Outstanding ☆

Central Manchester University Hospitals NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

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Date of inspection visit: 03-06 November 2015
Date of publication: 13/06/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RW3CH	Trust Headquarters, Manchester Royal Infirmary	The Winnicott Centre	M13 0JE
RW3CH	Trust Headquarters, Manchester Royal Infirmary	Pendleton Gateway Centre	M6 5FX

This report describes our judgement of the quality of care provided within this core service by Central Manchester University Hospitals NHS Foundation 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 Central Manchester University Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of Central Manchester University Hospitals NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

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 services for children and young people as **outstanding** because:

- CAMHS community services were continually reviewing, adapting and extending the services they provided to meet the changing needs of the local population.
- The service had developed standardised, integrated care pathways, delivered by multi-disciplinary/multi-agency teams, to provide effective care for patients with complex health needs.
- The service had made a strong commitment to research participation, in partnership with academic institutions, to improve the quality of service provision.
- The service had built positive relationships with partner agencies to deliver effective care and treatment. They ran regular multi-agency meetings to discuss how patients were progressing and how they could improve the service.
- The service ran fortnightly peer educational sessions so that best practice was shared throughout the multi-disciplinary and agency teams.
- CAMHS staff delivered specialist training to partner agencies. This included working with staff from the local authority to raise awareness of emotional health difficulties. They also delivered training to GP's to support children and young people diagnosed with attention deficit and hyperactive disorder.
- Patients were encouraged to identify what they wanted to change in the service to meet their needs. Patients identified that there was a lack of awareness of gender dysphoria, and how this affected young people in the local population. They produced a training video to raise awareness of these issues. The video was used as part of a training programme for new medical staff employed by the trust.
- A Patient Participation Group (PPG) was well established. Patients were encouraged to share their views and experiences so that changes to service delivery were made to meet their needs. There was a standing agenda item within clinical governance meetings where ideas for service improvement, expressed by the PPG, were discussed.
- Patients were actively involved in the recruitment of new staff to the service.
- Staff used rating scales and scoring systems to assess and monitor patients' health and the effect of treatment. This was used routinely to inform the care of patients.
- Carers said that the staff valued their well-being, as well as their children. The service ran educational courses to equip carers and parents with the skills, knowledge and emotional resilience to support their child with a specific mental health need.
- Carers said that CAMHS staff would go exceed their expectations to meet their child's individual needs. Examples given to us included a psychologist going into a child's school to explain and raise awareness of their condition to their peers.
- Staff received regular, monthly supervision from senior staff members.
- Staff felt valued by the organisation and thoroughly supported in their role by senior management.
- Every patient had a thorough risk assessment that was completed on referral to the service. Risk assessments were appropriately reviewed following any contact with the patient or following a change in their level of risk to self and/or others.
- Referrals to the community teams were triaged immediately upon receipt. Both teams had an effective on-call duty rota to deal with any emergency referrals to the service both within and out of service hours. The service set an indicative target from initial referral to treatment at 11 weeks for non-urgent, routine referrals. The service were consistently meeting this target, seeing most non-urgent, routine referrals within nine weeks.

However,

Summary of findings

- Hand-washing facilities were not available in all clinical areas at the Winnicott Centre. This increased the risk of cross-contamination.
- At the 16-17 Emerge team at Moss Side, alarms were not available for staff use in all clinical areas. Staff did not have access to personal alarms.
- Staff could not access care records electronically. This made it difficult for staff to have timely access to a child or young person's case history when conducting an emergency assessment off-site.
- The multi-disciplinary team did not use a standard, formalised care plan template to document a child or young person's current plan of care. This made it difficult to locate the care plan within the care records, and identify what the most current plan of treatment for the individual was.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- Staff completed a thorough risk assessment of every patient at initial triage. These were updated regularly as evidenced in individual care records. Patients and their carers had crisis management plans that they could refer to if the patient needed support in an emergency.
- Senior management consistently shared information about any adverse events with staff. This was done through the trust intranet that all staff had access to, within weekly team meetings and weekly staff bulletins that were displayed in staff rooms.
- Incident recording and reporting was effective and embedded across all services.
- There were enough staff with suitable training to deliver care safely. Staff had been trained in safeguarding, could recognise abuse and reported it appropriately.
- Incidents were reported and learned from locally and across the trust.

However,

- Hand washing facilities were not available in all areas where clinical contact took place at the Winnicott centre.
- Staff at the 16 -17 Emerge team did not have access to personal alarms in case of emergency. There were also no alarms fitted in rooms where clinical contact with a young person took place.

Are services effective?

Good

We rated effective as **good** because**:**

- The service used a wide range of outcome measures to assess the progress patients were making.
- The service delivered a wide range of psychological therapies recommended by NICE (National Institute of Care and Excellence), for patients with mental health difficulties.
- The service provided evidence based interventions and practices that NICE identified as being innovative work. This included the Child and Parenting Service that provides clinical interventions to pre-school children and their families.

Summary of findings

- Staff adopted a multi-disciplinary and collaborative approach to care and treatment. Staff shared best practice with other colleagues and respected and acknowledged each other's input.
- Staff received regular clinical and management supervision.
- The CAMHS service had positive working relationships with partner agencies to deliver effective care and treatment. CAMHS staff were integrated into some of the partner agency teams. This was to support their internal staff in meeting the needs of vulnerable young people using the service.
- CAMHS staff provided training to partner agencies, including the local authority. This was to raise awareness of emotional health difficulties in children and young people.

However,

- CAMHS staff could not access care records electronically when working off-site. This meant that when assessing a patient in an emergency, there could be a delay in completing a thorough assessment of their needs.
- Care was formulated into a plan that was discussed and shared with the patient. However, the service did not record this information using a standardised care plan template. This meant that when looking through a child or young person's care records, it could be difficult to locate their current plan of care.
- The service did not provide mandatory training in the Mental Health Act, Mental Capacity Act and the Gillick Competence Framework to all clinical members of staff.

Are services caring?

Outstanding ☆

We rated caring as **outstanding** because**:**

- Staff involved patients and their families as equal partners in their care and in making decisions. The patient's consent was sought throughout. Families and carers were involved as appropriate and according to the patient's wishes. Where appropriate, staff shared information with families and carers. Staff documented this within individual case notes.
- The service empowered patients to identify and raise awareness of issues that mattered to them. Patients at the

Summary of findings

16-17 Emerge team produced a training DVD to raise awareness of gender dysphoria and how this affects the emotional health of young people. This was used as part of the staff-training programme across Royal Manchester Children's Hospital.

- A patient participation group (PPG) was well established. Patients' views on how the service could be improved was presented to senior management within monthly governance meetings. Where appropriate, the service was adapted in response to their preferences.
- Patient's had sat on 12 interview panels to recruit new members of staff, and the service encouraged them to identify what qualities they would like staff supporting them to possess. Patients delivered training to medical students.
- The service supported the government endorsed project, Future in Mind. The project aims to transform CAMHS by placing more emphasis on what patients want and need from the service. The service actively sought young people's participation in shaping their CAMHS for the future.
- Carers told us that staff were interested in their well-being as well as their child's. Staff had gone the extra mile to support them during difficult times.
- The service provided educational courses to carers of patients using the service. Carers said that the service empowered them to increase their knowledge of their child's condition and learn new skills to meet their needs.

Are services responsive to people's needs?

Outstanding ☆

We rated responsive as **outstanding** because:

- All new referrals to the service were triaged immediately when received by the teams. A rota of senior clinicians in each team screened all new referrals to identify their level of risk. Staff allocated on the on-call duty rota saw emergency referrals the same day. A separate on-call rota responded to out of hours emergency referrals across all the Manchester and Salford teams.
- CAMHS psychiatrists provided training to local GP practices to support them in identifying and treating patients with attention deficit and hyperactive disorder. Part of the aim of this training was to reduce the amount of referrals to CAMHS that did not

Summary of findings

meet the criteria for further specialist community mental health support. This was effective in reducing staff case-loads and increasing face-to-face contact with patients already in the service.

- CAMHS were piloting a 2 plus 1 assessment clinic across all the core locations. Practitioners offered this service to patients when they required more information to identify whether their service is appropriate for their individual needs. CAMHS were then able to signpost, or refer onto, a more appropriate service if required. Children and young-people were therefore not left without professional support should CAMHS not be appropriate for them.
- The service was responsive to the specific needs of the local population. A wide range of teams had been established in response to this. For example, within Manchester, children and young people living within children's homes, being adopted or fostered, or involved in crime, is high compared to other areas within the UK. The CAMHS services established multi-agency teams to support patients with these specific experiences, including the Looked After Children's team and the CAMHS Youth Offending Service. These teams worked effectively together to deliver seamless care.
- The service worked well with other voluntary organisations to meet the specific needs of children and young people living within the local area. This included the charity 'Young Black Perspectives' based in inner city Manchester, Trafford and Salford. The charity worked with black and minority ethnicity groups to deliver peer-led education and one to one support for young people aged between 11 and 25 years of age.

Are services well-led?

Outstanding ☆

We rated well-led as **outstanding** because:

- Senior management were continually reviewing, adapting and extending the services they provided to meet the needs of patients. In November 2015, the service was one of nine CAMHS nationally to be successful in gaining a place on the i-thrive accelerator programme. 'I-thrive' is a needs based model that enables care to be provided specifically for a population that is determined by its needs.
- Senior management set up a team called Vision to Action to develop a series of initiatives to improve the CAMHS service. Referrals pathways and assessment methods were standardised. The team developed new integrated care

pathways that were delivered by multi-disciplinary and multi-agency teams. A work force training and recruitment strategy was also being developed and implemented to support the new care pathways.

- Staff praised the supportive, professional culture in which they worked. Clinical staff received regular supervision. Staff felt comfortable in accessing informal support if and when required from senior staff. Collectively, this had a positive effect of maintaining staff morale and improving staff performance within a challenging work environment.
- All staff said that senior management encouraged staff to share their views regarding service development. Staff ran peer education sessions to share their professional skills, knowledge and ideas. Clinical staff had access to further training, such as courses in psychological therapies recommended by National Institute of Care and Excellence.
- Staff were involved in providing specialist training to other local agencies and organisations who supported young people with mental health difficulties, such as GP's and school nurses.
- The service demonstrated a commitment to quality improvement and innovation. CAMHS staff were involved in carrying out applied research across The University of Manchester and throughout departments at the Royal Manchester Children's Hospital. The need to understand and meet the changing needs of the local population was at the forefront of all the research projects in which the service participated.

Summary of findings

Information about the service

Central Manchester University Hospitals NHS Foundation Trust was established in 2009. It provides tertiary and specialist healthcare services to Manchester, treating over 1 million patients per year.

Child and adolescent mental health services (CAMHS) is part of the Royal Manchester Children's Hospital (RMCH). It provides inpatient and community services for young people experiencing mental health difficulties.

Within CAMHS, there is a four tier strategic framework. This is nationally accepted as the basis for planning, commissioning, and delivering of services to children and young people with mental health needs.

The CAMHS community teams at Central Manchester University Hospitals Foundation Trust were multi-disciplinary and included psychiatrists, trainee doctors, nurses, speech and language therapists, psychologists and administrative staff.

Core district CAMHS sit under tier 3 services and clinics are based in four localities across Manchester and Salford. These include: The Bridge, based in Harperhey, Carol Kendrick in Wythenshawe, The Winnicott in Central and Pendleton Gateway in Salford. Tier 3 CAMHS services are provided in partnership with other targeted CAMHS services that sit within these four core teams. These include:

- Looked After Children Team (LACS)
- Child and Parent Service (CAPS)
- Children with Disabilities Service
- Emotional Health In Schools Team
- Youth Offending Service/Federation Team (YOS)
- Emerge 16-17 team, Moss Side, which provides services exclusively for young people between the ages of 16 and 17 experiencing mental health difficulties

The CAMHS community service has not been inspected by the CQC previously.

Our inspection team

Chair: Nick Hulme

Head of inspection: Ann Ford, Head of Hospital Inspections, Care Quality Commission

Team Leader: Sarah Dunnett, Inspection Manager Mental Health, Care Quality Commission

The team comprised three inspectors and a specialist child and adolescent mental health nurse

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of patients, 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 this service and asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of findings

- visited two community teams and looked at the quality of the office environment and observed how staff cared for patients
- visited one of the partnership teams, Emerge 16-17, in Moss Side, and attended a multi-agency team meeting
- observed two treatment review consultations between a patient, carer and psychiatrist
- observed a 'Future in Mind' group attended by young people and CAMHS staff
- attended a 'CAMHS Innovation Market' at the Royal Manchester Children's Hospital, where CAMHS staff, partner agencies, commissioners and young people showcased new, innovative practices being developed within the service
- attended a patient participation group at the Pendleton Gateway Centre, Salford
- attended three multi-disciplinary meetings
- attended one meeting with partner agencies, including local commissioners and the police
- spoke with five patients
- spoke with eight carers of patients
- spoke with the managers for each community team
- spoke with 12 other staff members, which included doctors, nurses and psychologists
- interviewed the divisional director with responsibility for these services
- looked at 16 care records
- 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

Patients told us that the staff were supportive and that they were easy to contact should they have any concerns. Patients were also assigned a key worker on entering the service. Some of the patients we spoke with said that although several professionals were involved in their care, everyone knew what was going on and the team worked well together to meet their individual needs. Patients also said that their lives had been transformed by the service and staff go the extra mile to support them. Patients who were about to enter adult mental health services praised CAMHS' staff support during the transition process.

Carers told us that staff always listened to them and they were encouraged to share their ideas. They told us that staff were proactive in suggesting other support and educational groups they could join to increase their skills and knowledge base to support their child. Carers that the service treated them as equal partners in delivering care. They said that the post-diagnostic workshop for carers of young people diagnosed with asperger's syndrome was an invaluable resource. Carers said that the workshop provided them with the practical skills and knowledge to support their child effectively. They also said that the service was concerned with their welfare as well as their childs.

Carers also confirmed that they had received information about other services available whilst waiting for their child's first appointment. Some carers identified that it could be 'frustrating' waiting for the initial assessment with a mental health practitioner following referral. However, carers we spoke with felt that despite their frustrations, the waiting time was proportionate to their child's level of risk.

Carers were aware that there was an on-call duty practitioner they could contact should their child's level of risk increase, and staff could see them sooner if required. Carers we spoke with praised the expertise and dedication of the services' staff to improve their child's health and well-being once treatment had started.

Carers identified that CAMHS work well with other organisations and services that their child also had involvement in. This included communicating regularly with the child's school and offering practical advice on how to support them. Carers identified how this reduced their stress levels by making them confident in CAMHS' ability to support them in all aspects of their child's life.

Summary of findings

Good practice

- The Specialist Community Mental Health Services for Children and Young People aspired to improve their service to meet the needs of the local population. This was evident across all the services we visited:

1. The Divisional Director of the service successfully placed a bid to become one of 9 CAMHS teams nationally to gain a place on the i-thrive accelerator programme. I-Thrive is a needs based model that enables care to be provided specifically for a population that is determined by its needs. Emphasis is placed on prevention and promotion of health. Patients are involved in decisions about their care through shared decision-making. In gaining a place on the national programme, the service will have access to national experts to further their vision in meeting the needs of the local population.

1. The service had established a range of specialist teams. These were offered in partnership with local agencies to meet the needs of the local population. This included the Youth Offending Service, the Looked After Children's team and the Riding the Rapids and Social Communication and Interaction Team. Many of the services these teams offered had been identified by the National Institute of Care and Excellence (NICE), as being innovative practices for treating children and young people with a mental health difficulty.

1. The need to understand and meet the changing needs of the local population was at the forefront of all the research projects the service participated in. The Social Development and Research Group conducted major treatment trials for children who had been diagnosed with autism. PACT (Pre-School Autism Communication Trial), was a large-scale treatment trial, funded by the Medical Research Council, that focused on parent-mediated interventions for young children with autism. This had gained recognition by NICE as a recommended treatment for symptoms of autism in children. The group secured funding to undertake further development of the PACT model. This will extend the trials and research into middle childhood, and is set to begin in January 2016.

- Services we visited ran a range of educational courses and parental support groups for carers. This included the post-diagnostic autism workshop and child and parenting courses. NICE had identified the child and parenting course as an innovative practice in improving relationships between pre-school children and parents with emotional health difficulties. Groups and courses enabled carers to develop new skills, knowledge and confidence to support their child with a mental health difficulty.

- The service provided specialist training to local agencies that were also involved in supporting children and young people with emotional health difficulties. CAMHS delivered the 'Behind the Behaviour Programme' for staff working within the local authority to raise awareness of mental health issues in young people.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should review the lack of alarms in all areas where 1:1 clinical contact takes place with a young person in the 16-17 Emerge team site at Moss Side.

- The provider should review the availability of suitable handwashing facilities at the Winnicott centre to promote good practice in infection control.

- The provider should improve staff access to patients' care records when working off-site.

- The provider should review how patients' care plans are documented. They should also review how they are shared with patients and their carer's.

- The provider should review the provision of clinical staff training in the Mental Health Act, Mental Capacity Act and the Gillick Competence Framework.

Central Manchester University Hospitals NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Winnicott Centre	
The Pendleton Gateway Centre	

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.

The trust did not provide mandatory training in the Mental Health Act (MHA) to specialist community mental health services for children and young people. Senior management identified this was an issue that required addressing. However, they could not provide any evidence of plans to introduce this training. Senior management were confident that all clinical staff had a good working knowledge of the Mental Health Act.

Clinical staff we spoke with demonstrated a sound knowledge of the MHA when interviewed. However, they said they rarely had to refer to the Act in their role.

Staff had good working relationships with psychiatrists within the teams we visited. Clinical staff would refer to them should they have concerns regarding a patient's welfare, particularly if they had identified the use of the MHA may be appropriate. All the consultant psychiatrists we spoke with were Section 12 approved and received annual training in the MHA. A doctor who is approved under Section 12 of the MHA has been given the authority on behalf of the Secretary of State as having sufficient expertise in the diagnosis and treatment of mental health disorders. Section 12 approved doctors play a key role in determining whether someone should be detained in hospital under the MHA.

Detailed findings

Where a patient receiving treatment from CAMHS had been detained under the MHA , care records showed that staff had acted promptly in alerting a consultant to the need for a MHA assessment. The consultants were accessible so that an assessment was completed as soon as required.

At the time of our inspection, no children or young people were subject to a Community Treatment Order (CTO).

All clinical staff knew that a Mental Health Act administrator was based at the tier 4 inpatient unit at Galaxy House, Central Manchester. Clinical staff would also refer to the MHA administrator should they have any queries or concerns regarding the proper use of the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust did not provide mandatory training in the mental capacity act (MCA) to specialist community mental health services for children and young people. Senior management could not provide assurance that there were any plans in place to facilitate this. However, they were confident that clinical staff had a sound knowledge of its purpose and proper use.

The MCA does not apply to young people under the age of 16. Where a child is under the age of 16, a framework called Gillick competence is used to determine a young person's decision-making ability. The Gillick competence framework recognises that some young people may possess a sufficient level of maturity to make some decisions themselves. Staff working with young people should routinely assess whether or not a young person has a sufficient level of understanding to make decisions. This can include decisions regarding their care and treatment.

Within the care records that we reviewed for patients below the age of 16, we saw evidence that staff were assessing the patients' decision-making ability in accordance with the principles of Gillick competence. Where staff identified that the patient lacked sufficient maturity to make decisions, staff sought consent from whoever had parental responsibility.

The MCA does apply to young people aged 16 and 17. Staff knew that they should always assume the capacity of a young person aged 16 or 17 unless there was evidence to suggest otherwise. In the care records we reviewed of patients assessed as not having capacity, there was evidence that the guiding principles of the MCA had been followed.

Care records we reviewed of patients aged 16 and 17 evidenced that patients assessed as having the capacity to make decisions were given the option to consent for information to be shared with others. This included their parent/s, carers and school. As part of their initial assessment protocol, the 16-17 Emerge team supplied all patients with an information sharing and confidentiality statement. This advised the patient of their rights regarding information sharing relating to their care and treatment.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- At the CAMHS services, we looked at the layout, design and cleanliness of all the areas where young people were cared for. At the 16-17 Emerge site in Moss Side, staff that saw patients did not have access to personal alarms in case of emergency. Rooms where meetings took place were also not fitted with an alarm system. However, rooms were next door to the staff office. Patients were risk assessed prior to meeting with staff, and if staff felt that their safety maybe compromised they would inform another staff member who would provide support. Staff would also consider inviting the patient to another CAMHS location for their appointment, (where there were alarms), following a risk assessment that indicated a potential risk of harm to staff. Joint appointments with another member of staff were also considered. Staff had not reported any incidents to the trust that identified the lack of an alarm system as the cause.
- Each community team had a clinic room and these were clean and appropriate for their use. Staff had completed up to date risk assessments to assess the safety and suitability of both clinic rooms.
- At the Winnicott Centre, there were no washbasins or soap dispensers installed where meetings with patients took place: these were only available in communal corridors within the building. This limited staff's ability to follow good infection control practices. The National Institute of Care and Excellence guidelines (NICE, policy CG139), state that practitioners must have access to hand de-contamination facilities immediately before and after direct contact with a patient. However, despite this, staff had not formally reported any infection control issues within the locality. Any invasive procedures that would carry a higher risk of cross infection, such as blood testing, were carried out on the main paediatric hospital site; Royal Manchester Children's Hospital. The majority of consultations between patients, carers and staff did not involve direct contact. Therefore, the risk of cross-infection was minimal.
- A health and safety policy was in place for both community sites and we saw that these were regularly reviewed and in date. At the Pendleton Gateway centre, an external company, SCC, maintained the building. The policies and procedures we reviewed identified that safety inspections were regularly taking place. Staff were aware of their roles and responsibilities for promoting a safe working environment.

Safe staffing

The trust provided the following figures that relate to the time-period September 2014 to September 2015

Establishment levels: qualified nurses (WTE) : Tier 1-3 CAMHS: 29.81

Establishment levels: nursing assistants (WTE): None

Number of vacancies: all professions (WTE): Tier 1-3 CAMHS: 8%

Staff sickness rate (%) in 12-month period: Tier 1-3 CAMHS: 3.9%

Staff turnover rate (%) in 12-month period: Tier 1-3 CAMHS: 1.2%

- A full-time CAMHS consultant vacancy had recently been filled. Management had identified a start date for January 2016. A part-time locum doctor was covering the full-time vacancy until the new consultant was in post. Staff we spoke with identified that they could easily access a psychiatrist when required. The care records we reviewed identified that patients continued to have a good level of contact with their psychiatrist despite the staffing short fall. Management had advertised a band 5 CAMHS nursing vacancy for recruitment.
- Staff we spoke with identified that they had heavy caseloads. Central Manchester Foundation Trust CAMHS' has the second highest rate of face-to-face contact with children and young people within the UK. The trust reports 3,674 per 100,000 of the population are seen by the service. Active caseloads ranged between 40 - 70 at the Winnicott and Pendleton Gateway Centres. Caseload size was in part determined by the practitioner's specialism. For example, referrals to

practitioners specialising in the treatment of Attention Deficit and Hyperactive Disorder (ADHD), were particularly high. At the time of our inspection, we saw that senior management were conducting a review of staffing skills mix across tier 3 services. The aim was to identify where more practitioners, skilled in treating particular disorders, may be required to meet the changing needs of the local population.

- All staff we spoke with said that they were well supported by senior management in managing their caseloads. Senior management review and monitor caseloads within staff's monthly managerial supervision. Senior management also monitored and reassessed staff caseloads in weekly referral meetings to ensure fairness and equity of allocations.
- The trust provided a corporate mandatory training course for all staff, including basic life support, moving and handling and infection control. Information provided by the trust before inspection identified that 88% of Winnicott staff, and 92% of Pendleton Gateway staff, had completed corporate mandatory training. All staff had completed their local induction.
- All clinical staff had completed level 3 safeguarding training at the time of our inspection.

Assessing and managing risk to patients and staff

- We reviewed 16 patient care records across the locations we visited. We saw evidence that all new referrals were triaged and risk assessed at the point of referral by an appropriately qualified practitioner. In each locality, there was a daily rota of senior clinicians. They were responsible for reviewing waiting lists and screening new referrals to the service. This rota covered the hours between 9am and 5pm.
- A standard risk assessment screening tool was used to identify the type and severity of risk. Referrals classified as non-urgent or routine with a lower level of risk would be discussed and allocated to a member of staff in a weekly referrals meeting. The patient's level of risk would continue to be monitored and assessed using a standardised risk assessment tool. This was evidenced in all the patient's care records.
- Clinical staff completed an enhanced risk assessment for patients identified as being medium or high risk. A comprehensive risk management plan was put in place and shared with the patient and their carer's (where appropriate). Carers we spoke with confirmed they had copies of these risk management plans and were clear what to do should a crisis emerge.
- Senior management kept a formal record of all cases that were identified as high risk and chaired weekly risk assessment management meetings (RAMM). Practitioners involved in the patient's care would attend to collaboratively discuss and identify a robust risk management plan.
- Every locality had an on-call duty practitioner rota that covered the hours between 9am and 5pm. This service was responsible for triaging any emergency referrals. Staff arranged direct contact with the patient to complete a thorough risk assessment and crisis management plan. The duty on-call practitioner attempted to alert the young person's key worker if they were known to the service. The key-worker tried to attend so that continuity of care was maintained. Patients and carers that we spoke with were all aware that there was on-call duty practitioner they could contact should they require emergency support.
- Patients under the age of 16 would attend their local Paediatric Accident and Emergency Department (A and E), if they presented in a crisis out of hours. An on-call Greater Manchester CAMHS rota, covering all core district locations, were then contacted by A and E staff to attend and complete an assessment. For patients over the age of 16, out of hours emergency referrals were directed to their local A and E department. Adult mental health services then attended to assess the patient.
- Staff demonstrated a thorough understanding of safeguarding and their responsibilities in relation to identifying and reporting allegations of abuse. The care records we reviewed identified that staff were following the trust's safeguarding policy and shared information with other agencies appropriately and in a timely manner.
- Staff knew the trust's lone working policy and followed this when carrying out home visits. Administrative staff printed off staff calendars and filed these chronologically so all staff were aware of each other's whereabouts. These calendars were also available to

Good

Are services safe?

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

staff electronically. The duty on-call practitioner in each locality would 'buddy up' with staff visiting young people off site via a telephone call immediately before and after a visit.

- Senior staff completed annual audits to review prescribing levels. Team psychiatrists prescribed medicines on hospital issued prescriptions known as FP10HPs. These were stored securely and audited by the trust's pharmacist team. Medicines for patients were dispensed in community pharmacies. CAMHS were currently piloting a pharmacy project that introduced pharmacy-prescribing support to community teams. This will include a full review of CAMHS' prescribing practices by a qualified team of pharmacists.

Track record on safety

- Between September 2014 and September 2015, the service reported no serious incidents.

Reporting incidents and learning from when things go wrong

- Senior management consistently shared information about any adverse events to staff within the teams we visited. This was done through the trust intranet, within weekly team meetings and weekly staff bulletins that were displayed within staff rooms. Staff were also made aware of incidents from across the trust and from outside the service.
- Incident recording and reporting was effective and embedded across all services. The trust had an electronic system, Ulysees, that was used by staff to record incidents.
- Staff discussed any incidents that had occurred with their line manager or clinical supervisor within monthly supervision, depending upon the nature of the incident that had occurred. All the staff we spoke with said that management were supportive and available to discuss any incidents informally upon request. Senior management also facilitated a fortnightly multi-disciplinary team meeting where any recent incidents were discussed. This included incidents both internal and external to the service.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- Across the localities we visited, we reviewed 16 patient care records. All of these showed that a comprehensive assessment of the patient's needs had been completed. The patient's key worker used a standardised assessment template called the initial assessment clinic (IAC).Part of the assessment invited the patient to share what their strengths and difficulties were and identify any goals they wanted to achieve whilst in the service. This took the form of a strengths and difficulties questionnaire (SDQ) which is a measure of psychological well-being in 2-17 year olds.
- Staff routinely involved the patient's family (where appropriate), and other agencies in collecting information to inform the initial assessment. For example, staff would contact with the patient's school to gain a wider perspective on how their life may have been affected by their current mental health difficulties.
- Some staff we spoke with raised concerns that it was difficult to access a patient's care records when conducting an emergency assessment off site. This was because they were not available in electronic format. Care records provided information regarding patient's history and current treatment plans. Accessing care records could be time consuming if they needed to be sourced from another location or if the patient was out of area. This meant that practitioners had limited knowledge available to them to assess promptly and thoroughly in an emergency situation.
- Senior management had plans in place to move to a full electronic system. This will make care records more accessible to staff. In the new year of 2016, the service will be using the Mental Health and Learning Disabilities Data Set (MHLDDS), which is an approved NHS Information Standard. It brings together key information from the mental health, learning disabilities and autism spectrum disorder care pathways. This information is captured on different clinical systems as part of patient care. During processing, the data set consolidates all the information into a single patient record.
- Of the 16 care records we reviewed, 15 contained detailed and relevant information regarding a patient's treatment. Treatment aims were identified in partnership with the patient that were recovery orientated and person centred. Fifteen of the 16 care records demonstrated that all members of staff involved in the patient's care had made a valuable and consistent contribution to the treatment plan. However, a standardised care plan template was not used to structure and record the treatment plan. This meant that it was difficult to locate the care plan when accessing patients' care records. This could make it difficult for any new practitioners providing support to the patient to identify what each professional was responsible for and what the current treatment plan was.

Best practice in treatment and care

- Most of the staff across the locations we visited were trained, or currently undertaking training in, CYP IAPT (Children and Young Person's Improving Access to Psychological Therapies). Staff had undertaken training in several psychological therapies recommended by the National Institute of Care and Excellence, including cognitive behavioural therapy, cognitive analytic therapy, dialectical behavioural therapy, interpersonal therapy and family therapy. Many of the staff we spoke with were trained to deliver more than one psychological therapy. Once referred, the waiting time to receive CYP IAPT was 8 weeks.
- The service provided a range of effective, evidence based, clinical interventions that NICE identified as being innovative practices. This included the Child and Parenting Service. This provides early intervention courses to parents of children with mental health difficulties. The parent-child game also had a strong evidence base for improving outcomes for patients who present with severe behavioural problems and relationships difficulties. The service offered three half-day clinics per week in north and south Manchester and Salford. The programme helps facilitate a positive relationship between parent and child by improving parental interaction. The programme focuses on rewarding positive behaviours and supporting parents to provide clear and consistent instructions and consequences to their child's behaviour.
- At the Pendleton Gateway centre, staff used Qb testing to assess whether a patient has attention deficit hyperactivity disorder (ADHD). Current research

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identified that the Qb test was effective in reaching an accurate diagnosis and more effective prescribing of medications for young people with ADHD. Several staff were trained to facilitate this.

- Consultant psychiatrists reported positive working relationships with paediatricians for treating the physical health needs of patients. Care records confirmed timely and appropriate referrals were made to paediatric services when specialist support was required.
- A range of outcome measures were used to rate the severity of the patient's condition, and any outcomes of treatment, throughout the patient's engagement with the service. Outcome measures used by practitioners included the Spence Children's Anxiety Scale (SCAS). This measures the type and level of anxiety the patient may be experiencing. RCADS (Revised Children's Anxiety and Depression Scale), was also used to measure any symptoms of depression and anxiety. Staff recorded the outcomes electronically on the trusts online data recording system, CORC, (CAMHS Outcome Research Consortium). The CORC system then collates and transfers all the outcome scores to the Department of Health CYP-IAPT project. This meant that an accredited body was continually reviewing outcomes of the treatment provided.
- The service conducted audits to monitor their progress in achieving improved outcomes for patients. The Salford CAMHS eating difficulties clinic completed an audit to identify how the service performed in achieving standardised outcomes in 2013. They then compared this to service performance in 2015. This meant that staff were aware of what was working for patients in their approach, and what they needed to change to reach positive outcomes. For example, staff within the eating difficulties clinic arranged to see patients within their own homes in addition to in clinic. This meant that the service was more accessible to patients, and therefore there were less appointment cancellations.

Skilled staff to deliver care

- Within specialist community services for children and young people there was a range of disciplines. This included speech and language therapists, consultant psychiatrists, trainee psychiatrists, family therapists, nurses, specialist nurse practitioners, consultant psychologists and psychologists. Many of the staff we spoke to across locations had extensive experience working within CAMHS, (both within the trust and for other organisations), in excess of ten years.
- Clinical staff received supervision monthly from both their line manager (managerial supervision), and clinical supervisor (clinical supervision). Clinical staff also received additional supervision from an appropriately qualified clinician who specialised in their area of professional expertise. All of the staff we spoke with said that they felt fully supported and valued by senior management and clinicians. They could access informal 1:1 supervision more regularly at their request. Senior management also facilitated fortnightly team time meetings. A formal time slot was designated for staff to discuss any difficult cases and gain professional advice and support from other colleagues.
- All staff at the Winnicott centre, and 76% of staff at the Pendleton Gateway centre, had received an appraisal. The 76% recorded for the Pendleton team fell below the overall CAMHS service performance of 84% compliance.

Multi-disciplinary and inter-agency team work

- Weekly multi-disciplinary team meetings took place at each locality we visited to discuss current caseloads, new referrals and share best practice. Regular multi-agency meetings took place with other teams external to the organisation that were also involved with children and young people. At the 16-17 Emerge team, we observed a multi-disciplinary team meeting that was highly effective. There was an equal voice and mutual respect between members of the team.
- We spoke with senior staff members from the local authority that worked closely with the service. They identified that the service were an invaluable source of support to their teams and, at times, had exceeded their expectations in the service they delivered. For example, a staff member said that a CAMHS practitioner had provided informal counselling to their staff following the death of a young person who used the service. External staff said that CAMHS were accessible and provided them with useful advice and tools to support young people and their carers more effectively.

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- Members of the CAMHS teams were placed in partner agencies, such as youth offending teams. This increased the sharing of skills and knowledge between multi-agency teams so that children and young people received more effective care and treatment.
- At the Pendleton Gateway centre, CAMHS staff explained how every fortnight they ran peer education sessions. Members of the multi-disciplinary team presented topics that related to any new training or evidence-based research they were involved in. The aim of the session was to share best practice with other members of the team, and to raise awareness of each professions contribution in providing care and treatment for patients. Members of external organisations, such as the police and the local authority, were also active in presenting and attending these sessions.

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

- The trust did not provide mandatory training in the Mental Health Act (MHA) to specialist community mental health services for children and young people. Senior management identified this was an issue that required addressing. However, they could not provide any evidence of plans to facilitate this training. Senior management were confident that all clinical staff had a good working knowledge of the Mental Health Act.
- Clinical staff we spoke with demonstrated a sound knowledge of the MHA when interviewed, however, they said they rarely had to refer to the Act in their role.
- Staff had good working relationships with psychiatrists within the teams we visited. Clinical staff would refer to them should they have concerns regarding a patient's welfare, particularly if they had identified the use of the MHA may be appropriate. All the consultant psychiatrists we spoke to were Section 12 approved and received annual training in the MHA. A doctor who is approved under Section 12 of the MHA has been given the authority on behalf of the Secretary of State as having sufficient expertise in the diagnosis and treatment of mental health disorders. Section 12 approved doctors play a key role in determining whether someone should be detained in hospital under the MHA.
- Where a patient receiving treatment from CAMHS had been detained under the MHA , care records showed that staff had acted promptly in alerting a consultant to the need for a MHA assessment. The consultants were accessible so that an assessment was completed as soon as required.
- At the time of our inspection, no children or young people were subject to a Community Treatment Order (CTO).
- All clinical staff knew that a Mental Health Act administrator was based at the tier 4 inpatient unit at Galaxy House, Central Manchester. Clinical staff would also refer to the MHA administrator should they have any queries or concerns regarding the proper use of the MHA.

Good practice in applying the Mental Capacity Act

- The trust did not provide mandatory training in the Mental Capacity Act (MCA) to specialist community mental health services for children and young people. Senior management could not provide assurance that there were any plans in place to facilitate this, although they were confident that clinical staff had a sound knowledge of its purpose and proper use.
- The MCA does not apply to young people under the age of 16. Where a child is under the age of 16, a framework called Gillick Competence is used to determine a young person's decision-making ability. The Gillick competence framework recognises that some young people may possess a sufficient level of maturity to make some decisions themselves. Staff working with patients should routinely assess whether or not the patient has a sufficient level of understanding to make decisions. This can include decisions regarding their care and treatment.
- Within the care records we reviewed for patients below the age of 16, we saw evidence that staff were routinely assessing the patient's decision-making ability in accordance with the principles of Gillick competence. When a patient did not have sufficient maturity to make decisions, staff appropriately sought consent from whoever had parental responsibility.
- The MCA does apply to young people aged 16 and 17. In the care records we reviewed of patients assessed as not having capacity, there was evidence that the guiding

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principles of the MCA had been followed. This included the assumption that a young person aged 16 or 17 had capacity unless there was any evidence to suggest otherwise.

- In the care records we reviewed of patients aged 16 and 17, we saw evidence that patients assessed as having the capacity to make decisions were given the option to consent for information to be shared with others. This included their parent/s, carers and school. As part of their initial assessment protocol, the 16-17 Emerge team supplied patients with an information sharing and confidentiality statement. This advised the patient of their rights regarding information-sharing relating to their care and treatment. Patients identified whom they were happy to receive information regarding their care and treatment.

Outstanding ☆

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

- We observed two treatment review meetings for a child diagnosed with a mental health difficulty. The child's parents also attended the review. The practitioner was attentive to the needs of both the patient and the parent. The practitioner sensitively invited the child's views, and discussed the pros and cons of particular courses of treatment. This was presented in an age appropriate way, whilst also ensuring the parent had enough detailed information to support and monitor their child effectively. The practitioner displayed a genuine interest in the parent's well-being. They also discussed options regarding additional support groups they may consider attending to build emotional resilience, skills and knowledge.
- The service respected patients' individuality and treated them with dignity and respect. We observed a patient participation group (PPG) at the Pendleton Gateway centre. This was attended by patients and was co-facilitated by staff. Staff respected patients' individuality and were knowledgeable about their life histories, circumstances and aspirations for the future. They also asked for the patients' consent before disclosing any personal information. Patients said they felt comfortable in voicing their opinions about the service without fear of retaliation should they say anything negative. Patients referred to CAMHS staff as an 'extended family' and said they felt reassured that they could contact the service at any time should they have any worries or concerns. Patients said that the CAMHS team had positively transformed their lives, and whilst they would miss the support of CAMHS when they reached the age of 18, the service had provided them with the skills and self-confidence to cope well in the future.
- Some patients said that they had been apprehensive about transitioning to adult services in the future. However, they said that CAMHS staff had went the extra mile and introduced them to a local charity organisation, 42nd Street, that supports people with emotional health difficulties between the ages of 11-25 years. Patients said that CAMHS staff had supported them to attend groups run by the charity until they felt confident enough to do so alone.
- Patients identified that they felt valued and respected as a person by staff within the service. They said that staff remembered details about their life and on-going care needs and were genuinely interested in their well-being. This was not just their key worker but all of the multi-disciplinary team involved in their care. Patients said that because staff had made an effort to understand their difficulties from their point of view, staff were consistently able to anticipate and respond to their needs effectively. Patients said that staff knew what triggers may cause them to become unwell and staff were consistently proactive, yet sensitive, in supporting them to remain as well as possible.
- Patients said that they had been inspired to help other young people who have emotional health difficulties because of the high level of support they have received from the service. They said that this is why they attend the patient participation group.

The involvement of people in the care that they receive

- Carers talked about how CAMHS had exceeded their expectations in the emotional and practical support they offered. This included accepting a child out of area very promptly, and also communicating with parents' employers to explain their current difficulties where they were unable to temporarily work due to carer stress. Carers said they felt valued and supported by the service during difficult times of their life.
- Carers praised the additional support CAMHS provided for carers of patients. Carers were encouraged to access parental support and educational groups within the service. They said that the aim was to increase their knowledge of their child's mental health condition and learn more skills so that they were more able to meet their needs independently of the service. Carers referred to the 'Riding the Rapids and Social Communication and Interaction Team' as being an excellent source of knowledge and support. This is a 10-week group intervention for parents and carers of children who have social communication and speech difficulties. Carers talked about how the post diagnostic workshop for carers of patients with attention deficit and hyperactivity disorder had helped them to understand more about the condition and develop new coping skills.

Outstanding ☆

Are services caring?

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

- The patient participation group (PPG) was open to young people that wanted to make a positive difference to child and adolescent mental health services. Some patients had completed a training video on gender dysphoria for trust staff. Patients had identified that gender dysphoria had become a condition more commonly experienced by young people within the local population, and staff empowered them to raise awareness of this within the trust. Children and young people were involved in delivering training to medical students to ensure their experiences were heard.
- Patients completed a booklet and leaflet to promote the service to other young people. They also co-produced a newsletter about work they do within the CAMHs service. This is sent to families and patients. The staff facilitating the group also encouraged patients to share their ideas. These would then be presented to senior management in CAMHS governance meetings. Patients talked about how their suggestions are listened and responded to by the service; they had redesigned the area waiting at the Pendleton Gateway centre to make it a more child and young person friendly. They also talked about their plans to use social media as way to make CAMHS more accessible to young people. The included the possibility of using face book, face time and text messaging to improve communication between staff and patients.
- Patients were actively involved in the recruitment of new staff to the service. Up until our inspection, the patients had sat on 12 interview panels. They told us that their views were seriously considered when appointing a new member of staff and they were invited to think of new questions that they could potentially ask interviewees.
- We attended a future in mind group where CAMHS staff invited patients to share their views about what a good CAMHS service should look like. The young people were able to give their views in a number of ways and were skilfully supported by staff. Staff presented feedback from the session and explained what the next steps would be. The future in mind project has been set up by NHS England and the Department of Health as part of the children and young people's mental health and wellbeing taskforce. Its aim is to increase access to mental health services for children and young people, and to make CAMHS more responsive to their individual needs.
- The service continually collected feedback from patients, their parents and carers. This was done via annual patient and carer surveys, feedback post-boxes in clinic waiting rooms and regular documentation in care records. Staff listened to feedback and actively used it to drive improvements within the service to make care delivery more person-centred and effective. For example, in a patient and carer survey one carer answered a question about if they could talk to staff easily. The carer identified that letters regarding referrals and appointments were not very clear and they needed more support to understand this. As a result, the service used more user-friendly language in the letters they sent out so that people using the service had a clearer understanding of what to expect.
- In 15 of the 16 care records we reviewed, there was evidence that patients and their carers, where appropriate, had been involved in the care planning process. Care records captured patients' views, and they identified goals that they were working towards achieving during their treatment. We spoke with seven carers of young people using the service. They all confirmed that they had had meaningful involvement in care planning and knew what their child's current plan of treatment was.

Are services responsive to people's needs?

Outstanding ☆

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

Our findings

Access and discharge

- Referrals to the Winnicott and Pendleton Gateway teams were triaged immediately upon receipt. A daily rota of senior clinicians at each core district CAMHS were responsible for doing this. All urgent referrals were assigned to a CAMHS practitioner within a weekly allocation meeting and were seen within seven days of referral. Fifteen of the sixteen care records we reviewed confirmed that patients were seen within the target time.
- The Pendleton Gateway and Winnicott teams had set a local target time of nine weeks to assess routine, non-urgent cases from point of referral. The trust's target to assess new referrals was set at 11 weeks. Five of the six carers we spoke with identified that their child was assessed within approximately 9-11 weeks of referral. Senior management at one of the locations demonstrated how all referrals awaiting initial assessment were logged on a computer database. Administrative staff at the Winnicott centre had access to the waiting times for all routine referrals across the four district CAMHS sites. If the waiting time from initial referral to assessment was approaching 11 weeks, the database sent an alert to senior management to advice that an assessment date should be identified as a priority. Once seen, treatment was offered and the only waiting time identified was for up to eight weeks for psychological therapies (CYP IAPT).
- At the 16-17 Emerge team, staff assessed emergency referrals on the same day. A local target was set to see urgent referrals within two to three working days, and routine referrals within eleven weeks. The records we reviewed confirmed that the service was achieving these targets.
- An opt-in letter to the service was sent to patients within two weeks of referral. The service sent further information about CAMHS and what to do in an emergency. Senior members of staff were devising a service user contract that the patient will be asked to consider whilst waiting for their initial assessment. The contract will ask the patient what they expect from the service, and also what the service expects from them. This was also part of the future in mind project that places the patient at the centre of all decision regarding care and treatment.
- Health care or children's services staff, including GP's, health visitors, school nurses and social workers, made referrals to CAMHs. The service used the children's global assessment scale (CGAS) which is a global rating of functioning aimed at children and young people aged 6-17 years. Patients were assessed against different levels of functioning from 0, needs constant supervision, to 100, superior functioning in all areas. The child or young person must fall below a certain level of functioning to meet the criteria for referral into the service. The criteria that the young person must meet was clearly identified in the CGAS assessment.
- Staff identified that most of the referrals they received were appropriate and met the referral criteria. Staff said that referrals to practitioners specialising in the treatment of attention deficit and hyperactive disorder (ADHD) was particularly high. At the time of our inspection, senior management were conducting a review of staffing skills mix across tier 3 services. The aim was to identify where more practitioners, skilled in treating particular disorders, are required. CAMHS psychiatrists were also providing training to local GP practices to support them in identifying and treating patients with ADHD. Part of the aim of this training was to reduce the amount of referrals to CAMHS of cases that did not meet the criteria for referral.
- The Winnicott and Pendleton Gateway teams were piloting a 2 plus 1 assessment clinic. CAMHS practitioners offered this service to young people when they required more information to identify whether their service was appropriate for their individual needs. CAMHS were then able to signpost, or refer onto, the more appropriate service if required. Children and young-people were therefore not left without professional support should CAMHS not be appropriate for them.
- Within staff caseloads, there was a level of non-engagement with services. In the first quarter of 2015/2016, there was a did not attend rate (DNA) of 15% in the Winnicott team, and 19% in the Pendleton Gateway team for first and follow up appointments. A preventing missed appointments policy was in place. Staff

Are services responsive to people's needs?

Outstanding ☆

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

screened patients that did not attend their appointments for any safeguarding concerns. Staff raised concerns to their safeguarding team when appropriate. Staff would also attempt to re-engage the patient by telephone and letter. Staff would also use alternative engagement methods if telephone contact or letters to the individual were ineffective. This included contacting the organisation that originally referred them to the service, such as their school or GP.

- The service offered patients appointments in alternative locations if this made the service more accessible to them. The core CAMHS district teams had two satellite clinics in Salford and Trafford. These ran twice a week in the afternoon.
- In all the teams we visited, appointment cancellations by the service were rare. If an appointment was cancelled, an alternative date was sent to the patient that week. Staff told us that the only time they may have to cancel an appointment was when an on-call duty practitioner alerted them to an emergency referral. If the staff member was the assigned key worker for the emergency referral, they would prioritise this to maintain continuity of care for that patient during a crisis period.

The facilities promote recovery, comfort, dignity and confidentiality

- The waiting areas at all locations we visited were calm and welcoming. Leaflets about the patient advice and liaison service (PALS) were available. This included information on how to make a formal complaint. They also displayed a variety of service information leaflets, including contact details for a translations service so that people could receive information in different languages.
- Patients identified that the waiting room at the Winnicott centre needed to be brighter and more child and young person friendly. The service responded by re-decorating the area to meet their expectations. Age appropriate toys were available for smaller children, books and magazines for older children. Posters advertising the patient participation group and the future in mind project were also displayed. Patient and carer feedback boxes were available in both waiting rooms. Posters advertising what changes had been made to the service as a result of feedback were also displayed.
- At the Winnicott centre, there was a purpose built kitchen where patients that had an eating disorder could attend for occupational therapy sessions to prepare meals. Qb testing equipment to diagnose and measure the severity of attention deficit and hyperactivity disorder were also available.

Meeting the needs of all people who use the service

- Access to the Winnicott centre was via the ground floor. At the Pendleton Gateway centre, the CAMHS service was based on the second floor but had lift access. Both centres were accessible to people with mobility issues.
- A large number of referrals to the Winnicott team were for young people from a diverse range of ethnic backgrounds. Care records we reviewed evidenced that staff were accessing translation and interpreting support for patients and their carers when appropriate. In the 16-17 Emerge team, staff had undertaken an audit to review the ethnicity of children and young people accessing the service. The service had a population of 33% from ethnic backgrounds and the service was seeing 29% of patients from diverse backgrounds.
- The service worked closely with voluntary organisations within Manchester and Salford to meet the needs of young people and children who identified as being of a black or minority ethnicity (BME). This included a local charity called 'Young Black Perspectives' that provides advice and one to one support to children and young people from ethnic minorities and asylum seekers. The service also employed staff from a variety of ethnic backgrounds so that cultural diversity was reflected and valued within the CAMHS teams.
- Across all the locations we visited, there were a variety of specialist workers and teams available to meet the individual and complex needs of the local population. This included:

1. Looked After Children's Service (LACS) including:

Adoptive Families Support Service, Fostering Service

and a Therapeutic Advisory Service

Are services responsive to people's needs?

Outstanding ☆

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

1. Riding the Rapids and Social Communication and Interaction Team (SCAIT)
2. Child and Parenting Service (CAPS)
3. CAMHS Youth Offending Service (YOS)
4. Psycho-Social Liaison Team
5. Working with Rapid Response Team
6. Chronic Fatigue Service
7. Eating Disorders Team
8. Emotional Health in Schools Team

- We saw that there were positive and strong effective working relationships across the community and specialist teams which meant that care was coordinated effectively for patients and carers.
- The SCAIT service was set up in response to a high level of demand for more targeted support for young people with a disability displaying challenging behaviours within the local population. The team delivering the programme are from a wide range of clinical backgrounds, including speech and language therapists, educational psychologists, psychiatrists and CAMHS clinicians.
- The CAMHS team, together with patients that use the 16-17 Emerge service, identified that the needs of young people who experience gender dysphoria needed to be more widely recognised. Staff empowered the young people to design and deliver a staff training DVD that addressed dilemmas for young people in relation to gender.
- The emotional health in schools team was set up in response to an increasing need to offer early interventions for young people in schools experiencing psychological distress. CAMHS clinicians were based in 9 high schools across Manchester. The service also aims to improve access to other specialist core CAMHS services if appropriate.
- The CAMHS service had identified that there has been an increase in suspected child suicides within Manchester. In response to this, a working group had been established to improve how people affected by the suicide of a young person could be improved. The group included local paediatricians, coroners, police, safeguarding leads and ambulance services who were working together to develop guidance for the support of family and peers following a suspected child suicide. For the service to be effective, the multi-agency team identified that families and peer networks needed to be supported more quickly, sensitively and in a structured way.
- CAMHS practitioners had also been placed in the local youth justice offices. The youth offending service (YOS) is an assertive outreach team, providing support to young people with a mental health difficulty in the criminal justice system. This was set up in response to the lack of support available to young people within the system due to its limited understanding of mental health issues.
- CAMHS staff have also provided a 2-day training programme for local school nurses and SENCo's (specialist educational needs co-ordinator) to raise awareness of emotional health issues in children and young people. CAMHS staff, in partnership with other local agencies, also delivered the 'behind the behaviour' training programme to staff working within the local authority. This was to raise awareness of young peoples' experience of mental illness.
- Carers said that CAMHS staff would often go beyond what they expected to meet their child's individual needs. Examples given to us included a staff member going into a child's school to explain and raise awareness of their condition to their peers.

Listening to and learning from concerns and complaints

- The four core district CAMHS teams accounted for 50% of the total complaints received to CAMHS as a whole. The Winnicott team received two formal complaints between September 2014 and September 2015. The Pendleton Gateway team also received two formal complaints. Communication failure was the most frequent theme of complaints made, however this also included complaints made regarding the administration and inpatient teams. Only one complaint made was still being investigated in September 2015. All other complaints were either resolved or withdrawn. The Ombudsman received no complaints from the service between September 2014 and September 2015.
- All the staff we spoke to demonstrated that they knew how to handle complaints appropriately. Staff explained how they would always alert their line manager to any complaints raised. They would try to resolve these

Are services responsive to people's needs?

Outstanding ☆

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

locally by inviting the complainant to have a discussion regarding their concerns before escalating this any further. All of the eight carers we spoke to confirmed that they felt comfortable to approach staff directly should they have any concerns regarding their child's care and treatment. They said that they had been provided with information regarding the patient advice and liaison service, however they had never had to refer to it due to the high quality service they had received.

- Staff received regular feedback regarding complaints and investigations via monthly supervision, weekly multi-disciplinary team meetings, the trust intranet (which all staff had access to), and staff bulletins that were displayed within staff rooms.

Are services well-led?

Outstanding ☆

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 identified with the wider trusts vision to be recognised internationally as a leader in healthcare; excelling in quality, safety, patient experience, research, innovation and teaching; dedicated to improving health and well-being for the diverse population they provided for. Many of the CAMHS staff were taking part in clinical research, in partnership with academic institutions, to develop their clinical practice and continue to provide a better service to meet the changing needs of a diverse population.
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- Senior management were continually reviewing, adapting and extending the services they provided to meet the needs of patients. In November 2015, the service was one of 9 CAMHS teams nationally to be successful in gaining a place on the i-thrive accelerator programme. I-Thrive is a needs based model that enables care to be provided for a population that is determined by its needs. Emphasis is placed on prevention and promotion of health, and patients are central to decisions about their care through shared decision-making. In gaining a place on the national programme, the service will have access to national experts to further their vision in meeting the needs of the local population.
- Staff we spoke with said that senior management within the organisation were well known, supportive and approachable. Senior management visited the teams regularly and demonstrated a strong commitment to improving the quality of services for patients.
- Since 2010, the service has been undertaking a programme of transformational change and improvement: CAMHS transformational agenda. This was influenced by the requirement to deliver NHS England's improving access to psychological therapies (IAPT) initiatives, and also due to a locally driven CAMHS review by Manchester health and council commissioners. Due to a reduced budget allocation of 40% to the service by Manchester city council, CAMHS was required to deliver both national and local directives with a service model that was backed by a smaller financial resource.
- Four years ago, the service adopted a new single line management structure. Since its introduction, clinical staff had more time to focus on working directly with children and young people, whilst new service managers had been responsible for oversight of the operational, financial and human resource elements of the service. Senior management we spoke with were acutely aware of the increasing pressures faced by the service, including an increase in demand from the local population for service and the reduction in financial resources to meet this need.
- Senior management had set up a team called Vision to Action to develop a series of initiatives to improve the CAMHS service. Referrals pathways and assessment methods were standardised. The team had developed new integrated care pathways that were to be delivered by multi-disciplinary and multi-agency teams. The pilot was scheduled to begin in January 2016. A work force training and recruitment strategy was also being developed to support the new care pathways.

Good governance

- The divisional director of the service chaired monthly performance meetings with service managers to review the teams' progress in achieving identified outcomes.
- Collectively the new management structure and integrated care pathways have had a positive effect on the outcomes for patients: staff received separate, monthly supervision from both their service manager and clinical lead. This meant that the most appropriate person to improve individual staff performance reviews different aspects of their performance.
- The service demonstrated good compliance rates in mandatory training. At the Winnicott centre, 88% of staff had completed the corporate mandatory training programme. At the Pendleton Gateway team, 92% of staff had completed this. All staff who were eligible but had not completed the course were booked on to complete within the next two months. All eligible staff had completed level 3 safeguarding training. However, the trust did not deliver mandatory training in the Mental Health Act, Mental Capacity Act, or Gillick competence framework to all clinical staff. Nevertheless, staff referred to the mental health act administrator, based at the inpatient unit, Galaxy House, should they have any queries regarding this.

Are services well-led?

Outstanding ☆

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.

- Staff were able to submit items to the Trust's risk register. Senior management maintained an over-sight of the risk register and it was a standing agenda item to be discussed within monthly governance meetings. Where appropriate, the service worked closely with the local authority, internal and local safeguarding teams to monitor and support children and young people who placed on the children's risk register.
- Key performance indicators (KPIs) were used effectively to monitor the performance of the teams. These were reviewed in monthly performance management meetings. Senior management developed action plans to address any issues that had been raised as a concern.
- The Pendleton Gateway and Winnicott teams had access to administrative support that processed referrals and supported the wider team with other operational tasks.

Leadership, morale and staff engagement

- The trust provided staff sickness rates for tiers 1-3 CAMHS, across all core district services, at 3.9% from September 2014 and September 2015.
- Senior management across tiers 1-4 attended monthly strategy and clinical effectiveness meetings. We reviewed the team minutes that detailed how lessons were shared throughout the CAMHS teams regarding any incidents. Examples of good practice were also discussed and goals were set to improve service delivery.
- All of the staff members we spoke with praised the supportive professional culture in which they worked. Staff said that there was no hierarchy between different grades and professions of staff, and all valued individual input and commitment to improving the lives of patients. All staff said that senior management encouraged front-line staff to share their views regarding service development, and they were encouraged to share their skills and knowledge base with the wider multi-disciplinary team. Many staff commented that although they worked within a challenging work environment, due to the high demand for the service from the local population, they thoroughly enjoyed their job. They felt that senior management were genuinely concerned for their well-being as well as that of the people the service provided for. Staff valued the introduction of the 2 plus 1 assessment clinic because this had a positive effect of reducing inappropriate referrals to the service.
- Staff ran peer education sessions on a fortnightly basis. The aim of these sessions was to share current best practice and raise awareness of each professions contribution in providing care and treatment for patients. Senior management also ran fortnightly team meetings. Within these, there was a formal time slot for staff to discuss any difficult cases. The multi-disciplinary team provided professional and emotional support.
- Senior management empowered staff to develop their skills and knowledge base with the over-arching aim of improving service delivery and maximising staff morale and job satisfaction. The service supported mental health practitioners to undertake formal training in psychological therapies in which they had developed a clinical interest. A staff member from the looked after children's team was also scheduled to be a guest speaker at a forthcoming ACAMH conference, (Association for Child and Adolescent Mental Health). Front-line staff were also involved in providing specialist training to other local agencies and organisations who supported patients with mental health difficulties, such a GP's and school nurses.

Commitment to quality improvement and innovation

- The service demonstrated a strong commitment to quality improvement and innovation. CAMHS staff were involved in carrying out applied research across The University of Manchester and throughout departments at the Royal Manchester Children's Hospital.
- The need to understand and meet the changing needs of the local population was at the forefront of all the research projects in which the service participated. The social development and research group conducted major treatment trials for children who had only recently being diagnosed with autism. 'PACT' (pre-school autism communication trial), was a large-scale treatment trial, funded by the medical research council that focused on parent-mediated intervention for young children with autism. This is recommended by the National Institute for Care and excellence, (NICE), as an evidenced-based treatment for symptoms of autism in

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children. The group secured funding to undertake a further development of the PACT model to extend the trials and research into middle childhood. This was set to begin in January 2016.

- In partnership with The University of Manchester, CAMHS staff at the Winnicott centre completed a research project. This was to identify satisfaction rates of carers who had attended the post diagnostic workshop following their child being diagnosed with a form of autism. The results of the project were used to improve service delivery for carers attending the workshop. This included simplifying the presentation on autistic spectrum disorder to make it more understandable to carers. They also facilitated a more informal session where carers could share their experiences with less time restrictions placed on them.