Care Quality Commission

Leicestershire 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)
RT5X1	Leicestershire Partnership NHS Trust, Trust Headquarters, Lakeside House	Children and Adolescent Mental Health Service (CAMHS) county team, Valentine Centre and Loughborough Hospital	LE7 7GX LE11 5JY
RT5X1	Leicestershire Partnership NHS Trust, Trust Headquarters, Lakeside House	Children and Adolescent Mental Health Service (CAMHS) city team, Westcotes Drive	LE3 0QU
RT5X1	Leicestershire Partnership NHS Trust, Trust Headquarters, Lakeside House	Children and Adolescent Mental Health Service (CAMHS) young persons team,Westcotes Drive	LE3 0QU

Summary of findings

RT5X1	Leicestershire Partnership NHS Trust, Trust Headquarters, Lakeside House	Children and Adolescent Mental Health Service (CAMHS) primary mental health service, Valentine Centre	LE7 7GX
RT5X1	Leicestershire Partnership NHS Trust, Trust Headquarters, Lakeside House	Psychosis Intervention and Early Recovery team (PIER), Swithland House andSt Peter's Health centre	LE2 2PL LE2 0TA

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the community mental health services for children and adolescents overall as '**requires improvement**' because:

- We had concerns about how environmental risks at CAMHS community sites were being assessed and managed.
- There had been several serious incidents (SI) within this service in the last year and it was not clear that learning from investigations and actions consistently took place to prevent recurrence. For example relating to assessment of ligature points at Westcotes.
- There had been an increase in the number of CAMHS referrals over the last two years. This impacted on staff's ability to assess and treat young people in a timely manner.
- Across teams risk assessments were not always completed and updated. Some care plans had not been updated and physical healthcare checks were not routinely documented in young people's notes.
- There could be risks posed by the use of different recording systems across teams as staff may not all have access to all records.
- There was a risk that staff did not receive adequate support or that their capability was not reviewed. Effective multi-disciplinary team working and joint working did not always take place across services.
- Staff at the PIER team had not received recent Mental Health Act training.
- The recording of discussions and assessments with people regarding consent to treatment was not always documented.
- There was a risk that young people may not get assessed out of hours in a timely manner by staff with CAMHS experience
- We found that there were often delays in hospital beds being identified with some people placed out of area away from their family, friends and community.

However:

- Staff referred to having reflective practice peer meetings when they were concerned about the risk to a young person.
- Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this effectively. Staff knew how to report any incidents on the trust's electronic reporting system.
- Assessments took place using nationally recognised assessment tools and staff provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence (NICE) guidelines where staffing allowed this.
- Regular team meetings took place and staff told us that they felt supported by colleagues.
- Most people and carers gave positive feedback about staff. Staff gave examples of working with people with diverse needs considering their ethnicity, gender, age and culture.
- PIER staff reported having good links with universities and colleges regarding students needing early intervention services.
- Staff described various ways in which they received information from the board and other governance meetings.

Summary of findings

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

Are services safe?

Inadequate

We rated the community mental health services for children and adolescents for safety as **'inadequate'** because:

- We had concerns about how environmental risks at CAMHS community sites were being risk assessed and managed.
- There had been several serious incidents (SI) within this service in the last year and it was not clear that learning from investigations were embedded at CAMHS teams. For example relating to a serious incident at Westcotes. However meeting minutes did not always capture the learning from incidents and some staff referred to not having feedback in a timely manner.
- There had been an increase in the number of CAMHS referrals over the last two years. This impacted on staff's ability to assess and treat young people in a timely manner.
- We found some areas where the level of mandatory training completion was not meeting the trust standard.
- Risk assessments were not always completed and updated.
- Vacancies in the county administration team had meant there had been delays in sending letters out. This was confirmed by the trust.

However:

- Environments were clean.
- Staff referred to having reflective practice peer meetings where they were concerned about the risk to a young person.
- Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this effectively in practice.
- We saw that CAMHS staff could raise concerns for the trust risk registers. Staff knew how to report incidents on the trust's electronic reporting system.

Are services effective?

Requires improvement

We rated the community mental health services for children and adolescents for effectiveness as **'requires improvement'** because:

- We found some care plans which had not been updated following a change to a person's needs.
- Out of hours staff using an electronic records system did not have access to relevant CAMHS paper records even if a young

Summary of findings

person was at high risk. Staff said there could be delays in receiving this information. MHA documentation at the PIER team was not easily accessible. This could pose a risk that staff would not have access to information about the person.

- Most CAMHS staff did not receive regular supervision and most had not had an appraisal within the last year as per the trust standard. This could mean that staff capability was not reviewed
- We had feedback that effective multi-disciplinary team working and joint working did not always take place across services.
- Staff at the PIER team had not received recent Mental Health Act training to refer to in their work.
- We found that discussions and assessments with young people regarding consent to treatment was not always documented.

However:

- Most assessments and treatment plans were documented in notes and these were reviewed as needs changed.
- Assessments took place using nationally recognised assessment tools and staff provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence (NICE) guidelines where staffing allowed this.
- CAMHS had a review group to monitored outcome measures for young people and had participated in in clinical research.
- CAMHS teams included or had access to a range of mental health disciplines required to care for young people**.**

Are services caring?

Good

We rated the community mental health services for children and adolescents for caring as **'good'** because:

- Most people and carers gave positive feedback about staff.
- Staff used a child friendly approach with young people. Staff showed an understanding of individual needs of people.
- Staff communicated in a calm and professional way and confidentiality was maintained.
- We found that people and carers were encouraged to give their views and were involved in their care. Carers groups were available.
- A 'youth forum' and service user reference forum (SURF) encouraged young people to give their feedback on the trust and influence services.
- The PIER team encouraged people to tell their recovery stories, for example on their website.

However:

Summary of findings

- However, not all treatment records seen captured this involvement. Some care plan details seen did not use age appropriate language.
- Some carers/young people told us that the consistency of care had been affected by staffing changes.

Are services responsive to people's needs?

We rated the community mental health services for children and adolescents for responsiveness as ‘**requires improvement’** because:

- Staff reported an increase in CAMHS referrals and there was an identified risk that young people would not be assessed in a timely way.
- Acute referrals were seen within four weeks however the 13 week routine assessment targets were breached for county and city teams.
- We saw examples of staff needing to arrange acute appointments for young people who had been offered a routine appointment and their situation had deteriorated or were in crisis.
- Staff reported higher caseloads than they expected.
- Systems for transferring people between services were not always responsive.
- There was a risk that young people may not get assessed out of hours in a timely manner by staff with CAMHS experience
- Staff reported there were often delays in hospital beds being identified with some people placed out of area away from their family, friends and community.
- Actions taken in response to the ‘friends and family test’ and complaints feedback were not always evident.

However:

- CAMHS teams offered group work and Saturday clinics to provide earlier intervention to reduce waiting lists.
- Staff had systems for monitoring and contacting people/carers and referrers when they did not attend appointments.
- CAMHS teams had child friendly waiting areas with toys.
- Staff gave examples of working with people with diverse needs considering their ethnicity, gender, age and culture.
- Information was available on their website regarding treatments. The trust website gave details for people to raise ‘Compliments, comments, suggestions, complaints and queries’. Primary mental health team workers offered a professional advisory line (PAS) for professionals to call for advice and information

Requires improvement

Summary of findings

- PIER staff reported having links with universities and colleges regarding students needing early intervention services.

Are services well-led?
We rated the community mental health services for children and adolescents for well led as '**requires improvement'** because:

- CAMHS managers had access to a range of data and it was not evident that this was being used to influence to improve the quality of the service. For example relating to complaints; the family and friends test and learning from incident investigations.
- Some CAMHS staff reported not having the time to attend staff engagement events.
- Information from the trust or other services were discussed at team meetings although CAMHS minutes seen did not always capture this

However:

- Staff morale across teams appeared good. Staff reported opportunities for away day to develop their visions and values in line with the trust.
- Staff referred to, 'ask the boss' and the chief executive giving feedback to staff on issues raised.
- Managers referred to systems for reviewing interagency working with the acute hospital.
- PIER staff were undertaking an access to education and employment study to improve accessibility.

Requires improvement

Summary of findings

Information about the service

- The trust provides specialist community mental health services for young people aged 0 to 18 years who have emotional and/or behavioural difficulties at a level which requires specialist support.
- CAMHS has two tier three teams, city and county. The county team is separated into east and west and is based at two sites. Teams are made up of doctors, nurses and therapists.
- CAMHS sees about 3700 young people a year from around the city and county. The support provided varies according to need, from a one-off appointment to a programme of on-going care. Most appointments are delivered in clinical bases, which differ depending where the young person lives.
- The young people's team works with vulnerable young people in care and those who are involved with the youth offending service. Primary mental health teams work with those children who do not need a specialist tier three service.
- The PIER team has been set up to work especially with people who have experienced a first episode of psychosis (aged 14 to 35 years) for up to three years.
- The CAMHS and PIER teams have not been previously inspected by the Care Quality Commission.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection Managers: Lyn Critchley and Yin Naing

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers, support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected this service consisted of a CQC inspector, a Mental Health Act reviewer, an expert by experience, four specialist professional advisors, a consultant child and adolescent psychiatrist, a nurse, a psychologist and a social worker. All of whom had child and adolescent mental health service or mental health experience.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and trust:

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

Summary of findings

Before visiting, we reviewed a range of information we hold about Leicestershire Partnership NHS Trust and asked other organisations to share what they knew.

We carried out an announced visit between 09 to 13 March 2015. Unannounced inspections were also carried out 23 March 2015.

During the inspection visit the inspection team:

- Visited county and city child and adolescent mental health Services (CAMHS) teams, including the young peoples and primary mental health teams.
- Visited the PIER (psychosis intervention and early recovery) team at both sites.
- Spoke with 15 people using the services.
- Had contact with 13 carers.
- Spoke with 40 staff.
- Reviewed 37 assessment and treatment records of a sample of young people and adults who used the services and the PIER team.
- We observed four appointments with young people and carers and a multi-agency professionals meeting.
- Interviewed Senior Staff. This included a CAMHS Team manager.
- Reviewed ten staff records relating to supervision and appraisals.
- Reviewed a range of policies, procedures and other records relating to the running of this service.
- Observed three team meetings, an on call doctors meeting and a team meeting to discuss eating disorder cases.
- Reviewed information we had asked the trust to provide.

What people who use the provider's services say

- We spoke with people who used these services and carers through individual interviews and we observed four appointments with young people and carers. Most people and carers told us that they were treated with dignity and respect and received good care. They told us that there were opportunities for involving them and their carer's in the service. Some young people and carers told us it was difficult to get support in a timely manner. Several carers told us they had limited support offered to them or information given.
- Some carers and young people told us that the consistency of care had been affected by staffing changes.
- Comments from the friends and family test for this service, August 2014 to January 2015, were often positive. The trust had various ways for people and carers to give feedback and raise queries using social media sites. This showed us that the trust were working to obtain the views of people and their carers and involve them in the provision of this core service.

Good practice

None of significance to note.

Areas for improvement

Action the provider MUST take to improve

Action the trust MUST take to improve

- The trust must review its procedures to ensure that the learning from investigations and actions are embedded in CAMHS teams.
- The trust must review its health and safety assessment procedures at CAMHS sites.
- The trust must review its systems for ensuring staff receive adequate supervision, training and appraisals.
- The trust must review its provision of assessment and treatment of young people to ensure they receive it in a timely manner.
- The trust must review its provision of crisis services for young people to ensure that young people using crisis services have an assessment by appropriately skilled staff to a responsive standard.

Action the provider SHOULD take to improve

Action the trust SHOULD take to improve

Summary of findings

- The trust should review its records systems to ensure staff across teams have access to relevant information about people they work with.
- The trust should review its procedures with commissioners for admitting young people to services and out of area placement arrangements.
- The trust should review its procedures for recording mental capacity and consent to treatment assessments of young people.
- The trust should review its procedures for using the information gained by the trust and feedback from people using the service, staff and others to continuously improve and ensure sustainability of its services.

Care Quality Commission

Leicestershire 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
CAMHS county team, Valentine Centre and Loughborough Hospital	Trust Headquarters
CAMHS city team, Westcotes Drive	Trust Headquarters
CAMHS young person's team, Westcotes Drive	Trust Headquarters
CAMHS primary mental health service, Valentine centre	Trust Headquarters
PIER team Swithland House and St Peter's health centre	Trust Headquarters

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 Trust.

We did not monitor responsibilities under the Mental Health Act (MHA) within CAMHS as during our inspection none of the young people we met were detained.

- Staff contacted the Mental Health Act administrative team if they needed any specific guidance about their roles and responsibilities under the Mental Health Act (MHA) 1983/2007.
- Staff could contact the approved mental health professionals (AMHP) service to co-ordinate assessments under the Mental Health Act 1983/2007.

Detailed findings

- Not all staff training had refresher training on the Mental Health Act 1983/2007 some PIER staff said they would like specific training about this. The PIER manager said staff did not receive specific Mental Health Act training.
- At the PIER team we did not see MHA assessment documentation in files or people being advised of their legal rights under Section132 MHA 1983. However staff indicated they were likely held on the trust electronic records.
- We found at PIER teams meetings that community treatment order (CTO) cases were discussed.

Mental Capacity Act and Deprivation of Liberty Safeguards

The CAMHS service caters for people under 18 years of age so the Deprivation of Liberty Safeguards do not apply.

Staff reported receiving training on the Mental Capacity Act 2005.

We saw use of consent to share information forms in the PIER team and regarding correspondence. We found that the recording of discussions and assessments with people regarding consent to treatment was not always documented.

Inadequate

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

Summary of findings

We rated the community mental health services for children and adolescents for safety as **'inadequate'** because:

- We had concerns about how environmental risks at CAMHS community sites were being risk assessed and managed.
- There had been several serious incidents (SI) within this service in the last year and it was not clear that learning from investigations were embedded at CAMHS teams. For example relating to a serious incident at Westcotes. However meeting minutes did not always capture the learning from incidents and some staff referred to not having feedback in a timely manner.
- There had been an increase in the number of CAMHS referrals over the last two years. This impacted on staff's ability to assess and treat young people in a timely manner.
- We found some areas where the level of mandatory training completion was not meeting the trust standard.
- Risk assessments were not always completed and updated.
- Vacancies in the county administration team had meant there had been delays in sending letters out. This was confirmed by the trust.

However:

- Environments were clean.
- Staff referred to having reflective practice peer meetings where they were concerned about the risk to a young person.
- Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this effectively in practice.
- We saw that CAMHS staff could raise concerns for the trust risk registers. Staff knew how to report incidents on the trust's electronic reporting system.

Our findings

Safe and clean environment

- Staff had areas where they could conduct physical health examination for young people.
- Environments were clean.
- At the Valentine centre and Westcotes sites, staff only areas were not secure and people could walk through to the areas.
- Interview rooms did not have alarms for staff to call others in an emergency or door vision panels that could be accessed. Some staff told us they had access to personal alarms on site if they wanted. They said that individual risk assessments included any concerns for interviewing young people on site. A recent serious incident had occurred at one site and the police were called. Staff told us that the staff member had to leave the room to call emergency assistance indicating there were times when staff needed access to alarms.
- Most teams had not achieved the trust standard for management of actual or potential aggression (MAPA) disengagement training to manage aggression from others.
- We observed a problem with a toilet at the county team of which the manager was not aware. Another staff member told us this was an outstanding repair. The trust had an independent contractor for maintenance.
- At the county team (west) site at Loughborough Hospital, the fire alarm sounded, which designated staff responded to. We saw that staff were aware of the evacuation procedures yet the systems for recording when young people were in the building were not clear. A staff fire warden could not recall when a fire drill had happened in the last year. Staff had not received training to use of the evacuation chair for people with mobility difficulties. Staff told us that they had fire training at the Loughborough site; trust information on training for the county team showed 63% of staff had updated fire safety training which was below the trust standard. We considered that these issues could pose a risk that staff may not have robust procedures for responding in the event of fire in the CAMHS area of the building.

Inadequate

Are services safe?

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

Safe staffing

- The trust had identified staffing levels for teams. A staff member told us there were difficulties recruiting specialty registrar grades (StR) with approximately six vacancies and staff reported vacancies across sites. A locum consultant psychiatrist was covering one who was on long term sick leave and cover was arranged for staff on maternity leave. Trust information on staff vacancies stated 0.7 whole time equivalent (WTE) in the city team; 1.0 WTE in the young persons and primary mental health teams and 1.8 in the county team. Recruitment plans were in place to address shortfalls. The primary mental health team had the highest staff turnover of 13% and 6.3% sickness in the last year. However there were no identified themes.
- A senior manager told us there had been a significant increase in the number of CAMHS referrals over the last two years. The figure is disputed, but we saw that this had impacted on staff's ability to assess and treat young people in a timely manner.
- We found some areas where the level of mandatory training completion was not meeting the trust standard. Several staff reported that due to workload pressure there was not enough time to complete specialist training for their role. This could mean that staff were not receiving adequate training to fulfil their roles.

Assessing and managing risk to patients and staff

- Across county and city teams we could not find any risk assessments in five cases and twelve were not updated. We raised this with staff. Risk assessments in notes took into account historic risks and identified where additional support was required. Staff referred to having reflective practice peer meetings when they were concerned about the risk to a young person.
- Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this effectively in practice. Most staff had completed safeguarding level three training. Staff referred to being able to contact staff using the trust safeguarding telephone line or the trust safeguarding lead. Managers could access details of the number of safeguarding referrals and any identified themes.
- Staff explained systems for monitoring young people on the assessment and treatment waiting list to detect increases in levels of risk.
- Staff were aware of lone working procedures and told us of arrangements such as visiting with a colleague or arranging appointments on site or at satellite clinics. Most staff had access to mobile phones to call support when remote working.
- Administration staff in the county team referred to vacancies and working overtime on Saturday and use of agency staff. Some staff reported difficulties in the sending of letters for example waiting over three weeks. The risk register showed for February 2015, a risk that CAMHS city and county typing was not being completed on time. We saw actions were identified to address this.

Track record on safety

- We saw CAMHS staff could raise concerns for the trust risk registers.
- Staff told us there had been several serious incidents (SI) within this service in the last year.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents on the trust's electronic reporting system. Staff received email bulletins with trust updates and alerts following learning from incidents and to communicate issues for an example after an incident at an inpatient unit. Staff told us incidents were discussed at staff team meetings. However meeting minutes did not always capture this and some staff referred to not having feedback in a timely manner. Some staff told us that they received feedback about the outcome of incidents that had happened and gave some examples. We saw examples of reports and investigations taking place.
- There had been incident of a young person attempting suicide through use of a ligature at the city team site. We saw the SI investigation for this and recommendations had included staff knowing the location of ligature cutters. Reference was also made to there not being an annual ligature assessment. We found areas where ligatures could be used in public areas across sites. The trust policy stated that these were exempt from assessment and individual risk assessment should take place and within care plan there would be an environmental risk assessment recorded. However records reviewed did not state this. Health and safety assessments were not available to see on two sites. Staff told us at Westcotes that the health and safety risk assessment was not updated following the last incident

and we were told that these were held centrally. We considered that due to these issues there was a risk that young people could still self-harm with a ligature on site.

- **PIER team Safe environment**
- Environments were clean.
- Interview rooms had alarms for staff to call others in an emergency or door vision panels that could be accessed.
- Staff told us they undertook individual risk assessments when interviewing people on site or in the community and referred to health and safety audits of the site.
- The team had achieved the trust standard with 86% staff completing for management of actual or potential aggression (MAPA) disengagement training.
- **Safe staffing**

- There were 35 staff and two WTE staff vacancies. Recruitment plans were in place to address shortfalls.
- There was an identified CAMHS worker. Staff told us there used to be a child and adolescent psychiatrist giving input as recommended by national guidelines but that ceased.
- For the last year, the average staff sickness was 5.4% which is above the average for mental health and learning disability trusts in England. There were not identifiable themes.
- **Assessing and managing risk to patients and staff**

- Each person had an individual risk assessment except for one person**.** The majority had been reviewed by the multi-disciplinary team as per the trust standard except one which had not been updated since 2013 which staff agreed should have been updated. Risk assessments took into account historic risks and identified where additional support was required. When appropriate staff created and made use of contingency plans.
- Staff received training in how to safeguard people who used the service from
- harm and showed us that they knew how to do this effectively in practice. Staff said they could call the trust safeguarding advice line for support and guidance. 96% of staff had completed safeguarding adults alert and level two safeguarding children training.

- Staff were aware of lone working procedures and told us of arrangements they made. Staff had access to mobile phones to keep in contact with colleagues and use in crisis and were due to get laptops to access records when remote working.
- **Track record on safety**

- Staff could raise concerns for the trust risk registers.
- Staff told us there had been several serious incidents (SI) within this service in the last year.
- **Reporting incidents and learning from when things go wrong**

- Staff knew how to report incidents on the trust's electronic reporting system.
- We saw an email bulletin with trust updates, 'Quality matters' was sent to staff following learning from incidents across the trust to communicate issues. Staff told us incidents were discussed at staff team meetings and we saw evidence of this. Staff told us that they received feedback about the outcome of incidents that had happened and gave some examples. We saw examples of investigations and reports taking place. Staff told us that they could have debriefs after incidents, although one staff was not aware of this. The manager said staff had access to counselling services as required. A 'clinical validation project' February 2014 reviewed SIs with lessons learnt and identified actions where relevant.

Are services effective?

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.

Summary of findings

We rated the community mental health services for children and adolescents for safety as **'inadequate'** because:

- We had concerns about how environmental risks at CAMHS community sites were being risk assessed and managed.
- There had been several serious incidents (SI) within this service in the last year and it was not clear that learning from investigations were embedded at CAMHS teams. For example relating to a serious incident at Westcotes. However meeting minutes did not always capture the learning from incidents and some staff referred to not having feedback in a timely manner.
- We found some areas where the level of mandatory training completion was not meeting the trust standard.
- Risk assessments were not always completed and updated.
- Vacancies in the county administration team had meant there had been delays in sending letters out. This was confirmed by the trust.

However:

- Environments were clean.
- Staff referred to having reflective practice peer meetings where they were concerned about the risk to a young person.
- Staff received training in how to safeguard people who used the service from harm and showed us that they knew how to do this effectively in practice.
- We saw that CAMHS staff could raise concerns for the trust risk registers. Staff knew how to report incidents on the trust's electronic reporting system.

Our findings

Assessment of needs and planning of care

- Most assessments and treatment plans were documented in notes and these were reviewed as needs changed. We found one care plan in the county team which had not been updated following a change to a person's needs.
- CAMHS staff had a system for assessing young people with mental health needs on acute hospital paediatric wards in the week.
- Out of hours staff using an electronic records system did not have access to CAMHS paper records. This could pose a risk that staff would not have access to information about the person.
- We found examples of staff using the common assessment for families with other agencies

Best practice in treatment and care

- Assessments took place using nationally recognised assessment tools including the Paddington complexity scale (PCS) and the Health of the Nation Outcome Scales Child and Adolescent Mental Health (HONOSCA).
- Staff provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence (NICE) such as cognitive behavioural therapy, dialectical behavioural therapy, family therapy and interpersonal psychotherapy.
- NICE guidance was followed when prescribing medication for individuals.
- CAHMS had a review group which monitored outcome measures for young people and staff used the 'child outcomes research consortium' to rate their service and measure improvements for young people.
- CAMHS staff had participated in in clinical research. For example, relating to attention deficit hyperactivity disorder.

Skilled staff to deliver care

- CAMHS teams included or had access to a range of mental health disciplines required to care for young people**.**
- Systems were in place for new or temporary staff to receive inductions to the trust and the service.
- Staff reported receiving supervision opportunities as well as peer supervision and yearly appraisals.Trust records showed since December 2014 most staff were not receiving regular supervision as per the trust standard. For example 18% in the city team, 28% the primary mental health team, 33% the county team, 45% the young person's team. A manager told us that staff were being encouraged to log their supervision dates on the trust electronic database to more effectively monitor this. We did not see other plans to address this shortfall. Supervision recording and structure was not standardised across CAMHS with variable quality.

Are services effective?

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.

- Most staff had not had an appraisal within the last year. For example most teams showed less than 50% across teams except the primary mental health team with 78%. This could mean that staff were not receiving adequate support or that their capability was reviewed.
- Training records seen showed the majority of staff were up to date with mandatory training identified by the trust. However most teams were not achieving the trust standard for information governance. Five teams had not achieved the standard for 'adult and paediatric life support', which could mean that staff may not have the most up to date skills.
- Most staff reported opportunities for specialist training for their role and had continuous professional development (CPD) as part of maintaining their professional registration with examples given. However several staff reported said that due to workload pressure there was not enough time to complete this.
- Regular team meetings took place and staff told us that they felt supported by colleagues.
- Trainees in child psychotherapy were on placement with the teams.

Multi-disciplinary and inter-agency team work

- Staff gave examples of effective multi-disciplinary team working and joint working across services. There were assessment and treatment handovers between teams within the trust such as out of hour's crisis services. Two staff said there could be delays in receiving this information. Additionally staff liaised with other agencies such as in patient units, GP's, PIER team. We received feedback from CAMHS staff, some school nurses, mental health and acute hospital staff that there were difficulties accessing CAMHS for assessment. A manager told us that the relationship with acute hospitals was poor. Operational group meeting minutes referred to developing joint working arrangements with substance misuse services. Staff across teams expressed frustration about their ability to liaise effectively with the local authority which they had escalated to managers.
- CAMHS had small teams of staff working with young people with an eating disorder and also autistic spectrum disorder (ASD).

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

- Staff contacted the Mental Health Act administrative team if they needed specific guidance about their roles and responsibilities under the Mental Health Act (MHA) 1983/2007.
- Staff could contact the approved mental health professionals (AMHP) service to co-ordinate assessments under the Mental Health Act 1983.
- Staff reported receiving training on the Mental Health Act however training records seen did not indicate staff had refresher training.
- During our inspection we did not review any notes or speak with any young people who were subject to a community treatment order or guardianship.

Consent

- Staff reported receiving training on the Mental Capacity Act 2005 within safeguarding training.
- We found that discussions and assessments with young people regarding consent to treatment were not always documented.

PIER team

Assessment of needs and planning of care

- Assessments and treatment plans were documented and these were reviewed as needs changed. For one person we could not find a care plan. Another person's assessment had not been updated since 2013, although was reviewed in June 2014, which staff agreed should have been updated.
- Physical healthcare checks were not routinely documented in people's notes.
- Teams held paper records but were moving to an electronic records system in May 2015 so as to easily access other team's notes. Out of hour's staff using an electronic records system did not have access to other teams paper records if a person was at high risk. This could pose a risk that staff would not have access to information about the person.

Best practice in treatment and care

- Staff provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence (NICE) such as cognitive behavioural therapy (CBT) and Interpersonal Psychotherapy (IPT).

Are services effective?

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 referenced the cross agency best practice guidance 'No Health Without Mental Health: Implementation Framework.' Most people received a service up to three years then if required transferred usually to adult services in line with NICE guidance.
- Assessments took place using nationally recognised assessment tools including the Health of the Nation Outcome Scales (HONOS) and the Steve Morgan risk management tool

Skilled staff to deliver care

- Teams included or had access to a range of mental health disciplines required to provide treatment for people.
- Systems were in place for new or temporary staff to receive induction to the trust and the service.
- Staff reported receiving supervision opportunities as well as peer supervision and yearly appraisals. Trust records showed since December 2014 most staff were not receiving regular supervision as per the trust standard with 62% compliance. A manager told us that staff were being encouraged to log their supervision dates on the trust electronic database to more effectively monitor this. Which staff confirmed and we saw evidence of this. Supervision recording and structure was not standardised but those seen were adequate.
- Most staff had an appraisal within the last year with trust information showing 85% compliance.
- Most staff reported opportunities for specialist training for their role and had continuous professional development (CPD) as part of maintaining their professional registration with examples given.

Multi-disciplinary and inter-agency team work

- Staff reported effective multi-disciplinary team working. However several staff reported difficulties with assessment and treatment handovers between teams within the trust such as crisis, CAMHS, forensic adult and inpatient teams
- Staff told us that there had been a two years delay in transferring a person to adult services due to the other teams' lack of capacity to take on new work. This meant that staff were sometimes keeping people for treatment longer than up to three years that was expected.
- Additionally staff liaised with other agencies such as acute hospitals and GP's. Staff across teams expressed frustration with their inability to liaise effectively with the local authority.

Adherence to the MHA and the MHA Code of Practice

- Staff contacted the Mental Health Act administrative team if they needed specific guidance about their roles and responsibilities under the Mental Health Act (MHA) 1983/2007.
- Staff could contact the approved mental health professionals (AMHP) service to co-ordinate assessments under the Mental Health Act 1983.
- The manager said staff did not receive Mental Health Act training.
- During our inspection we reviewed notes relating to two people who were subject to a CTO. We did not see documentation of their legal rights under section 132 MHA 1983. However staff indicated they were likely held on the trust electronic records. Staff said they would like specific training about this.
- We found at teams meetings that CTO cases were discussed.
- We saw copies of MHA assessment documentation in files except for one person who had several detentions including January 2015.

Consent

- Staff reported receiving training on the Mental Capacity Act 2005 within safeguarding training.
- We saw use of consent to share information forms and regarding correspondence. We found that discussions and assessments with people regarding consent to treatment were not always documented.

Are services caring?

Good

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

Summary of findings

We rated the community mental health services for children and adolescents for caring as **'good'** because:

- Most people and carers gave positive feedback about staff.
- Staff used a child friendly approach with young people. Staff showed an understanding of individual needs of people.
- Staff communicated in a calm and professional way and confidentiality was maintained.
- We found that people and carers were encouraged to give their views and were involved in their care. Carers groups were available.
- A 'youth forum' and service user reference forum (SURF) encouraged young people to give their feedback on the trust and influence services.
- The PIER team encouraged people to tell their recovery stories, for example on their website.

However:

- However, not all treatment records seen captured this involvement. Some care plan details seen did not use age appropriate language.
- Some carers/young people told us that the consistency of care had been affected by staffing changes.

Our findings

Kindness, dignity, respect and support

- Most young people and carers reported they were treated with dignity and respect and gave positive feedback about staff.
- Staff spoke about young people in a caring and compassionate manner and used a child friendly approach.
- Carers gave feedback of helpful reception staff at the Loughborough hospital site county team.
- We observed interactions with staff and young people and carers using the service and found that staff communicated in a calm and professional way and confidentiality was maintained. Staff showed an understanding of individual needs of young people.
- We saw that teams had received mostly positive feedback from the 'Family and friends' test results.

The involvement of people in the care that they receive

- Young people and carers were encouraged to give their views and were involved in their care. However most treatment records seen did not always capture this involvement and did not detail if the young person or their carer had received a copy of their care plan. Four carers told us they were not aware of the treatment plans for their child. Some care plan details seen did not use age appropriate language.
- Some carers/young people told us that the consistency of care had been affected by staffing changes.
- Information was available regarding treatments such as for CBT for young people and carers
- Several carers told us they had limited support offered to them or information given.
- The trust website for CAMHS gave details of advocacy support and other information for young people and carers. However the 'Parent carer council' website link was unobtainable.
- The trust website detailed ways for people to give feedback and raise queries using social media sites such as twitter. Staff referred to a 'youth forum' which encouraged young people to give their feedback on the trust and influence services. In March 2014, the trust launched a 'Health for Teens' website developed 80 young people from Leicestershire's secondary schools to give information on physical and mental health issues.
- The trust had a 'Patient and Carers Experience Group' which had carer representation and a staff representative from the division.

PIER team

Kindness, dignity, respect and compassion

- People reported they were treated with dignity and respect and gave positive feedback about staff. We observed interactions with staff and people and carers using the service and found that staff communicated in a calm and professional way and confidentiality was maintained.
- Staff spoke about people in a caring and compassionate manner.

Are services caring?

Good

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

- Staff showed an understanding of individual needs of people. Staff gave people a choice of gender when allocating workers.
- We saw that the team had received some positive feedback from the 'family and friends' test results and compliments.

The involvement of people in the care they receive

- We found that people and carers were encouraged to give their views and were involved in their care. However most treatment records seen did not always capture this involvement. We saw evidence of people being offered their care plans to sign.
- Staff referred to the service user reference forum which encouraged people to give their feedback on the trust and influence services.
- The trust had a 'patients and carers experience group' which had patient and carer representation and a staff representative from the division.
- A carers group took place at the weekend.
- The trust website detailed ways for people to give feedback and raise queries using social media sites such as twitter. The PIER website had links to information and site for people. This included people's recovery stories, such as, 'my journey from psychosis to psychology' which had also been reported on in a local newspaper.

Are services responsive to people's needs?

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

Summary of findings

We rated the community mental health services for children and adolescents for responsiveness as '**requires improvement'** because:

- Staff reported an increase in CAMHS referrals and there was an identified risk that young people would not be assessed in a timely way.
- Acute referrals were seen within four weeks however the 13 week routine assessment targets were breached for county and city teams.
- We saw examples of staff needing to arrange acute appointments for young people who had been offered a routine appointment and their situation had deteriorated or were in crisis.
- Staff reported higher caseloads than they expected.
- Systems for transferring people between services were not always responsive.
- There was a risk that young people may not get assessed out of hours in a timely manner by staff with CAMHS experience
- Staff reported there were often delays in hospital beds being identified with some people placed out of area away from their family, friends and community.
- Actions taken in response to the 'friends and family test' and complaints feedback were not always evident.

However:

- CAMHS teams offered group work and Saturday clinics to provide earlier intervention to reduce waiting lists.
- Staff had systems for monitoring and contacting people/carers and referrers when they did not attend appointments.
- CAMHS teams had child friendly waiting areas with toys.
- Staff gave examples of working with people with diverse needs considering their ethnicity, gender, age and culture.
- Information was available on their website regarding treatments. The trust website gave details for people to raise 'Compliments, comments, suggestions, complaints and queries'. Primary mental health team workers offered a professional advisory line (PAS) for professionals to call for advice and information
- PIER staff reported having links with universities and colleges regarding students needing early intervention services.

Our findings

Access and discharge

- Referrals were made through a single point of contact. Allocated staff screened the referral and then the single point of access team meetings screened them, to determine the most appropriate course of action. There were processes for responding to emergency, urgent, acute and routine referrals within identified time frames. Teams had systems for monitoring referral and waiting lists.
- Staff reported an increase in referrals over the last year. A risk that young people would not be assessed in a timely way was entered on the February 2015 risk register. This was confirmed by the trust chief executive. A manager said all acute referrals were seen within four weeks however the 13 week routine assessment targets were breached for county and city teams. Trust information as of January 2015 showed 97 young people had been seen less than 13 weeks and 42 were seen outside that time. The manager in the young people team said they were now meeting the 13 week standard and acute referrals were seen within two weeks. The primary mental health team in the county had 75 referrals waiting for assessment as of December 2014.
- We saw examples of staff needing to arrange acute appointments for young people who had been offered a routine appointment and their situation had deteriorated or were in crisis, one person had been waiting 39 weeks. One carer told us their child was referred as urgent and had no contact until after four weeks. They waited treatment for seven months after assessment.
- Two staff told us there were difficulties managing to see acute referrals. Several staff told us that sometimes acute referrals were received which were routine and

this impacted on the waiting list. Staff and carers referred to long waiting times for example over seven months to start treatment. This meant that young people were not always able to access assessment and treatment in a timely way and there was a risk that a young person's mental health may deteriorate further.

- CAMHS teams offered group work to provide earlier intervention and reduce the need for specialist intervention services. Saturday clinics were being offered to reduce waiting lists.
- Three staff also told us that once assessed there were difficulties with carrying out reviews and follow up appointments. This was confirmed by information on the trust risk register.
- There were systems to monitor when young people had a follow up appointment within six months.
- The trust informed us that all young people accepted for treatment are allocated a worker as per service protocol.
- One doctor told us they had a caseload of 335 young people to be seen, another staff member said they had 55 cases when they should have a caseload of 25, a primary mental health worker said they had13 cases whereas the caseload limit was 10.
- We learnt that there may be difficulties with transferring young people to adult services as 45 people were over 18 years.
- Staff had systems for monitoring and contacting young people/carers and referrers when they did not attend appointments.
- This service was not commissioned to provide a 24 hour service. Out of hours, the psychiatric liaison service could be contacted. A consultant CAMHS psychiatrist was available for telephone advice.
- Two carers for children with ASD told us there were difficulties accessing this service. Also we received feedback from an acute hospital staff member with concerns about the length of time waiting for assessments. Some young people told us that they could only get help in crisis and were not signposted to services after completing groups.These issues meant that young people may not get assessed in a timely manner by staff with CAMHS experience.
- Teams had systems for assessing people in acute hospitals and offer follow up appointments after seven days. Staff told us there had been an increase in the number of young people presenting in acute hospitals, 113 in 2013 and 354 in 2014.
- There was an identified referral pathway for requesting hospital admission and staff reported there were often delays in hospital beds being identified with some young people placed out of area away from their family, friends and community.
- A manager told us that the trust was liaising with commissioners regarding developing an intensive support team within CAMHS.
- Primary mental health team workers offered a professional advisory line (PAS) for professionals to call for advice and information.

The facilities promote recovery, comfort, dignity and confidentiality

- Offices and environments varied across the teams visited. None were purpose built.
- Sites were accessible for wheelchair users although at Loughborough hospital site the disabled toilet was away from the CAMHS area although there was a designated children's toilet.
- Appointments were offered at site premises or other venues as required. Interview rooms at the county and city team sites were limited and we found doctors were seeing young people in their offices.
- Teams had child friendly waiting areas with toys with processes for cleaning. The Valentine centre reception was being redesigned and young people had been involved in choosing the décor.
- The county team Loughborough site shared a reception area with other trust services. This meant young people shared waiting areas with adults which could pose risks.
- There was a lack of leaflets and service information displayed for young people and carers available across team sites.

Meeting the needs of all people who use the service

- Staff gave examples of working with people with diverse needs considering their ethnicity, gender, age and culture.
- Staff showed us systems for arranging interpreters and/or signers to assist with communicating with young people and carers as required.
- Staff were allocated to a rota to respond to self-harm 9am to 5pm, five days per week.

Are services responsive to people's needs?

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

Listening to and learning from concerns and complaints

- Most sites had complaints information displayed, however we saw comments boxes and the 'friends and family test' cards/consoles. Comments from the friends and family test, August 2014 - January 2015, were mixed. Three gave negative feedback regarding the environment and cleanliness. Some feedback related to not receiving timely appointments. A manager told us that feedback was reviewed and actions taken however we did not see that this was documented.
- The trust website gave details for people to raised 'compliments, comments, suggestions, complaints and queries'. A 'complaints, concerns, comments, compliments and enquiries annual report 2013-14'. identified CAMHS were in the top five services for the highest number of complaints.
- Operational group meeting minutes for September and October 2014 indicted that there had been an increase of complaints and concerns into the CAMHS. Themes identified included referral criteria, communication and waiting times. It was not evident how individual teams had used this information to be able to give feedback to teams and develop their service. A senior manager said that people were given a response.
- One carer contacted us with concerns about the timeliness of the trust responding to their complaint. The trust informed us that six complaints were reported since December 2014. Themes included waiting times, communication and treatment. One had been upheld and the others had investigations continuing.
- **PIER team -**
  Access, discharge and transfer

- Allocated staff screened referrals and this was discussed at weekly team meetings to determine the most appropriate course of action. The manager told us there were currently no waiting lists for assessment and treatment.
- Out of hours, the psychiatric liaison service could be contacted or the crisis team however staff reported this could be difficult to access.
- There was an identified referral pathway for requesting hospital admission. Staff reported there were often delays in beds being identified for young people or adults. Examples were given including a young person spending 24 hours in police custody until one was sourced or people being placed out of area making it difficult for family, friends and staff to have contact.
- Teams had systems for monitoring and contacting people/carers and referrers when people did not attend appointments.
- The manager said that caseloads ranged from on average 16 to 17 whereas the national recommendation was 15. Some staff had had higher caseloads. The manager said that staff had been lost over time to cost improvement plans.
- Two staff reported problems with transferring people to adult and forensic services which they had escalated to managers.
- **The facilities promote recovery, dignity and confidentiality**

- Offices and environments varied across the teams. The team was split over two sites and staff at Swithland were planning to move to the St Peters site.
- Staff reported sites were more easily accessible for people in the east but not for the west. However people could be seen in their own homes or other sites. Sites were accessible for wheelchair users.
- Leaflets and service information for people and carers were available across team sites.
- **Meeting the needs of all people who use the service**

- Staff said there was access to specialist services if people using the service required specific help. For example crisis services.
- Staff gave examples of working with people with diverse needs considering their ethnicity, gender, age and culture. Staff showed us systems for arranging interpreters and/or signers to assist with communicating with people and carers as required.
- Saturday and evening clinics were offered to give people options for appointment times.
- The trust had a recovery college which people could enrol at as part of treatment and recovery.
- Staff reported having links with universities and colleges regarding students needing early intervention services.
- **Listening to and learning from concerns and complaints**

Are services responsive to people's needs?

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

- Across site there were complaints information displayed, comments boxes and the 'friends and family test' cards. Comments from the friends and family test, August 2014 - January 2015, were often positive.
- The trust website gave details for people to raised 'Compliments, comments, suggestions, complaints and queries'. The manager told us there had been no complaints in the last year but had systems for tracking these as required.

Are services well-led?

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.

Summary of findings

We rated the community mental health services for children and adolescents for well led as '**requires improvement'** because:

- CAMHS managers had access to a range of data and it was not evident that this was being used to influence to improve the quality of the service. For example relating to complaints; the family and friends test and learning from incident investigations.
- Some CAMHS staff reported not having the time to attend staff engagement events.
- Information from the trust or other services were discussed at team meetings although CAMHS minutes seen did not always capture this

However:

- Staff morale across teams appeared good. Staff reported opportunities for away day to develop their visions and values in line with the trust.
- Staff referred to, 'ask the boss' and the chief executive giving feedback to staff on issues raised.
- Managers referred to systems for reviewing interagency working with the acute hospital.
- PIER staff were undertaking an access to education and employment study to improve accessibility.

Our findings

Vision and values

- Information on the trust's vision and values were available across teams and staff appraisals were linked. Staff knew who the most senior managers in the trust were although could not show an organisational chart. The chief executive had visited some teams. Staff reported opportunities for away day to develop their visions and values in line with the trust.
- A tier three service review was taking place with staff engagement and 'listening into action' sessions. Although some staff reported having difficulties to have the time to attend. This was following a review by commissioners following concerns from GPs regarding waiting times and openness.
- Staff referred to, 'ask the boss' and the chief executive giving feedback to staff on issues raised.

Good governance

- Staff described various ways in which they received information from the trust board and other governance meetings.
- A monthly 'CAMHS ops group meeting' took place with managers and a 'families, young people and children's services, communities and youth services sub-divisional management team' monthly meeting took place with CAMHS representation.
- Information from the trust or other services were discussed at team meetings although minutes seen did not always capture this.
- Managers had access to trust data such as assessment and treatment waiting times to gauge the performance of the team and compare against others. However, it was not evident how this improved outcomes. These governance systems included the trust's electronic staff training record.
- Staff received emails and newsletters from the trust giving updates on trust developments.
- Managers referred to systems for reviewing interagency working with the acute hospital.

Leadership, morale and staff engagement

- A service manager and other manager posts in the city team had changed in the last six months.

- Staff morale across teams appeared good.
- Staff said their manager/supervisor was accessible for advice and guidance as required. Staff said they would approach their manager if they had any concerns and were aware of the trust whistleblowing policy.
- The trust had a human resources department and referred staff to occupational health services where applicable.

Commitment to quality improvement and innovation

- Teams had qualified non-medical prescribers.
- The city team had undertaken an audit of the referral management following a CAMHS tier three review to identify patterns and themes for referrals.
- However we had concerns about this core service being well led as managers had access to a range of data and it was not evident that this was being used to influence to improve the quality of the service. For example relating to complaints; the family and friends test and learning from incident investigations.

Are services well-led?

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.

- **PIER team - Vision and values**

- Information on the trust's vision and values were available across teams and staff appraisals were linked to them.
- Staff knew who the most senior managers in the trust were.
- Staff reported opportunities for away days to develop their visions and values in line with the trust.
- **Good governance**

- Staff described various ways in which they received information from the trust board and other governance meetings.
- A 'families, young people and children's services, communities and youth services sub-divisional management team' monthly meeting took place with PIER staff representation.
- Managers had access to trust data such as assessment and treatment waiting times to gauge the performance of the team and compare against others. Information from the trust or other services was discussed at team meetings and we saw clear examples of disseminating information to develop the service. Staff received emails and newsletters from the trust giving updates on trust developments.
- **Leadership, morale and staff engagement**

- Staff morale was good. Staff said they would approach their manager if they had any concerns and were aware of the trust whistleblowing policy. Staff said their manager/supervisor was accessible for advice and guidance as required.
- The trust had a human resources department and referred staff to occupational health services where applicable.
- Staff referred to, 'ask the boss' and the chief executive giving feedback to staff on issues raised.
- **Commitment to quality improvement and innovation**

- We saw quarterly FYPC 'quality of services division progress reports' which identified incidents by teams and enquiries.
- We saw that staff were undertaking an access to education and employment study so as to improve the accessibility.
- The team had qualified non-medical prescribers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not being protected against the risks of receiving care or treatment that is inappropriate or unsafe. The trust had not review its provision of assessment and treatment to young people to ensure they receive it in a timely manner This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The trust did not protect people against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. The trust had not reviewed its provision of crisis services for young people to ensure that young people using crisis services have an assessment by appropriately skilled staff to a responsive standard. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The trust did not protect people, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. And where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a trust should be aware, relating to the analysis of incidents that resulted in, or had the potential to result in, harm to a person. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The trust had not made suitable arrangements to ensure that staff were appropriately supported in relation to their responsibilities, including receiving appropriate training, professional development, supervision and appraisal. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.