care and treat young people safely.
- The provider must ensure all staff receive training specific to their role. In Southampton, assessments were being completed by clinicians who did not have sufficient training to do so.

Summary of findings

- The provider must ensure that young people and children do not have access to knives in the unlocked kitchen in Southampton CAMHS and access to the photocopying cupboard and doctor's interview room in Portsmouth CAMHS.
- The provider must ensure their governance systems are effective. Systems should ensure consistency in standards and work processes across the different community CAMHS teams; manage the waiting lists; ensure there are sufficient staff to care and treat young

people; ensure recommendations from serious incidents are met and systems are in place to assess the risks to young people whilst they were waiting for assessment and treatment.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 9 Care and welfare of people who use services

Regulation 12 Safe care and treatment

Regulation 17 Good governance

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 specialist community mental health services for children and young people. We requested further information from the trust, including the action plan they created to address the issues raised at the last inspection.

During the inspection visit, the inspection team:

- visited the team offices and clinical environments where treatment was provided, looking at the quality of the environment and observed how staff were caring for young people
- spoke with 2 young people using the service
- spoke with 13 parents or carers of young people using the service
- spoke with the managers of both community teams we visited
- spoke with 45 other staff members; including psychiatrists, doctors, nurses, therapy staff and administration staff
- met with the divisional management team in charge of these services
- looked at 28 treatment records of young people.
- 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

All young people and carers we spoke to were positive about the staff and the care they received. We spoke to a carer whose child was attending the 'Bounce' building resilience and strength programme and they told us their child was developing confidence and self-esteem and enjoying the programme. They described the group facilitator as fantastic. We asked the young people for one

word to describe the group. They said it was fun, funny, amazing, phenomenal and helpful. Carers we spoke with said that the waiting times to receive treatment were long. However, they told us that once the young person was receiving treatment the staff were kind, supportive and very helpful.

Summary of findings

Good practice

- In Portsmouth, the team had an agreement with six local secondary schools to attend for one day a month to provide appointments to pupils experiencing mental health difficulties. If the outcome of the appointment was that the young person required treatment, the team completed no further assessments and the young person received treatment as soon as possible. The team facilitated time for teachers to discuss pupils they were concerned about to give them strategies to help the young person. The team also delivered training to members of the teaching staff on topics such as eating disorders and self-harm.
- A future in mind workshop, led by the local clinical commissioning group (CCG) and the Portsmouth

CAMHS team including other local partners created the “Emotional wellbeing service pathway information: Portsmouth” document. This document contained different levels of severity of illness from mild to crisis, cross-referenced with the symptoms the young person presented with. This then gave clear guidance as to the most appropriate agency to which the professional should refer the young person. This included local charities and voluntary groups, up to statutory providers. The team sent out the document to all GPs and schools in the local area. The team was formulating a young person’s version and the local young person’s advisory group is currently reviewing the document.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that they complete all possible actions required to reduce the number of people on internal waiting lists for treatment after staff have assessed their needs.

Action the provider **SHOULD** take to improve

- The provider should ensure they make improvements in how staff in Southampton CAMHS record the consent and capacity to consent to treatment of young people using the service.
- The provider should ensure that procedures for cleaning toys used by young people follows the trust’s young people’s services cleaning toys guidelines and that these processes are fully embedded.

- The trust should ensure that staff complete mandatory training, particularly in areas specifically targeted at staff working with young people such as safeguarding and paediatric life support.
- The trust should ensure they provide staff with guidance to ensure they report all incidents, including those resulting in low harm or that they regard as near misses.
- The trust should ensure that the completion of non-medical staff appraisals increases from its current rate of 60%.
- The trust should ensure that staff complete mandatory training, especially in subjects relating directly to the care of young people.

Solent NHS Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)

Name of CQC registered location

Portsmouth CAMHS

St James Hospital

Southampton CAMHS

Adelaide Health Centre

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.

The service rarely used the Mental Health Act, however consultant psychiatrists received the necessary training and were supported by the trust Mental Health Act office where necessary.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us the consultant psychiatrist had delivered some training to the teams on the Mental Capacity Act. The mandatory training programme provided by the trust had a completion rate of 63.9 % against a trust target of 85%. However, staff were able to describe the use of the Mental Capacity Act and their responsibilities under it.
- Staff had received training in how to assess Gillick competency (where a child's maturity and ability to understand the treatment proposed means their consent and not the consent of the parent is the one that is sought).
- A review of care records in Southampton showed staff were not recording consent and capacity to consent to treatment. In Portsmouth, the service had devised a form for Gillick competent young people to sign during

Detailed findings

their assessment if they wished to access treatment without a parent or carer's involvement. The form also

recorded consent by parents where applicable. The trust confirmed that staff in Southampton would use this form in assessment appointments from our inspection.

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

- All rooms staff used to see young people and their carers were equipped with an alarm system to which their colleagues responded if a situation occurred.
- The clinic room at Southampton contained equipment to complete physical health checks. Staff had identified the need to have a separate room where they could complete physical checks in a manner that maintained the young people's privacy and dignity. Following a recent audit by the trust, an automated electronic defibrillator (AED) was stored within the clinic room in Southampton.
- All areas seen within the team buildings were clean and well maintained. Staff completed cleaning records to confirm that they cleaned offices, clinical areas and equipment regularly.
- Staff in Southampton had commenced a cleaning process for the toys used in their offices when working with young people. They had implemented this at the beginning of April 2017. Staff told us that toys were cleaned monthly following advice from the infection control lead within the trust. However, the trust's policy clearly stated that staff should clean items such as dolls, play dough, water toys and play mats more frequently than at monthly intervals. The frequency of cleaning was dependant on the item, varying from before each use for play tables to at least weekly for play dough.
- During the last inspection in June 2016, we found that young people had access to knives in an unlocked kitchen in Southampton CAMHS. They could also access the photocopying room and the doctor's office in Portsmouth CAMHS. At this inspection, we found that the trust had addressed these issues by fixing keypad locks to each of the previously unlocked doors.

Safe staffing

- The teams in Southampton and Portsmouth had a total establishment of 27 whole time equivalent (WTE) qualified nurses. At the time of inspection, Portsmouth had one qualified nurse vacancy, Southampton had no

vacancies since recently appointing more staff following a period of recruitment. At the time of inspection, the sickness rate in Southampton was 5.9% and 0.5% in Portsmouth. This compares to a trust wide sickness average rate of 4%. The sickness rate in Portsmouth had dropped since the previous inspection in June 2016. The sickness rate in Southampton had increased since that time. However, there had been a lot of upheaval in the last 12 months including uncertainty following the service redesign that had resulted in a merging of two teams. Staff we spoke with felt more positive about how things had changed recently, including the appointment of a new, dynamic manager.

- Staff discussed caseloads with managers during clinical supervision. This gave an overview and ensured that they discharged young people in a timely manner. Staff also discussed issues regarding caseloads during weekly clinical meetings and monthly business meetings.
- Vacancies in the service had meant that the early intervention team in Southampton had not been operational but new staff were due to start and the team would then be at full complement. The team provided initial assessments and screening assessments. To reduce the waiting list, the team in Southampton had employed three locum professionals to contact people who had been waiting a substantial period. They completed a telephone risk screen and arranged face to face appointments if the young people required one.
- There were psychiatrists available during office hours if staff members needed to discuss any concerns with them. Out of hours, the service provided an on call psychiatrists rota to enable young people to see a doctor in an emergency. This happened at hospital accident and emergency departments or in the community if needed for a Mental Health Act assessment.
- Staff completion of mandatory training was inconsistent. The trust's compliance rate was 85%. Of 20 subjects that the trust provided, only five had reached the trust's compliance rate. Some of the subjects, such as dementia awareness, had less impact on the team as they were working with young people. However, the subjects with the lowest completion rates were

Are services safe?

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

safeguarding adults level 2 (35.3%), infection prevention and control level 2 (47.7%), paediatric basic life support (54.1%), duty of candour (54.5%) and safeguarding children level 3 (55.8%). This is of particular concern when the service is working with vulnerable young people. However, staff discussed the process of making safeguarding alerts and knew how to do this.

Assessing and managing risk to patients and staff

- There was a system for triaging referrals. The triage included a telephone call to the family or referrer. Staff saw priority cases for assessment within four weeks and urgent cases within one day.
- At the last inspection, we found that the child and adolescent mental health services (CAMHS) team in Southampton did not complete risk assessments at the initial triage/assessment meeting. Staff had not updated these regularly afterwards. At this inspection, we reviewed 20 records and all contained fully completed risk assessments. The service had developed a risk assessment template that enabled staff to record and categorise risk. Staff completed risk assessments in the first assessment session with a client or beforehand based on the referral information. The care records system prompted staff to update a young person's risk assessment each time they accessed the record. If they indicated that the risk had not changed, the system recorded the following "the clinician has indicated that the risk assessment does not need updating or cannot be rerated based on available evidence". Staff received briefings in team meetings on the new risk assessment process. Managers talked about completing risk assessments in supervision in order to identify any barriers to staff completing this task. There were plans to show highlights on the landing page in the clinical records system that would include safeguarding and risk. Managers reported the completion rate of risk assessments was now at 97%, which was above the 95% trust target. All eight records we reviewed in Portsmouth contained a completed risk assessment.
- Clinicians in both services had been involved in the development of the new risk assessment. This meant that it contained clinically appropriate information to young people's needs. Staff completed risk assessments well, with relevant information recorded and risks rated appropriately.
- At the last inspection in June 2016, we found that none of the records for young people at high risk in

Southampton CAMHS contained a crisis management plan. During this inspection, we found that all records for young people that required a crisis plan had one in place. All the records in Portsmouth CAMHS contained a crisis management plan if required.

- The service maintained a duty staff system to enable them to respond to concerns of young people and carers and deterioration in a young person's health. Staff gave this telephone number to young people and their carers. Using this system, staff could arrange emergency appointments to see doctors or nurses or give advice or reassurance to callers. Young people were able to access input from a psychiatrist out of office hours by presenting to the accident and emergency departments at local hospitals. We saw an instance of a member of staff responding appropriately, promptly and with empathy to a young person telephoning in distress. The service had appointed three locums to cover vacancies, maternity and sickness. They telephoned the young people who had waited longest to screen and risk assess them by phone and book them in for a face-to-face assessment.
- Staff we spoke with understood the importance of making safeguarding referrals and were confident they knew the procedure to make an alert.
- Most of the staff worked in clinics and did not work in isolation in the community. However, there was a buddy system in place to ensure safe lone working where it was required.

Track record on safety

- Following a recent incident, the manager had reviewed the service response to physical and psychiatric emergencies and developed a standard operation policy. This included ensuring staff were aware of who was to attend if the emergency alarm sounded. In house training in de-escalation for all staff was also being set up. The trust planned for this training to include the teams from both Southampton and Portsmouth CAMHS.

Reporting incidents and learning from when things go wrong

- Staff described the kinds of the incidents they would report. They told us they discussed incidents and learning from them in business meetings. Managers told us staff had received training in entering incidents into the database in early 2016. Managers escalated

Are services safe?

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

incidents to the service line governance meeting and specific groups of managers depending on the type of incident. The team manager reviewed and responded to the each incident.

- There was evidence of under reporting of incidents. For example, one member of staff said they sometimes had to work with young people in unsuitable rooms but that they would only report this as an incident if the child showed distress. In Southampton staff members confirmed that they reported incidents that were of a high level. If they perceived the incident was low harm or a near miss (an unplanned event that did not result in injury, illness, or damage – but had the potential to do so) they did not report it. Staff were aware of the process of reporting an incident, however one member of staff said they had never reported an incident. Another said they found the length of the form they had to complete off putting. Managers confirmed they were aware of this and encouraged staff to report them. They were concerned that the team may miss a potential escalation in risk or patterns of negative behaviour if they were not aware of all incidents that occurred.
- Staff we spoke with understood the importance of being open and honest with young people if things went wrong. They understood the principles of the duty of candour.
- The trust produced a quarterly governance newsletter that contained details of incidents. Staff and managers discussed incidents within team briefings and business meetings. Managers added incidents to the service line and corporate risk registers. The trust had developed a learning database to collate learning from incidents and complaints in one place. Staff we spoke with confirmed the governance newsletter contained learning from elsewhere in the organisation. Staff told us the newsletters also included important information external to the organisation. For example, information about national self-harming trends including how they work with young people affected by these issues.
- Managers and staff discussed action plans from incidents and complaints in business meetings and the team manager monitored the implementation of agreed actions.
- Following a recent incident, managers implemented a new standard operation policy that included the development of a standard debrief format for all incidents.
- In a further incident, confidential information about a child was sent to a school that they no longer attended. In response to this, the trust now had a policy of having a named individual at each school to whom they sent correspondence. The team telephoned the named individual before they sent any information to a school.
- One member of staff who had been involved in an incident said the learning from the incident had been excellent. They felt confident that managers would complete the identified actions and that this would lead to positive change. However, they had given feedback about the lack of a debrief following the incident. As a result, managers had invited the member of staff to become involved in writing a relevant policy to manage the use of debrief after an incident.

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

- All 28 records that we examined included a comprehensive assessment young person's needs that staff completed at their first appointment. Staff confirmed that they requested further information from other organisations involved in the young person's care if required as part of the assessment process.
- At the June 2016 inspection, we found that young peoples' records did not consistently include up to date care plans with sufficient information to assist in the safe care of young people. They did not contain clear documentation of young peoples' views or discussions of treatment options or best practice. At this inspection, we found that all records contained up to date care plans that showed clear references to young peoples' views and discussions between staff, young people and their carers. However, these were stored in a variety of locations which may make it hard for staff to find them if they were not involved in formulating the plan. Managers reviewed care plans during caseload management supervision. The trust had plans to implement a standardised care plan for young people. This was to ensure the completion and content of the document was more consistent. They would be more easily accessible as they would be stored in the same location on each young person's record.
- All records were stored in a computerised system that all staff had access to at levels appropriate to their job role. The trust had rolled this system out at the same time as the team amalgamation in April 2016, which had added pressure to this change. However, now staff were used to the system they felt it was better than the one it replaced.

Best practice in treatment and care

- The provider offered psychological therapies recommended in the National Institute for Health and Care Excellence (NICE) guidelines for the treatment of young people including systemic family therapy and cognitive behavioural therapy.

- We saw evidence in the records of young people with learning disabilities that when staff suggested interventions to parents they provided the relevant NICE guidance and evidence of research or studies as an explanation for the suggested treatment plan.
- Doctors completed prescribing within the appropriate NICE guidelines. However, doctors in Southampton raised concerns that due to waiting list times affecting access to psychology, they sometimes had to prescribe medication to manage issues that psychological interventions could have dealt with.
- Where doctors prescribed medicines for young people, there was appropriate use of physical health monitoring to manage any side effects or concerns the use of medicine may cause. These included regular monitoring blood pressure and weight, the use of electrocardiograms (ECGs) to monitor the young people's heart and blood tests.
- The service used a selection of outcome measures to check the efficacy of the treatment their staff provided. These included the revised children's anxiety and depression scale (RCADS) and the children's global assessment scale (CGAS). The service had also agreed additional funding from its commissioners for a data analyst post for a year to create databases for outcome measures and train clinicians in how to use them to produce reports.
- Staff completed clinical audits. These included doctors completing the prescribing observatory for mental health (POMH) for antipsychotics used with young people. Managers completed care record audits.

Skilled staff to deliver care

- There was a wide range of staff available within the teams to enable them to deliver effective care to the young people on their caseloads. This included consultant psychiatrists and other grades of doctors. There was a wide range of therapy staff, this included art therapists, play therapists, family therapists and cognitive behavioural therapists. Also in the teams were psychologists, nurses, occupational therapists, social workers and mental health practitioners of various grades and specialities.
- All staff we spoke with were experienced, appropriately qualified, and understood the nature of their roles and what managers and other team members expected of them.

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.

- Staff confirmed that they received an appropriate induction. We spoke to new starters who confirmed that they had received appropriate training and that their manager was supportive of them in their new roles. In Southampton, they were very complimentary of their immediate line manager who was ensuring that they completed their induction process before they started working unsupervised. This was in spite of pressure for them to commence assessing and working with young people as soon as possible.
- Staff received regular clinical and managerial supervision. There was also a selection of supervision groups staff could attend including occupational therapy, psychodynamic and cognitive behavioural therapy (CBT) supervision groups. There were specialist nurses staff could seek advice from. The team held weekly clinical case discussion meetings.
- All medical staff had received an annual appraisal. However, in Portsmouth, 79% of non-medical staff had received an appraisal. In Southampton, 60% of non-medical staff had received an annual appraisal.
- During the last inspection, we found that staff had not received the appropriate training to enable them to complete their roles and work safely with young people. At this inspection staff confirmed that they had received appropriate training to enable them to work safely with the young people in their care. Following our last inspection, the provider rolled out in house training events and asked staff in the team to deliver them. Managers enabled staff to share their knowledge, skills and experience in working with specific age groups. These sessions continued to run once a month. Staff spoke about other training opportunities available for them to complete training externally.
- The autism pathway was now comprised of the child and adolescent mental health services (CAMHS) teams and the local paediatric services to try to ensure a more joined up method of working with the young people and their parents.
- Staff said they were building links between the Portsmouth and Southampton teams. Southampton managers were seeking to learn from the Portsmouth team. For example, regarding how they conducted their triage and assessment clinics. Managers told us there was a link with the local hospital that offered a 24-hour crisis support service for young people. The trust were planning to work with a neighbouring trust on a new continuous quality improvement network (CQIN) target on transitions from child and adolescent mental health services (CAMHS) to adult mental health care. They also had peer arrangements with another neighbouring trust with which they were sharing information and benchmarking. The manager told us they had good links with a local charity counselling service. They were also attending a parent forum run by the commissioners. The service ran a 12-week mental health awareness course that was open to school staff. Schools gave good feedback about the training. The local authority employed two social workers based in the team.
- Portsmouth had a number of inter-agency working partnerships, including with local schools to provide assessment appointments to young people. They had also formulated a care pathway document so professionals such as doctors knew the most appropriate service to refer young people to dependant on their level of need.

Adherence to the MHA and the MHA Code of Practice

- The community CAMHS service provided doctors who were qualified to work as a Section 12 doctor and could assess young people for detention under the Mental Health Act if required. These doctors attended out of hours to assess young people in local hospitals in the area. The service rarely used the Mental Health Act. However, consultant psychiatrists received the necessary training and they were supported by the trust Mental Health Act office where necessary.

Good practice in applying the MCA

- Staff told us the consultant psychiatrist had delivered some training to the team on the mental capacity act.

Multi-disciplinary and inter-agency team work

- All staff described regular weekly meetings involving the complete multidisciplinary team. They discussed issues such as caseloads, adding young people to waiting lists, escalation of risks and other issues. All staff felt this was very beneficial and supported their efforts to care for the young people using the service effectively.

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.

The mandatory training programme provided by the trust had a completion rate of 63.9 % against a trust target of 85%. However, staff were able to describe the mental capacity act and their responsibilities.

- A review of care records in Southampton showed staff were not recording consent and capacity to consent to treatment. In Portsmouth, the service had devised a form for Gillick competent young people to sign during their assessment if they wished to access treatment without a parent or carer's involvement. The form also

recorded consent by parents where applicable. The trust confirmed that staff in Southampton would use this form in assessment appointments from our inspection.

- In Portsmouth, we saw evidence where staff completed documentation regarding consent to treatment by the young person. For example if young people with learning disabilities were nonverbal, staff documented how to ensure they obtained their consent where possible.



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 witnessed a number of interactions between staff, young people and their carers that were respectful, kind, empathic and supportive.
 - Young people we spoke with reported that the care they received was great and had helped them through difficult times. They felt that the staff they worked with treated them like individuals and respected their views and opinions in spite of their age. Carers we spoke with were overwhelmingly positive about the support they received from the staff. They felt involved with the planning of care and that staff were accessible and supportive when concerns arose. This was supported by the feedback that the trust collected through feedback on the services.
 - Staff demonstrated a clear understanding of the needs of the young people on their caseload. Each young person had an individualised care plan that highlighted the level of staff understanding of his or her needs. These documents included the young person's views, opinions and contained an action plan that all parties had collaborated in creating. Young people and their carers were active partners in their care.
 - Staff understood the need to maintain the confidentiality of young people in all their dealings with outside agencies. Staff asked young people to sign a consent form to share information. This included with young peoples' parents. We witnessed a member of staff clarifying with a young person if they could divulge information about them to their parent.
 - We witnessed an intervention by a member of staff talking on the telephone with a distressed young person and their carer. This was a very skilled piece of work by the member of staff. The staff member displayed high levels of care and empathy whilst talking to the young person and then to the carer. This staff member ensured the young person's safety was maintained in the kindest, supportive way.
- letter included a plan that had a summary of the assessment they had completed and an agreed action plan that the parent signed. If the staff member deemed the young person to be Gillick competent, the young person signed the form.
- There was a high level of participation work occurring in both services. The trust had a change manager who had links with the local college who was involved in training young people to take part in recruitment. Staff told us young people were involved in interviewing new staff. One child had taken part in a video about art therapy shown recently at a conference for allied health professions. Managers invited a parent who had made a complaint about the service to join the transformation implementation group. Service users were involved in the mental health awareness course and had spoken about their mental health difficulties. In Portsmouth, they had used an innovative method to increase the engagement of young people in shaping the service. They had established a "pizza and chat" discussion group.
 - When the team formulated a new eating disorder treatment pathway for the area, the team involved parents of service users to identify how the pathway would look and how it would be accessed. Young people and their carers were actively involved in the development and review of all care pathways.
 - Young people and their carers were being consulted on the move to the new premises in Portsmouth including the decoration and furniture.
 - We saw evidence of the appropriate involvement of parents and carers in young peoples' care. Staff recorded this in young peoples' records.
 - People were able to give feedback on their care using questionnaires and surveys. A parent of a young person had set up a parent support group in the local area. Members of staff from the Southampton team had periodically attended those meetings to present information on a variety of subjects. As part of this process, staff answered general questions about care and other issues.

The involvement of people in the care they receive

- When young people had attended an assessment "options" appointment in Portsmouth, staff printed out a letter for the young person or their parent to sign. This
- Staff were proactive in providing contact details for a national youth advocacy service due to the lack of advocacy services commissioned for young people in the local area. A local charity specifically provided



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advocacy support for looked after young people. Staff provided other young people with a telephone number for a national young person's advocacy service if they needed their support. In Portsmouth, the service had

engaged young people in the planning of the new building the team was moving to in April 2018. This included consultation regarding the use and availability of rooms and how the team base was decorated.

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

- The service had two key performance indicators issued by their commissioners. They were required to triage 95% of referrals within two working days. They told us they had achieved 97% in the previous month. They were required to assess new non-priority referrals within 18 weeks. The team had recently breached this target and the manager had placed this on the risk register. Staff saw urgent referrals within four weeks and emergency cases within one to two days. There was no target for the time between assessment and treatment.
- The service in Southampton had significant waiting lists for all of the treatments that it provided. For example, the autism pathway had a longest wait for treatment of 73 weeks with 95 people on the list. Eighty-three of those had been waiting for six months or more. The trust had not calculated the average waiting time. In contrast, the equivalent pathway in Portsmouth had a longest wait of 21 weeks with 29 people on the list. At this time there was no person having waited longer for six months, although this may change due to a recent increase in referrals. In Southampton, the waiting list for art therapy was 37 weeks. Nine people were on this list and six had waited for longer than six months. In Portsmouth, the longest wait was five weeks and no one had waited longer than six months. In Southampton, the waiting lists for other psychological interventions were also long. For cognitive behavioural therapy (CBT), the longest wait was 51 weeks with 63 people on the list. Nineteen of these had been waiting for longer than six months.
- The team in Southampton had sent letters to all young people on the waiting list for treatment for six months or more to confirm they were still on the list, they had not been forgotten and asking if they still required input from the team. In Portsmouth, the team had set up a number of initiatives to enable young people to maintain contact with the team whilst awaiting treatment so they could manage the young person's risks. These included a drop-in clinic that saw up to eight young people a week and staff attending clinics in schools to enable them to have access to young people. Staff also encouraged young people and carers to attend group therapy sessions if appropriate.
- Carers of young people said their only frustration was the length of time they had to wait to receive treatment after their initial assessment.
- The service in Southampton had implemented measures to enable them to work more efficiently and to reduce waiting times. While on the waiting list for 'treatment', young people sometimes received ongoing support. They were running a social anxiety group and a new cognitive behavioural therapist starting in July would run groups. They planned to scrutinise referrals in the clinical meeting before allocating them to waiting lists to ensure staff used the resources wisely and to stop staff placing young people on multiple lists. There were discussions about young people having group therapy as a first line treatment and offering individual therapy only if needed. There were art therapy groups and staff prioritised young people at risk. They had begun completing initial assessments to ensure young people were on the appropriate list. Therapists were rolling out short term and group delivered therapies for young people suited to these. In April 2017, the autistic spectrum disorder service had changed the way they conducted assessments to enable them to assess four cases in one day. This was in response to them receiving more referrals than their original commissioning agreement had specified to assess. Managers in both services provided staff caseload management supervision once per month that looked at every case to ensure they were being treated effectively and discharged when necessary. The trust was developing job plans to outline the numbers of clinical contacts expected per clinician each week.
- The Portsmouth team had also implemented a number of measures to reduce waiting times for access to support. The team had created a number of different community groups. These included the controlling worries group that was cognitive behavioural therapy (CBT) based for age groups between eight and twelve and then thirteen to eighteen. They also provided an emotional coping skills group based on dialectical behavioural therapy (DBT) for young people over fourteen. A final example of a group offered was the building confidence and mood group to promote self-esteem and emotional resilience.
- In Portsmouth, the team had arrangements with six local secondary schools to provide appointments one day a month to young people experiencing mental

Are services responsive to people's needs?

Requires improvement 

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

health difficulties. If the result of this appointment was that the young person required treatment, the team would do no further assessments and the young person received treatment as soon as possible. The team also facilitated time for teachers to discuss pupils they were concerned about and provided training to the teaching staff on topics including eating disorders and self-harm.

- A future in mind workshop, led by the local clinical commissioning group (CCG) and the Portsmouth CAMHS team including other local partners created the "Emotional wellbeing service pathway information: Portsmouth" document. This document contained different levels of severity of illness from mild to crisis, cross-referenced with the symptoms the young person presented with. This then gave clear guidance as to the most appropriate agency to which the professional should refer the young person. This included local charities and voluntary groups, up to statutory providers. The team sent out the document to all GPs and schools in the local area. The team was formulating a young person's version and the local young person's advisory group is currently reviewing the document. This had a positive effect on the service caseload by ensuring referrals went to the appropriate agency rather than automatically going to CAMHS.
- The team provided young people and their carers with a telephone number to contact if they had any concerns. A skilled member of staff acted as duty clinician and dealt with any queries that arose. This involved giving advice and support, information and arranging emergency assessments if required. We saw staff responding to parents and young people using this service and they were supportive, empathic and dealt appropriately with the concerns callers raised.
- In order to improve attendance at appointments and enable the service to operate efficiently, administrators telephoned young people the week before their appointments to remind them to attend.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a wide range of rooms staff used to provide treatment and care to young people. These included interview rooms, a family therapy suite, activity rooms and a clinic room. Activity rooms contained a wide range of toys, equipment and art materials to enable staff to work in a variety of ways with different ages of young people. Staff used the clinic room to examine

young people in a private space to maintain their privacy and dignity. The clinic room was equipped with items such as scales and blood pressure machines so staff could monitor young people's physical health. The room also contained an automated electronic defibrillator in case of an emergency.

- The reception area contained information leaflets and posters on a variety of topics that may have been of use or interest to young people and their carers. These included details of available treatment, information about autism, attention deficit hyperactivity disorder (ADHD) and eating disorders and how to complain. Information leaflets also provided details of local agencies available to provide counselling services, advocacy and activities for young people.
- The team building in Portsmouth was very well maintained. It was clean and tidy with a wide range of facilities. There were two family therapy observation rooms and a wide range of therapy rooms. The reception area contained two games consoles. Young people had access to a garden area if they felt they needed this.

Meeting the needs of all people who use the service

- In Southampton, the building where staff saw young people had a ramp to the front door and lift access to the first floor so people with mobility difficulties could access the team facilities. This ensured that young people and carers were fully able to engage with treatment and care the team provided. In Portsmouth, all clinic rooms were on the ground floor.
- Where young people or carers were not English speakers, staff contacted the trust or used the internet to access information leaflets in the appropriate language. If young people needed an interpreter or signer, staff arranged this.

Listening to and learning from concerns and complaints

- In the 12 months prior to this inspection, the service received eight complaints across both teams. Of those, the service fully upheld five and partially upheld two. None of the patients involved had referred these complaints to the parliamentary health service ombudsman.

Are services responsive to people's needs?

Requires improvement 

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

- Young people and carers received information on how to complain as part of the pack of information received when they had attended their first assessment. The reception area also had posters and leaflets explaining how to complain, including details of the young people advice and liaison service (PALS).
- Staff we spoke with confirmed that they knew how to deal with complaints appropriately. They referred all complaints to their relevant team manager.
- Staff received feedback regarding complaints during monthly business meetings, weekly clinical meetings and during supervision. The trust also shared lessons learnt from complaints in their governance newsletter.
- Staff confirmed that they also celebrated successes and when things went right. In Southampton, staff felt the culture had shifted to include two-way communication. Before it felt like they only used to hear about things going wrong.

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 we spoke with were positive about the values of the service and felt that the team's values and objectives were in line with those of the wider organisation.
- Staff we spoke with were aware of the senior managers of the service. They were extremely positive about the leadership that managers at local level provided to the team.

Good governance

- There were a number of governance systems in place to maintain standards. Managers completed supervision with staff and shared information and lessons learnt from incidents and complaints with staff. Staff completed clinical audits and research projects. However, appraisal rates and completion of mandatory training were low. This indicated that the trust's systems to monitor this were not fully embedded.
- The provider had two key performance indicators (KPI) that they used to manage access to their services. They had recently breached the 18-week target for assessing from the point of referral. The manager had placed this on the service's risk register. The service used a wide range of outcome measure to manage the efficacy of the care and treatment the team provided.
- The team managers felt they had sufficient authority to implement change and they felt validated by their senior managers to do this.
- Team staff had the ability to submit items to the service risk register if they felt that the concern was severe enough.

Leadership, morale and staff engagement

- Staff told us the team had been anxious throughout the changes to the service design in Southampton before our last inspection and that there was still some anxiety amongst the staff but morale had improved. Managers recognised some staff needed more support in adapting to changes in the service. Staff spoke very positively about the team manager who they described as efficient, committed, responsive and a good listener. Staff told us they enjoyed their jobs and liked the challenges. However, staff complained about working

across two buildings and no longer having desks and team rooms. They said this was a cause of stress and the loss of a team room meant they missed opportunities to debrief and ask for support and advice. Managers had listened to the concerns and had placed lockers in one of the buildings to prevent staff having to carry their belongings around with them. However, the change of buildings had been a necessary estates rationalisation. Staff described a large volume of work that could occasionally be stressful. The manager told us they held conversations with staff about stress and offered occupational health and stress buster support as appropriate. The manager had recently worked with occupational health to send a questionnaire to staff about their stress and was awaiting the results. One member of staff said their workload was too high and that they became overwhelmed. They said they felt under pressure to accept new cases on to their caseload. One member of staff said their progression in the organisation was stifled.

- Staff we spoke with commented that the leadership in Southampton had changed drastically in the last few months since the merger. There is now a flowchart of management and structures in place to allow the service to continue in a safe and controlled way.
- In order to improve morale in the Southampton team, the service had recruited an external agency to provide support and team building away days. Staff reported these had a positive impact. The away days were continuing to run. Staff described each other as caring and taking an interest in one another. Staff told us they had supportive relationships with one another.
- One member of staff had spoken to senior management about their concerns about how they had managed the changes in Southampton. They had welcomed the opportunity to do so and felt managers had listened to them. Managers used questionnaires to gain an understanding of staff concerns. The trust's friends and family survey showed that the trust's staff felt that it had improved as an organisation to work for.
- There was strong leadership within the Portsmouth team. There were robust links between the nurse managers and the clinical leadership. This meant staff felt supported and able to raise concerns and issues
- Staff in Portsmouth raised concerns about moving to a new building in April 2018. However, they confirmed that

Are services well-led?

Good 

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the management team have put a lot of effort into engaging with the team to reduce the anxieties. Actions they have completed include a car-parking audit, consultations about room use and room design and discussions about joint working practises. Staff we spoke with liked managers asking them what they wanted or needed from the new office building.

- Staff reported no bullying or harassment concerns.
- Staff we spoke with understood the whistle blowing process and felt that they would be able to raise concerns without fear of victimisation

Commitment to quality improvement and innovation

- The team in Southampton has signed up to the Quality Network for Community CAMHS (QNCC) and was starting their accreditation process in June. The team in Portsmouth had already completed this accreditation programme.
- Clinical staff of all grades were involved in a number of research projects. Some of these projects covered self-harm in social media, sexually harmful behaviour and pharmacological and non-pharmacological solutions for sleep difficulties.

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The length of time young people spent waiting between assessment and treatment was high and although the service had taken action, these had not reduced significantly.

Regulation 17 (1) (2) (b)