Requires improvement

Plymouth Community Healthcare CIC

Specialist community mental health services for children and young people

Quality Report

Local Care Centre
Mount Gould Hospital
Plymouth
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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)
1-297622270	Plymouth Community Healthcare CIC	Community CAMHS multi-disciplinary team	PL4 7QD
1-297622270	Plymouth Community Healthcare CIC	CAMHS severe learning disability service	PL4 7QD
1-297622270	Plymouth Community Healthcare CIC	CAMHS Neurodevelopmental Team	PL4 7QD
1-297622270	Plymouth Community Healthcare CIC	CAMHS Crisis Outreach Team	PL4 7QD
1-297622270	Plymouth Community Healthcare CIC	CAMHS Primary Mental Health Team	PL4 7QD

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC, also known as Livewell Southwest. 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 Plymouth Community Healthcare CIC and these are brought together to inform our overall judgement of Plymouth Community Healthcare CIC.

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?	**Good** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Overall summary

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

- An agency worker was working with children and young people without a disclosure and barring check.
- Waiting times to access most services were very long for many patients. The provider was not transparent in the way it reported waiting times for treatment.
- The complaints process was not promoted to people effectively and concerns of parents and carers were not always listened to.
- Staff were not following the lone worker policy consistently.
- When assessments of mental capacity for young people aged 16 and over were required, these were not properly recorded and compliance with the Mental Capacity Act was not monitored.
- Some carers felt they had been ignored and this had led to them making a complaint.

However:

- Services were provided by well trained staff with a wide range of specialisms.
- Effective systems were in place to make sure that the most urgent needs were dealt with quickly.
- Managers and staff were committed to improving the service through new therapies and better relationships with other services.
- The provider showed evidence of learning from incidents that affect patient safety.
- Care plans were prepared in partnership with young people and their carers

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- A psychiatrist or paediatrician was always available for urgent appointments.
- Staff were trained in safeguarding children, emergency first aid, resuscitation and fire safety.
- Staff understood how to report a serious safety issue or incident and were aware of how such incidents would be managed.
- The provider showed evidence of learning from incidents that affect patient safety.
- The service had low levels of staff sickness. Short periods of staff sickness were well managed so that children and young people continued to receive a service.
- Premises and equipment were well maintained and any problems were addressed promptly.

However:

- Two out of 14 records did not have a current or up to date risk assessment.
- Staff were not following the lone worker policy consistently.
- Signs were not in place in one of the consulting rooms to inform people that audio and video monitoring and recording could be taking place.

Are services effective?

Good

We rated effective as good because:

- Staff had a wide range of assessment tools that they used skilfully to identify patients' needs.
- There was a range of National Institute for Health and Care Excellence approved therapies available to patients and these were well matched to patient needs.
- Staff had access to supervision and training that supported their professional development.
- The provider regularly reviewed the skills within the team and recruited staff to meet the needs of the patient group. For example the recruitment of a speech and language therapist was ongoing at the time of the inspection.
- The service had developed positive partnerships with families and other agencies, such as education and social care to support the young people using the service.

However:

Summary of findings

- When assessments of mental capacity for young people aged 16 and over were required, these were not properly recorded and compliance with the Mental Capacity Act was not monitored.
- Staff were not always aware of the CAMHS community policy on consent for children aged 11 or over.
- Care plans were not always stored on the main electronic record and so were not available to all key staff within the service.
- Staff did not receive up to date training on assessing the mental capacity and Gillick competence of children and young people.

Are services caring?

Good

We rated caring as good because:

- Children, young people and their carers told us that the service they received was supportive and that all staff treated them with dignity and respect.
- People felt fully involved in their care, including the creation of their care plans.
- Young people told us that doctors took time to explain things to them, and were never in a rush to finish appointments.
- We observed that staff were empathetic, supportive and promoted people's ability to take the lead in deciding on their treatment and care.

However:

- Some carers felt they had been ignored and this had led to them making a complaint.
- The service did not provide access to independent advocates, who could support children and young people to make their views known.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Families and clinicians reported long waiting times for specialist treatment. The provider was recording initial assessment as the start of treatment, even though people were placed on waiting lists for specialist treatment following initial assessment. The provider was not reporting this second wait as part of people's waiting times, so key performance indicators were not reflecting the true experience of children and young people.

Summary of findings

- When key workers were seconded to other work or on long term leave, carers found it difficult to get support for their child from the team.
- Some carers were unhappy with the way the service responded in times of crisis.
- The service did not operate an effective complaints procedure as four out of eight carers we spoke with did not know how to make a formal complaint.
- The provider did not make discharge planning a key part of its care planning process.

However:

- Young people in crisis were seen by the crisis and outreach team within 24 hrs and most of this group were assessed within a week of referral.
- The service was accessible to people with impaired mobility, including wheelchair users.
- The service had access to translation and interpreting service and was able to prepare easy read information for people with communication needs.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff did not actively inform carers, children and young people about how to raise concerns or complaints should they wish to. Some carers reported poor responses from managers to their informal complaints.
- An agency worker was working with children and young people without a disclosure and barring check.
- The provider was not transparent and open with regard to waiting times for treatment.

However:

- Staff were aware of the goals of the service and were committed to them.
- Staff were confident in the management team.
- Good systems were in place to manage safeguarding children, safety incidents and maintenance needs.

Summary of findings

Information about the service

Plymouth Community Healthcare CIC provided a wide range of community based child and adolescent mental health services (CAMHS) across the city of Plymouth. The service had the following specialist teams:

- The CAMHS community service based at the Revive building at Mount Gould hospital.
- The neuro-developmental team, which included a day service for assessment of autistic spectrum condition based at Mount Gould hospital.
- The severe learning disability team based at Mount Gould hospital.
- The crisis and outreach team that supported children and young people to minimise hospital admissions.
- The primary mental health team which worked with GPs, schools and other agencies to identify and support mental health issues based at Plym Bridge house.
- The children in care team were based with local children's services at Midland House.
- The infant mental health team for under-5s at Tamar Folk children's centre

We did not review the children in care team or the infant mental health team as part of this inspection.

Our inspection team

The inspection team was led by:

Chair: Andy Brogan, executive director of nursing, South Essex Partnership Trust

Head of Hospital Inspections: Pauline Carpenter, Care Quality Commission

Inspection manager: Nigel Timmins

The team that inspected this core service comprised of two CQC inspectors, a social worker and a specialist child and adolescent mental health nurse.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information and feedback.

During the inspection visit, the inspection team:

- visited five teams and looked at the quality of environments;
- spoke with three young people and eight parents or other carers of patients who were using the service;
- collected feedback from seven patients and carers using comment cards;
- spoke with the team leaders for each of the teams;
- spoke with 16 other staff members; including doctors, nurses and therapists and collected feedback from one member of staff using a comment card;
- interviewed the modern matron and locality manager with responsibility for these services;

Summary of findings

- attended and observed four multi disciplinary meetings involving clinical case discussions;
- attended and observed two consultations with patients and two consultations with carers of patients;
- looked at 14 treatment records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with three young people and eight parents. We also received seven comment cards. Responses were mixed with half of the people totally positive in their comments.

Overall, young people and their carers expressed satisfaction with the therapy and treatment once they had been triaged and accepted into the service. However, seven carers and young people told us that waiting times were too long to access the correct treatment.

Four carers told us that the CAMHS multi disciplinary team had not always responded to concerns raised about children and young people. Arrangements to provide an alternative contact when the keyworker was not available were not in place. Two carers had complained about this when the keyworker was not available and had not received a satisfactory response. This had resulted in complaints to managers.

Good practice

The neuro development team were piloting a parenting skills course, Ascend, for parents of children with autistic spectrum conditions (ASC). As current practice within CAMHS teams nationally is only to diagnose ASC and then offer advice, this was a significant addition to what would be expected from similar services.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff assess young people promptly after they have been referred and are transparent with people about waiting times.
- The provider must ensure that all staff including agency staff have current DBS checks in place before commencing work with children and young people.
- The provider must operate an effective complaints procedure.

Action the provider SHOULD take to improve

- The provider should ensure risk assessments are up to date and cover known risks for the people the provider supports, particularly people with severe learning disabilities.
- The provider should ensure that care plans are accessible to all relevant staff.
- The provider should ensure that the lone working policy is implemented including staff carrying appropriate alarms.
- The provider should ensure signs are in place so that people are aware when audio and video monitoring is taking place.
- The provider should ensure staff have training to understand mental capacity, Gillick competence, Fraser guidelines and best interest decision making.
- The provider should ensure that discharge planning is a key part of treatment and support plans.

Plymouth Community Healthcare CIC

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
Community CAMHS multi-disciplinary team	Plymouth Community Healthcare CIC Head Office
CAMHS severe learning disability service	Plymouth Community Healthcare CIC Head Office
CAMHS neurodevelopmental Team	Plymouth Community Healthcare CIC Head Office
CAMHS crisis outreach team	Plymouth Community Healthcare CIC Head Office
CAMHS primary mental health team	Plymouth Community Healthcare CIC Head Office

Mental Health Act responsibilities

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

Only the crisis and outreach team had regular experience of working with the Mental Health Act (MHA). They and the psychiatrists across the service were able to offer advice and support if other teams had queries.

There were no patients subject to the MHA using CAMHS community services at the time of our inspection.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) applies to young people and adults aged 16 and over. For children and young people under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.

Training in the Mental Capacity Act (MCA) was not mandatory for staff in this service. Most staff showed awareness in their practice of the issues around assessing a child or young person's capacity to make a decision. However, this was not consistent across the service. For example, not all staff were aware of the team policy to consider Gillick competency for all children aged 11 years and over.

There were adequate assessment tools available on the electronic record system to support staff to make a best interest decision if a young person lacked capacity.

Good

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

- The crisis and outreach team and the primary mental health service did not see patients at their base at Plym Bridge House. Patients referred to the crisis and outreach team were seen at accident and emergency services, other inpatient settings or at home. The primary mental health team worked with young people at their school or in other settings. This team referred people with significant mental health needs to the multidisciplinary team at Mount Gould hospital.
- The provider had three buildings on the Mount Gould hospital site set apart for the children's mental health services. One of these was used for outpatient appointments and a second hosted a day service for assessing patients as part of a structured program; the third building was for staff use only.
- The building for outpatient appointments had a range of consultation rooms. These were kept presentable and clean. The management team had identified some seating as requiring replacement but enough furniture was available to meet the needs of the service.
- The team had set up two rooms for observation via one way windows and video and audio monitoring. However, only one of the rooms had signs to inform people that this observation was taking place. We brought this to the attention of the team management at the time of the inspection. The signage was not corrected before the end of the inspection.
- Equipment was available to measure height, weight and blood pressure, and these had annual calibration checks. Any other physical health care checks required for patients were referred to the individual GP.
- The provider kept up to date records of cleaning and maintenance tasks.

Safe staffing

- The service had a substantive team of 69 staff. At the time of our inspection two administrative posts and three specialist clinician posts were vacant. The vacant clinical posts were in the neuro development team and cover was provided from clinicians in other teams. The provider had also recruited agency staff as a response to growing waiting lists. This minimised the impact of staff shortages.
- Two out of seven doctors' posts were vacant and consequently the primary mental health team had no dedicated psychiatric cover. Doctors we spoke with said there were arrangements between the teams to provide cover but that they were stretched at times. However, nurses told us that they were always able to arrange an urgent patient appointment with a doctor when it was required.
- There were low sickness rates in the CAMHS community team. Staff sickness was at 3% for the year leading up to the inspection. At times when a staff member was sick, appointments were postponed or arranged with an alternative clinician, depending on urgency.
- We observed a team meeting where the caseload of a departing worker was discussed and prioritised. Plans were put in place to ensure that patients with higher levels of need were re-allocated to reduce any known risks. The service was not always making good use of crisis plans or responding promptly to deterioration in children and young people's health. For example, two carers of young people accessing the neuro development team and the severe learning disability team told us that when a key worker left or they were on long term leave it was hard to get their child seen by the team, even when they felt their child was in crisis. Two carers told us that the multidisciplinary team did not respond to their requests for support until their children were admitted to a general hospital.
- Staff received mandatory training including safeguarding children level 3, safeguarding adults and manual handling, fire, diversity, information governance, infection control and basic life support. The CAMHS service had a high compliance rate of 87% for training, with the lowest compliance being for safeguarding children level 3 at 81%. This was due to the recent staff turnover in the service.

Assessing and managing risk to patients and staff

- The service had comprehensive risk assessment tools in place for initial assessment and triage of referrals. Referrals to all the teams were triaged on a daily basis

Good

Are services safe?

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

and urgent cases were diverted to the crisis and outreach team. Other referrals waited for a routine triage, which included a range of risk assessment options depending on the presenting needs of the patient. People were able to contact the team if needs changed whilst on the waiting list, the team did not routinely carry out follow up checks with people who were waiting for triage.

- Most of the specialist teams told us that the risk assessment tools were comprehensive. However, the severe learning disability team told us that the tools did not cover all the risks that their client group could present. This included behavioural and physical health risks related to lack of mobility and behavioural risks such as being sexually uninhibited due to poor social awareness. Staff in this team relied on their experience and knowledge of risks to carry out effective risk assessments. We observed discussions on risks to children and young people accessing this service in multidisciplinary meetings.
- We reviewed 14 care records and looked at risk assessments. One care record did not have a risk assessment, another had a risk assessment that had not been updated or reviewed in the six months since initial assessment. This was brought to the attention of the matron at the time of the inspection. The other records all had risk assessments that had been regularly reviewed and updated as the patient's needs changed.
- The service had a comprehensive policy on lone working and global positioning system (GPS) based personal alarms were provided for staff carrying out home visits. However, we observed that many staff were not taking these devices with them when going out on visits. We discussed this with managers who showed us that enforcing the lone worker policy was a recognised issue in the service and was on the matron's risk register.

Track record on safety

- We reviewed incidents reported to CQC in the 12 months leading up to the inspection. There were no reports of serious incidents in this service.
- The provider had reported three incidents of restraint of a patient accessing the neuro development day program. We discussed these with managers as part of the inspection and reviewed the incident report. This showed that the potential need for restraint was part of the risk assessment and was discussed with the young person and carers before the day program began. The incident had happened in the community and the incident had been investigated by mangers, Staff actions during the incident had been in line with the risk management plan.

Reporting incidents and learning from when things go wrong

- Staff discussed feedback they received from incident reviews. This was usually delivered in team meetings. We reviewed records of team meetings that showed reviews of incidents were part of the agenda of these meetings. Staff were very clear on how incidents at their place of work had been dealt with and identified learning from this. Staff told us that debriefing after incidents took place in team meetings. Staff that had been involved in incidents told us they felt they had been well supported by their managers following the incident.
- Most staff we spoke with were able to describe the process for reporting incidents. Some students and agency workers were unsure but were confident they could get advice if they needed to report an incident.
- We reviewed the risk register and discussed learning from incidents with managers. One example given was that following incidents of restraint on site in the day program internal doors and windows were changed to improve lines of sight within the building. The increased levels of observation had led to a reduction in incidents.

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

- The service carried out a triage assessment following referrals to the service. This involved two clinicians for up to three sessions. The exception to this was the crisis and outreach team, who carried out a single session assessment focussed on safety planning.
- We reviewed 14 care records, two of these were not continued past triage and reasons for this were in place. The other 12 had evidence of care planning. However, copies of the care plans were not always on the electronic record. For example, in the crisis and outreach team's records. However, the electronic record did indicate that the patient or their carer had received a copy. The electronic records did not indicate where the care plans could be accessed. This meant that new staff would not always know what care or treatment was being given or had been provided. Care plans that we were able to review were client focussed, and where ongoing care took place there was evidence of patient and carer involvement in formulating the care plan.
- Some services relied on paper records where assessments took place off site or when assessment scoring sheets were kept for future reference. These were stored in a locked records room at the Mount Gould hospital site and could be accessed via the administration team.

Best practice in treatment and care

- The service followed National Institute for Health and Care Excellence (NICE) guidelines for many of the therapies it provided, and updates on guidelines was a standing agenda item at team meetings. Occupational therapy was not covered by NICE guidance but therapists used a wide range of accredited tools in assessing and monitoring young people's skills and needs.
- The psychiatrist and paediatrician we spoke with discussed the NICE guidance on monitoring anti-psychotics and neuro developmental medicine. Monitoring included physical health checks and blood tests. Physical health checks were carried out at the service and blood tests were requested via the GP. Patients with attention deficit hyperactivity disorder had height and weight monitoring charts specific to that condition on their care records. Carers told us that they received clear guidance from doctors on the potential side effects of medicines.
- Different therapists used appropriate outcome measures, such as health of the nation outcome scales or children's global assessment scale to measure the effectiveness of their work.
- Staff were involved in clinical audits to improve aspects of the service, such as reducing the use of restraint, reductions in referrals from primary services to specialist services and good practice with regards to safeguarding children.

Skilled staff to deliver care

- The teams included psychiatrists, a paediatrician, nurse prescribers, occupational therapists, and a wide range of psychology and psychotherapy specialists that were able to offer one to one or family therapy sessions. One team manger took the lead role for improved access to psychological therapies. At the time of the inspection the team were trying to recruit a speech and language therapist, as this was an identified gap in provision. Whilst this was ongoing, staff accessed this support from the children's development centre, which was part of the local NHS trust.
- There were a number of specialist groups to support young people and carers. One project the neuro development team was piloting was a programme to support parenting of children with autistic spectrum conditions. Current practice for CAMHS teams was to diagnose the condition and then signpost families to educational or social care support. The Plymouth neuro-development team were piloting a project, called Ascend, to develop parent and carer understanding of conditions, and to learn strategies to support the child with autistic spectrum conditions.
- Therapists had developed specialisms and care pathways to address presenting needs, such as eating disorders or post-traumatic stress disorder.
- Clinicians were assigned to a specialist team, but they were available to consult with other teams if their expertise was needed.
- All the team members were registered members of a professional body.
- All four doctors had undergone revalidation in the preceding year. However, only 49 out of 62 non-medical staff had received an appraisal in the last year.

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.

- Most teams were compliant with clinical supervision with compliance rates of 80% or more. However, the severe learning disability team reported only 25% compliance. The supervision policy states that no records were kept of clinical supervision, so we were not able to look further at how the data was recorded. Staff had access to specialist training for their roles. For example, one staff member had recently received training on assessing the risk of suicide and self harm. Other staff told us they were able to identify training in new therapies relevant to the children and young people they supported.
- Eighty-six per cent of staff had received a corporate induction which included mandatory training on fire safety, diversity, information governance, infection control and customer care.

Multi-disciplinary and inter-agency team work

- Each team within the service had regular team meetings to discuss referrals, team business and to look at particular cases that team members wished to discuss. These meetings were well attended by staff, who told us that they valued them. There was discussion of new referrals, identified issues and questions that could be taken to the referrer, if appropriate. Ongoing case discussions covered safeguarding issues and the most appropriate type of therapy or treatment for a patient. For example one discussion we observed focussed on the risks posed by a young person who had specific behavioural issues, and support that the team could provide to the young person and their family.
- Team members could meet regularly with senior practitioners or specialists in particular therapies, such as cognitive behaviour therapy, to discuss cases in more depth. Staff told us that they found these helpful; for example, in focussing their time with patients on the right issues.
- Communication between the specialist CAMHS teams appeared to be good, and managers communicated across teams effectively. As teams were small, some mangers led more than one team. For example, one manger was responsible for the neuro development, severe learning disability and children in care teams.
- A single modern matron post covered all CAMHS community and inpatient services. This meant, for example, that the crisis and outreach team had close links with the CAMHS inpatient ward. This enabled more efficient admission and discharge between inpatient and community services.
- Partnership working with other agencies was effective. We observed a CAMHS clinician contribute to a meeting with a parent, school staff and children's services. We spoke to a senior member of the school staff after the meeting and received positive feedback on the CAMHS team's contribution, such as interagency meetings and the work CAMHS teams undertook within the school. We received similar positive feedback from other schools and from parents and carers.
- The primary mental health team (PMHT) had close links to schools and GP surgeries to promote mental health. The team members spent one third of their working time on training other professionals in topics such as safeguarding children and mental health awareness. The team also offered a daily helpline for school and health staff to discuss issues confidentially and could offer further support if appropriate.
- The PMHT was beginning a process of transformation due to a change in its contract with the specialist clinical commissioning group. The intention was to reduce the referrals that the PMHT made to the other CAMHS teams and inpatient services by working within GP services and schools to improve other professionals' awareness of, and response to, mental health issues. All the local schools were involved in the process.
- One of the targets that the management team had set for CAMHS in the next year was to improve the transition process for patients moving to adult services. Many staff told us that this had been a challenge, as formal processes were not in place. For example there were no target times for referrals to be made before a person reached adulthood. Adult mental health services did not always accept the young people as eligible for treatment and support, and staff in CAMHS wanted to be able to communicate this to carers and young people in good time before CAMHS support ended. However staff also told us that relationships between the services were improving.
- The clinical commissioning group and the provider had set a target and structured plan, known as a CQUIN (commissioning for quality and innovation), to bring the transition process up to the national standards set by NHS England within a year.

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.

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

- Training in the Mental Health Act (MHA) was not mandatory for staff in this service, though all the doctors and many nurses were familiar with it. The nurses in the primary mental health team were not familiar with the MHA. They told us training was available for them, but it was not a priority for the team. The crisis and outreach team were trained in the MHA and MHA Code of Practice and their knowledge was good. Managers in other community teams knew how to access support from the crisis and outreach team or the MHA administration team if they had any questions or if a child or young person was subject to the MHA.
- All the doctors we spoke with were familiar with assessing capacity as part of their MHA training.
- Staff told us they would discuss any issues with their line manager or a psychiatrist. Managers were not able to identify a person within the organisation who was responsible for monitoring use of the MHA.

Good practice in applying the Mental Capacity Act

- Training in the Mental Capacity Act (MCA) was not mandatory for staff in this service, and no data was available on how many staff were trained. However, we observed good working knowledge of issues around mental capacity in the team discussions and consultations. We were told by managers that there is an expectation that children aged eleven and over will be asked to consent to sharing their information with other professionals, in addition to parental consent being obtained. However, not all staff were aware of this when we discussed consent with them.
- All care records we reviewed, where treatment was offered, contained evidence that the clinician or doctor had sought informed consent from the young person. However recording of consideration or assessment of capacity was poor as staff we spoke with did not know this was required.
- Many staff lacked knowledge of terms, such as, Gillick competence and Fraser guidelines. They were aware that they could get support from a psychologist or psychiatrist to assess a patient's competence to make a decision. However this could create unnecessary delay in agreeing treatment, as clinician's should be competent to agree a plan of care and treatment with the child or young person and their carer in most circumstances without seeking support from another specialist.
- We also saw that there was a form in place for supporting best interest decision making, and managers were aware of how to use it.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Of the 11 young people and carers we spoke with and seven people we received written feedback from, 17 had positive things to say about the service they received. They found professionals to be caring, polite and helpful. They told us they felt that they were treated as individuals and they felt listened to. We saw staff offer emotional support to young people during consultations, and children and young people were given time to articulate their views.
- Carers of children and young people told us that their privacy was respected, and the team supported them to liaise directly between school, health and social services so that they were aware of information being shared. We observed a multiagency meeting where the parent was supported to lead the discussion about their child's needs.
- However we also received negative comments from four people about a lack of response from the multidisciplinary team and the neuro developmental team when asking for more support.

The involvement of people in the care that they receive

- Patients and carers told us that they felt listened to and involved in planning care. They told us that clinicians and doctors had great expertise in understanding the patient's needs. Six out of eight carers or young people had been given copies of care plans or had detailed correspondence on the team's treatment plan. These included contact details for emergencies.
- However six out of 14 care records we reviewed did not state that patients and carers were given copies of their care plan.
- Children felt that doctors took time to explain things to them, and were never in a rush to finish appointments.
- Children and young people and carers were given details of groups and organisations that offered more informal support. Many carers told us that they found these helpful.
- The provider had support in place to help former patients take part in recruiting new staff; young people were supported to sit on interview panels. Support included training on the recruitment process and having a support worker available for the young person between interviews.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- The provider accepted referral to the service from GPs, schools and other specialist services. Families could also contact the team directly to request support. Referrals were manged by the administrative team and team leaders at the multidisciplinary CAMHS team meetings. They were placed on waiting list for triage at the MDT or referred on to the waiting list for a specialist team such as neurodevelopment or severe learning disabilities. Following triage, the person would be referred on to the appropriate therapist or doctor for ongoing treatment.
- Data on waiting times for treatment showed that the provider was meeting the target waiting time from referral to treatment of 18 weeks. However, the provider considered the triage as the start of treatment, rather than the initial assessment. Following triage patients were put on a waiting list for a specialist team or therapist, but these waiting times were not reported as part of the key performance indicators. Therefore people were waiting much longer than the target time of 18 weeks to begin the treatment they were assessed as needing, but the provider could not give accurate figures on how long people waited from triage to assessment.
- This led to complaints to us during the inspection from clinicians and from eight carers, children and young people about long waiting times to get the right service.
- We were told by carers that the wait from triage to seeing the correct specialist was often a year. One clinician reported a wait of two years between triage and specialist treatment. However patients did have access to the main multidisciplinary team while waiting to see the specialist. Carers told us that this did help them to manage while they waited but it was not ideal.
- However, a breakdown of waiting times by team at the time of the inspection showed that the longest wait from referral to treatment was 33 weeks, for the only person on the neuro development team waiting list. The severe learning disability team had two people waiting 18 to 22 weeks out of nine on their waiting list. The main triage team had three out of 189 people waiting 18 to 22 weeks.
- The crisis and outreach team had a 24 hour target for urgent contact and a seven day target for assessing urgent referrals, and 18 weeks for other referrals. Their average waiting time at the time of inspection for non-urgent referrals was three weeks; the longest waiting time was 13 weeks.
- Many specialist teams did not make discharge planning a key part of their treatment. There was an assumption, particularly within the severe learning disability team, that cases would stay active until the person was able to transfer to adult services. This made it difficult to allocate new cases from the waiting list.
- Non-attendance or disengagement by children and young people was part of the ongoing risk assessment and the team were proactive in re-engaging high risk patients. This also formed part of the discussion at team meetings.

The facilities promote recovery, comfort, dignity and confidentiality

- The outpatient building at Mount Gould had a comfortable waiting area and was only used by the CAMHS service. However, the consulting rooms were varied in their comfort as some had poor natural light while others had ample natural light and pleasant views. This was reflected in comments from carers and staff. Children, young people and carers were happy with the level of privacy offered by the facilities.

Meeting the needs of all people who use the service

- There was a wide range of information on different health conditions, child development and treatments available in the waiting room. There was accessible information tailored to the needs of people with communication difficulties and a translation and interpreting service.
- There was also information on many support groups. However there was no information on any advocacy service, and information on how to complain was not displayed. Some carers we spoke to were not aware of how they could make a formal complaint.
- The day service and outpatients buildings were accessible by wheelchair, however the outpatients building required a person to support someone in a wheelchair due to the many internal doors. The provider had imposed parking restrictions close to the outpatient building but a disabled parking space was available.

Are services responsive to people's needs?

Requires improvement

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

Listening to and learning from concerns and complaints

- Complaints data from the year preceding the inspection showed that seven complaints regarding CAMHS were upheld in the year before the inspection. We did not receive data on the number of complaints not upheld.
- Four out of eight of the carers we spoke with were not aware of the complaints procedure. Some had complained informally, and only one person was satisfied with the response of the manager they spoke with.
- Staff were aware of the complaints procedure and some had supported carers to take complaints further when they were not happy with the service.
- Staff told us they received feedback when complaints were made, and were offered support when complaints were made about them. Staff did not identify any changes that needed to be made as a result of a complaint.

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 provider had set out four core values for the service and a set of quality priorities with associated plans. Staff did not state them in our discussions with them. However, the staff were fully engaged in the quality priorities that were relevant to their service. For example, staff in all teams were focussed on the improved transition from CAMHS to adult mental health services, reduction in restrictive practices and improved professional leadership which were all quality priorities for the service. Staff at all levels were positive about the future development of the service.
- Staff were aware of who senior managers were, and how they could talk to them. However, staff reported that the senior management team did not routinely visit the services.

Good governance

- The systems for managing waiting lists were not clear, it was not possible to identify if the waiting time targets were being met or if young people's risk was appropriately managed during time spent on the waiting list.
- The provider did not always cover long term leave of staff, and carers told us that it was difficult to get an appointment for their child if their key worker was on long term leave.
- At the multidisciplinary team meeting an agency worker had started work with patients under supervision of a permanent member of staff before a disclosure and barring (DBS) check had been completed. The team leader had believed the arrangement for their supervision had been agreed with the human resources team, however when we queried it, they found this was not the case. The team leader and matron clarified with the DBS agency when the worker's check would be completed and moved the person from patient contact to other duties until a satisfactory check could be completed.
- The service had an administration team which helped clinicians and doctors to maximise time with patients as the admin team were able to, for example, manage waiting lists, make initial enquiries with people who did not attend and help managers prioritise new referrals.
- Managers reported that systems for preparing reports on key performance indicators were very straightforward and senior management were clear with them about what was needed.
- Safeguarding procedures were robust, and management responsibilities for this were clear to staff.
- Clear incident procedures were in place. However, procedures for complaints were not clear. For example, the complaints policy was not readily accessible to patients and carers. Therefore the complaints procedures were not working effectively for children, young people and their carers.

Leadership, morale and staff engagement

- Staff we spoke with had confidence in their team leaders and morale was good. Sickness rates were low amongst all the teams. In the year preceding the inspection, management posts had been restructured and many managers had been in post a short period of time. Managers told us that they felt supported in the transition to the new system, and team members were positive about the management structure.
- Managers were positive about their roles, and positive about the direction that the provider wanted the service to develop.
- The whistleblowing policy was clear, and staff we spoke with were familiar with it. Staff were also able to raise concerns through team meetings and supervision.
- Staff had opportunities for professional and leadership development. We spoke to staff who had recently completed or were about to start the organisation's management course.

Commitment to quality improvement and innovation

- The service prioritised internal clinical audits. Managers supported practitioners to develop new models of practice for the team based on their own research interests and their specialist roles. For example the neuro development team were piloting a new course to develop parenting skills of parents of children with autistic spectrum conditions.
- However, there was a lack of participation in external audits, apart from those required under the contract with the clinical commissioning group. There was also lack of awareness of peer to peer accreditation schemes, such as Quality Network for Community CAMHS.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints This is a breach of Health and Social Care Act 2008 reg. 16 (2):

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not maintain accurate records of waiting times for services people required and in so doing failed to assess, monitor and mitigate the risks relating to health safety, and welfare of the services users. This is a breach of the Health and Social Care act 2008 reg. 17 (2) (a):

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider allowed a member of staff to work directly with children and young people without obtaining a Disclosure and Barring Service (DBS) check.

This section is primarily information for the provider

Requirement notices

This is a breach of the Health and Social Care act 2008 reg. 19 (3) (a)