Northamptonshire Healthcare NHS Foundation 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)
RP1X1	Trust Headquarters Sudborough House	Children and adolescent mental health service (CMHT) specialist intervention team North	NN15 7PW
RP1X1	Trust Headquarters Sudborough House	North Children and adolescent mental health service (CMHT) specialist intervention team South	NN1 5EB
RP1X1	Trust Headquarters Sudborough House	Child and young person referral management centre	NN8 1LP

Summary of findings

RP1X1	Trust Headquarters Sudborough House	Children's response team	NN8 1LP
RP1X1	Trust Headquarters Sudborough House	Initial assessment and intervention team	NN8 1LP

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Good** 
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:

- Following restructure, there were 25 staff vacancies across CAMHS teams. Staffing vacancies had affected service delivery. Therefore contingency planning for managing the transformation had been affected.
- Amongst the 16 care records that we examined. We found three examples of a risk assessment not being updated after a young person's risks had increased across north and south teams. We found two examples of safeguarding issues that were not managed effectively at the time they were reported. Managers were made aware of this and told us of the actions they would take. Five care plans in the South team which had not been updated following a change to a person's needs. The recording of discussions and assessments with young people regarding consent to treatment varied across teams. This included the recording of prescribing "off licence" medication. Assessment and treatment records seen did not always reflect young people's involvement.
- There were delays with the referrals process. This meant that young people were not always able to access support in a timely way. Complaints had been made by people related to the length of waiting times.
- The service was commissioned to provide 24 hour cover this was operated via an on call Consultant rota
- A response team was developed to work intensively with young people in crisis but was not fully operational due to staffing vacancies.
- There was a pathway for requesting hospital admission; the trust was not responsible for any delay as this sort of placement was commissioned by NHS England. The children would be placed out of county according to local availability and their risk profile.
- In 2014/15 two young people were admitted to adult wards both were over 17 years of age at time of admission. Currently if a young person below the age of 18 is admitted on the adult ward, this is immediately placed on the risk register and NHS England is informed. There is a meeting arranged to discuss why the young person is on the adult ward and all effort is made to move them to a suitable environment.

However

- There had been no serious untoward incidents within this service in the last year.
- Staff could arrange interagency complex case panels where they were concerned about the risk to a young person.
- Staff received training in how to safeguard young people who used the service from harm.
- Staff used nationally recognised assessment tools. For example, the child and young person's self-harm pathway completing integrated assessment tools with acute hospital staff.
- Staff provided a range of therapeutic interventions in line with National Institute for Health and Care Excellence (NICE) guidance such as cognitive behavioural therapy (CBT).
- Regular team meetings took place and staff told us that they felt supported by colleagues.
- Young people and carers reported they were treated with dignity and respect and gave positive feedback about staff.
- Brief intervention and skills-based workshop programmes were offered to provide earlier intervention and reduce the need for specialist intervention services.
- The trust had set up an ADHD and ASD team to work with young people in response to a high number of referrals.
- The service had undergone a transformation that included how services would be delivered to young people through an integrated service. Consultations with staff and the public had been undertaken to gain feedback. This meant people were given the opportunity to have a say in the way the services were designed.

Summary of findings

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

Are services safe?

Good

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

- There had been no serious untoward incidents within this service in the last year.
- Staff knew how to report any incidents on the trust's electronic reporting system and received feedback about the outcome of incidents
- Each young person had an individualised risk assessment**.** These had been reviewed by the multi-disciplinary team.
- Staff could arrange interagency complex case panels where they were concerned about the risk to a young person.
- Staff received training in how to safeguard young people. However we identified two examples of safeguarding issues that were not managed effectively at the time they were reported. Managers were made aware of this and told us of the actions they would take.
- Staff were aware of lone working procedures and had access to mobile phones and laptops to call support or access records when remote working.
- Some areas of potential risk to young people and staff were found at the North team location such as faulty door locks.
- Following restructure, there were 25 staff vacancies across CAMHS teams (16% as of September 2014) out of approximately 65 posts. Staff said this had affected the service delivery. This meant there was a risk that the safety of some young people could be compromised due to staff vacancies.
- We found three examples of a risk assessment not being updated after a young person's risks had increased across the North and South teams.

However:

- Some areas of potential risk to young people and staff were found at the North team location such as faulty door locks.
- Following restructure, there were 25 staff vacancies across CAMHS teams (16% as of September 2014) out of approximately 65 posts. Staff said this had affected the service delivery. This meant there was a risk that the safety of some young people could be compromised due to staff vacancies.
- We found three examples of a risk assessment not being updated after a young person's risks had increased across the North and South teams.

Summary of findings

Are services effective?

Requires improvement

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

- We identified five care plans in the South team which had not been updated following a change to a person's needs.
- We found an example where the Common Assessment for Families (CAF) was identified as a need for a young person but this had not been completed.
- Physical healthcare checks were not routinely documented in young people's notes.
- Staff told us that family therapy was not being consistently provided due to staffing vacancies.
- A referrer had not been sent an update on one young person's assessment and treatment.
- The recording of discussions and assessments with young people regarding consent to treatment varied across teams.
- We found two examples where staff had spoken with a young person's parents when they were aged over 17 years without evidence that they had consented to this.

However:

- Assessments took place using nationally recognised assessment tools
- There was a system for assessing young people with mental health needs on acute hospital paediatric wards daily.
- The child and young person's self-harm pathway integrated assessment tools was completed with acute hospital staff.
- Staff provided a range of therapeutic interventions in line with NICE guidance such as cognitive behavioural therapy (CBT).
- Regular team meetings took place and staff told us that they felt supported by colleagues.

Are services caring?

Good

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

- Young people and carers reported they were treated with dignity and respect and gave positive feedback about staff.
- 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 found that young people and carers were encouraged them to give their views and involved them in their care.

Summary of findings

- The trust was conducting a, 'Have your say' survey on children and young people's services for young people and others to give feedback with completion by April 2015.

However:

- Assessment and treatment records seen did not always reflect young people's involvement.

Are services responsive to people's needs?

Requires improvement

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

- We found there were delays with the referrals process. 107 young people were waiting longer than the 13 week assessment target with 476 young people in total waiting. This meant that young people were not able to access support in a timely way.
- Since November 2014 13 CAMHS screened referrals had not been passed on to frontline teams which we raised with the manager who said they would take action.
- Complaints had been made by people related to the length of waiting times.
- Initial assessment and intervention staff told us they sometimes undertook work with young people as there were delays in allocating workers at specialist intervention teams.
- There was a pathway for requesting hospital admission; the trust was not responsible for any delay as this sort of placement was commissioned by NHS England. The children would be placed out of county according to local availability and their risk profile.
- A response team that had been developed to work intensively with young people in crisis was not fully operational due to staffing vacancies.
- In 2014/15 two young people were admitted to adult wards both were over 17 years of age at time of admission.

However:

- CAMHS services offered brief intervention and skills-based workshop programmes to provide earlier intervention and reduce the need for specialist intervention services.
- The South team had a child friendly waiting area with toys and the North team had a play area in a group room.
- A range of leaflets and service information for young people and carers was available across team sites. Self-help guides were available to young people on the trust website.

Summary of findings

- The trust had set up an ADHD and ASD team to work with young people in response to a high level of referrals.
- The trust had recently introduced the, 'I want great care,' test. In January 2015, the south team was highly rated as 4.6 stars showing satisfaction with the service.

Are services well-led?

Requires improvement

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

- Staff links were made with acute hospital services. Systems for formally reviewing interagency working were not demonstrated.
- Staffing vacancies had affected the service delivery. Therefore contingency planning for managing the transformation had not been well led.
- It was not clear how feedback from young people and carers was being used to influence and improve the quality of all of the services provided.

However:

- Information from the trust or other services was discussed at business team meetings.
- Staff knew who the most senior managers in the trust were and we saw some senior managers based themselves in team offices.
- Staff spoke positively about the supportive culture in their teams.
- Staff reported opportunities for staff engagement events and away days.
- Managers had access to trust data such as assessment and treatment waiting times to gauge the performance of the team and compare against others.
- The service had undergone a transformation that included how services would be delivered to young people through an integrated service. Consultations with staff and the public had been undertaken to gain feedback. This meant people were given the opportunity to have a say in the way the services were designed.

Summary of findings

Information about the service

- The trust provides specialist community mental health services for young people aged 0 to 18 years who are experiencing mental health difficulties that are severe, enduring and complex.
- The core service provides consultation, support and advice to professionals working with young people and families.
- All referrals were made to a single point of access child and young person referral management centre.
- The trust had six CAMHS teams. These were:-
- A prevention and community engagement team that provided training based on referral trends and needs and short-term brief intervention.
- An initial assessment and intervention team that assessed and followed up referrals and provided a skills-based workshop programme for young people and parent workshops.
- A children's response team that worked with young people when a case worker is not currently allocated or available. They responded to crisis situations that may otherwise result in hospital attendance or admissions.
- There were two specialist intervention team providing therapies and psychiatric assessments and reviews based in Kettering and Northampton.
- A children and young person's attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorder (ASD) team.
- Teams were made up of a range of professionals including doctors, psychologists, nurses, therapists, social workers and mental health practitioners, as well as assistant practitioners and administration staff.
- This core service was managed under the children's and ambulatory services directorate.
- This core service had not been previously inspected by the Care Quality Commission.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett - Consultant Psychiatrist, Oxleas NHS Foundation Trust

Team Leader: James Mullins - Head of Hospital Inspection (mental health) CQC

The team included CQC managers, inspection managers, inspectors and 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, and three specialist professional advisors; a consultant child and adolescent psychiatrist, a mental health nurse and a psychologist. All of whom had recent experience of working in child and adolescent mental health services.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

To 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?

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

We carried out an announced visit to this core service between 03 and 05 February 2015.

During the inspection visit the inspection team:

- Visited two child and adolescent mental health services teams (CAMHS) based in Kettering and Northampton.
- Visited the initial assessment and intervention team.
- Visited the children's response team.
- Visited the child and young person referral management centre (RMC).
- Met with two carers.
- Spoke with 23 staff.
- Reviewed 16 assessment and treatment records of people who used the service.
- Observed four appointments and met with seven young people and carers.
- Interviewed senior clinicians. This included a CAMHS operations manager, a service manager and the head of specialist children's services.
- Reviewed a range of policies, procedures and other records relating to the running of this service.
- Held focus groups with different staff groups.
- Reviewed information we had asked the trust to provide.

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.

What people who use the provider's services say

- Young 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 carers in the service.
- Patients felt that staff listened to them and were responsive when concerns were identified.

Good practice

- The trust had set up an ADHD and ASD team to work with young people in response to a high number of referrals.

Areas for improvement

Action the provider MUST take to improve
Action the trust MUST take to improve

- The trust must review its contingency arrangements for staffing to ensure adequate service delivery to young people.

Summary of findings

- The trust must review its provision of assessment and treatment to 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.

Action the trust SHOULD take to improve

- 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 assessing mental capacity and consent to treatment.
- 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 the sustainability of its services.

Northamptonshire Healthcare NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Child and young person referral management centre	Trust Headquarters
Initial assessment and intervention team	Trust Headquarters
Children's response team	Trust Headquarters
Children and adolescent mental health service (CMHT) specialist intervention team North	Trust Headquarters
Children and adolescent mental health service (CMHT) specialist intervention team South	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 this core service as during our inspection none of the young people were subject to community treatment orders.

Staff would contact the Mental Health Act administrative team if they needed any specific guidance about their roles and responsibilities under the Act.

When required staff could contact the approved mental health professionals (AMHP) service to co-ordinate assessments under the Mental Health Act 1983.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

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

A standardised consent form for recording the consent of children and young people and carers in relation to the Data Protection Act 1998 was used.

The quality and recording of discussions and assessments with young people regarding consent to treatment varied across teams with some records holding limited information.

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

Summary of findings

Our findings

Child and young person referral management centre, Initial assessment and intervention team, Children's response team, North and South CAMHS specialist intervention teams

Safe environment

- Closed circuit television (CCTV) was monitoring the outside of the premises at the North team with signage evident.
- Staff undertook individual risk assessments when interviewing young people as interview rooms did not have alarms for staff to call others in an emergency.
- Staff had access to a clinic for treatment in the North. In the South of the county other suitable accommodation had been sought for interventions.
- Areas of potential risk to young people and staff were found at the North team location where 15 rooms had faulty locks with keys left in them. This meant young people or others could access them.
- The North team had recently moved premises. We found boxes were being stored above staff's height on cabinets and staff reported difficulties in accessing them.

Safe staffing

- The trust had identified staffing levels for teams although were not using a recognised patient dependency tool. Following a recent service restructure, there were 25 staff vacancies across CAMHS teams, (16% as of September 2014) out of approximately 65 staff posts. Three staff were on maternity leave. There was no cover meaning the posts remained vacant during this time. The levels of vacancies meant that existing staff and agency staff were required to cover the vacancies in order to provide a service to young people. From October to December 2014, 1074 hours were booked and some staff had moved across teams to give support. A manager reported difficulties booking external agency staff with the correct skills and knowledge. Staffing vacancies meant there was a risk that the safety of some young people could be compromised due to a lack of and inconsistent staffing**.** The trust had identified on their risk register the risk of this impacting on service delivery. Senior managers were regularly updating the trust board. Senior managers had developed a transition plan dated January to April 2015 detailing CAMHS staffing and recruitment, to address staffing vacancies. The staffing levels within the service also had a detrimental effect on other areas such as waiting times, staff morale and the effectiveness of the service.

Assessing and managing risk to patients and staff

- Each young person had an individualised risk assessment**.** These had been reviewed by the multi-disciplinary team. Risk assessments took into account historic risks and identified where additional support was required. Staff created and made use of crisis plans when required. Staff could arrange interagency complex case panels where they were concerned about the risk to a young person. We found three examples of a risk assessment not being updated after a young person's risks had increased across North and South teams. This meant that staff may not have updated information to support a young person.
- Staff received training in how to safeguard people who used the service from harm and gave examples showing that they knew how to do this effectively in practice. Trust information received showed 87% of staff had completed safeguarding level three training. Safeguarding staff attended team meetings for a review of individual cases where appropriate. However, we found two examples of safeguarding issues that were not managed effectively at the time they were reported. Managers were made aware of this and told us of the actions they would take. The number of safeguarding referrals and any identified themes stating this information was held by the trust safeguarding team. This information was not available locally. Staff received safeguarding group supervision quarterly and there was a staff lead in the service.

Good

Are services safe?

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

- Staff gave examples of 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. A staff member in the response team said there were difficulties with arranging meeting venues with young people out of hours which had been reported to managers.
- Staff had access to mobile phones and laptops to call support or access records when remote working.

Track record on safety

- There had been no serious untoward incidents within this service in the last year. The trust had safety thermometers at service line and team level regarding risks for their area with identified actions.

Reporting incidents and learning from when things go wrong

- Staff knew how to report any incidents on the trust's electronic reporting system.
- Staff received e-mail bulletins with trust updates and alerts following learning from incidents and to communicate issues for example after an incident at an inpatient unit.
- Staff told us that incidents were discussed at staff team meetings. However meeting minutes did not always detail this.
- Staff received feedback about the outcome of incidents that had happened and gave us some examples.

Are services effective?

Requires improvement

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

Our findings

Child and young person referral management centre, Initial assessment and intervention team, Children's response team, North and South CAMHS specialist intervention teams

Assessment of needs and planning of care

- Assessments and care planning were completed to meet young people's needs with systems for ensuring these were updated as needs changed.
- We found five care plans in the South team which had not been updated following a change to a person's needs.
- The trust used the common assessment for families (CAF) as a single interagency assessment. We found examples of this being use but also found an example where it was identified as a need but had not been completed.
- Physical healthcare checks were not routinely documented in young people's notes. Staff monitored young people's body mass index and weight and referred to working with dieticians regarding meal plans where a person had an eating disorder. Staff had a system for assessing young people with mental health needs on acute hospital paediatric wards daily.
- Out of hour's staff using an electronic records system had access to CAMHS paper records if a young person was at high risk.

Best practice in treatment and care

- Assessments took place using nationally recognised assessment tools including the children's global assessment scale (CGAS) which measures children's general functioning and the health of the nation outcome scales child and adolescent mental health (HONOS-CA) and the Steve Morgan risk management tool.
- CAMHS used the child and young person's self-harm pathway completing integrated assessment tools with acute hospital staff.
- Staff provided a range of therapeutic interventions in line with NICE guidance such as cognitive behavioural therapy (CBT). Staff told us family therapy was not being consistently provided due to staffing vacancies.
- NICE guidance was followed when prescribing medication for individual young people.
- Psychology staff were monitoring improvements following treatment.

Skilled staff to deliver care

- The teams included or had access to the 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. However, one agency worker had worked for four weeks without one. We raised this with staff who took action to address this.
- Staff received supervision opportunities as well as peer supervision and yearly appraisals.
- Staff had opportunities for specialist training for their role and had continuous professional development as part of maintaining their professional registration with examples given.
- Regular team meetings took place and staff told us that they felt supported by colleagues.
- Managers explained supervision and other monitoring systems to ensure staff competence and capability for their work.
- Manager's had systems to track when staff had completed mandatory training and further training dates were scheduled.

Multi-disciplinary and inter-agency team work

- We found examples of effective multi-disciplinary team working and joint working across services.
- Assessment and treatment handovers between teams within the trust such as community to response team took place.
- Additionally staff liaised with other agencies such as in patient units, GP's, early intervention in psychosis team and reported good working relationships with acute hospitals.
- Staff attended interagency meetings and gave positive feedback on the integrated child and young person's service'.

Are services effective?

Requires improvement

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.

- A referrer had not been sent an update on one young people's assessment and treatment.
- Staff used a targeted mental health in schools (TaMHS) approach liaising with school nurses.

Adherence to the MHA and the MHA Code of Practice

- Staff would contact the Mental Health Act administrative team if they needed any specific guidance about their roles and responsibilities under the Act. They could contact the approved mental health professionals (AMHP) service to co-ordinate assessments under the Mental Health Act 1983.
- There were systems to monitor the number of people being assessed under the Mental Health Act 1983 when detained by the police using section 136 powers. For example, response team staff could be contacted to work with young people if they were at an acute hospital under Section 136 MHA.
- A senior manager reported an increase in the number of assessments being required for young people.

Consent

- Training records showed that staff had received training on the Mental Capacity Act 2005.
- The recording of discussions and assessments with young people regarding consent to treatment varied across teams. We saw inconsistent use of a standardised consent form for recording the consent of children and young people and carers.
- Trust policy and staff used the 'Gillick competency and Fraser guidelines' for young people under the age of 16 years.
- At the North team we found two examples where staff had spoken with a young person's parents when they were aged over 17 years. Their consent for other people to be involved in their treatment had not been formally recorded.

Are services caring?

Good

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

Summary of findings

Our findings

Child and young person referral management centre, Initial assessment and intervention team, Children's response team, North and South CAMHS specialist intervention teams

Kindness, dignity, respect and compassion

- 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.
- 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.

The involvement of people in the care they receive

- We found that staff encouraged young people and carers to give their views and involved them in their care. Some records referred to, 'the voice of the child'.
- Carers were involved in the recruitment of crisis.
- The trust had a 'service user and carer involvement team' to encourage involvement of young people and others in developing services. A monthly carers group was established for people looking after young people with ADHD.
- The trust website detailed ways for people to give feedback and raise queries using social media sites, twitter and Facebook. The trust was conducting a, 'have your say' survey on children and young people's services for young people and others to give feedback with completion by April 2015.
- Assessment and treatment records seen did not always reflect young people's involvement.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

Our findings

Child and young person referral management centre, Initial assessment and intervention team, Children's response team, North and South CAMHS specialist intervention teams

Access, discharge and transfer

- CAMHS services had recently been reconfigured under the children and young people's service transformation. Referrals were screened the next working day by a team at the RMC with CAMHS staff representation and to determine the most appropriate course of action.
- We found there were delays with this process. During our inspection we found that CAMHS staff were called away from the screening due to work pressures. Staff had to approach the CAMHS staff member to help with the screening later.
- There were processes for responding to emergency, urgent and non-urgent referrals within identified time frames. Managers anticipated approximately 220 referrals a month excluding referrals for young people with ADHD and ASD. Two staff told us some days they had 90 referrals to the RMC. There were no protocols for the CAMHS referral to aid with the screening process.
- We found 13 CAMHS referrals screened since November 2014 had not been passed on to front line teams, which we raised with the manager who said they would take action. We found other examples of delays such as a referral made on 02 February that was not screened until 05 February 2015.
- Trust monitoring systems for waiting times showed CAMHS referral to triage to treatment were seven to eight weeks from October to December 2014.
- Staff and carers referred to long waiting times for example over 12 months to start treatment. A manager said 94% were within 13 week assessment targets; however 107 young people were waiting longer with 476 young people in total. Managers could not explain the delays. This meant that young people were not able to access support in a timely way.
- CAMHS services offered brief intervention and skills-based workshop programmes to provide earlier intervention and reduce the need for specialist intervention services. Initial assessment and intervention staff told us they sometimes undertook work with young people as there were delays in allocating workers at specialist intervention teams.
- There was an identified referral pathway for requesting hospital admission. Staff confirmed that there could be delays in appropriate in-patient beds being accessed with some young people placed out of area. A response team was developed to work intensively with young people to prevent hospital admission or to link in with them before and after discharge from out of area hospital placement. The ability to deliver this responsive service had been affected by staffing vacancies. Four staff expressed concern about this. A seven day 09:00 hours to 22:00 hours service was planned. Instead 09:00 hours to 17:00 hours service was operating with staff working additional hours on call as required.
- The service was commissioned to provide 24 hour cover this was operated via an on call Consultant rota (see. The consultant on-call was expected to provide telephone advice as well as face to face contact inclusive of assessing young people in line with the Mental Health Act 1983.
- Young people with complex eating disorder or if a local bed was not available were placed out of area via specialist commissioning.
- There was a pathway for requesting hospital admission; the trust was not responsible for any delay as this sort of placement was commissioned by NHS England. The children would be placed out of county according to local availability and their risk profile.

The facilities promote recovery, dignity and confidentiality

- Offices and environments varied across the teams visited and none were purpose built.
- North and South teams were accessible for wheelchair users. Appointments were offered at site premises or other venues as required. A receptionist was not available until 09:00 hours at the South team, which meant young people and parents waiting outside when they arrived early for an appointment.

Are services responsive to people's needs?

Requires improvement

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

- Teams shared reception areas with other trust services, which meant young people shared waiting areas with other services. The South team had a child friendly waiting area with toys and the North had a play area in a group room.
- We found some issues relating to privacy. In the South team meeting rooms' doors had glass panels which meant young people were visible from outside. In the North team a staff member reported doors with observing panels that were too high up to use.
- A range of leaflets and service information for young people and carers was available across team sites. Self-help guides were available to young people on the trust website.

Meeting the needs of all people who use the service

- Young people with a learning disability were provided a service in another team. However, this was not clearly defined. Systems were in in place for the transition of young people to adult services.
- There was access to specialist services if people using the service required specific help. For example a young person's drug and alcohol worker was based with the CAMHS team one day per week.
- Age appropriate website information was available to young people and carers giving information on the service.
- Systems for arranging interpreters and/or signers to assist with communicating with young people and carers as required were in place.
- Staff worked with the trust specialist eating disorder service and had lead staff identified for this role.

Listening to and learning from concerns and complaints

- Patient advisory liaison service (PALS) and advocacy services information was displayed except at the North team.
- The trust website gave details on how to give 'concerns, complaints and compliments'.
- There had been 31 concerns, 26 complaints and no compliments for community services between Decembers 2013 and December 2014. The highest number received was for the North team. Teams had systems for responding to and monitoring this.
- Managers said the main themes for 2014 complaints related to the length of waiting times and lack of support for young people with ADHD and ASD. The trust had set up an ADHD and ASD team to work with young people in response to a high number of referrals.
- The trust had recently introduced the, 'I want great care,' test. This was a way for young people and others to provide anonymised, real time feedback about the service they were receiving.
- In December 2014 there were no responses for the north and response team. The South team had been highly rated as 4.6 stars out of five and in January rated the same showing continued satisfaction with the service.

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.

Summary of findings

Our findings

CAMHS team North, South, Children's response team, Initial assessment and intervention team

Vision and values

- Information on the trust's vision, values and mission statement (PRIDE) were available across teams. Staff knew who the most senior managers in the trust were and we saw some senior managers based themselves in team offices. Managers were planning a staff away day to develop their visions and values in line with the trust.

Good governance

- Staff described the ways in which they received information from the board and other governance meetings. Information from the trust or other services was discussed at business team meetings. These governance systems included the trust's electronic incident reporting system and staff training record.
- Managers had access to trust data such as assessment and treatment waiting times to gauge the performance of the team and compare against others. Systems included monitoring staff attendance at the trust's mandatory training and complaints. Staff received emails and newsletters from the trust giving updates on trust developments.
- Staff links were made with acute hospital services. Systems for formally reviewing interagency working were not demonstrated.

Leadership, morale and staff engagement

- The service had undergone a transformation that included how services would be delivered to young people through an integrated service. Consultations with staff and the public had been undertaken to gain feedback. This meant people were given the opportunity to have a say in the way the services were designed. A 'summary document' had been developed to inform CAMHS staff and others about the reconfiguration.
- Senior managers had identified significant staffing vacancies as a risk to the service and explained actions taken to minimise the risk. Staff explained that recruitment for some jobs had been delayed whilst waiting for trust finance approval. Staffing vacancies had impacted on service delivery and therefore contingency planning for managing the transformation had not been effective.
- We received mixed feedback about staff morale. Nine staff expressed concern about staffing, including jobs being re-graded and needing to reapply for jobs with staff redundancies and loss of skills mix. Others were positive about the integrated service.
- Staff said their manager/supervisor was accessible for advice and guidance as required.
- Managers had systems for monitoring sickness levels and conducted exit interviews to identify any themes for why people left the trust. The trust had a human resources department and referred staff to occupational health services where applicable.
- Managers told us that most staff sickness was not work related and that there were no identifiable themes. Staff sickness data October to December 2014 showed 4.4% across the teams. This was near the average for similar trusts in England.
- The trust had a system for staff to raise any concerns confidentially. Staff spoke positively about the supportive culture in their teams. They reported opportunities for staff engagement events and away days.

Commitment to quality improvement and innovation

- We identified difficulties in the RMC referral process and found there was no system in place to audit the effectiveness of this.
- CAMHS staff reported systems to seek feedback from young people and carers such as, 'I want great care'. However, it was not evident how this was being used to influence to improve the quality of the service.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **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.** The trust must protect service users, 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. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation (10)(1)(b). **And** Care and treatment must be provided in a safe way for service users. The service must: • assess the risks to the health and safety of service users of receiving the care or treatment. • do all that is reasonably practicable to mitigate any such risks. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (1) (2) (a) (b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Requirement notices

The trust must review its contingency arrangements for staffing to ensure adequate service delivery to young people.

In order to safeguard the health, safety and welfare of service users, the trust must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation (22).

And

Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18(1).

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 **The trust must review its provision of assessment and treatment to young people to ensure they receive it in a timely manner.** The trust must take proper steps to ensure that each person is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the person's individual needs, ensure the welfare and safety of the person. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (9) (1) (b) (i) (ii). **And** Care and treatment must be provided in a safe way for service users. The service must: - assess the risks to the health and safety of service users of receiving the care or treatment.

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Requirement notices

- do all that is reasonably practicable to mitigate any such risks.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12 (1)(2)(a)(b)