

Requires improvement

Coventry and Warwickshire Partnership 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)
RYG	Coventry and Warwickshire Partnership NHS Trust	Coventry CAMHS	CV1 4FS
RYG	Coventry and Warwickshire Partnership NHS Trust	North Warwickshire CAMHS	CV11 4SG
RYG	Coventry and Warwickshire Partnership NHS Trust	South Warwickshire CAMHS	CV31 1JG
RYG	Coventry and Warwickshire Partnership NHS Trust	Stratford Healthcare CAMHS	CV37 6NQ

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

Summary of findings

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 Coventry and Warwickshire Partnership NHS Trust and these are brought together to inform our overall judgement of Coventry and Warwickshire Partnership 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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Inadequate



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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Summary of findings

Overall summary

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

- Governance systems were not robust and had not addressed the considerable issues with resource to ensure timely triage of referrals, assessments and waiting times.

The service had long waiting lists for neurodevelopmental assessments and follow on treatment for core child and adolescent interventions. There were no formal mechanisms in place to monitor patients on the waiting lists. There were no targets set for follow up appointments.

- Staff did not report all incidents. This meant themes and improvement from incidents could not be analysed.
- Staffing levels were highlighted as a risk on the trust risk register. Some areas of the service were left with reduced staffing levels during periods of leave, in particular the single point of entry and acute liaison team. This affected the timeliness of interventions and impacted upon staff workload.
- The trust had not updated its safeguarding policy to ensure staff were working to current guidelines.
- The safeguarding team did not ensure that staff followed best practice guidelines for safeguarding supervision. This would result in staff not working to current recognised standards.

- Staff had not ensured that all physical observation equipment, such as scales and blood pressure machines were calibrated and serviced as recommended by manufacturers' guidelines.
- The trust was not able to provide us with data to inform how many staff had completed Mental Health Act training.
- In order for the service to meet target performance indicators, routine appointments had been cancelled in order to offer initial assessments.

However:

- The service took part in national quality improvement programmes and research to improve patient care. They were in the process of developing their own internet based tool, which they hoped would streamline referrals and direct patients to the right service at the right time. Patients had access to a wide range of skilled and experienced professionals.
- The core service worked well with other agencies to ensure a joined up approach to patient care.
- Staff had regular managerial and clinical supervision, as well as access to a number of multidisciplinary forums to keep up to date with continued professional development.
- Staff routinely used outcome measures and completed audits to improve patient care.
- Patients, families and carers all said that the team were supportive, caring and professional. We observed staff to be kind, approachable and passionate about their roles within the service.

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:

- On inspection, staff told us of incidents that should have been reported but had not. We found that numbers of incidents reported were low.
- There were not sufficient numbers of skilled and qualified staff to provide an effective single point of entry service. This meant the referrals were not always clinically triaged in a timely manner. Staffing for the whole of the core service was on the trust risk register at the time of our inspection.
- Staff at the Stratford-upon-Avon team base had not ensured weighing scales and blood pressure monitors were maintained according to manufacturer's guidelines.
- The trust safeguarding policy contained references to out of date national guidance.

However:

- Staff completed detailed risk assessments on initial assessments, which included risk management plans that fed in to care plans.
- All premises were visibly clean and well maintained.
- Caseloads were manageable and staff used routine outcome measures to periodically audit them.
- The trust had introduced a personal alarm system for staff to summon assistance if needed.
- All staff had completed and were up to date with safeguarding children and vulnerable adults training.

Requires improvement



Are services effective?

We rated effective as good because:

- Patients had access to a wide range of professionals across all services, including occupational therapists, nurses, psychologists and psychotherapists.
- Staff completed comprehensive assessments of patients' needs. Care plans were personalised, holistic and recovery orientated.
- The core service was part of the Children and Young People's Improving Access to Psychological Therapies Programme and were developing care pathways in line with this and the National Institute for Health and Care Excellence guidance.

Good



Summary of findings

- The trust supported staff to access additional training in cognitive behavioural therapy, dialectical behaviour therapy, family therapy and eye movement reprocessing therapy.
- Staff routinely used a variety of clinical outcome measures and rating scales, which were recorded in patient care records and audited on a regular basis.
- Staff had effective working links with primary care, paediatric wards, schools, local authorities and partnership agencies.
- All staff accessed regular managerial and clinical supervision. Peer group and specific intervention supervision was also in place. All staff had an appraisal in place or had one booked for future completion.

However:

- The trust was unable to provide us with data to confirm the numbers of staff who had undertaken Mental Health Act training. The core service had developed bespoke child and adolescent Mental Health Act training for staff, but this was yet to be delivered.
- Staff used a number of systems to record patients' information. This meant that information was not easily accessible.
- We found that safeguarding advice sheets and multi-agency safeguarding referrals were not always uploaded in a timely manner to the electronic care records.

Are services caring?

We rated caring as good because:

- Staff demonstrated a respectful, caring and compassionate attitude towards patients and their carers.
- Staff were sensitive to the needs of patients and showed good knowledge of issues they faced.
- Staff documented consent to share information and staff understood when and how to breach confidentiality if needed.
- Care and treatment plans demonstrated involvement from people who used services. Plans were individual, reflected views of patients and families and or carers.
- The children and young people's directorate had a patient engagement strategy and we spoke with carers and patients who had been actively been involved in the development of services.

Good



Are services responsive to people's needs?

We rated responsive as inadequate because:

Inadequate



Summary of findings

- There were 1357 children and young people waiting for a neurodevelopment assessment; the average length of wait across Coventry and Warwickshire was 63 weeks. The longest waits were in Coventry, with the average waiting time of 124 weeks.
- Internal waiting times to access follow up intervention were long. One hundred and twenty six children and young people were waiting for follow up intervention across the care pathways.
- The single point of entry had a backlog of referrals which needed clinical triage. Systems in place did not ensure referrals were processed efficiently and there were not enough clinical staff to ensure that all referrals were triaged on the day received.
- The service had cancelled patients' regular appointments in order to prioritise initial assessments and ensure that new referrals were assessed within the key performance indicator timeframe.

However:

- The core service had a lot of useful information for the public on the trust website, including psychoeducational material, links to other services and its recent conference explaining new ways of working.
- The service involved children, young people in the development of services, leaflets and had a patient experience and involvement strategy for 2017/18.
- Staff handled complaints appropriately and we could see some changes were made to the service in response to complaints.
- Staff had sufficient access to rooms and resources to support treatment and care.

Are services well-led?

We rated well led as requires improvement because:

- Governance systems were not robust and had not addressed the considerable issues with resource to ensure timely triage of referrals, assessments and waiting times.
- The single point of entry operational procedure was incomplete and had not been updated to reflect increased demand. We were not assured that the administrative processes to support the service were adequate and the arrangements to cover staffing within the team were weak, relying on staff from other

Requires improvement



Summary of findings

parts of the core service to cover. We were concerned that there no long term plan in place to deal with this or the extra duties the single point of entry will undertake when it becomes the service navigation hub in August 2017. The service did not ensure that all referrals were clinically screened on the day of receipt.

- The trust had not updated its safeguarding policy to ensure staff were working to current guidelines and the safeguarding team did not ensure staff followed best practice guidelines for safeguarding supervision.
- There were no key performance indicators in place for timeliness of follow up after initial assessments.
- Staff morale was mixed. Many staff indicated that there was too much change at once and that they did not always feel that decisions made by management were fed back in a timely way.
- There was no system for monitoring patients on waiting lists other than asking the referrer, patient, family and or carer to contact the service if the situation deteriorated.

However:

- The service took part in national quality improvement programmes and research to improve the quality of the service.
- Staff were given the opportunity to develop their leadership skills.
- Staff knew what the trust's values and vision were and had developed additional core service values and vision to work alongside.

Summary of findings

Information about the service

Coventry and Warwickshire Partnership NHS Trust provides child and adolescent mental health services from five locations across Coventry and Warwickshire. These services were based at:

1. Coventry - City of Coventry Health Centre
2. North Warwickshire - Whitestone Centre
3. Rugby – The Railings
4. South Warwickshire (Warwick district including Leamington Spa, Kenilworth and Southam) – Orchard House
5. Stratford Healthcare – Building One

Child and adolescent mental health services describe the levels of intervention required by each young person and family as tiers.

- Tier 1 are universal services which are accessible to all; GPs, school nurses, health visitors.
- Tier 2 are more targeted services around general wellbeing and mental health.
- Tier 3 is specialist outpatient mental health intervention, which includes specialised assessment, and treatment of complex and co-morbid mental health difficulties in children under 18 years of age.
- Tier 4 is inpatient mental health.

The trust provided the following services within the specialist child and adolescent community service:

- Primary mental health team - staff worked specifically with other agencies. Their remit was to share knowledge and skills to anyone working with children and young people who had low level mental health needs, to provide early intervention. They ran workshops, gave general advice and offered one to one case consultation.
- Single point of entry – Staff on this team processed and triaged all referrals for tier 2, partnership agencies, core child and adolescent mental health services and the neurodevelopmental team
- Core child and adolescent mental health services – Staff worked across Coventry and Warwickshire providing tier 3 interventions. The team was in the process of moving away from geographical based services to care pathways.
- Neurodevelopmental team – provided neurodevelopment assessments and interventions.
- Acute liaison team – staff on this team provided assessment, short term interventions and seven day follow up to children and young people admitted to a paediatric ward with mental health needs.
- The Looked After Children's Team is commissioned by Coventry Commissioners and is delivered using an integrated team model approach
- Child and adolescent mental health services were commissioned by five different commissioning groups. This resulted in some variation of services.

Our inspection team

The inspection team was led by: Head of Inspection: James Mullins, Care Quality Commission.

Inspection manager: Paul Bingham, Care Quality Commission.

The team that inspected the core service consisted of two CQC inspectors, three specialist advisors and one expert

by experience. The specialist advisors were a specialist child and adolescent nurse, a social worker and a psychologist. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them, for example as a carer.

Summary of findings

Why we carried out this inspection

The CQC last inspected these services April 2016. Overall the core service was rated as good. The domains of safe, effective, caring and well led were rated as good. The domain responsive was rated as requires improvement.

The following areas were identified for this core service where the trust MUST improve:

- The trust must ensure all eligible young people are allocated a care coordinator.

The following areas were identified for this core service where the trust SHOULD improve:

- The trust should ensure that systems are in place for effective staff recruitment and retention.

- The trust should ensure that all staff are up to date with mandatory training including the Mental Health Act and the Mental Capacity Act.
- The trust should ensure that staff follow the trust safeguarding policy correctly to maintain the safety of the young people who use the service.

Prior to inspection the trust provided the CQC with its most recent action plan resulting from the last CQC inspection (as of 17 March 2017). This action plan stated that all musts and shoulds had been completed.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited four team bases and reviewed the quality of the environment
- spoke with six patients who were using the service and eight carers

- spoke with the service manager
- spoke with 33 other staff members; including doctors, nurses, psychologists, occupational therapists, family therapists, students and trainees and administrative staff
- attended and observed three multi-disciplinary meetings
- observed five clinical appointments
- spent time with single point of entry team to review how referrals were processed and triaged
- looked at safeguarding processes
- case tracked six care records to look at safeguarding
- collected feedback from eight patients using comment cards
- Looked at 18 care and treatment records of patients
- 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

Children, young people and their families and carers who used the service gave positive feedback about staff and the care they provided.

We were told the service provided was good, all staff were friendly, helpful and genuinely cared about making young

people and their families comfortable. Families and carers told us they were involved in the care planning process when appropriate and received information about treatment aims and interventions via

Summary of findings

correspondence from the team in the form of letters. Families and carers did express concerns around the waiting times for treatment post assessment and the lack of crisis provision out of hours.

One carer told us their child had been involved in a project with to develop leaflets for other patients. They said it had benefited their child in that they had felt heard and valued.

One mum told us they were involved in the consultation about the development of care pathways, including speaking at a trust conference by giving a presentation.

Areas for improvement

Action the provider **MUST** take to improve

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

- The trust must ensure that all referrals are clinically triaged on the day of receipt to ascertain urgency of follow up and level of risk.
- The trust must ensure that the single point of entry standard operating policy is reviewed and fully completed.
- The trust must ensure that staff report all incidents on the electronic reporting system.
- The trust must ensure that the safeguarding policy is reviewed and updated in line with current national guidance.
- The trust must ensure that referral to treatment waits for all patients are reduced to comply with the NHS waiting time target of 18 weeks.
- The trust must ensure that waiting lists and length of waits for follow up interventions are reduced.
- The trust must ensure that the staff actively monitor patients on waiting lists and not rely on patient, family and or carers, or referrer to contact the service.

Action the provider **SHOULD** take to improve

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

The trust should ensure that:

- Safeguarding supervision is carried out in line with best practice guidance.
- All discussions within safeguarding supervision are accessible to staff and recorded within the patients care records in a timely manner.
- Equipment for the use of physical health monitoring is maintained in line with manufactures recommendations.
- Hot water dispensers have up to date safety tests.
- Managers continue to implement strategies to support effective recruitment.
- Managers review assessment procedures for those patients on the paediatric wards to reduce the amount of time they spend on a paediatric ward at weekends.
- Staff continue to work with commissioners to improve parity of care across Coventry and Warwickshire.
- Staff work with referrers to ensure appropriate referrals are received in the agreed format to ensure efficient administrative processes and clinical triage.

Coventry and Warwickshire Partnership 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
Coventry CAMHS	Coventry and Warwickshire Partnership NHS Trust
North Warwickshire CAMHS	Coventry and Warwickshire Partnership NHS Trust
South Warwickshire CAMHS	Coventry and Warwickshire Partnership NHS Trust
Stratford Healthcare CAMHS	Coventry and Warwickshire Partnership NHS Trust

Mental Health Act responsibilities

In response to the 2016 CQC inspection the trust told us a three year training programme has been developed and training commenced in March 2017. Prior to inspection the trust did not have any data on the numbers of staff who had completed Mental Health Act training. The core service manager told us bespoke Mental Health Act training had been developed in house and training days were set for August 2017.

A Mental Health Act policy was in place to provide guidance to staff on the application and use of the Mental Health and its Code of Practice.

In the 12 months prior to inspection, one patient had been discharged back to community teams on a community treatment order.

All of the core service consultant psychiatrists were section 12 approved. This meant that they had extra training and they were approved to carry out particular duties under the Mental Health Act. Consultants were part of an out of hours on call rota and could provide specialist child and adolescent mental health specific support when requested.

Staff could contact the trust Mental Health Act administrative and legal team if they needed guidance.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection, 87 % of staff had completed Mental Capacity Act training.

We found evidence of the documentation of parental responsibility care records we reviewed. Parental responsibility means the legal rights, duties, powers, and authority a parent has for a child and the child's property.

We saw evidence in care records that mental capacity was assessed for their patients aged 16 years and above. For

patients less than 16 years old, we saw competency was thought about and the staff we spoke with were able to give us definitions and examples of Gillick competence. We found evidence in care records that documented staff had considered Gillick competence where appropriate This is a term used to decide whether a child under 16 years old is able to consent to treatment without the need for parental consent or knowledge.

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 locations had secure entrances. Receptionists welcomed visitors and could clearly see who was leaving and exiting the buildings. All receptions had signing in and out books which all visitors and staff used.
- Alarms for staff to summon assistance if needed were present in some rooms at Orchard House; Stratford Health Centre, Building One (Leamington) and the Coventry base clinic rooms. However, alarm systems were not in place in all clinical areas the core service worked from. This did not appear to impact upon safety. Staff told us there had been no incidents and if they felt there were risks they would see the patient in pairs. The trust was in the process of rolling out lone worker devices. These could be used by staff to summon assistance whilst in the community or clinical settings.
- The trust undertook regular fire risk assessments of its premises and confirmed that they were compliant with regulatory and legislative requirements. Across the sites we visited, we saw that fire extinguishers were maintained within correct dates. Where appropriate, there were 'evac' chairs to assist the evacuation of people in case of a fire. Team bases had nominated fire wardens.
- Staff across the core service had access to the necessary equipment to complete basic physical observations such as height, weight and blood pressure. All equipment was visibly clean and kept in clinic rooms. Most equipment had a safety test and calibrated as per manufacturers' guidelines; except at Building One, Stratford. At this site, we found that the weighing scales had not been calibrated since 2012 and staff were unable to tell us when the blood pressure machine was last serviced. Staff at Orchard House said equipment was maintained, however they were not able to provide evidence that suggested equipment had been portable appliance tested. The hot water dispenser at Orchard House did not have an up to date safety test; it had expired in February 2017.

- All of the premises we visited were visibly clean and well maintained. Housekeeping staff completed cleaning audits of premises and followed a set schedule of cleaning. Staff took responsibility for ensuring toys were cleaned after use in therapy sessions. They had access to hand disinfectant hand gel and wipes to clean toys after use. Staff told us they encouraged all children to wash hands prior to play. Toys available to children and young people in waiting areas looked visibly clean and in good order. These were also cleaned on a regular basis by the trusts facilities team.
- We observed staff adhere to infection control principles. Staff and patients had access to hand gel dispensers. There were posters displayed in the locations we visited, reminding people of hand washing principles and the importance of infection control. We saw posters reminding staff to 'fling the bling' and not wear excessive jewellery and highly polished nails. Staff had access to a trust infection control policy.

Safe staffing

- As at 31 January 2017, the core service had a total of 80.7 whole time equivalent substantive staff. This included nurses, psychologists, psychotherapists, occupational therapists, social workers, family therapists, counsellors and psychiatrists.
- Staff we spoke with told us there was no recognised tool used for estimating the numbers and grades of staff within the community child and adolescent mental health services. Managers told us staffing was planned and discussed with commissioners, taking into account local need.
- Across the core service, there were nine whole time equivalent band 6 mental health practitioner vacancies. There were 2.4 whole time equivalent clinical psychologist vacancies.
- Between 1 February 2016 and 31 January 2017, the sickness rate for the core service was 4.3%, which is below the trust target of 4.65% and the overall trust sickness rate of 5.2%.

Are services safe?

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- This core service had a total of 6.2 staff leavers between 1 February 2016 and 31 January 2017 and a turnover rate of 9.4%, which is lower than the trust average of 13.8%.
- The single point of entry was staffed by 1.5 whole time equivalent clinical staff Monday to Thursday, 2 whole time equivalent clinical staff on a Friday. This did not appear to be sufficient due to the high numbers of referrals. They also had to respond phone calls and communicate with other professionals, carers and families. Ten staff we spoke with told us the single point of entry team did not have enough staff to meet the demands of the service. The team processed and triaged all referrals to tier 2 and 3 child and adolescent mental health services, the acute liaison team and the primary mental health team. The single point of entry team was covered daily by one clinician with the support of another clinician for half a day. The team was supported by 5 administrative staff. Staff told us that the introduction of electronic records and the volume of referrals they receive means that referrals were not triaged in a timely manner.
- The trust told us a plan was put in place to increase the administration capacity by an extra 100 hours. However, we did not see a plan for extra clinical capacity to triage referrals.
- We were not assured there were sufficient systems or staff in place to cover annual leave arrangements, sickness and vacant posts. For example, we were told the single point of entry team was not always directly clinically covered if the main clinician was off. Administration staff would take calls and pass on to team leaders within the core service if referrals were urgent. The acute liaison team consisted of four staff. When staff took leave, their duties were covered by staff from the core child and adolescent mental health team. This meant those staff covering leave had extra workload and less time to complete ongoing caseload work.
- Staff told us caseloads varied dependent on acuity of patient's needs and the care pathway staff worked in. Staff did not raise concerns about size of caseloads. Staff told us the average caseload was between 15 – 20 patients. However, concerns were raised about additional duties they are requested to undertake. For example, to cover the rota for the acute liaison team and single point of entry. The service planned to audit caseloads in November 2017. Staff told us they reviewed caseloads regularly within supervision. They used the routine outcome measures tool to review effectiveness and quality of casework when reviewing at caseloads. This tool is a questionnaire which monitors symptoms and effectiveness of therapy
- Patients were held on the initial assessor's caseload until they were allocated a clinician for treatment. All patients with more than one professional involved in their care had an allocated care co-ordinator.
- The core service employed bank and agency staff to offer one to one support to patients on the paediatric ward. This is usually for patients who are awaiting admission to an in child and adolescent mental health ward or who have ongoing needs whilst waiting for assessment.
- Over the three months prior to inspection, the core service had used trust bank staff to work on Saturdays and evenings. This has been to complete initial assessments and assist with the administration processes of referrals.
- Staff told us they had rapid access to a psychiatrist when needed. The core service had nine full time psychiatrists, three locum psychiatrists, two senior psychiatric house officers and one paediatric senior house officer. There was one specialist registrar vacancy. The child and adolescent mental health service consultants participated in an on call rota which covered out of hours. This meant there was specialist consultant advice available day and night.
- Data shared with the CQC prior to inspection showed staff were required to attend mandatory training. This included basic life support, equality and diversity, fire, health and safety, infection prevention, information governance, Mental Capacity Act, safeguarding children and vulnerable adults' levels 1, 2 and 3. As at 31 January 2017, the overall staff compliance for this core service was 86% against a trust target of 95%. Out of 11 sub teams within the core service, four reported total compliance for all courses at 100% and seven teams reported figures below the trust target of 95%. As at 31/01/2017 - 73% of CAMHS staff had received manual handling (object) training. The trusts' statutory and mandatory training policy identified that this training

Are services safe?

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was not mandatory for this staff team. In contrast, 96.8 % core service staff had completed Prevent training. Prevent is part of the government's strategy for counter terrorism and seeks to reduce the risks and impact of terrorism on the UK.

Assessing and managing risk to patients and staff

- The single point of entry clinicians undertook an initial risk screen upon triage of every referral received, except referrals from the paediatric inpatient ward. Referrals from the paediatric inpatient ward were triaged and risk assessed by the acute liaison team within 48 hours of referral. Single point of entry clinicians established if the referral was appropriate and undertook initial screening to establish if the referral was routine, priority or urgent.
- The inspection team were not assured that the system in place to triage referrals received by the single point of entry was effective. We were told administrative staff filtered referrals on receipt to separate those marked urgent and routine. They passed urgent referrals to the clinician to be clinically triaged that day. However, this relied on referrers completing the correct referral form. The service had its own referral form which requested the referrer mark urgent or routine; however, they also accepted referral letters or referrals completed on an older form which had no urgent/ routine tick box. This risked urgent referrals being missed, as administrative staff did not read through the older referral forms or letters to ascertain level of risk, and even if they did, they were not trained to screen for risk indicators. This should be the role of a clinician. It is good practice for clinical staff to triage referrals on the day of receipt to ascertain level of risk and urgency of assessment required.
- Administrative staff printed off all referrals and collated them in daily batches. During inspection we found 600 referrals waiting to be clinically triaged. On the first day of inspection (27 June 2017), staff were clinically triaging referrals received on the 24 May 2017. This meant there was a five week delay in referrals being clinically triaged. Unknown clinical risks may have been within the referrals, which could have impacted upon the patients' mental health. We looked at 14 random samples from this batch and found two that had been marked urgent by the referrer. We shared this with the staff and the referrals were triaged that day. The trust later stated that one of the referrals was not deemed to be clinically urgent upon triage and the other case was already subject to a previous referral received three weeks earlier. This demonstrated that it is not clinically meaningful to rely on a referrer to identify whether a referral is urgent or not. It also showed there was not a clear administration process that could identify whether a young person referred is already open to child and adolescent mental health services or not. The delay in triage may impact upon care in a number of other ways. For example, a referrer may have a delayed response in being told the referral is inappropriate for the service and therefore a delay in signposting on to other more appropriate services. During inspection we raised our concerns with management and the referrals were clinically screened the next day.
- The standard operating procedure for the single point of entry states that some referrals may be triaged as priority non-medical and should be given an assessment appointment within the agreed time frame of four to six weeks. As there was a five week delay in triaging referrals, staff told us those that were deemed priority on triage were unlikely to have an assessment allocated within the set time frame.
- Following initial triage, clinical staff completed risk assessments on every initial assessment they completed. On inspection we reviewed seven risk assessments completed by the acute liaison team. We found them to be personalised and comprehensive. All had a risk management plan. Staff also completed a suicide risk scoring tool for all patients they assessed. Eleven of the care records we reviewed from the core child and adolescent mental health services team had a completed risk assessment. We found these to be personalised, up to date with management plans in place. Records showed staff reviewed risk assessments every six months or as and when needed.
- We saw evidence in care records to show relapse and crisis plans had been developed where appropriate. These were individualised and evidenced patient, family/carer involvement.
- Staff advised patients, families and or carers to contact the service if the patient experienced deterioration in their health. If a patient was open to the service, the key worker would be the first point of contact. If the patient was on a waiting list they were told to contact the single

Are services safe?

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point of entry. It would then be the clinician's responsibility co-ordinate an appropriate response. Staff told us that if the keyworker was unavailable, other staff would assist.

- Referrers, patients, parents and or carers were informed they could contact the single point of entry if they had increased concern whilst a patient was on the waiting list for assessment. The single point of entry clinician would review any calls received and arrange earlier assessment if needed.
- The neurodevelopmental team had high numbers of children & young people waiting for assessment. The service directed parents to the trust website to access information. They were also offered 'our parent & carer education sessions'. The acknowledgement of referral letter also provided direction to support from other agencies. The neurodevelopmental team had set up 15-minute telephone consultations, both pre-assessment and after assessment for parents to access whilst waiting assessment.
- The previous CQC inspection of April 2016 had said the trust should ensure staff follow the trust safeguarding policy correctly to maintain the safety of the young people who use the service. However, we found that the safeguarding policy contained references to out of date national guidance, for example it referred to Working Together 2013 rather than 2015. This results in staff consulting the policy not working to current recognised standards. Although, the trust had made some amendments to the policy in April 2016, it was not a full review of the policy. The policy omits the organisations requirements for mandatory safeguarding training, which was verbally reported by the safeguarding team as three yearly. Again, this does not meet the requirements of Working Together 2015 which includes acceptance of the Royal College of Paediatrics and Child Health (2014) guidance (Children's and Young People: Roles and Competencies for Health care Staff, Royal College of Paediatrics and Child Health 2014), which identifies groups of staff and the level and frequency of their training required. The guidance states "over a three year period staff should receive refresher training" rather than every three years. The guidance also cites a range of learning opportunities that should be used; however the focus within the organisation is on face to face training.

- Safeguarding training rates for clinical staff was 89.2 % for childrens safeguarding level 2 and 86.1% for level 3. For adult safeguarding training, level 2 rates were 89.4% and level 3 were 69.2%. All non clinical staff had level 2 safeguarding children and vulnerable adults training.
- The core service had named professionals responsible for child protection. The trust safeguarding team had nine members of staff who were nurses or named professionals including a child sexual exploitation nurse who worked across the health economy.
- The majority of patient appointments took place on trust premises, in childrens centres and in schools. Staff occasionally made home visits. In these circumstances, staff said they followed the trusts lone working policy. Staff on the acute liaison team had a buddy system in place for when working after 5 p.m. If staff had assessed patient contact to have an increased risk, they would complete assessments in pairs. We noted that all staff signed in and out of their base. Staff did not raise any concerns regarding personal safety.
- The core service did not dispense or store medication.

Track record on safety

- In the twelve months prior to inspection, there were no serious case reviews or serious incidents for this core service.
- Staff told us incidents from other areas of the trust were shared on the intranet staff bulletin page. The service manager told us that any learning from lessons would be discussed in team meetings.

Reporting incidents and learning from when things go wrong

- All staff had access to an electronic incident reporting system. Staff had reported 24 incidents in the six months prior to inspection. We reviewed these on inspection and found that five incidents included administration errors. This included letters been incorrectly typed or sent out to the wrong address. The service manager told us letters were now double checked in an effort to reduce administration errors.
- We were not assured all staff understood the importance of completing incident reports. During inspection, two staff told us about a physical assault from a child, which had not been reported as an

Are services safe?

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

incident. Short staffing issues that impacted upon timeliness of patient care were not routinely reported. A new member of staff told us they were not sure what the incident reporting system was even though they had attended a staff induction.

- The child and adolescent mental health acute liaison team told us any incidents that occur on the paediatric ward involving patients they were in contact with, were reported by the paediatric staff. The acute liaison team were included in reviewing these incidents. An example given was when the acute liaison team had prescribed medication that was not routinely stocked and this led to a delay in treatment. The medication is now stocked.
- Senior staff attended the Children and Family directorate Quality and Safety group, in which incidents were reviewed and reported upon. This information was fed back to all staff through email and discussed in business meetings.
- Staff told us they were aware of the trust's duty of candour policy and said they would explain to patients if things went wrong.

Are services effective?

Good 

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

Our findings

Assessment of needs and planning of care

- We reviewed 18 patients' care and treatment records. All of the records contained comprehensive assessments and care plans. The format used to document care planning varied between patients. In some records there were completed care plan templates and others, care plans were included within a clinic letter. Letters were addressed to and sent to the child or young person and their families and or carer. All 18 care plans were up to date, personalised, holistic and recovery orientated.
- Staff agreed care plans with the patient and if appropriate, families and or carers were involved. Some care plans had a combination of the patients' goals alongside the service/ parental goals. This reflected that a child or young person's goals may not always be the same as the service or parent and demonstrated that individual preferences were taken into account.
- At the time of inspection, staff were using three different systems to record and access historical information. The service was in the process of replacing one electronic system for another and phasing out the use of paper files. Staff told us this had presented the service with a number of issues which they were trying to address. For example, the increased amount of administration time needed to scan referrals on the system lengthened the amount of time to process all new referrals.
- The trust safeguarding team gave specific case advice to clinical staff, which was recorded on an email and sent to the clinician to be uploaded on to the patients care record. This process was not confirmed by the clinical staff. We found that most clinical staff recorded advice given by the safeguarding team themselves. However, in one case, information had not been uploaded into the care record. Reliance on other practitioners to upload records within the child's record cause's delay, and an unnecessary workload to already stretched clinical staff. All records should be immediately available to practitioners involved with a child at all times. Delays in accessing a full record can impact on the care of children, interagency working and advice and support to families.
- We saw staff followed guidance from the national institute for health and care excellence when prescribing medication for children and young people; including guidance for the treatment of depression in children and people (CG28).
- The core service were part of the Children and Young People's Improving Access to Psychological Therapies Programme (CYP-IAPT). This was a transformation programme delivered by NHS England. It aimed to improve patient access to evidence based therapies through self-referral and receiving regular feedback by using session by session outcome measures to track symptoms and severity of mental health, CYP-IAPT also aimed to improve patient participation in treatment, service, design and delivery and train managers and leads in how to manage and implement change and balance demand and capacity. So far, three staff have completed the CYP-IAPT leadership module and two staff had completed the recruit to train module. Four staff had completed the CYP-IAPT cognitive behavioural therapy training and two staff had completed the parent training module.
- The service was in the process of rolling out care pathways in accordance with the National Institute for Health and Care Excellence (NICE) and in line with CYP-IAPT principles. This aimed to improve access countywide; to ensure children and young people could have equal access to specific interventions wherever they lived. We spoke with three clinical staff leading the development of care pathways. We were told staff had been involved in the development of each pathway. The pathways were at various stages of development. The service aimed to have them all in place by September 2017. Most staff were positive about this new way of working. However, several staff told us this change, alongside the introduction of electronic recording system, the expansion of the single point of entry, waiting lists and staffing pressures was a lot to deal with at once. We reviewed minutes from three care pathway meetings. They showed staff were meeting regularly to plan for the care pathways and they identified actions and timelines for the pathways to be introduced. The care pathways developed or under development were: self-harm, Attention Deficit Hyperactivity Disorder, Anxiety, Attachment, depression, eating disorders and neurodevelopmental.

Best practice in treatment and care

Are services effective?

Good 

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- The core service offered a number of psychological therapies recommended by National Institute for Health and Care Excellence (NICE) and as part of CYP-IAPT programme. These included; cognitive behavioural therapy, attachment based parenting and family therapy. Play therapy, art therapy, parenting therapies and eye movement desensitisation and reprocessing were also offered. Staff working in the eating disorders pathway were working towards offering a family based treatment model of care. We saw evidence to show they followed Junior MARSIPAN (The Management of Really Sick Patients with Anorexia Nervosa) and Maudsley guidelines specific to eating disorders. The core service team also followed the National Institute for Health and Care Excellence (NICE) guidance 'Self-harm in over 8s: short-term management and prevention of recurrence' (CG16).
- Care records reviewed showed staff considered or completed physical health reviews on assessment and throughout treatment. Staff explained they would refer patients to an appropriate health care provider for physical health care reviews if needed; for example, GP or paediatrician. Care records showed basic health reviews were undertaken, including height and weight when medication was prescribed. Staff on the eating disorders pathway routinely monitored, weight, height and body mass index.
- All staff used a range of outcome measures to rate the measure the effectiveness of interventions offered. These included routine outcome measures (ROMS); questionnaires which monitor symptoms and effectiveness of therapy. They also gave the patient a chance to tell staff how they feel their therapy is going. Staff also completed strengths and difficulties questionnaires, Health of the Nation Outcome Scales for children and adolescents and took part in child outcomes research consortium (CORC) to assess and record severity and outcomes for children and young people. Staff who worked within the depression and anxiety pathways used the revised children's anxiety and depression scale (RCADS).
- All staff participated in a wide range of clinical audit. For example, the primary mental health team collected and evaluated feedback from training sessions they provided to other agencies. As a result, they found they had needed to pitch the level of training at a different

level for the audience. Staff on the neurodevelopmental team audited a carers group and found carers felt supported and listened to. The team lead for the acute liaison team had developed an audit document to review referrals and gather evidence to present to the commissioners to show the level of service demand and need. We found that the review was detailed and took into account service demands including referrals, delayed discharges, patient demographics, needs and outcomes.

Skilled staff to deliver care

- The team consisted of a wide range of mental health disciplines including; nurses (registered mental health, learning disability and school nurses), psychologists, social workers, family therapists, psychotherapists, counselling psychologists, psychiatrists, primary mental health workers and occupational therapists. Staff were experienced and sufficiently qualified to carry out their roles.
- Staff in the eating disorders team had training to interpret blood results. This meant they did not have to rely on a doctor or professionals from outside the team and results could be analysed in a timely manner
- Staff told us they received a three day trust induction and an additional local induction to the core service. Student nurses told us they received an induction specific to child and adolescent mental health when they started placement. On inspection we saw an induction pack student nurses are given. This was available to both year 2 and 3 mental health and child branch nurse students.
- All staff we spoke with told us they had regular one to one managerial and clinical supervision. Staff received supervision from other clinicians within the service or they were externally sourced. The trust paid some therapists to have external clinical supervision, for example, the family therapists and psychotherapists had supervision from other practitioners within their field, outside of the trust. We reviewed five staff managerial and clinical supervision files; each file had a supervision contract; agenda for supervision and staff had signed and dated the minutes of supervision. Staff documented any actions agreed, by whom and by when were also noted. We could see from email calendars that clinicians had booked supervision in advance.

Are services effective?

Good 

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- A psychotherapist held monthly psychodynamic case work discussion groups for staff to reflect on casework. Staff also had access to other group supervision focusing on other specific interventions for example family therapy. Nurses had access to a quarterly forum specific to child and adolescent mental health service nurses' professional development, as did staff from psychological therapy and occupational therapy disciplines.
 - As of 31 January 2017, 86% of permanent staff within this core service had received appraisals against a trust target of 95%. The remaining staff had appraisal dates booked in. As of the same date, 100% of staff who required revalidation had received it.
 - Staff had opportunities to receive specialist training for their roles. As part of the care pathway development, staff specific training needs had been identified. Occupational therapists in the neurodevelopmental team had training in Sensory Integration. This is a therapy which aims to support patients with sensory processing needs. All staff had completed skills based training on risk management (STORM). STORM is an evidenced based training package developed by the University of Manchester to equip staff in assessing and managing risk of suicide and deliberate self-harm. All staff on the eating disorders pathway had completed a two day family based treatment training in order to develop the family based treatment model of care they plan to offer. The staff were also trained in CBTe. This is an enhanced cognitive therapy specifically for patients with eating disorders.
 - The core service gave bank staff who worked Saturdays, additional training specific to child and adolescent mental health.
 - Managers told us they received support from human resources with staff performance concerns. There was one ongoing concern being addressed at the time of inspection.
 - All staff, including temporary staff had undergone a disclosure and barring service check and checked against the Protection of Children act register before appointment.
- Multi-disciplinary and inter-agency team work**
- All care pathways and teams within the service held regular multidisciplinary meetings. During inspection we observed three meetings; all appeared effective in that they ran to time, had set agendas and were recorded. We were told all business meeting minutes were stored on the staff shared drive and accessible to all staff. We observed staff documenting any clinical case discussion regarding patients within the care records. We reviewed business meeting minutes from the acute liaison team; they showed that the staff met regularly to discuss developments within the service. The agenda was structured and any actions were agreed stated who would do what and by when.
 - We saw many examples of the core service working in partnership with primary services and other relevant services (such as schools) to ensure people using the service with particular needs (e.g. autistic spectrum conditions) received coordinated care. For example, the primary mental health team staff provided specific case consultation to education staff. Staff who worked within the primary mental health team worked specifically with other agencies. Their remit was to share knowledge and skills to anyone working with children and young people who had low level mental health needs. They ran workshops, gave general advice and offered one to case consultation. We observed one training workshop during inspection. This was attended by teachers and local authority staff. Staff from the acute liaison team provided training to the paediatric ward staff. They providing each of the three wards four training sessions a year. The training covered aspects of children and young persons mental health needs, such as autistic spectrum conditions and deliberate self-harm. The service had good links with external agencies and plans to develop more partnership working. For example, a worker from Young Minds will be assisting the eating disorders team with group work.
 - Staff from child and adolescent mental health services had been seconded to work within the early intervention in psychosis service and the local authority Looked after Children team. This meant staff could offer expert knowledge to other professionals within the team and patients who used the service.
 - All children and young people who presented at accident and emergency with episode of self-harm were admitted to a paediatric ward and assessed by the child and adolescent mental health services Acute Liaison team.

Are services effective?

Good 

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

- The trust stated that, as this was an area identified for improvement in the last CQC inspection, a three year training programme for this had been developed and training commenced in March 2017, but no figures were available at the time of inspection.
- The core service did not have any approved mental health professionals. However, all the child and adolescent mental health service consultant psychiatrists were section 12 Mental Health Act approved. This meant they had extra training and they were approved to carry out particular duties under the Mental Health Act.
- Staff we spoke to had variable knowledge about the Mental Health Act and told us it was rarely used. They said they would seek advice from the consultant psychiatrist or their managers if they felt a patient needed assessment under the Mental Health Act.
- The trust had a Mental Health Act policy in place and available to staff on the intranet.
- Staff and the general public could access a copy of the Mental Health Act Code of practice from the trust website. The site also had information for patients and visitors about being detained under the Mental Health Act, the main sections in use, appeal processes and patients' rights.

- The core service has developed bespoke Mental Health Act training for child and adolescent mental health service staff and plan to deliver this in August 2017.

Good practice in applying the Mental Capacity Act

- The MCA only applies to young people 16 years old and over. For young people under 16 years old, Gillick competence is used to determine if the young person is able to consent to their treatment.
- As of 31 January 2017, 87% of staff had received training in the Mental Capacity Act, below the trust target of 95%.
- Staff were prompted to consider capacity and Gillick competence when completing initial assessments. The assessments forms had a specific area on the form for staff to complete. We saw these sections had been completed by staff. Gillick Competence is a term originating in England and is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- Staff we spoke with was able to explain the concept of Gillick competence and describe situations where it may be used.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

- During inspection we observed five clinical appointments. We saw that staff were thoughtful; they phrased questions in different ways so that the young person could understand. Staff were patient and kind and developed a good rapport with both carer and the young person. Staff created deliberate pauses for any discussion or feedback. This meant that patients and carers were given opportunities to think and feedback as necessary.
- Patients and their families and or carers we spoke to told us staff were polite, respectful and warm in their interactions. They felt that the staff were very caring and sought their views.
- Staff ensured personal information about patients was kept confidential unless it was detrimental to their care and took account of relevant guidelines e.g. Fraser guidelines and Gillick competence. They ensured patients and their families/ carers understood the nature of confidentiality and information sharing and consent and the legal frameworks underlying this for under 18's, including the nature of parental responsibility.

The involvement of people in the care they receive

- All carers we spoke with said staff included them (where appropriate) and their child in setting goals and reviewing care when necessary. Care records we viewed documented the views of the patient and families/

carers. However, it was not clear from records if patients were given a copy of their care plan. However, when we spoke with young people and their families, they said they were clear what their plan of care was. They felt listened to by the staff and said their preferences had been taken into account when planning their care and treatment. The child and adolescent mental health service referral form specifically requested information about consent and if the parent/ carer/ young person had agreed.

- Staff told us they had a poor response rate from the trusts friends and family questionnaires. However, in November 2016, the core service gathered the views of children, young people and carers using the service user's experience of service questionnaire (Commission for Health Improvement). One hundred and twenty two questionnaires were completed with 79% of respondents reporting that overall, the help that they received was good. Ninety seven per cent felt that they were listened to and taken seriously, while 87.5 % said that they would recommend a friend.
- The service offered various support groups to families and carers. For example, a carers support group for autistic spectrum condition.
- Staff were able to refer children, young people and their families to local advocacy services.
- The children and young family directorate had patient experience and involvement strategy and action plan for 2017 -2018. This outlined how patients would be involved in service development and the care they received.

Are services responsive to people's needs?

Inadequate 

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

Our findings

Access and discharge

- The service had clear referral criteria. This was available in the form of a handbook on the trust website. The single point of entry team signposted those who did not meet the criteria to other services who could support them.
- On inspection we found a backlog of 600 referrals that needed clinical triage. Data shared by the trust showed that referral rates had increased markedly from 2500 at the start of 2016 to 4500 in 2017. Between 1 December 2016 and 31 May 2017 the single point of entry team had received 4045 referrals. This meant (on average) that the clinicians would need to triage 31 referrals a day. We discussed the backlog of referrals with the service manager. We were told that it had occurred due to an increase in referrals coinciding with the introduction of a new electronic notes system. The service completed a time and motion study to analyse the process and had identified the need for more administrative staff. A new additional administrative worker started the week of inspection and they planned to recruit one more. In addition, they had used bank administrative staff at weekends to complete scanning of referrals on to the electronic care record system. On inspection the trust stated that they felt the administrative processes were robust. However, we did not agree with this because of the following reasons: We found referrals were not stamp dated on day of receipt and as such had no reliable audit trail. We found referrals that had been placed in batches out of date, for example a referral with the date of 3 May 2017 was found in the referrals batch received on 16 June 2017. Because the referral had not been stamp dated, staff could not confirm if they had misfiled the referral or if the referral had been delayed in the post and received by the team on the 16 June 2017. Staff told us that they would have to individually count all the referrals to tell us how many were waiting triage. Referrers were using different referral forms (which complicated screening). The administration team had to prioritise time each morning setting up the electronic care records for all referrals for the acute liaison team prior to dealing with other referrals received that day. Post inspection the trust informed us that in April 2017 the service recognised the increase in referrals. In order to manage the increase, additional initial assessment slots to meet demand were put in place from June 2017.
- We reviewed the single point of entry service operational procedure. Section 3 entitled 'Triaging of referrals' made reference to all referrals needing clinical triage on receipt of referral within a set time frame. However, the document had failed to give a specific time frame. The space where it should have been written was filled with question marks. Furthermore, the document was dated 2015 and had not been reviewed in light of increased referrals and the introduction of new electronic care record systems.
- The core service had a set target time of 18 weeks from referral to treatment. Staff told us if the service was close to breaching this key performance indicator, managers would ask for them to clear their diary for a week to make space for initial assessments. Staff had they had to reschedule routine appointments and cancel meetings to make space for initial assessments. This meant some patients' regular treatment sessions would be cancelled that week and may impact on their care and engagement with services. Managers informed us they had organised a number of Saturday clinics in order to offer initial assessments within the target time. These were staffed by existing child and adolescent mental health services staff or bank staff.
- Data shared by the trust stated that treatment began at the first assessment. However, we were told by staff, patients, families and or carers, of long waits for specific treatment interventions to begin. The service manager told us there was an internal waiting list for the core service across Coventry and Warwickshire child and adolescent mental health service (excluding neurodevelopmental) of 257 patients waiting for treatment interventions. On inspection we were told that the longest wait on the anxiety/ depression pathway was 49 weeks, the attention and hyperactivity disorder pathway was 82 weeks. The eating disorder team did not have any waiting list were able to offer appointments within two weeks. To manage the lengthy waits, the service offered patients groups in preparation for one to one interventions. For example, a patient may

Are services responsive to people's needs?

Inadequate 

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

be offered a psychoeducational group or body image group. Four parents said that a delay in receiving a diagnosis and support had negative impacts on their child's self-esteem, behaviour and education.

- We were told by staff that patients could be offered initial assessments at locations other than at their local team base in order that the service does not breach its commissioning target. This would mean the patient would have further to travel. If this appointment was declined, they would have to wait for the next available appointment at the local base. The service then reset the referral to treatment time back to the beginning. Therefore referral to treatment figures may not reflect the true experience for all patients.
- The neurodevelopmental team did not have set targets for referral to assessment/ treatment. Data shared by the trust showed that between 1 December 2016 and 31 May 2017, average waiting times were as follows:

Coventry – 124 weeks

Rugby – 21 weeks

North Warwickshire – 45 weeks

South Warwickshire – 64 weeks

- As at May 2017, there were a total of 1357 patients awaiting neurodevelopmental assessment across Coventry and Warwickshire. This is an assessment which is to look specifically at neurodevelopmental disorders including Autism spectrum conditions and Attention deficit hyperactivity disorder.
- The commissioners and the trust had noted that there was an unusually high demand for neurodevelopmental assessments within Coventry compared to the rest of England. Coventry Commissioners acknowledged the uniqueness of the referral pattern for Coventry and had commissioned a specific piece of work via Public Health England in order to understand the basis of this.
- At the time of the inspection, staff told us they were providing initial assessments to patients referred in November 2015.
- During inspection we were told that it had been clinically agreed to use an independent company to complete a set amount of initial assessments and they were waiting for this agreement to be signed of at senior management level.

- Managers had identified that 50 clinic appointments were needed each week to complete initial assessments following referrals. However, current staff capacity only allowed for 35 slots. To manage this, a contract had been agreed with an independent company to undertake online initial assessments with patients. We were told that the company would be undertaking 100 initial assessments and offering 80 patients a 10 session online cognitive behavioural course via skype. This was due to start July 2017.
- Patients admitted to a paediatric acute ward for assessment following self-harm were usually seen the next day by the acute liaison team. The acute liaison team was available from 0800 hrs to 2000 hrs Monday to Friday. However, if a patient was admitted after 4 p.m. on a Friday they would not be seen until the following Monday, as the acute liaison team was not commissioned to provide a weekend service. This may mean a patient is in hospital longer than they need to be. The paediatric ward staff did have access to an on call child and adolescent mental health service consultants during this period if the clinical need had been assessed to be urgent.
- The service was not commissioned to provide a crisis or home treatment team in order to respond to urgent referrals for patients who contacted the service in crisis in order to offer patients under 16 years of age an alternative to hospital admission. When known patients contacted the service, they would need to contact their keyworker directly. Patients not allocated a keyworker (those on the assessment allocation waiting list) contacted the single point of entry team. The service met its 48 hours target for an emergency assessment when required and 5 working days to see a psychiatrist for urgent referrals.
- Staff told us they would offer home or school based visits and work with other agencies to those reluctant to engage with services. Staff offered flexibility in appointments where possible, for example after school and early mornings.
- The core service had a policy to guide staff when dealing with patients who did not attend appointments. Staff would assess each case individually and respond proactively when considered necessary. For example, a patient whom presented with high levels of risk would be contacted by letter, phone, text or home visit. Staff

Are services responsive to people's needs?

Inadequate 

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

would alert other agencies involved of the non-attendance and alert the referrer. If staff assessed the patient risk as low, the team would notify the referrer that they would be removed from the waiting list after failing to attend two appointments.

- Staff told us appointments generally ran on time. They said they would inform patients, families and or carers if they would need to wait more than 15 minutes.
- Staff planned transition to adult services in advance of discharge. Staff sent GP'S a guide to attention deficit hyperactivity disorder in adulthood when they discharged patients back to their care.

The facilities promote recovery, comfort, dignity and confidentiality

- All locations we visited had a full range of rooms and equipment to support treatment and care, including art therapy and family therapy rooms. The family therapy room was complete with video recording equipment and a one way viewing window.
- Waiting rooms were clean, welcoming and had a range of age appropriate toys, books and magazines available.

Meeting the needs of all people who use the service

- The locations we visited were fully accessible for people requiring disabled access. This included accessible toilet facilities for people with disabilities. There were smaller toilets for younger children and baby changing facilities.
- Staff said they had good, timely access to signers and interpreters if required.
- We saw a range of leaflets on display. These included leaflets regarding mental wellbeing, advocacy and support groups, including information on what to do if they were unhappy with their care. We observed on the bottom of the complaints leaflet that it stated in English and three other languages to contact customer services if they need a different format or language.
- Staff told us the core service had worked in partnership with youth council and youth parliament within Warwickshire, to develop mental health information leaflets aimed at young people.
- Coventry and Warwick child and adolescent mental health services were commissioned by five different commissioning groups. This meant some services

across Coventry and Warwickshire had different service level agreements. For example, the eating disorders team were commissioned to work with patients up to the age of 18 from Coventry and 17 in Warwickshire. Neurodevelopmental patients in Coventry had access to a full multidisciplinary team; however patients from Warwickshire did not have access to a speech therapist or occupational therapist. This was because these posts had not been commissioned within that area. This meant patients did not have equal access to specialist professions

- The core service has a good presence on the trust website. This included information about the services, referral criteria and self-help guides. The website had accessible videos describing service developments, pathways and who was who on the team.

Listening to and learning from concerns and complaints

- The core service had received seven complaints between 1 February 2016 and 31 January 2017; this amounted to 7% of the trust total.
- Within the improvements identified by the trust as a result of complaints were two issues relating to mental health services for young people and children. These were the self-harm referral form being reviewed and amended and the service leaflet being reviewed and re-issued to include a description of the role of the child and adolescent Acute Liaison Team.
- Staff we spoke to understood how to handle complaints. Although staff were not always clear how learning from and action from complaints was shared. Although a breakdown of themes by core service was not available, the three most prominent themes across the trust were identified as communication, patient care and values/behaviour of staff.
- In the same period, the core service received 45 compliments, which amounted to 5% of the trust total.
- All locations had suggestion boxes and forms for patients, families and or carers to post comments to feedback suggestion, comments, compliments and concerns.

Are services responsive to people's needs?

Inadequate 

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- Half of the Patients, families and carers we spoke with said they were not aware of the complaints procedure but would ask if they needed to complain. The other half said they were aware. All the families we spoke with on inspection said they had no need to complain.

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 trust had visions and values; these were “to improve the wellbeing of the people we serve and to be recognised for always doing the best we can.” Staff we spoke to were able to describe these values and gave examples of how they were demonstrated through the care they provided.
- The core service also had an additional vision and value of “no door is the wrong door”. This was demonstrated in their strive to work towards a “tier less” child and adolescent service and being able to direct any child or young person to a service that would meet their needs, in order that a person gets to the right service at the right time at the right place.
- Staff knew who the senior managers within the organisation were both at the directorate and executive level.

Good governance

- The managers were aware and concerned about the large amount of patients on long waiting lists. On inspection, we were told it had just been agreed to contract work out to two private companies to offer initial assessments and specific interventions on line. This was due to start in August 2017.
- Staffing capacity was highlighted as a concern on the trust risk register. It had highlighted the potential risks to patients and actions the trust would take to reduce risks. This included employing locums, liaison with commissioners, monitoring of waiting lists and offering substantive staff extra hours.
- A total of 86% of staff were compliant with mandatory training against a trust target of 95%. Staff also received evidence based training for specific interventions.
- Managers’ ensured staff received supervision and appraisals. However, the safeguarding supervision arrangements were not robust. Staff received safeguarding supervision from the trust safeguarding team. However, the system was not robust. The safeguarding database showed that staff accessed safeguarding supervision, however the records did not differentiate between children with child protection plans and children in need. We found that clinical staff

self-selected cases to be discussed at supervision. This is not best practice, as case workers do not necessarily identify high risk cases that require supervision, as demonstrated within the Bristol serious case review published 2017 This lacked oversight from the trusts safeguarding team.

- There were systems in place to report incidents. However, levels of incident reporting were low and staff told us of incidents that they had not reported. Therefore, we were not assured all incidents were reported. Staff told us of some incidents that had not been reported. Therefore we were not assured that lessons were learnt.
- Staff told us the introduction of a new electronic care record recording system was increasing the amount of time they spent on administrative tasks. However, they recognised this would improve as they got used to the new system. This had impacted the most on the single point of entry and contributed to the backlog of referrals created. Managers had responded to this by completing a time in motion study and since requested three extra staff, with one starting the week of inspection. However, we still found a large number of unprocessed referrals. There did not appear to be an ongoing system in place to monitor the timeliness of referrals being processed.
- Clinical staff participated in a wide range of clinical audits and research.
- The service had some key performance indicators set by the commissioners. For example, 18 weeks from referral to assessment, seven day follow ups and urgent psychiatry consultation within five working days. The trust told us they were meeting the seven day follow up and urgent psychiatry consultation targets. However, there were no key performance indicators set for referral to assessment for neurodevelopmental assessments.
- The core service managers were able to access and place items on the trust risk register. We reviewed the register during inspection. Clinical staffing was cited as a risk which may impact upon service provision and safety. We noted there was reference to waiting times for treatment, locum consultants and care pathway implementation. However, we did not see reference to the increased demands and the backlog of referrals within the single point of entry.

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.

- The trust had reviewed each core service within the trust and allocated a set amount of administrative support from administrative central services. Staff told us support from the administrative services was variable. The neurodevelopmental team had not been included in this review as it was a 'new' service. This meant they were not allocated administrative support. To address this one band 5 clinical post was converted into administrative posts to support the clinical staff in maximising clinicians time on direct care activities.
- Mental Capacity Act procedures were being followed where appropriate and competence was considered for children under 16 years of age.
- Managers dealt with complaints where appropriate and guided complainants to make formal complaints through the patient and liaison service where appropriate.
- All staff we spoke with said they could contribute and give feedback regarding service development in the team meetings and the majority felt heard.
- Staff told us about away days and conferences held to evaluate and shape the future of the service. Several staff had attended these, facilitating or contributing to sessions. The majority of staff (83) attended the away day in April 2017. The presentations had been videoed and accessible to all on the trusts website.
- The trust provided staff with opportunities to develop leadership skills. Twelve band 7 staff from the service had completed the trust five day leadership courses. This included mentoring, coaching and investigating officer training. There were opportunities for leadership development through CYP-IAPT programme and the trust.

Leadership, morale and staff engagement

- The sickness rate for the core service was 4.3% between 1 February 2016 and 31 January 2017, which is below the trust target of 4.65% and the overall trust sickness rate of 5.2%.
- There was one reported bullying and harassment case reported. This was being managed by human resources department.
- Staff were open and transparent in their work and felt able to raise issues and concerns without fear of victimisation. They were aware of the whistleblowing process.
- A small number of staff were concerned that the increased workload, waiting list pressures and care pathway transformation plans affected the morale of staff negatively. One member of staff said that managers did not tackle problems at source, but moved staff around the service to deal with bottlenecks for example within the single point of entry, 18 week referral to treatment target time and to support the acute liaison team. Four staff reflected that there were too many changes happening at once and expressed concern about the level of consultation with staff before the change. One staff said it feels chaotic with lots of new initiative starting within months of each other. Managers and team leads we spoke with also reflected on how committed the staff were to the service.

Commitment to quality improvement and innovation

- The core service was a member of the Quality Network for Community Child and Adolescent Mental Health services (QNCC). North Warwickshire services were peer reviewed in November 2016. This is a national peer reviewing programme where staff review other services against a set of national standards in order to share learning and good practice.
- The service had developed an electronic tool called Dimensions. The Dimensions tool is an internet platform on which anyone can rate levels of personal functioning. For example, a parent could rate levels of their child or a teenager could rate themselves. After ratings are completed, it produces a report which aims to signpost the person to the correct service/ intervention. Staff were in the process of completing a second test pilot during the inspection. And they were hoping it would be fully functional within the next few months.
- The eating disorder team had been nominated for a trust quality award.
- The primary mental health team had secured extra funding to offer an enhanced model of service within two schools in Coventry.

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

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- Referrals were not clinically triaged in a timely manner. There was a backlog of 600 referrals waiting clinical triage.
- Waiting times for neurodevelopmental assessments were long
- Internal waiting lists for follow up interventions were long
- Patients mental health and risk were not being regularly reviewed and monitored on the waiting list from initial assessment to treatment.

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The standard operating policy for the single point of entry was incomplete.
- The trust safeguarding policy was not updated to ensure staff were working to current guidelines.
- Staff did not report all incidents. Learning from incidents was limited.