North Staffordshire Combined Healthcare 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)
RLY00	Trust Headquarters	South Stoke CAMHS	ST3 3BS
RLY00	Trust Headquarters	North Stoke CAMHS	ST6 5JJ
RLY00	Trust Headquarters	North Staffordshire CAMHS	ST5 7HL
RLY00	Trust Headquarters	CAMHS ASD Assessment Team	ST5 7HL
RLY00	Trust Headquarters	Central Referral Hub and Priority Service	ST4 6TH

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

Summary of findings

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

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

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

Following the inspection in September 2015, CQC issued compliance actions to ensure that the trust made improvements to their community-based child and adolescent mental health services.

Summary of findings

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

Are services safe?

- The directorate workforce plan was in place at the time of re-inspection and was based on staff and skill mix recommendations from a workforce assessment of Child and Adolescent Mental Health Services (CAMHS). Following this assessment there had been an increase in 9.6 whole time equivalent (WTE) posts across all the CAMHS teams. The trust also developed a new team and management structure and prioritised the appointment of new service managers. This increased the capacity of senior management to lead on safety and other issues within the directorate.
- Allocation of staff from each CAMHS team for duty work meant that clinical staff were always available to respond to patients and carers contacting the service outside of appointments. Staff were assessed against competencies to make sure they had the required skills for this role.
- A review of case files showed improvement in risk assessment documentation and practice. Of the 13 cases we reviewed, all risk assessments were regularly completed and up to date. In addition, there was now an effective system to assess risks whilst patients waited for assessment or treatment. Clinicians contacted all patients on waiting lists and developed a risk management plan for each person meaning a reduction in the risk of harm before full assessment.
- There was full compliance with infection control procedures, equipment monitoring and maintenance across teams. Cleaning logs and calibration of equipment was up to date and first aid boxes with correct content were subject to monthly checks.
- Reception and administration staff had undertaken safeguarding children training to level 1. The trust requirement was for level 1.

However:

- Recruitment was not fully completed at the time of re inspection, which meant there were continued vacancies. Staff said that this had negatively affected their capacity to manage their caseloads as they were covering these vacancies as well doing their own jobs.
- Staff reported high levels of stress and restricted ability to focus on risk assessment due to high workloads.
- The duty team had no operational policy.

Summary of findings

- The trust's risk assessment tool was considered by the trust to be acceptable for children and young people using CAMHS services. However, front line staff interviewed at inspection reported that they did not consider it to be fit for its purpose. The directorate were researching alternative risk assessment tools for their new electronic system.

Are services effective?

- All staff had received training on care planning. A review of 18 case notes demonstrated improvement in care planning since the inspection in September 2015. Eleven care plans met the standards agreed in the trust action plan and seven required a greater emphasis on patient involvement and recovery. They also required signing and dating by the clinician and patient.
- Staff and clinical managers agreed caseload numbers after consideration of workloads and Royal College of Psychiatry guidance. A new caseload management tool assisted the monitoring of team and individual caseloads.
- The inspection team discussed with staff the improvements in electronic recording of patient information. They said that essential clinical information was becoming more accessible to staff.
- The inspection team found that clinical staff had the right qualifications, skills, knowledge and experience. They were experienced Child and Adolescent Mental Health Services (CAMHS) practitioners supported through regular clinical supervision.
- Staff welcomed plans to recruit skilled and competent staff and said that more staff would increase their capacity to complete care plans better and provide greater therapeutic input into patient care.
- The CAMHS senior management team had introduced the Improving Access to Psychological Therapy (IAPT) routine outcome measure. This tool brought about consistency in measuring outcomes and in staff's understanding of them.
- Staff working in the central referral hub had now all completed a competency assessment to demonstrate they had the relevant skills and experience.

However:

- The transfer of historical clinical documentation in paper files, to the new electronic recording system was not complete meaning duty workers did not always have access to historical clinical information when needed.

Summary of findings

- The trust reported that average caseload sizes for each of the CAMHS teams in April 2016 were in line with Royal College of Psychiatry guidance. However, staff the inspection team spoke to said that their caseloads were difficult to manage due to the pressure of covering for the staff vacancies across the teams.

Are services caring?

This key question was not inspected

Are services responsive to people's needs?

- There was improvement in the waiting times for patients. Since our last inspection, the longest waiting time for assessment had reduced by 53 weeks and the average wait by 2.5 weeks. This was partly due to a 6.29 WTE increase in staff.
- The central referral hub was responsive to patients providing prompt and timely clinical and administrative action in response to patient presentation.
- The trust had developed additional means to communicate with and gain patients views of Child and Adolescent Mental Health Services (CAMHS) services. These included a recent patient satisfaction survey that sought CAMHS patients' views and notice boards at CAMHS prominently displaying the complaints procedure. The directorate's 'young person's council' had input into service re-design including involvement in the move of services to new premises at Dragon Square. A discharge questionnaire was also available. In future quarterly reports of the results were to be made available to staff.

However:

- The patient satisfaction survey did not ask patients whether they knew how to complain.
- Waiting lists for school observations and the CAMHS Autistic Spectrum Disorder (ASD) service remained long. These waiting lists were a year or more.
- The directorate had set itself an internal stretch target for a first appointment for new referrals within four weeks; this was not met.

Are services well-led?

- The introduction of new outcome measures had improved governance across the Child and Adolescent Mental Health Services (CAMHS). A strong senior management team, with increased capacity, had also helped increase staff involvement in change and service improvement.

Summary of findings

- Staff commended the new programme head and service manager for their lead on care planning and risk assessment improvements.
- The trust had initiated two projects to help staff develop skills and increase their engagement. Staff were invited to participate in a team development day and participated in the Listening into Action (LIA, re-engaging with employees and unlocking their potential) programme. Staff we spoke to were positive about these developments.

However:

- Staff said that the impact of staff shortages contributed to high caseloads and increased stress, however the teams' average caseloads were reported by the trust to be in line with Royal College of Psychiatry'sguidelines

Summary of findings

Information about the service

North Staffordshire Combined Healthcare Trust's children, young people and families' directorate includes four Child and Adolescent Mental Health Services (CAMHS) teams and a central referral hub.

- North and South Stoke CAMHS and North Staffordshire CAMHS are multidisciplinary services providing young people with support for their mental health, behaviour or emotions.
- CAMHS Autistic Spectrum Disorder Service (CAMHS ASD) is a specialist assessment and diagnosis service. The service also provided time-limited support following a diagnosis of autism.
- The central referral hub and priority service is a single point of contact for referrals to the teams.

The CQC conducted a comprehensive inspection of the trust in September 2015 and found the following regulations of the Health and Social Care Act 2008 to have been breached:

- Regulation 9 – Person-centred care
- Regulation 12 - Safe care and treatment
- Regulation 17 – Good governance
- Regulation 18 – Safe staffing

The inspection in September 2015 found that services were not safe because:

- there were staff shortages across the CAMHS teams of all types of clinical staff.
- risk assessments, management and safety plans were not always completed or fit for the purpose of recording or assessing risk.
- the CAMHS team 'duty worker' system was not consistently well staffed and unable to respond to urgent need.
- there was poor infection control management with regards to toys and some medical equipment.

We found that services were not effective in September 2015 because:

- not all patients had a care plan that addressed identified needs or who was to be involved in a young person's treatment and care.
- a young person's ability to understand the treatment being provided to them was also inadequately assessed within the care plans.
- CAMHS had no regular communication with general practitioners and National Institute for Health and Care Excellence (NICE) guidance was not followed for the physical health of young people with eating disorders.
- outcome measures used for measuring the effectiveness of the work of CAMHS were used inconsistently.
- records for the supervision of staff were missing meaning it was not possible to track whether staff received adequate clinical support. Supervision records kept lacked detail.

We found that they services were not responsive in September 2015 because:

- waiting times for a non-urgent initial assessment, partnership appointments and school observations were excessive. This meant that some patients were receiving treatment over a year after the initial referral.
- carers did not know the complaints procedure and patients and were not consistently informed of the complaints procedure. Both carers and patients could not therefore make their complaints and concerns known in formal manner.

We found that services were not well led in September 2015 because:

- staff morale was low due to high caseload levels.
- governance systems were not in place, as staff did not adhere to guidance, measure outcomes correctly or take effective action to reduce long waiting times.

Following the inspection in September 2015, the CQC issued compliance actions to ensure the trust made the required improvements. The trust developed an action plan in response to these and CQC continued to meet with them to monitor progress.

Summary of findings

The trust took several actions and held events for staff in response to their regulation breaches. These focused on care planning, risk assessment, audit, quality assurance, supervision and appraisal, infection control and safe staffing.

- The trust distributed a revised care plan document to all clinicians. It contained a section for the young person's comments, the young person's signature and parent signature. Staff were also asked to review their care plans to identify where they could be improved. Supervision and clinical audit monitored and assured quality of these care plan reviews.
- The trust facilitated several staff training programmes that included workshops on care planning and risk assessment to develop their skills. Skills included tips on writing and identifying risks within care plans and within assessments. Clinical staff attended this training as a mandatory requirement at induction and throughout their employment. All staff in community CAMHS also received safeguarding training at appropriate levels for vulnerable adults and children and knew how to make safeguarding referrals. The trust reissued and made all CAMHS staff aware of the trust's clinical risk assessment policy. A review of standards in relation to the Care Programme Approach (CPA), a statutory system that says how mental health services should support people also took place. As did reviews of person centred care, service user involvement and risk and case management Trust corporate and local risk registers had risk assessment processes added to ensure senior clinical staff could monitor their effectiveness.
- The trust reviewed all equipment in CAMHS to ensure adequate maintenance and testing. This included the development of an 'Equipment Work Book' and cleaning regimes in line with national and local infection control guidelines. Maintenance of safety, monitoring of quality and management of risk were include in all new operational policies. Environmental risk assessments were completed and action against them monitored.
- As part of its staff recruitment strategy the trust reviewed its capacity to respond to patient demand. Royal College of Psychiatry's report – Building and sustaining specialist CAMHS (CR182) guidelines informed staffing levels for medical staff. The development of a duty psychiatry rota made sure of medical cover, which the clinical governance lead monitored.
- New staff to the CAMHS were assessed against a duty worker checklist to ensure all staff on the duty worker rota system had the required competencies
- Discharge questionnaires given to young people monitored patient satisfaction as they left the service and a quarterly report on the findings supported service improvement.

Our inspection team

The team was comprised of seven CQC inspectors, one inspection manager and two specialist advisors.

Why we carried out this inspection

This report describes our judgement of the quality of care provided within this core service by North Staffordshire Combined Healthcare NHS Trust (NSCHT).

This inspection followed the comprehensive inspection of the trust made in September 2015 and the report published on 22nd March 2016. In March 2016, the trust received an overall rating of Requires Improvement with Child and Adolescent Mental Health Services (CAMHS) community teams rated as Inadequate.

Warning notices given to the trust and to the CAMHS community teams in particular were the focus of this unannounced inspection.

Summary of findings

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?

During the inspection visit, the inspection team:

- visited all four Child and Adolescent Mental Health Services (CAMHS) teams and the new priority hub service
- spoke with the managers or acting managers for each of the CAMHS teams
- spoke with 17 staff members; including doctors, nurses and social workers
- spoke with two patients
- reviewed 18 sets of clinical notes
- carried out specific checks of the environment and health and hygiene.

What people who use the provider's services say

We spoke to two patients who said they had been involved in their care planning. One patient said they had seen their care plan and discussed their risk assessment. Both said they felt involved in the decisions made about them.

During our inspection, one patient told us that her nurse was easy to talk to and explained their treatment well. Another said they got the helped that they needed.

Information on how complain was given to one patient. Dialectical behaviour therapy (DBT, a therapy developed to meet the particular needs of people who experience emotions very intensely) was offered to one of the patients we spoke with during inspection.

There were concerns about waiting times, one patient old us that they had waited six months to see the doctor.

Good practice

- Training on risk assessment and care planning impacted positively on staff practice and meant staff felt engaged in the improvement process.
- A protocol was in place for fast tracking waiting list patients for assessment.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should continue to monitor and progress its staff recruitment strategy.
- The provider should ensure all services and teams have operational policies.
- The provider should continue to ensure caseload levels and complexities are manageable, allowing staff to complete relevant paperwork.
- The provider should ensure the risk assessments used within services are informed by expert Child and Adolescent Mental Health Services (CAMHS) clinicians to assess the needs of the range of patients presenting for CAMHS.
- The provider should ensure all care plans are holistic, recovery focused, and involve the patient.
- The provider should continue to develop structures to promote staff engagement in change in practices and services.

Summary of findings

- The provider should ensure that all information required on either or both paper files or electronic systems are available to the duty worker team at point of contact.
- The provider should continue its efforts to ensure all patients and carers understand the complaints process and know how to complain if they wish to do so.
- The provider should implement measures to meet its targets for referral to assessment time and for waiting lists.

North Staffordshire Combined Healthcare NHS Trust

Specialist community mental health services for children and young people

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
South Stoke CAMHS	Trust Headquarters
North Stoke CAMHS	Trust Headquarters
North Staffordshire CAMHS	Trust Headquarters
CAMHS ASD Assessment Team	Trust Headquarters
Central Referral Hub and Priority Service	Trust Headquarters

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

- There were up-to-date and complete cleaning logs for medical equipment, which evidenced good compliance with infection and control procedures. Child and Adolescent Mental Health Services (CAMHS) services had revised the cleaning regime for the plastic toys at its locations. However, there was some dispute at North Stoke CAMHS over the agreed frequency for cleaning. All CAMHS now completed a quarterly health and safety, and annual ligature risk audit.
- All first aid boxes seen were complete and subject to monthly checks.
- All equipment inspected was in good working order, including the calibration of equipment such as scales

Safe staffing

- There had been an increase in 9.6 whole time equivalent (WTE) posts. Some recruited staff had not started at the time of inspection and the remainder of vacancies were out to advert. Staff had therefore not seen the benefits of new staff recruitment at the time of the follow up inspection. The trust prioritised the appointment of new service managers for, North and South Stoke CAMHS, North Staffordshire and the central referral hub.
- The new staffing establishment for CAMHS teams was 79.7 WTE, made up of 55.4 WTE substantive staff and 24.3 WTE vacancies. Agency and locum staff covered 5.9 of these vacancies.
- CAMHS managers interviewed acknowledged the challenging national recruitment picture for CAMHS clinical staff but there was no evidence of a permanent working group, chaired at a senior level, to drive through the required improvements needed to attract more staff to the CAMHS teams. However, the trust reported that it had employed the following strategies to support recruitment and retention of existing staff:
  - re-vamped rolling adverts posted both on NHS jobs and local and national newspapers
  - developed radio adverts for local radio
  - developed videos showing a day in the life of staff
  - used social media to encourage the recruitment of staff
  - attended careers fairs
  - supported rolling recruitment to the trust's staff bank
  - offered relocation packages for new staff of up to £8,000
  - set up one stop recruitment shops to reduce appointment timescales
  - developed a retention and loyalty bonus for staff in key areas, a refer a friend scheme and a welcome bonus
  - developed a nursing strategy reviewing return to practise posts
  - held a children and young people's directorate recruitment open day.
- The trust undertook a workforce assessment of CAMHS, which considered the staffing levels and skill mix required to inform what constituted a model team. The findings from this assessment found the most effective team included a service manager, consultant psychiatrists, nurse prescribers, psychologists, and CAMHS practitioners, specialist posts such as cognitive behavioural, family and art therapists and administrators. Following this assessment and modelling, the trust implemented a new management structure, which created four specific teams with increased leadership capacity. The consultant psychiatrist capacity increased by three locums across all the CAMHS and the 2.0 WTE substantive consultant psychiatry posts for generic CAMHS and specialist teams put out to advert. The learning difficulties CAMHS consultant job description was being finalised prior to submission to the Royal College of Psychiatry's regional advisor for approval.
- The trust had a directorate workforce plan in place, approved by the senior leadership team in January 2016, based on Royal College of Psychiatry's guidance and local intelligence. This included the number of referrals received, the number accepted, patient presentations and information in relation to waiting lists and caseloads. The trust wanted to recruit staff of the highest quality but was prepared to recruit candidates

with generic skills and support their achievement of appropriate competencies. However, staff levels in CAMHS remained inadequate and caseloads were as high as 100 patients to a single member of CAMHS staff.

- All CAMHS teams had experienced an increase in the establishment of staffing. However, at the time of inspection there were vacancies in all teams while recruitment took place.
- South Stoke CAMHS had a 15.5 WTE clinical establishment. At inspection, there were 6.6 vacancies and they were employing 2.2 WTE agency & locum staff. This left an operational shortfall of 4.4 WTE staff.
- North Stoke CAMHS had an 18.8 WTE clinical establishment. At the time of inspection, they had 4.8 vacancies, which left an operational shortfall of 4.8 WTE staff.
- North Staffordshire CAMHS had a 15.2 WTE clinical establishment. At the time of inspection, they had 5.4 vacancies, which left an operational shortfall of 5.4 staff.
- CAMHS ASD Assessment Team had a 3.79 WTE clinical establishment. This team had 1.1 vacancies, which left an operational shortfall of 1.1 staff at the time of inspection.
- Central Referral HUB and Priority had a 5.75 WTE clinical establishment. They had 2.5 vacancies at the time of our inspection, which left an operational shortfall of 2.5 staff.
- Staffing at CAMHS was not adequate and continued to contribute to high caseloads. Staff reported high levels of stress and restricted ability to focus on risk assessment. However, the trust informed us of a recruitment drive among third-year student nurses due to have completed their training in September 2016. Students who expressed a preference to work in CAMHS were to attend full time funded training for CAMHS on the understanding that they worked within CAMHS. Fourteen third-year student nurses had accepted a conditional offer of employment across the trust; some were to take up posts in CAMHS upon appropriate qualification.

Assessing and managing risk to patients and staff

- CAMHS had implemented a system to manage and prioritise patients on waiting lists. CAMHS staff triaged all new referrals, including self-referral, over the telephone. Prioritisation of these was according to the level of assessed risk. A member of the CAMHS teams contacted all existing patients on the waiting list and a risk assessment put in place for each person while waiting. This was a definite improvement from the inspection in 2015 were it was found that there was no effective system to assess the risks whilst patients waited for assessment or treatment.
- Teams had revised team meeting agendas to include the trust action plan in response to CQC warning notices. This enabled all team members to be aware of actions and progress against the actions agreed.
- The clinical risk assessment and management policy issued to all staff informed team level discussion of local risk registers.
- The majority of staff we spoke with felt that the risk assessment used across the trust was not suitable for children and young as it did not enable assessment of the variety of issues young people present with across the age range CAMHS cover. Staff from the community CAMHS directorate were involved in the development of the risk assessment tool currently used; however the staff that we spoke to had not been involved. Our review of case files showed that risk assessments were not always revised at the time of incidents and not always reflective of risk in case file notes. Staff had given feedback about risk assessment document and the trust had agreed to review this again. However, this meant that despite attempts to improve risk assessment current forms remained unsuitable for the range of patients' ages and presentations to CAMHS.
- A review of 18 case files showed that risk assessment practice had improved since the last inspection in 2015. In 13 cases, risk assessments were regularly completed and up to date, however in four cases staff had not completed up to date risk assessments. Although the inspection team saw improvement in the completion of risk assessments within files, they lacked evidence of strategies to mitigate against risk and did not assimilate risks identified at assessment, in care plans and within clinical notes. This meant that risk could still be missed and not acted on.
- Staff said that caseloads for clinicians remained too high and reduced their capacity to assess risk adequately. The trust said staff caseloads were agreed and reviewed in clinical supervision.
- Trust data showed that consultant psychiatrists were to see one to two new cases per week and offer between 10 to 17 follow-up appointments depending on the other resources available in the team such as nurse

Are services safe?

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

prescribing. The Royal College of Psychiatry's report "Safe patients and high quality services: a guide to job descriptions and job plans for consultant psychiatrists" (CR174) informed this practice.

- The CAMHS duty work system had improved by the introduction and coordination of one worker from each of the CAMHS working 'duty' on a rota basis. This system was working well with no reported problems. A checklist of required competencies for the role of duty worker made sure appropriately, experienced individuals were available to provide duty cover. One senior member of staff said that the duty work system would be better when electronic notes were fully available as there was sometimes no access to notes.
- All reception and administration staff had undertaken safeguarding children training. However,one of the newly appointed reception staff at the North Stoke CAMHS team had not completed safeguarding adult training at the time of inspection.

Are services effective?

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

Our findings

Assessment of needs and planning of care

- We found that seven of the 18 sets of case notes we reviewed were not specific, detailed or personalised and did not address identified needs. Staff did not record patient and carer views and care plans were negative, focussed on problems, not recovery orientated and not always signed or dated.
- The review of 18 case notes demonstrated a mixed improvement in care planning since the inspection in September 2015. Eleven sets of case notes achieved a good standard of dated and signed care plans linking to clinical notes. However, the remainder lacked a holistic, recovery-orientated approach and did not show clear patient involvement. The four care plans reviewed at the Child and Adolescent Mental Health Services (CAMHS)Autistic Spectrum Disorder (ASD) service were holistic, up-to-date, and recovery oriented.
- Staff stored information securely within electronic recording systems and within paper files. Full access to clinical information in either system was not complete.
- There were improvements in electronic recording of patient information and care plans audited monthly. The last audit completed confirmed 10 out of 10 completion for care plans at CAMHS ASD.
- In response to the previous inspections findings regarding care planning, the trust delivered workshops to meet staff's learning needs and provided examples of best practice care plans. Consultation with patients also produced a set of 'top tips' for care plan completion.

Best practice in treatment and care

- A caseload management tool developed and distributed across the trust was an electronic means of allowing service managers to monitor team and individual caseloads. The trust stated that in calculating caseload numbers it was essential to consider the staff member's hours of work, their job plan, other commitments, experience and seniority, complexity of cases and contribution to group work. The Royal College of Psychiatry's report "Building and Sustaining Specialist CAMHS" was used as guidance in setting caseloads and the trust stated that a clinician would see approximately 40 new referrals per year.
- There were arrangements for supporting staff through clinical supervision with the service manager. Most staff had supervision records. However, the quality of content and note taking varied and there were records of supervision missing at CAMHS ASD.
- Information about the outcomes of people's care and treatment, collected and monitored using the children and young people's (CYP) Improving Access to Psychological Therapy (IAPT, an outcome measure, designed nationally as a means of developing meaningful service user participation and greater accessibility to therapeutic services), was the preferred means of evaluating the effectiveness of treatment interventions. Training provided on IAPT for staff in November and December 2015 improved the consistency of measuring outcomes.

Skilled staff to deliver care

- The inspection team found from looking at personnel records and interviewing clinical staff that staff had the right qualifications, skills, knowledge and experience to do their job.
- Interviewed staff said more nurses and social workers of band six and band seven grades was required and that the slow progress on recruitment was having a significant impact on staff morale of some staff. There was hope expressed that plans to recruit skilled and competent staff would soon be realised.
- All the nurses working in the hub were experienced CAMHS practitioners. All those working the duty rota had completed a competency assessment to demonstrate they had the relevant skills and experience to manage crisis assessments. Where workers were not competent we saw plans to develop their skills to the level required. The duty worker professional competency list was held in one file at north Stoke CAMHS. Seventeen staff were available for duty work and assessed as competent against the framework. Three staff were judged as not competent.

Good practice in applying the Mental Capacity Act

- At the inspection in 2015, it was found that a young person's ability to understand the treatment being provided to them was inadequately assessed and documented within care plans. Staff we interviewed confirmed that staff did understand the principles set out in the 'Gillick competency' and 'Fraser guidelines' (guidelines used to help assess whether a child has the

Are services effective?

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.

maturity to make their own decisions and to understand the implications of those decisions). Clinical notes did not contain evidence of these discussions or expressly state that patients had capacity to understand their treatment. However, principles of capacity were implicit within the clinical process.

Are services caring?

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

Our findings

This key question was not inspected

Are services responsive to people's needs?

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

Our findings

Access and discharge

- Referrals to Child and Adolescent Mental Health Services (CAMHS) were rated as either routine or urgent. Routine referrals forwarded to the relevant locality team leader for initial assessment and allocation and for urgent referrals, the young person and their parents invited to an initial assessment at the central referral hub. The nursing team could ask a consultant psychiatrist to support them in the urgent reviews that might lead to an inpatient admission. Trust data showed that the number of young people waiting over 18 weeks for first assessment had decreased. The trust was further aiming to offer a first appointment to new referrals within four weeks. New staffing in the central referral hub was a means of achieving this improvement.
- The trust had also commissioned a private consultant to assess demand and capacity within the directorate. The number of accepted referrals was on average 30 per week. To achieve a four-week assessment wait the trust had to offer 30 assessments per week. At the time of inspection this target was not being met.
- The number of new referrals waiting for assessment over 18 weeks was 66, 31 for South Stoke, 26 for North Stoke, six for North Staffordshire CAMHS, two for paediatric psychology and one for the CAMHS learning difficulties team.
- The total number of referrals waiting under the 18-week trust threshold was 509, 118 for South Stoke, 180 for North Stoke, and 159 for North Staffordshire, seven for the central referral hub and 45 for the remainder of the directorate. This represented a small improvement from the inspection in 2015 when waiting times were three to four months to receive a non-urgent initial assessment. Trust figures for waiting times between September 2015 and March 2016 showed that the average wait had reduced by 2.5 weeks and the longest wait by 53 weeks. This was partly due to an increase in staff and an improvement in the referral pathway at the central referral hub.
- Waiting times for a non-urgent initial assessment, partnership appointments and school observations remained too long primarily due to their still not being sufficient clinical staff in each CAMHS. Waiting lists for school observations and the CAMHS ASD service were a year or more. This had resulted in one formal complaint from the local Member of Parliament (MP) to the CAMHS ASD team
- At the time of inspection, inspectors observed the central referral hub respond adequately and promptly to calls from young people, their parents and concerned professionals. The duty worker recorded all calls along with any action points to inform the young person's keyworker of the contact and details were updated if the young person was on the waiting list.
- The hospital liaison worker was available to attend the paediatric services at local general hospitals to complete psychiatric assessments of young people in distress and following any acts of self-harm or suicidal thoughts and actions.

Listening to and learning from concerns and complaints

- At the inspection in 2015 young people and their carers did not know the procedure for making complaints and there was no system in place for monitoring their concerns. At the time of re-inspection, team notice boards displayed information on the complaints process. There had been a recent patient satisfaction survey, which asked what patients thought of CAMHS. However, the survey did not specifically ask patients whether they knew how to complain.
- The directorate had developed a young person's council in conjunction with a local voluntary agency. Members of the council have sat on interview panels, had input into service re-design, and recently been involved in the move of services to Dragon square.
- CAMHS teams had three versions of a discharge questionnaire available to cater for all patients' communication needs; for example, a pictorial questionnaire for children aged nine to eleven, a young person's form for ages 12-18 and another version for young people's parents. CAMHS staff routinely had these sent to patients and carers with a stamped addressed envelope and returned to a central location. However, a quarterly report for staff on patients and carers information was not available at the time of inspection.
- The draft report on service users' satisfaction 2015-2016 had 30 respondents, 18 of whom were parents who delivered positive feedback.

Are services well-led?

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

Good governance

- The trust's workforce plans, audits and human resources strategies within the action plans had encouraged staff to participate positively in the improvements in governance made across the Child and Adolescent Mental Health Services (CAMHS) teams.
- Outcome measures, previously not consistently applied but now embedded in the team with were improving services, as was a strong leadership team with increased capacity.
- Staff recruitment strategies continued to be work in progress and there were insufficient staff to fulfil all governance improvement plans.

Leadership, morale and staff engagement

- The inspection team found that the restructuring of the service management team in CAMHS had clarified lines of responsibility and had a positive impact on staff engagement. The new programme head and service manager lead for care planning and risk assessment was cited by staff interviewed, as being supportive to quality improvement initiatives and to individual members of the team. Some staff we spoke with stated that decision-making felt top-down from management and that they sometimes felt alienated by management decisions.
- There were commendations from two staff at South Stoke for a member of the senior clinical team. Staff said they experienced stress in offering a compassionate and empathic service on very limited resources but felt supported and inspired by their manager. The inspection team observed that the morale of some staff had improved somewhat from that observed at the 2105 inspection. Staff generally felt this would improve further with newly recruited staff and the positive impact this would have on waiting times.
- The trust had implemented initiatives to help staff develop the skills, knowledge and experience to deliver effective care and treatment including a team development day and participation in the Listening into Action (LIA) programme. These initiatives focused on team cohesion, consolidation of change and staff engagement within the directorate. The vision was that participation in both these encouraged staff to be more able to manage change, raise concerns and promote good practice.