Requires improvement

Shropshire Community Health NHS Trust

Child and adolescent mental health wards

Quality Report

Shropshire Community Health NHS Trust
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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)
R1DHQ	Shropshire Community Health NHS Trust - HQ	CAMHS Learning disability team	SY1 3GZ
R1DHQ	Shropshire Community Health NHS Trust - HQ	Shropshire CAMHS Team	SY1 3GZ
R1DHQ	Shropshire Community Health NHS Trust - HQ	Telford and Wrekin CAMHS Team	TF4 2EX
R1DHQ	Shropshire Community Health NHS Trust - HQ	Compass Shropshire CAMHS tier 2 staff	SY2 6FG

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

Summary of findings

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

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**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 this service as requires improvement. This is because:

- The service did not have sufficient staff to provide effective care. None of the CAMHS teams could provide the full range of psychological therapies recommended by the National Institute for Health and Care Excellence (NICE).
- Average caseloads within the CAMHS learning disability team exceeded national guidance.
- The tier 2 Telford and Wrekin service was not fully staffed and was unable to triage referrals to CAMHS or offer interventions on a Friday.
- Staff did not feel engaged by senior managers. Staff found out about a major CAMHS transformation plan after its public release and did not broadly believe that senior managers understood CAMHS services or listened to their concerns.
- The trust failed to consistently inform staff about lessons learnt from CAMHS incident investigations.
- The service did not effectively manage waiting lists. Teams organised waiting lists around where patients lived rather than the urgency of patients' needs. Staff did not actively monitor for changes to waiting list patient risk levels.
- The service made limited use of outcome measures and did not undertake regular audits of performance and quality. The service did not use key performance indicators other than referral-to-treatment waiting times to measure and monitor the quality of services.
- The environment was not suitable for delivering effective care. Soundproofing was ineffective across all CAMHS sites. Conversations and movement were heard between staff offices, consultation rooms and adjacent rooms, disturbing work and compromising confidentiality.

However we also saw that:

- The service worked around patient, family and carer needs.
- The teams had flexible appointment times, and carers told us they could access support quickly if needed.
- Staff were respectful and supportive and adapted their behaviour to match patients' ages and specific requirements.
- Staff completed detailed and recovery-focused care records. Staff also worked with patients, families and carers to produce written plans that set out how the service would meet the patient's care and support needs.
- The service encouraged and facilitated patient feedback, and made changes based on this feedback where possible.
- When the service received formal complaints, the trust investigated responded and implemented changes when appropriate.

Summary of findings

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

Are services safe?

Requires improvement

We rated this service as requires improvement for safe. This was because:

- CAMHS learning disability had a high staff vacancy rate. This stressed existing staff and reduced the range of treatments available to patients.
- Average caseloads within CAMHS learning disability exceeded national guidance. Two staff members' caseloads were double the recommended levels.
- The service did not actively monitor waiting lists for changes to patient risk levels.
- Not all eligible staff were up to date with Safeguarding children training levels 2 and 3.

However, we also saw that:

- All areas we inspected were visibly clean and well maintained.
- Reach-out service staff completed and regularly reviewed patient risk assessments and care management plans.
- Staff prioritised work to respond to patient crises.

Are services effective?

Requires improvement

We rated this service as requires improvement for effective. This was because:

- The service did not have a sufficient staff skill mix to provide a range of psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE).
- The service made limited use of outcome measures. This reduced their ability to monitor patient progress.
- Staff considered patients' capacity to make decisions about their care but did not consistently record these considerations in the patient' notes.

However, we also saw that:

- All staff we met with were skilled in their fields and had experience of working in CAMHS environments.
- Staff shared information and discussed cases to inform patient care. They also documented these interactions in patient care records.
- All teams worked well with other agencies to ensure a joined-up approach to patient care.
- Staff produced recovery-focused patient care plans that also covered patients' physical health needs.

Summary of findings

Are services caring?

Good

We rated this service as good for caring. This was because:

- Staff were respectful, responsive and supportive to patients, families and carers.
- The service involved patients, families and carers in care decisions. Staff adapted their behaviour to match patients' ages and needs.
- Staff had a good understanding of their patient confidentiality obligations.
- The service encouraged patients, families and carers to provide feedback about the service. Staff made changes based on this feedback where possible.

Are services responsive to people's needs?

Requires improvement

We rated this service as requires improvement for responsive. This was because:

- Noise and vibrations from a public gym above the Telford and Wrekin CAMHS team base caused significant and consistent disturbance to staff and patients at this location.
- There were long waiting times for neurodevelopmental assessments and specialist psychological therapy treatments.
- Soundproofing was ineffective in staff offices and consultation rooms at all service locations. This meant conversations could be overhead, causing disturbances and confidentiality issues for staff and patients.

However, we also saw that:

- The trust investigated all formal complaints, gave apologies, and reviewed systems when complaints were upheld.
- The CAMHS learning disability team moved patients up treatment waiting lists in response to reported increases to risk or need.
- Carers told us they could always access support quickly if needed and all teams had flexible appointment times.
- All teams provided patients, families and carers with written, easy-to-read information about their services as well as patient rights, complaints procedures and other important details.

Are services well-led?

Requires improvement

We rated this service as requires improvement for well-led. This was because:

- Staff did not feel involved in the trust's CAMHS development plans. Staff recently found out about a major transformation plan after its public release.

Summary of findings

- Staff could identify senior managers but felt they were not visible, did not understand CAMHS services and did not respond when staff raised concerns or made complaints.
- The teams measured referral-to-treatment waiting times but did not otherwise use key performance indicators to track and improve performance.
- New team leaders did not receive sufficient induction to their roles and lacked key skills and awareness as a result. No staff had access to leadership development opportunities.
- The trust did not keep a centralised database to monitor compliance with level 2 & 3 children's safeguarding training.

However, we also saw that:

- At a local level, staff respected their team leaders and felt supported by them.
- Staff received regular clinical and managerial supervision as well as annual appraisals.
- Staff used risk registers to identify and rate risks. Managers reviewed these registers, created action plans, and review dates for identified risks.
- The service employed administrative staff to allow clinical staff to concentrate on patient needs.

Summary of findings

Information about the service

Child and adolescent mental health services (CAMHS) are delivered in line with a four-tier strategic framework, which is now widely accepted as the basis for planning, commissioning and delivering services. Although there is some variation in the way the framework has been developed and applied across the country, it has created a common language for describing and commissioning services.

Shropshire Community Health NHS Trust provides tier 2 and tier 3 CAMHS services. The tier 2 staff work within multiagency teams that offer single point of access to a range of services and professionals. There were two single points of access services, Compass in Shropshire and Family Connect in Telford and Wrekin. They also provide tier 3 CAMHS within three core teams; CAMHS learning disability team, CAMHS Shropshire and CAMHS Telford and Wrekin.

We visited all three tier 3 teams and met with tier 2 staff from family connect.

CAMHS Shropshire and CAMHS Telford and Wrekin provided assessment and interventions for children and young people up to the age of 18. They shared a group of staff who offered a reach out service for patients with increased risks and needs. They were able to provide more intensive support.

CAMHS learning disability offer a service to all children and young people with a learning disability across the Shropshire, Telford and Wrekin. They share a team base with Shropshire CAMHS just outside of Shrewsbury. Telford and Wrekin CAMHS were based on a school/ leisure centre campus.

Each of the three core teams had a band 7 team leader. The service has recently appointed a band 8 CAMHS clinical services manager, due to start April 2016

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included two CQC inspectors and two CAMHS practitioners, a CQC observer and an Expert by Experience. Experts by Experience are people who have had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, 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?

Summary of findings

- Is it well-led?

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

During the inspection visit we visited Shropshire child and adolescent mental health services (CAMHS) team base, Telford and Wrekin CAMHS team base, CAMHS learning disability team base and Family Connect. The inspection team spoke with four patients who were using the service, 11 carers, the team leaders for each of the core teams and 27 other staff members including a clinical psychologist, doctors, nurses and a social worker. The inspection team also attended and observed four multidisciplinary team meetings, two home visits and three appointments. During the course of the inspection we looked at 28 patient care records and a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

A carers forum, Parents Opening Doors (POD), participated in a CQC survey prior to inspection. They found parents were concerned about waiting times for assessments and accessing a psychiatrist. All carers we spoke with during the inspection were also concerned about waiting times to access CAMHS services and four specifically highlighted difficulties in booking appointments to meet with the psychiatrists.

The survey also highlighted that most parents and carers were happy with the service they received once in receipt of CAMHS interventions.

Carers had also shared experiences via Healthwatch, a health-monitoring agency. These were long waiting lists, concerns around transition to adult services, no support following a neuro development diagnosis. Positive comments were shared about the reach out service and individual staff being very supportive.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure they have sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people using the service. In particular, within the CAMHS learning disability team and tier 2 staffing.
- The trust must review caseload capacity for all staff.
- The trust must review the systems for monitoring waiting time for patients requiring a neurodevelopmental assessment and put in place systems to reduce length of wait.

Action the provider SHOULD take to improve

- The trust should ensure systems are in place to monitor staffs compliance with children's safeguarding training and ensure that all eligible staff are up to date with required training levels.
- The trust should review the impact of noise and vibrations within premises upon staff and patients.

Shropshire Community Health NHS Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CAMHS Learning Disability team	Shropshire Community Health NHS Trust - HQ
Shropshire CAMHS Team	Shropshire Community Health NHS Trust - HQ
Telford and Wrekin CAMHS Team	Shropshire Community Health NHS Trust - HQ
Compass Shropshire CAMHS tier 2 staff	Shropshire Community Health NHS Trust - HQ

Mental Health Act responsibilities

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.

Requires improvement

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- All areas we inspected were visibly clean and well maintained. Cleaning records were not available as cleaning contractor kept these.
- Staff were aware of the trust-wide infection control policy. Hand gels and wipes were available to staff to use whilst out on community visits. There were laminated posters in bathrooms, demonstrating good hand washing techniques. Eighty one per cent of staff were up to date with the trusts mandatory infection control training. The trusts target for this training was at least 85% of its staff would have completed it.
- Toys and equipment in the waiting rooms and consultation rooms were visibly clean. Records confirmed these were cleaned on a regular basis.
- Telford and Wrekin CAMHS had alarms in rooms to summon assistance if needed. Staff told us they were tested on a regular basis. We did not see documentation to confirm this.
- There were no alarms in consultation rooms at Coral House, but staff had access to personal alarms.
- The team bases did not have clinic rooms and did not store medication. This is standard practice in a community CAMHS environment and did not affect patient care.

Safe staffing

- The service did not use any recognised approach to assess staffing levels. Commissioners had agreed current staffing levels with the trust. There were proposals in place to address identified staffing shortfalls. The trust was negotiating funding for these posts with commissioners.
- Across CAMHS, there were 50.7 whole time equivalent (WTE) clinical substantive staff.
- In the last 12 months (1 October 2014 – 30 September 2015), 6.14 WTE staff had left. CAMHS had a 13% vacancy rate. This was the second highest vacancy rate within the trust. CAMHS had a staff sickness rate of 4.5 %. All staff said the impact of vacancies resulted in large caseloads, high stress levels and less therapeutic interventions offered to the patients.
- Staff did not use any caseload management tools to monitor caseloads. Caseloads were managed through supervision and at referral and allocation meetings.
- Caseloads for clinical staff varied. Within the two generic CAMHS teams, caseloads were between 35 and 45 cases. A Royal College of Psychiatrist's a report dated November 2013, "CAMHS in the UK" advised that 40 is the recommended average caseload across a team, but individual clinicians may have more or less than this according to their role and work. The trust told us that weekly meetings were held with consultants to manage risk.
- The average caseload within the CAMHS learning disability team was 50, however, two nurse prescribers on this team held a caseload of approximately 100 patients.
- There were 3.8 WTE psychiatry posts. Of which, 2.9 were covered by locum psychiatrists. The locums we spoke with had been in place for some time. One locum consultant psychiatrist had been in post for two years.
- Psychiatrists across CAMHS reported having 200 – 250 patients on their caseload. There was one vacant psychiatry post that had no locum cover. The remaining psychiatrists said they covered the urgent cases but it was not clear how the service managed this cover.
- There was a 24-hour CAMHS consultant on call rota. All staff we spoke to reported psychiatrists were accessible.
- Average mandatory training compliance across CAMHS was 85%. This met the trusts target rate.

Assessing and managing risk to patients and staff

- Staff reported they completed initial risk screening on all patients. Staff used an in-depth risk assessment and management following screening if indicated. Staff said

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they used an adapted version of the Sainsbury Risk Assessment Tool. It had recently been amended to include specific risks identified for patients with a learning disability.

- Out of the 28 care records we reviewed, 24 had full risk assessment and management plans. Three care records had an initial risk screen and one care record had no risk assessment or screening. The 24 risk assessments were up to date and signed by staff. Where there was no risk assessment present, we found reference to risk and management plans in letters and ongoing contacts.
- Four of the risk assessments and management plans we reviewed were for patients under the Reach Out service. Staff reviewed and updated them weekly. They also included detailed and personalised safety plans. Staff and the patients had signed them all. They included reminders of what coping strategies worked or did not work for that patient in a crisis and supportive telephone contacts.
- We could see when reviewing contact entries in notes that risk monitoring was taking place where appropriate.
- Both generic CAMHS teams were able to respond to deterioration in a patient's mental health via the duty system. There was no duty system within the CAMHS learning disability team. However, they reported they would respond quickly to patients, carers or other agencies concerns. We observed this during inspection, when staff prioritised work to respond to a crisis.
- The services did not actively monitor the waiting lists to detect increases in level of risk. Patients, families and or carers were encouraged to contact the service if risks increased. Shropshire schools for the children and young people with learning disabilities could also contact services if they felt risks were increasing.
- The trust had a named safeguarding nurse and doctor. Staff told us that they knew who they were and how to contact them.
- Staff had a clear understanding of safeguarding and their responsibilities in relation to identifying and reporting allegations of abuse.
- The safeguarding lead in Telford and Wrekin CAMHS attended child exploitation meetings with the local authority.
- Ninety eight percent of staff had completed level one adult safeguarding training. This was provided within the trusts mandatory training.
- National guidance from an intercollegiate document published by the Royal College of Paediatrics and Child Health set out minimum safeguarding children training requirements for NHS staff. All staff within a CAMHS service should be trained to level 2 minimum and all clinical staff who work directly with children and young people should be trained to minimum level 3. It was not clear from data provided by the trust if all CAMHS staff met these requirements. Data given by the trust showed that 41 % of eligible staff within CAMHS had were up to date with safeguarding children level 3 training and 32 % of eligible staff were up to date with level 2 training. The trust said that it was likely that more staff had completed levels 2 and 3; however, they did not record completed training on centralised records for this service.
- However, the trust did not keep centralised data and were unable to tell us accurately how many staff had completed level two and level three children's safeguarding training.
- One clinician had completed additional level four safeguarding training with the NSPCC.

Track record on safety

- There were no serious incidents reported by the service between 1 December 2014 and 1 December 2015.
- The trust shared with the CQC actions and learning from a local serious case review and a multi-agency public protection arrangement discretionary review.

Reporting incidents and learning from when things go wrong

- Staff reported incidents in the electronic reporting system called Datix.
- The service had reported 85 incidents on Datix between March 2015 and March 2016. All incidents reported had been reviewed by the trust and had an outcome and local action plan. There was evidence that some changes had been made to practices to ensure incidents were not repeated. For example,

Requires improvement

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implementing changes to administration systems. We saw that staff had reported some incidents repeatedly but they had not yet been resolved. For example, noise within consultation rooms and increase in workloads.

- All staff we spoke with were aware of duty of candour principles and the importance of being open and transparent in their work.
- Nine of the staff we spoke to were concerned they did not receive feedback from investigation incidents. They felt the trust did not share lessons learnt. The teams discussed incidents from a local perspective. Staff said the trust did not feedback lessons learnt from incidents. Senior managers had recently invited team leaders to this meeting and on that occasion, team leaders had fed back information to the teams. Senior management had not previously included team leaders at this meeting and it was unclear if this as to be a regular feature. Team leaders felt that it would be beneficial to attend to improve communication between management levels.
- Staff said they could debrief following incidents in various settings. For example, team handover, meetings and peer supervision.

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.

Our findings

Assessment of needs and planning of care

- We looked at 28 care records, all of which had care plans. We found the majority were personalised, holistic and recovery focused. Recovery based means focused on helping patients to be in control of their lives and build their resilience so they can stay in the community and avoid admission to hospital wherever possible. All records reviewed were up to date and signed.
- Staff had completed comprehensive and timely initial assessments with patients, and where appropriate family and or carers.
- Assessments included physical health care issues.
- Following assessment, staff agreed a plan of care with patient and parent/carer.
- All care records were paper based and were stored securely. Staff had access to a locked case to transport notes within the community.
- Staff were able to access care records easily and a tracker system was in place to identify the whereabouts of notes if they were removed from cabinets. The tracker system reduced the likelihood of care records going missing. We observed staff using this system throughout the inspection.
- Tier 2 staff had some difficulty accessing records as they used the local authority electronic records system. Staff told us that after 3pm Monday to Thursday and all day on Fridays, they did not have access to administrative support. This meant to ensure any urgent referrals for tier 3 staff were hand delivered. This impacted upon their time to carry out direct patient work.

Best practice in treatment and care

- Tier 2 staff had easily accessible National Institute for Health and Clinical Excellence (NICE) guidelines available to support their triage of referrals.
- Nurse prescribers followed NICE guidelines when prescribing medication. For example, staff monitored physical observations of patients prescribed anti-psychotic, i.e. electrocardiograms, height, weight and other physical observations taken.
- The service could not offer sufficient psychological therapies to match NICE recommendations. This was due to limited skill mix and availability of suitable trained staff. Four staff commented they feel they were more likely to prescribe medication in the first instance because of this.
- The use of patient and clinician rated outcome measures was limited. There was evidence of Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA), goal-based outcomes, strengths and difficulties questionnaire and the Sheffield learning disability scale. However, these were not in all notes we reviewed and appeared to be used inconsistently. We found that outcome measures were not personalised and there was no corresponding evidence of individual goals.
- One psychiatrist reported they had completed one audit in the last year. They felt this was insufficient but felt pressured to prioritise clinical work. Another psychiatrist confirmed that there was little time to complete audit.
- CAMHS learning disability completed a case note audit last August 2015. They found care records had no clear evidence of a care plan or risk assessment. Following this, they implemented the use of an easily accessible and distinct care plan document. They also amended the risk assessment to include specific sections relating to risks specific to patients with a learning disability. The team plan to complete further case note audits this during 2016.

Skilled staff to deliver care

- Staff we met were skilled and experienced in working within CAMHS.
- The teams did not have a full range of mental health disciplines. They did not have occupational therapists, social workers, psychologists, family therapists or play therapists. They consisted mainly of nursing and medical staff. The CAMHS learning disability team had two psychologists and two behaviour support workers. The CAMHS team had access to a speech and language therapist and an occupational therapist.
- A family therapist had been recruited within the Telford and Wrekin CAMHS and was due to start in May 2016.
- There was one nurse trained in cognitive behaviour therapy (CBT) and they trained and supervised other

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staff to use CBT within their work. Another nurse was qualified in eye movement desensitization reprocessing therapy (EMDR). They held a small caseload providing specific EMDR interventions.

- CAMHS learning disability staff had training in intensive applied behaviour analysis (ABA). ABA is the techniques and principles used to bring about meaningful and positive change in behaviour.One member of staff had also completed skills-based training on risk management (STORM). STORM is an evidenced based training package developed by the University of Manchester to equip staff in assessing and managing risk of suicide and deliberate self-harm.
- An agency worker said she had been given two weeks to shadow the CAMHS learning disability team before working with their caseload. They felt this was supportive and gave them time to become accustomed to processes used within the team.
- Records showed individual clinical and managerial supervision regularly took place. Staff reported they had access to peer supervision as well as one to one supervision. Staff told us if supervision had been cancelled, it was always rebooked.
- Across CAMHS, there were three nurse prescribers. Supervision for these staff had been intermittent; this had left them feeling unsupported. However, since December 2015 regular supervision had been in place and were feeling increasingly supported.

Multi-disciplinary and inter-agency team work

- We observed multidisciplinary team working across all teams. We observed staff sharing information and discussing cases to inform practice and treatment.
- All teams had a weekly multidisciplinary team meeting, which included discussion of referrals, allocation of cases and business agendas. Some meetings were longer than necessary and were repetitive, which we felt was an ineffective use of staff time. For example, one meeting focussed on discussing and allocating referrals leaving little time for case discussion.
- We observed good joint working with schools. The CAMHS learning disability service held joint nurse prescribing and psychology clinics. This meant advice regarding management and strategies of behaviours could be given to a parent, carer, school or young person. Staff acknowledged this was in the absence of being able to provide specialist-talking therapies.
- Psychiatrists told us they had limited opportunity to provide any consultation work with other agencies due to capacity issues.
- We noted documented evidence of staff liaising with other agencies in the care records we reviewed.
- Staff sought information and participation from schools and other agencies involved with the young person and their family. This was included in the planning of their treatment and care.
- CAMHS had staff who worked alongside youth offending services (YOS). This meant they were able to offer mental health interventions to young people within the YOS.

Adherence to the MHA and the MHA Code of Practice

- Consultants were section 12 approved. This meant they were approved to carry out particular duties under the Mental Health Act (MHA).
- CAMHS consultants were part of an on call rota so could be requested to attend out of hours MHA assessments for patients under the age of 18. This follows good practice guidance within the MHA code of practice.
- All clinical staff had access to MHA training. Staff we spoke to had adequate knowledge of the MHA and code of practice. All staff knew how to initiate a MHA assessment if needed.
- Staff could contact the local mental health trust MHA administrative and legal team if they needed guidance. Not all staff we spoke to were aware of this.

Good practice in applying the MCA

- The Mental Capacity Act (MCA) act does not apply to young people aged under 16 years of age. For children under the age of 16, the young persons' 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.

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.

- Staff we spoke with demonstrated knowledge of Gillick competence. This showed that staff understood the importance of judging and assessing a child's capacity to consent.
- Staff did not routinely document Gillick competence.
- The Mental Capacity Act does apply to young people aged 16 and 17 and mental capacity assessments should be carried out if it is established that a person lacks capacity to make a decision.
- The trust provided Mental Capacity Act (MCA) training. Eighty one percent of staff were up to date with MCA training. This was just below the trusts target of 85%.
- Patients over the age of 16 were supported to make decisions where appropriate and when they lacked capacity, staff said decisions were made in their best interests, consulting with parents and or carers and taking into account the young person's wishes, feelings, culture and history. We discussed examples with staff and saw that capacity issues were considered. However, we did not see evidence of this recorded consistently within notes. One psychiatrist felt staff needed reminding that capacity issues were decision specific and not generalised.
- The Deprivation of Liberty Safeguards (DoLS) do not apply to people under the age of 18 years. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. These would include the existing powers of the court, particularly those under section 25 of the Children Act, or use of the Mental Health Act.
- There were no arrangements in place to monitor adherence to the MCA.

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

- Staff attitudes and behaviours were respectful, responsive and provided appropriate practical and emotional support.
- Staff were sensitive to the needs of different age groups. We observed staff adjusting their language to explain treatment options to younger children.
- It was clear from interactions we observed between staff and patients that staff had a good understanding of individual patient needs.
- Staff sought consent to share and permissions to gather information with others from patients and parents/ carers. These permissions were documented within the care records we reviewed. Staff understood the criteria for breaching confidentiality to protect children and young people and staff explained this to patients and parents/carers. One parent told us initially they were not sure if the CAMHS worker told her what she needed to know – but now had complete confidence they respected their child's confidentiality but would alert parents to any risks if needed.

The involvement of people in the care they receive

- Within CAMHS learning disability, it was clear from records we reviewed that staff involved parents/carers in care planning. Carers we spoke with confirmed that staff involved them with care planning.
- It was not clear how much patients with a learning disability were involved in their care planning. Staff said involving some patients in their care could be challenging due to the patients cognitive levels. However, staff said they worked with relatives and carers where applicable to develop care plans and attempted to care plan with the patients where appropriate.
- Records showed within the CAMHS teams children, young people and their carers usually received a clinic letter rather than a care plan. This detailed the support they would receive, how and why.
- Observations of CAMHS home visits showed staff involving patients and family. This was through discussion of treatment choices, individualised care plans and development of safety plans.
- Staff said some patients had participated in staff recruitment interviews. The team planned to start meetings with local advocacy groups.
- Staff said changes to the décor of the waiting rooms followed feedback from young people that it was too childish. Staff collected feedback from suggestion boxes placed in waiting rooms.
- Staff were aware of various local and national advocacy groups for patients and said they shared this information with patients and families/carers as needed.
- Friends and family surveys were available for patients and families/ carers to complete and provide feedback to the trust.
- The reach out staff had completed a survey with patients and families they had previously worked with. The survey from October 2014 to March 2015 focused on the patient and family experience of the reach out service. From this survey the team set action plans to address findings. For example, they addressed the amount of staff involved in each patients care.

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 CAMHS learning disability team had clear referral criteria and processes. The generic CAMHS teams referral criteria were unclear. Two staff told us they were not sure whether they accepted referrals for children under five years of age.
- The service took referrals from tier 2 colleagues based within the multi-agency single point of access services.
- Telford and Wrekin CAMHS had 2.8 whole time equivalent (WTE) staff working within the multi-agency single point of access. These staff triaged referrals to CAMHS and provided tier 2 interventions and consultancy work. However, due to long-term sickness only 1.4 WTE staff were working within the service. This meant there had been no cover when staff were absent on leave. This meant referrals were not being processed in a timely manner. The team leader said referrals could be made direct to the tier 3 team in this situation. However, we were concerned this would increase the workload of already pressured tier 3 staff and it had the potential for referrals to be delayed.
- Shropshire CAMHS had tier 2 staff working within a different multi-agency single point of access service. This meant processes to access Shropshire CAMHS were slightly different. The tier 2 staff were concerned the local authority did not always tell them about changes in processes. For example, the multi-agency single point of access changed to allow direct referrals from patients/ families and carers. However, CAMHS did not accept direct referrals. This caused confusion and extra work for the tier 2 staff. They have to redirect patients and parents/ carers back to a professional to re refer.
- Tier 2 staff prioritised referrals using a three-level system. All patients triaged as priority level one were seen within 24 hours by tier 3 duty staff. Following initial assessment, all other priority patients were placed on a waiting list for treatment.
- CAMHS had target times of 18 weeks to see a priority level 2- 3 patients for assessment following referral. The average waiting time for CAMHS learning disability team was six weeks, CAMHS Shropshire was eight weeks and CAMHS Telford and Wrekin was seven weeks.
- Waiting times across CAMHS for treatments varied. Cognitive behavioural and eye movement desensitisation reprocessing therapies had waiting times of approximately five months.This meant that patients went unsupported for a lengthy period.
- The CAMHS learning disability team waiting time for treatment varied between 12 and 16 weeks. Records showed patients were moved up the waiting list if there had been a reported increase in need or risk.
- The waiting list for neuro developmental assessment was up to 12 months. Carers we spoke to and feedback from a survey expressed concern for the length of wait. Post neuro development diagnosis support was not available to patients unless they had an additional mental health problem. Staff would refer these patients on to voluntary agencies that support children and young people with Autism.
- Teams offered flexible appointment times before 9 am and after 5 p.m. Two carers we spoke with confirmed this happened and said the services were very flexible.
- Staff told us they followed up with patients who did not attend by phone call or letter, dependent on level of risk. If levels of risk were high, staff would visit the patients home and if necessary make a referral to safeguarding if concerns remained.
- CAMHS monitored their did not attend (DNA) rates. Data shared by the trust showed that between September 2015 and February 2016 approximately 9 % of planned contacts were DNA. They had displayed posters in waiting rooms to remind people the impact of DNA'S onthe service.
- Services did not monitor if appointments ran to time or were cancelled.
- Four carers we spoke with said phone calls were always returned quickly and they could access support quickly if needed.

The facilities promote recovery, comfort, dignity and confidentiality

- Waiting areas across all services were child friendly. Toys and reading materials were available in the waiting areas. CAMHS services responded to feedback from children, young people and parents/carers by updating

Are services responsive to people's needs?

Requires improvement

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

aspects of the waiting area environment. For example, they put up artwork targeted towards the older age group following comments that some teenagers found the artwork childish.

- Consultation rooms were available across all sites. However, a common theme staff reported was there could be difficulties booking rooms. This could make booking regular slots with patients difficult. Staff managed this by booking in advance and seeing patients at school and home. Some staff said home and school visits meant they would see fewer patients due to lengthy travel times.
- All staff offices and consultation rooms had inadequate soundproofing. Staff reported that conversations could be over heard and our observations confirmed this during inspection. This made dealing with sensitive issues difficult for team leaders. It was also distracting for staff trying to carry out work. It could potentially breach confidentiality if other people can hear conversations.
- The Telford and Wrekin team base was situated underneath a public gym. Staff told us that this was problematic as noise from gym equipment could be heard throughout the day. Our observations during the inspection confirmed this, we heard loud noises and felt vibrations from the gym equipment. Whilst observing one care session, we had to change rooms as the noise above one consultation room had become too much for the patient to tolerate and it was interfering with their therapy session.
- Staff said environmental health had assessed noise levels following complaints by staff. However, it was deemed that the noise level did not meet environmental health thresholds for action to be taken. We raised our concerns about the level of noise to senior management and pointed out the interference from the gym and the impact this could have on children and young people on the autistic spectrum as they may find these disturbances particularly distressing. Senior managers told us they could not do anything about it, as they did not own the building.
- There were information leaflets available in the main receptions and numerous notice boards around the buildings to share information with patients, parents and carers. Information included details about patients' rights, how to complain and support services available.
- The reach out service had a leaflet explaining who they were and what they did. The leaflet had useful links and contact details (i.e. young minds) for the patient to access. This was given to all patients working with reach out staff.
- The CAMHS learning disability team had its own leaflet that explained its role and what interventions they offered. Patients, parents and carers were given this leaflet on initial assessment.

Meeting the needs of all people who use the service

- All sites were fully accessible to people with physical disabilities.
- Information leaflets in waiting rooms were in an easy to read format. Staff told us they could access leaflets printed in different languages if needed.
- Staff told us it was easy to access interpreters when needed.

Listening to and learning from concerns and complaints

- We saw patient and liaison service (PALS) leaflets in patient waiting rooms. This meant patients, families and carers had details of the complaints and compliments procedures. CAMHS learning disability staff gave all families a form at the initial assessment but the other teams did not.
- Between October 2014 – October 2015 CAMHS received 16 complaints. Following investigation by the trust, 11 were upheld and five partially upheld. No complaints were forwarded to the ombudsman. A common theme from the complaints was poor communication and waiting times. Where complaints were upheld, records showed the trust had given apologies and systems had been reviewed to reduce further issues. For example, an apology was given for breach of confidentiality and staff were advised to leave minimal information on answerphone messages.

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- Two carers we spoke with said they wanted to make complaint but did not feel it would be answered. They were worried it would impact negatively on the care they received.
- Team leaders said they dealt with informal complaints at a local level. However, due to a lack of communication and induction, they had only recently found out they needed to log these with PALS.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- The trust had visions and values of 'Strive to make a difference'. All staff we spoke to within CAMHS wanted to work within the field to make a difference in children and young people's lives.
- In line with government policy, a transformation plan for children and young people's mental health and wellbeing 2015 -2020 had been prepared by local clinical commissioning groups and the local authorities. However, all staff we spoke to said they had not been consulted about this document. Staff reported they had first seen the document when it was publicly accessible on the internet.
- Staff reported they did not feel part of the development of CAMHS services and had concerns about the future tendering of services. Several staff said they did not feel the trust understood what CAMHS services did and did not feel part of the trusts overall development plan.

Good governance

- All staff had regular supervision and yearly appraisals. There were systems in place to monitor these events.
- There were administrative staff in place who allowed staff to focus on direct care activities.
- Teams had one key performance indicator. They measured referral to treatment waiting times and were aware they were in breach of this if a patient wait was more than 18 weeks.
- There was a CAMHS risk register. The CAMHS learning disability team reviewed their section of the risk register every two weeks in a team business meeting.
- The risk registers were accessible by team leaders. This meant they could review and input information on the registers.
- We reviewed the risk registers. Staff had identified and rated risks. They had additional action plans and review dates. Concerns we had identified on inspection were on the risk register. Examples of risk identified were length of waiting lists, noise at team bases and issues with commissioning.
- We met with admin staff across the teams.They were concerned they had no regular business meetings. When business meetings happened, they were conducted in the main staff office. This meant there was no privacy and they were interrupted. They felt this caused a lack of communication between themselves and clinical staff.
- Each team had a business meeting. We reviewed minutes of these meetings. We could see from the minutes that they were attended by staff and local team issues were discussed. It was not evident that there was clear communication between teams and the board. Team leaders told us that they had only been invited to one governance meeting with the operational managers. This was in February and they were unsure if they were going to be invited again.
- The service did not keep centralised records to monitor which staff were up to date with level 2 and level 3 children's safeguarding training. This meant the service was unable to monitor if staff were trained to the required standard.

Leadership, morale and staff engagement

- Most staff we spoke with felt senior leaders within the trust and managers above band seven were not visible, did not communicate with CAMHS teams, did not know and understand CAMHS services and its needs.They did not feel listened to when they raised concerns and complaints. They did not feel involved in CAMHS service planning.The CAMHS staff group had written a letter to managers sharing their concerns prior to the inspection. However, they had not been responded to and felt disappointed by the lack of response. All staff said changes in the management of CAMHS over last few years has meant messages do not get conveyed, processes were not implemented and staff were constantly 'firefighting'. Comments made by staff in the CQC staff survey also reiterated these concerns.
- CAMHS staff reported they did not feel part of the development of CAMHS services and had concerns about the future tendering of services. Several staff said they did not feel that the trust understood what CAMHS services did and did not feel part of the trusts.
- Team members felt supported by each other but several staff indicated they were stressed and overstretched due to workloads.

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- Staff told us they felt there were limited opportunities for them to access leadership development courses.
- There was no local induction for team leaders. They had not been given guidance to their full range of duties in a timely manner. A team leader shared they had not had full training on the datix and were not aware of their roles as team leaders in the datix process.
- One member of staff had reported harassment and bullying to their line manager. They felt able to report this and that It was dealt with effectively.. They had received support through supervision and team leaders.
- A comment in the CQC staff survey stated staff would not feel safe whistle blowing due to pending tendering process , in that they were concerned they would not get job if they whistle blew.

Commitment to quality improvement and innovation

- The CAMHS team were helping with recruitment to a national research project being organised by the Anna Freud centre, a national children's mental health training and research organisation.