Inadequate

Leicestershire Partnership NHS Trust

Specialist community mental health services for children and young people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT5X1	Leicestershire Partnership NHS Trust, Trust headquarters, Riverside House	Child and Adolescent Mental Health Service (CAMHS) county team, Valentine Centre and Loughborough Hospital	LE7 7GX LE11 5JY
RT5X1	Leicestershire Partnership NHS Trust, Trust headquarters, Riverside House	Child and Adolescent Mental Health Service (CAMHS) access team, Valentine Centre	LE7 7GX

Summary of findings

RT5X1	Leicestershire Partnership NHS Trust, Trust headquarters, Riverside House	Child and Adolescent Mental Health Service (CAMHS) city team, Westcotes Drive, Leicester	LE3 0QU
RT5X1	Leicestershire Partnership NHS Trust, Trust headquarters, Riverside House	Child and Adolescent Mental Health Service (CAMHS) young person's team, Westcotes Drive	LE3 0QU

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Inadequate
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated specialist community mental health service for children and young people as inadequate because:

- Staff managed high caseloads and reported low morale.
- Care plans reviewed were not personalised, holistic or recovery orientated.
- The trust reported a 10% increase in the number of referrals received into the CAMHS service.
- There were delays in staff delivering treatments to young people and young people following assessment. We found multiple internal waiting lists where the longest wait for young people was 108 weeks. There were significant waiting times for a range of further assessments and treatments including psychology, school observations, psychiatric opinion and group work.
- Four young people told us they felt involved in developing their care plan however, they had not received a copy.
- Staff did not always record or update comprehensive risk assessments.
- Cleaning products in a cupboard in the waiting area was unlocked, which posed a risk to the young people.

However

- Environments were visibly clean and welcoming.
- Staff reported they felt supported by their colleagues and managers.
- Young people and their carers spoke positively about the CAMHS service.
- Staff had received specialist child safeguarding training and were able to make referrals when appropriate.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as inadequate because:

- There had been periods of low staffing. The CAMHS county young people's team had a high rate of sickness during the 12 months prior to the inspection. However, sickness levels had improved at the time of inspection.
- We found that staff did not regularly update risk assessments. Although staff contacted young people who were on the waiting list for treatment every six months to update their records. We found a serious breach, which was brought to the trust's attention immediately. Staff reported that they informed patients and families that if the patient's condition deteriorated they could contact the service.
- There was no provision for young people to access support during a crisis at night or at weekends.
- Some caseloads were high at 25 to 55, on average, per clinician.
- Across the county and city teams we found that out of 22 care records reviewed, seven did not have risk assessments either present or up to date.
- At the Valentine centre, cleaning products in a cupboard in the waiting area was unlocked, which posed a risk to the young people.

However:

- The teams knew how to report serious incidents and could access their manager to seek advice on when an incident occurred.
- Staff had received specialist child safeguarding training and were able to make referrals when appropriate.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff followed National Institute for Health and Care Excellence guidance when prescribing medication for young people. The non-medical prescriber and doctors liaised with the young persons' general practitioner to monitor blood pressure checks, blood tests and electrocardiograms.
- The CAMHS teams both at city and county followed a care pathway model. This care pathway referred to both pharmacological and psychological interventions and outcome measures that were staff used to monitor progress.

Summary of findings

- Staff provided psychological therapies as recommended by the National Institute for Health and Care Excellence, such group work, art therapy, interpersonal psychotherapy, eye movement desensitisation reprocessing and cognitive behavioural therapy.
- Staff we spoke with had an awareness of the principles of the Mental Capacity Act. We saw evidence on the computerised records system of consent to share information and how it was recorded. Staff told us that young people aged under 16 had their consent assessed under Gillick competency frameworks in relation to consent to treatment.

However:

- Eight out of the 22 care plans reviewed were not personalised, holistic or recovery orientated. Four records contained no care plan.
- Training records from the trust recorded that CAMHS county team had only 60% of doctors trained in the Mental Health Act.

Are services caring?

Good

We rated caring as good because:

- Staff treated young people who used the service with respect, kindness and dignity. We observed a group therapy session. Staff spoke with young people in a supportive way and was age appropriate.
- Young people were able to get involved in the recruitment and interviewing of staff and have input into developing the services provided by CAMHS.
- Staff reported that young people and their carers were involved in their care plans.
- Friend and family test responses were generally positive about the CAMHS service.

However:

- Three out of the 22 care records reviewed did not show that a copy had been given to the young person or family.
- Carers and parents reported there was a long wait for treatment.

Are services responsive to people's needs?

Inadequate

We rated responsive as inadequate because:

Summary of findings

- At the time of inspection, there were a total of 647 children and young people currently waiting to be seen in a specialised treatment pathways. 87 of the total patients had been waiting over a year to begin treatment. The longest wait was 108 weeks for four patients to access group work or outpatients.
- Whilst waiting for treatment, CAMHS staff contacted the child or young person every six months to update their care records. However, we found two young people had not been contacted by the service in over six months.
- The crisis on-call team worked 9am to 5pm Monday to Friday, which meant that there was limited provision for those young people who required crisis service support out of hours. Between 9pm and 9am, a CAMHS consultant psychiatrist was available for telephone consultation.

However:

- Funding had been received for the delivery of a crisis team, which would cover out of hour's provision for those young people requiring immediate assessment or treatment.
- Waiting times from referral to initial assessment was less than 13 weeks. The service met the national target times from referral to initial assessment.
- At all three locations visited there were adequate rooms available to support the assessment and treatment of young people and young people who were using the services.
- The service received 10 compliments in the last 12 months. The young person's team received the highest number of six compliments.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff we spoke with knew the trust's visions and values and spoke about the pride they took in demonstrating these.
- Staff we spoke with said they felt able to raise concerns without fear of victimisation and would approach their manager in the first instance.
- We found that staff were aware of the duty of candour and were open and transparent when something went wrong.

However:

- Morale was reported as low by staff due to the transformation of the service over the last six months.

Summary of findings

Information about the service

The trust provides specialist community mental health services for children and young people up to the age of 18 years. The service sees around 4000 young people and carers each year. The service covers Leicester, Leicestershire and Rutland. They provide specialist mental health assessments and treatments for a wide range of mental health conditions, emotional and/or behavioural difficulties at a level that requires specialist support. Staff teams include doctors, nurses, psychologists, family therapists, occupational therapists and other allied health professionals.

We inspected the following services:

- county and city child and adolescent mental health services (CAMHS) teams
- access team
- primary mental health team
- outpatients
- young person's team
- on-call for unscheduled care at Valentine Centre, Loughborough and Westcotes
- the Valentine centre-county CAMHS team
- Loughborough - county CAMHS west team
- Westcotes House - city team.

The CAMHS team was last inspected 9 to13 March 2015. There were requirement notices in relation to Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The trust had not reviewed its provision of assessment and treatment to young people to ensure they received it in a timely manner.
- The trust had not reviewed its provision of crisis services for young people to ensure that the young people using crisis services have an assessment by appropriately skilled staff to a responsive standard.
- The trust did not protect young people and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of young people and others who may be at risk from carrying out the regulated activity.
- The trust had not made suitable arrangements to ensure that staff were appropriately supported in relation to their responsibilities, including receiving appropriate training, professional development, supervision and appraisal.

The trust returned an action plan of which there was only one outstanding action. This related to funding for a crisis team. There were plans and a service specification in place at the time of inspection, and some staff had been appointed. This action point remains on the trust's action plan response.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team leader: Julie Meikle, Head of Hospital Inspection, mental health, CQC

Inspection Manager: Sarah Duncanson, Inspection Manager, mental health hospitals, CQC

The team that inspected the community mental health services for children and young people consisted of three inspectors, one expert by experience and three specialist advisors, a child and adolescent psychiatrist, social worker and a nurse.

Summary of findings

The team would like to thank all those who met and spoke with them during the inspection and who shared their experiences and perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information including stakeholders and put out comment cards for people who use the services to complete.

During the inspection visit, the inspection team:

- spoke with seven carers/parents of young people who were using the service
- spoke with six young people who use services
- spoke with the four managers across the county and city teams
- visited three locations across both the city and county CAMHS teams
- spoke with 28 other staff members; primary mental health workers, including doctors, nurses, and social workers
- observed a therapy treatment group with three young people who were using the services
- reviewed at 22 care records of young people
- observed the interactions of the access team staff with professionals, parents and carers
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Young people and their carers told us that there was a long wait to receive treatment from the service after they had been assessed.

However, six out of seven carers we spoke with were complimentary and positive about the treatment they had received and said that staff were kind and compassionate.

Young people felt that staff listened to them and they involved in developing their care plans and felt informed about the treatment options.

Summary of findings

Good practice

The Primary Mental Health team have a professionals' consultation line and respond to questions from young people and adolescents. The use of social media had been developed to help engage young people in asking questions and to seek help and advice about mental health issues.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that treatment is delivered in a timely manner.
- The trust must ensure that young people on the waiting list have up to date risk assessments in place, which are regularly reviewed.
- The trust must ensure the cleaning materials are securely stored and equipment is safely maintained.

Action the provider SHOULD take to improve

- When fully commissioned the trust should continue to implement the provision of a crisis service as previously identified at the last inspection to ensure that young people who require the crisis service have access to this out of hours.
- The trust should ensure that young people care plans are up to date and written in a holistic and personalised manner.
- The trust should ensure all staff are trained in the Mental Health Act.

Leicestershire Partnership NHS Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Young people and Adolescent Mental Health Service (CAMHS) Loughborough Hospital-county team west	Leicestershire Partnership NHS Trust, Trust headquarters, Riverside House
Young people and Adolescent Mental Health Service (CAMHS) Valentine Centre-county team east, access team and primary mental health team	Leicestershire Partnership NHS Trust, Trust headquarters, Riverside House
Child and Adolescent Mental Health Service (CAMHS) Westcotes House-city team, on-call team and young persons' team	Leicestershire Partnership NHS Trust, Trust headquarters, Riverside House

Mental Health Act responsibilities

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

- 37 nurses (74%) and 15 doctors (75%) had been trained in the Mental Health Act (MHA) 1983/2007. During our inspection, no young people were subject to a community treatment order (CTO) or guardianship. Staff told us that there have been young people subject to CTOs and that they were able to contact the Mental Health Act administrator when necessary.
- The on-call/crisis team staff informed us that they were able to contact and liaise with the approved mental health professional service to coordinate assessments under the MHA 1983.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- 84% of staff received training in the Mental Capacity Act (MCA), which applies to those young people over the age of 16 years.
- We spoke with staff who told us that young people and young people under 16 had their consent assessed under Gillick competency frameworks in relation to consent to treatment. We saw records to confirm this. Gillick competence is the principle used to judge capacity in young people to consent to medical treatment.
- We saw evidence on the computerised records system of consent to share information and how it was recorded.

Inadequate

Are services safe?

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

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

Our findings

Safe and clean environment

- Interview rooms at Valentine centre and Westcotes House were not equipped with alarms. Staff told us that they carry personal alarms that they can use to raise an alert if necessary. At Westcotes House, the reception was equipped with an alarm button for staff to summon help if required. In Loughborough county CAMHS team there a nurse call system in place. When activated other staff and porters from the community hospital would respond.
- Staff had rooms where they could conduct a physical health examination for young people including height and weight measures away from the public areas ensuring their privacy and dignity.
- The majority of the team areas were clean and well maintained. Although, Westcotes House City team décor in poor condition and was reported as being hot throughout the year. Staff had reported the heating issues to maintenance.
- Environments were visibly clean and cleaning schedules were in place at all locations. However, cleaning schedules were not always completed at Loughborough County team in accordance with timescales. At the Valentine centre, cleaning products in a cupboard in the waiting area was unlocked, which posed a risk to the young people.
- The trust provided PLACE cleanliness scores for Loughborough Community hospital and the cleanliness rate was 99%, which was above the trust and national averages. Figures were not provided for Westcotes House city team or Valentine Centre county team, as they were not included in the assessments.
- The blood pressure machines at all three locations were out of date for calibration. Therefore, staff could not ensure an accurate measure of blood pressure was being recorded.
- Across all CAMHS services, we found ligature risks, including door handles, windows, blind cords and fire door latches. However, the managers had ligature audits in place, which identified how staff would mitigate these risks. Ligature cutters were available at all locations.

Safe staffing

- There had been a high vacancy rate in some teams. The trust set the core staffing levels for the service. The established levels of qualified nurses across the service were 89 whole time equivalent (WTE). Data from June to August 2016 showed there were 38 vacancies. The established level of unqualified nurses was 20.4 WTE and there were 4.4 WTE vacancies. The CAMHS city administration staff, young person's team and the CAMHS County team had the highest vacancy rate with 31%. Two managers reported that there were recruitment plans in place to address the vacancies. At the time of the inspection, there was 0.4 nurse vacancy and 1.4 consultant vacancy.
- Six months prior the inspection the sickness rate was 6.4%. The service had experienced a high level of sickness and staff leaving the service during May and August 2016, staff reported that this had reduced. There was one member of staff on long term sick at the time of inspection. 10.9% of staff had left the service in the last twelve months. This was higher than the trust average of 9.1%. Sickness rates from May 2016 to October 2016 ranged from 8.4% in July 2016 to 4.5% in October 2016.
- The CAMHS county team had the highest sickness rate with 15%.Staff reported that the introduction of a computerised notes system, three new operational managers and the implementation of the access team impacted negatively on sickness levels
- At the CAMHS city team there was no use of agency for nursing or occupational therapy staff. Managers used bank and agency staff at CAMHS county team to focus on reducing the waiting lists.
- Caseloads were between 25 to 55 per clinician. At the higher end, this was above the nationally recommended

Inadequate

Are services safe?

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

number. Psychiatrists held higher caseloads in relation to the prescribing and monitoring of medication. Managers reviewed caseloads with staff during management supervision management.

- There was an on-call rota for a CAMHS psychiatrist that covered daytime from 9am until 5pm and then from 9pm until 9am. Between 5pm and 9pm there was an on-call CAMHS consultant psychiatrist available.

Assessing and managing risk to patients and staff

- We reviewed 22 care records. Seven records did not have a risk assessments present or staff had not updated the assessment. The risk assessments that were in place were comprehensive and had specific areas around safeguarding and any risk of child sexual exploitation identified.
- The service had an on-call service, which responded to young people in crisis. However, the team comprised four staff and did not provide cover at night or at weekends.
- A CAMHS psychiatrist between 9pm and 9am, seven days per week provided on-call cover. There was an action from the last inspection on provision of crisis services for young people and the full service provision for the crisis service was not in place at time of inspection. However, funding had been agreed for the service to begin April 2017 and some recruitment had taken place.
- The access team had provision to see urgent cases on a daily basis during the week. CAMHS on-call team completed assessments for those young people who were experiencing deterioration in their presentation.
- We found that staff did not regularly record their review of patients on the waiting list for changes in risk behaviours or update risk assessments. Although staff contacted young people who were on the waiting list for treatment every six months to update their records. Staff reported that they informed patients and families that if the patient's condition deteriorated they could contact the service. However, we found that one patient with low body mass index (BMI) had not been monitored for eight months by the service whilst awaiting a treatment group. We raised this with the manager who took immediate action.
- The trust had a lone-working policy in place. Staff reported that they had a system in place to inform colleagues when they were out. Staff risk assessed before home visits if staff had not met the young person and their family.
- No medications were stored in any of the locations or teams we inspected.
- Compliance with mandatory training for the service was 82%. The lowest mandatory training rates were for Mental Capacity Act 63%; safeguarding adults 68%, adult and paediatric life support 72%, Mental Health Act for nurses 74% and fire safety awareness 74%. Overall 87% of staff had received safeguarding young people level 3 training. Staff were aware of the policies relating to safeguarding and how to make a safeguarding referral. There had been 17 safeguarding referrals made in the last twelve months.

Track record on safety

- Two serious incidents were reported in the last twelve months for this core service. Staff had investigated one regarding a data breach. Managers shared the outcomes of this investigation were shared across the teams to minimise a risk of recurrence. Managers were still completing the investigation for the second.

Reporting incidents and learning from when things go wrong

- Staff knew what and how to report incidents. Staff reported incidents using the electronic incident form system.
- Staff were able to describe their duty of candour as the need to be open and honest with young people when things go wrong.
- Managers ensured that staff were debriefed after serious incidents.
- Managers shared outcomes form investigations, including lesson learnt at monthly business meetings.

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

- Staff completed comprehensive assessments for all young people in a timely manner.
- We looked at 22 care records. Seven out of the 22 care records reviewed did not have care plans that were personalised, holistic or recovery orientated. Four records did not have care plans in place at all.
- The information needed to deliver care and treatment effectively was stored securely within a computerised record system. However, there were still paper records in use for young people who had entered the service before June 2016.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication for young people. This included regular reviews and physical heath monitoring such as electrocardiograms, blood tests and blood pressure checks.
- Staff provided psychological therapies as recommended by NICE, such as group work, art therapy, interpersonal psychotherapy, and eye movement desensitisation reprocessing and cognitive behavioural therapy for young people and young people.
- Staff completed height and weight growth charts for young people who had been prescribed attention deficit and hyperactivity disorder (ADHD) medication. The service adhered to prescribing guidelines regarding ADHD medication set out by the Royal College of Psychiatrists.
- The CAMHS teams both at city and county followed a care pathway model. This care pathway referred to both pharmacological and psychological interventions and outcome measures used to monitor progress.
- Staff completed outcome measures such as the health of the nation outcome scales for young people and adolescents, global outcome scales, strength and difficulties questionnaires.
- The CAMHS service for city and county participated in national audits.

Skilled staff to deliver care

- CAMHS teams across all three locations had a wide range of mental health disciplines including child and adolescent psychiatrists, mental health nurses, occupational therapists, family therapists and psychologists. CAMHS offered placements for student nurses and trainee psychologists and doctors. There was an art therapist and trainee art therapist at Westcotes House city team.
- New staff received an induction period and mandatory training, clinical supervision and appraisal. They reported having opportunities to shadow other disciplines for example, a family therapist or psychologist to help understand their roles and responsibilities.
- Managers had access to an electronic programme, which enabled them to monitor staff training and compliance. However, mandatory training levels remained low. We saw evidence that managers had booked staff for future training to increase compliance.
- Staff were qualified and experienced in delivering treatments specific psychological treatments.
- Data showed 76% of staff across the service had completed their appraisals in the last 12 months. This was below the trust average appraisal rated of 83%.
- Staff reported having regular clinical supervision and they recorded this electronically. The trust had a clinical supervision target rate of 85%. CAMHS teams both county and city were below this target.
- The lowest supervision rates were for the county outpatients' team at 64%. The highest was the primary mental health team, young person's team and the on-call team who were all achieving 75% clinical supervision rates. Clinical supervision is a requirement of registration for nurses. Two nurses told us that they were not always able to record the supervision they received on to the electronic system.

Multi-disciplinary and inter-agency team work

- The access team had daily multidisciplinary team meetings at lunchtime. Other teams in the service met weekly as a multidisciplinary team to discuss cases.

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.

- Caseworkers have a slot in the multidisciplinary team meeting to present the risks, concerns and to obtain further consultation regarding a child or young person. A doctor told us that they were unable to hand a case over to another team because there were not enough resources.
- One doctor told us that the service teams have good working links with the General Practitioner, educational psychologists, and paediatric departments and with adult mental health crisis team.
- Staff worked effectively as a multi-disciplinary team. They were able to give examples of how they presented cases at multidisciplinary team meetings, and referred young people to other disciplines within the team for further assessment and treatment. The primary mental health team offered a telephone consultation line for professionals such as school nurses, teaching staff and allied professionals. This service was available from 8.30am until 3.30pm Monday to Friday.
- There was a young person's team based at Westcotes House who supported young people and young people who were looked after by the local authority and included a provision for unaccompanied asylum seekers who were young people.
- Within the CAMHS teams, there was provision for the young person's team to work with young people who were involved with the youth offending teams and young people who were homeless.

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

- 74% of nurses and 75% of doctors had been trained in the Mental Health Act (MHA) 1983/2007. During our inspection, there were no young people subject to a community treatment order (CTO) or guardianship. Staff told us that there had been young people subject to CTOs and that they were able to contact the Mental Health Act administrator when necessary.
- The on-call/crisis team staff informed us that they were able to contact and liaise with the approved mental health professional service to coordinate assessments under the MHA 1983.

Good practice in applying the Mental Capacity Act

- 84% of staff received training in the Mental Capacity Act, which applies to those young people over the age of 16 years.
- We spoke with staff who told us that young people and young people under 16 had their consent assessed under Fraser guidance and Gillick competency frameworks in relation to consent to treatment. Gillick competence is the principle used to judge capacity in young people to consent to medical treatment.
- Staff we spoke with had an awareness of the principles of the MCA. Two staff identified that it applied to only those young people who were 16 years of age or older.
- We also saw evidence on the computerised records system of consent to share information and how it was recorded.

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 treated young people and young people who used the service with respect, kindness and dignity. We observed a group therapy session. Staff spoke with young people in a supportive way and were age appropriate.
- Carers reported that the staff were professional, kept their boundaries and provided treatment and advice.
- Young people reported that they felt the staff understood their needs and listened to them.
- Whilst reviewing records we found that staff completed information sharing requests indicating whether a young person had consented to sharing information with other agencies.

The involvement of people in the care that they receive

- Three out of the 22 care records reviewed showed that a copy of the care plan had not been given to the young person or family.
- Staff reported that young people and their carers' were involved in the care plans. Some young people had copies of their care plans. Four young people told us they felt involved in developing their care plan however they had not received a copy
- Staff wrote young people' care plans within the assessment letter. The assessment reflected the needs of the child or young person in detail. However, they were not always written using child-friendly language.
- Carers and parents interviewed reported that the staff listened and provided a good service. However, most of them reported a long wait for follow up treatment following assessment. One carer stated staff informed them about the long wait for treatment at the assessment appointment.
- Managers told us that young people had been involved in interview panels and in the development of service provision such as the crisis team.
- Young people attended an 'evolving minds' group that was facilitated by a member of staff, and through this meeting they had input into CAMHS service development.

Are services responsive to people's needs?

Inadequate

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

Our findings

Access and discharge

- Waiting times from referral to initial assessment was less than 13 weeks. The service was meeting its target in this area.
- Patients waited a long time to start many forms of specialist intervention. These included specialist psychological therapy, an assessment by a psychiatrist, school observations and group work. In order to address this managers had put in place numerous internal waiting lists across all the teams within the service. However, managers did not ensure that these waiting lists were regularly monitored, reviewed. Staff contacted young people every six months.
- However, at the time of inspection, there were a total of 647 children and young people currently waiting to be seen in a specialised treatment pathway. 87 of the total patients had been waiting over a year to begin treatment. The longest wait was 108 weeks for four patients to access group work or outpatients. 64 young people were found to be on two or more waiting lists to receive treatment. The team with the longest waiting list for treatmentwas the County West Outpatient. Data showed that 149 young people had been waiting for treatment for27 weeks and three young people waiting up to 108 weeks at the time of the inspection.
- The on-call team worked 9am to 5pm Monday to Friday. Outside of these times, a CAMHS consultant psychiatrist was available for telephone consultation. However, funding had been received for the delivery of a crisis team, which would cover out of hour's provision for those young people requiring immediate assessment.
- Staff reported the adult crisis team staff assessed young people aged between 16-18 years who presented at the local hospitals. Staff admitted one young person under 16 years to the paediatric ward after 11pm at night for assessment by the on-call CAMHS team the next day. An "all age" team at the local acute hospital provided out of hours, evening and weekend for comprehensive mental health assessment by an all age mental health practitioner.There was a CAMHS specialist nurse in post to provide child specific expertise to the all age team.
- Staff screened the referrals into the service on a daily basis and assessment slots for urgent cases were available on the same day.
- A manager told us that there were ten young people receiving treatment who were over 18 years of age. The oldest was 21 years old. Staff decided on a case by case basis if young people over 18 years old required their treatment to be continued within the service.
- CAMHS had clear exclusion criteria and a policy for how to respond when a patient did not attend and appointment. In the event of a young person, not engaging staff attempted to contact them via phone calls and letters and sent a letter to the referrer.
- Staff informed young people and carers if they cancelled an appointment or if the appointment was delayed.

The facilities promote recovery, comfort, dignity and confidentiality

- There were adequate rooms available to support the assessment and treatment of young people and young people who were using the services. However, staff reported at the Valentine centre that rooms were difficult to book owing to the access service block-booking rooms. At the Loughborough community hospital and the Valentine centre, we found that therapy rooms were also equipped with desks and computers so that the rooms were dual purpose. However, there were toys available and staff reported buying cushions and soft furnishings to help make it more child-friendly.
- The city team at Westcotes House was an older building with separate therapy rooms. The décor and quality of furnishings needed updating.
- Across the service, there were information posters and leaflets for young people in relation to the services provided and external agencies that may also provide support.

Meeting the needs of all people who use the service

- The buildings at all three locations were suitable for those young people requiring disabled access, including toilet facilities.

Are services responsive to people's needs?

Inadequate

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

- At the Loughborough county team, there were separate toilets for young people.
- Following a serious incident investigation, interpreting services were highlighted as a resource to be used where necessary. This enabled young people and carers whose first language was not English to access care and treatment.
- There were welcome posters in multiple languages in waiting areas, and leaflets could be downloaded or printed in other languages.

Listening to and learning from concerns and complaints

- During the last 12 months, (1 August 2015 to 31 July 2016) specialist community mental health services for young people and young people had received 23 complaints, 15 of which were upheld. None of these complaints was referred to the Ombudsman. We saw comments from carers and young people on the notice boards about the long waits for treatment.
- A manager reported that there were a number of complaints about the length of time young people waited for treatment.
- Young people and their carers told us they knew how to complain.Staff were aware of the complaints process.
- CAMHS received ten compliments in the last 12 months; the young person's team received the highest amount of six compliments.
- The trust displayed feedback from young people using the service on their notice boards. They used the "you said, we did" format and the friends and family test feedback using a computer tablet. However, administration staff reported that the tablet had not been working for a few weeks.

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

- Staff we spoke with knew the trust's visions and values and spoke about the pride they took in demonstrating these. The vision and values were displayed on posters in offices and reception areas.
- The service had undergone several stages of transformation during the last six months and staff reported that they felt supported by senior managers. Two members of staff reported they had not seen any board members visiting the service recently.

Good governance

- We saw evidence that managers had booked staff for future training to increase the compliance rates for mandatory training.
- Whilst managers had a system in place for those young people awaiting specialist treatment pathway, this system did not reduce the waiting times for young people to receive care and treatment. Staff reported that they felt overwhelmed by the waiting lists. However, the waiting list was a standing item on the teams' business meeting agenda and was reviewed regularly.
- Staff knew how to report incidents and felt confident to do so following trust policies and procedures.
- Operational managers received monthly reports of key performance indicators. They had developed plans to address any issues identified in reports. There were safeguarding procedures in place and staff had received training in safeguarding level 3, Mental Health Act and Mental Capacity Act. Not all staff had completed this training and across the service, compliance was lower than the trust average.
- Staff told us that they would inform managers if they had any concerns regarding risks and that the managers would feed this back to the board through their meeting and submit to the trust risk register.
- The operational managers had sufficient authority within their roles to manage staff. One of the managers told us that they did not have any administration support.

Leadership, morale and staff engagement

- Managers completed return to work interview when staff returned to work after a period of sickness, if needed they would refer staff to occupational health.
- There were no active bullying and harassment cases across the service,
- Staff we spoke with felt able to raise concerns without fear of victimisation. However, three staff expressed frustration that concerns raised were not resolved and they did not receive feedback about their concern.
- Staff reported that they had high caseloads and felt pressure due to the multiple waiting lists. However, they felt supported by their colleagues and managers. Staff reported low morale owing to the transformation of the service over the last six months.
- Some staff reported that they felt stressed at times by their caseloads. However, they felt supported by their managers and colleagues. Flexible working was available for staff to work term only however staff reported that this had an impact on the other members of the teamwork during the school holidays.
- We found that staff were aware of the duty of candour and were open and transparent when something went wrong.
- Managers had systems in place to monitor levels of clinical supervision. Staff were not always recording supervision sessions.

Commitment to quality improvement and innovation

- The service does not participate in the Quality Network for Community CAMHS.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust had a large number of young people awaiting treatment and waits for certain treatments were up to 108 weeks. • Risk assessments and care plans were not always in place or updated whilst young people were waiting for treatment. • At the Valentine centre, cleaning products in a cupboard in the waiting area was unlocked, which posed a risk to the young people. • The blood pressure machines at all three locations were out of date for calibration. Therefore, staff could not ensure an accurate measure of blood pressure was being recorded. This was a breach of Regulation 12