Good

Berkshire Healthcare NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Berkshire Healthcare NHS Foundation Trust
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/team)
RXWAS	Royal Shrewsbury Hospital	West Berkshire CAMHS (Newbury) Lower Henwick Farm House, Turnpike Road, Thatcham, Newbury	RG18 3AP
RXWAS	Royal Shrewsbury Hospital	West Berkshire CAMHS (Reading) 3 – 5 Craven Road, Reading.	RG12 5LF
RXWAS	Royal Shrewsbury Hospital	East Berkshire CAMHS (Slough) Fir Tree House	SL1 2BL

Summary of findings

		Upton Hospital, Albert Street, Slough.	
RXWAS	Royal Shrewsbury Hospital	Central Berkshire CAMHS (Wokingham and Bracknell) Wokingham Community Hospital 41 Barkham Road, Wokingham.	RG41 2RE
RXWAS	Royal Shrewsbury Hospital	CAMHS Common Point of Entry (CPE) The Old Forge 2nd Floor 45 – 47 Peach Street Wokingham	RG40 1XJ
RXWAS	Royal Shrewsbury Hospital	East Berkshire CAMHS (Windsor , Ascot and Maidenhead) 1st Floor, Nicholsons House, Nicholsons Walk, Maidenhead, SL6 1LD	<Placeholder text>

This report describes our judgement of the quality of care provided within this core service by

Berkshire Healthcare NHS Foundation Trust

. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by

Berkshire Healthcare NHS Foundation Trust

and these are brought together to inform our overall judgement of

Berkshire Healthcare NHS Foundation Trust

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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	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Requires improvement 
Are services well-led?	Good 

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 good because:

· The trust had recently secured funding to increase staffing and capacity in order to reduce the significantly long waiting times for patients.

- At the time of our inspection the service was in the process of embedding the increased staffing and the extended opening hours for the common point of entry service at Wokingham. New staff had been recruited and the service was in the process of inducting staff on programmes that included shadowing staff in all the care pathways. The service had fully recruited in East Berkshire.

· The waiting list was actively managed and this included face to face as well as telephone contact to young people and their families. Patients on all the pathways could be seen quickly based on prioritisation relating to urgency, risk or need. For example, 15% of patients on the autistic spectrum disorder (ASD) diagnostic pathway where waits were longest were seen within 12 weeks based on need.

- Young people and their families were mainly satisfied with their care although there were concerns in relation to the long waiting times.

· There was an active participation group that had contributed to improvements in the service design such as arts and crafts displays and areas for younger children, such as in Slough. The group were in the process of developing CAMHS leaflets and a social networking site to support young people between appointments.

· We observed a range of multi-disciplinary meetings and appointments. Staff were skilled and showed respect and empathy towards young people. There were robust discussions around risk.

· There were skilled staff to deliver the service and most staff were up to date with their mandatory and statutory training. In addition, staff received values based appraisal and as part of this they identified their training needs. There was satisfaction expressed about the quality of the leadership training in the trust.

· Most staff felt well supported by their manager and were familiar with the senior management team who visited the areas that staff worked in.

· There was an open culture towards reporting incidents, bullying and whistle blowing and learning from complaints.

However;

· The ongoing increase in demand and capacity issues for CAMHS services in Berkshire had created long waiting times. For example, 38% of patients on the autistic spectrum disorder (ASD) diagnostic pathway were not seen within 12 months , including a wait of more than two years for some young people on the autistic spectrum disorder (ASD) diagnostic pathway. This had created some dissatisfaction with young people and their families. This was expected to improve significantly as vacancies were filled following the increase in funding. However, at the time of our inspection it was too early to see the effects from the significant improvements in capacity.

· In Wokingham care plans records were not well managed and staff at the service found it difficult to find evidence of whether some patients had a care plan. There was also variation in the quality of risk assessment records.

· Caseload management tools were not consistently used, although this was being piloted in Newbury.

- Although there had been no ligature incidents in the community CAMHS buildings, there were multiple ligature risks in the community buildings due to the age of some buildings. Action plans had been developed to mitigate risks but staff were not aware of these.

Summary of findings

- Recruitment had been less successful in Wokingham and West Berkshire where waiting lists were longer and staff felt under pressure; particularly in services were there were more temporary staff.
- Morale was generally good amongst staff, despite the work pressures. However, at Wokingham where half the workforce were locum and agency staff this had adversely affected morale.

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:

- Clinic rooms were equipped with the necessary equipment to carry out physical examinations and equipment and appliances were regularly checked.
- All areas we inspected were visually clean with some evidence of regular cleaning checks.
- Staffing levels were improving to manage capacity and reduce the long waiting lists.
- Weekly allocation meetings included clear risk planning and risk mitigation.
- Staff were compliant with the appropriate statutory and mandatory training.
- There was an open culture of reporting incidents and a clear process to learn from incidents.

However;

- Staff did not routinely carry personal alarms and there were no alarms in treatment and interview rooms.
- Environmental risk assessments, including ligature risk assessments had not been shared with staff teams.
- There was some variation in the quality and detail of the risk assessment records.

Are services effective?

Good

We rated effective as good because:

- Routine outcome measures were used to rate severity and outcomes and evidence based testing was used for to support in the diagnosis of ADHD.
- Smoking cessation was offered for all young people over 16 who smoked.
- Staff had received a recent annual appraisal.
- Most staff were up to date with their statutory and mandatory training and had received specialist training opportunities to support their role.
- There were well managed multidisciplinary meetings across the service.
- Staff were experienced and well qualified.

However;

Summary of findings

- We did not see evidence of a care plan in five of the seven patient case records we reviewed at Wokingham.
- There was variation in the quality of recording in care plans.
- There were some gaps in adherence to National Institute for Health and Care Excellence (NICE) guidelines, such as availability of cognitive behaviour therapy for patients on the attention deficit and hyperactivity disorder (ADHD) pathway.
- Annual physical health checks were not routinely carried out although there was liaison with GPs who held responsibility for their overall physical health management.
- Some agency staff reported that they had not received adequate training.
- There were some gaps in supervision recording.

Are services caring?

We rated caring as good because:

Good

- Young people and their families were generally very satisfied with the care and treatment provided.
- We observed care and care discussions and saw that staff consistently treated young people and their families with care, respect and warmth.
- There was an active participation group that met monthly and made contributions to service redesign and improvement.
- Most young people and their carers expressed satisfaction about the services they received.

However;

- Dissatisfaction was expressed about the length of waits for treatment.
- Some carers needed support with signposting to other agencies as were not clear where to get help for themselves.

Are services responsive to people's needs?

We rated responsive as requires improvement because:

Requires improvement

- There were long waiting times from referral to treatment for all pathway and specialist services which meant that access to the service was not responsive enough.
- Some of the furnishings and décor in Newbury were tired and worn.

However

Summary of findings

- Waiting lists were safely managed and risks were mitigated through regular monitoring including multi-disciplinary weekly discussion and face to face contact with young people on the lists.
- The CAMHS pathways were in the early stages of reducing waiting times following an increase in staffing and capacity and the common point of entry had recently extended hours to provide a more responsive service.
- Young people and their carers knew how to complain and there was well signposted information on how to do this.

Are services well-led?

Good

We rated well-led as good because:

- Staff showed commitment to the trust core values and some teams had created their own values that linked to their organisational values.
- There were robust governance arrangements for waiting list management.
- There were systems in place to ensure that staff were appraised and supervised and received mandatory training.
- There were development opportunities for staff.
- Managers and interim mangers were well supported and had received leadership training
- Staff knew how to whistle blow and raise concerns without fear of victimisation.

However;

- There were morale issues and a reduced sense of empowerment in parts of the service where there were more temporary staff and vacancies.

Summary of findings

Information about the service

Berkshire Healthcare NHS Foundation Trust provides tier three services, which offers specialist multi-disciplinary community child and adolescent mental health services (CAMHs). The services are commissioned across Berkshire and support young people and their families with mental health problems, including severe and complex needs.

Seven different clinical commissioning groups commission the trust to deliver child and adolescent community mental health services (CAMHS) across Berkshire. The trust provides services in West and East and central Berkshire in sites at Reading, Newbury, Bracknell, Wokingham, Slough and Maidenhead.

The trust provided tier two CAMHS services in the West Berkshire and Wokingham localities. Specialist CAMHS workers in these areas worked alongside colleagues in community and primary care, education and social care as part of the targeted and early intervention services in these localities. The West Berkshire service is funded until April 2016 when responsibility moves to the local authority. The Wokingham service will continue. Tier two provision was provided by the local authorities for the rest of the county.

The Berkshire CAMHS service is divided into a number of care pathways, to which young people could be referred after an assessment has taken place by the common point of entry team.

The mental health pathways include:

- The specialist community team (SCT)
- The anxiety and depression pathway (A&D)
- The attention deficit hyperactivity disorder pathway (ADHD)
- The autism spectrum disorder diagnostic pathway (ASD)

Services were commissioned slightly differently in each area. For example, ASD diagnostic services for children under the age of five were commissioned from the provider for the three West Berkshire localities, but were provided by the community paediatricians for the three East Berkshire localities.

There was no crisis home treatment team for younger people in Berkshire. However, an urgent care response was provided through CAMHS Common Point of Entry 8am-8pm Monday to Friday and from the Trust on-call system out of hours.

Our inspection team

The inspection team was led by:

Chair: **Dr C I Okocha, Medical Director and Responsible Officer, Oxleas NHS Foundation Trust;**

Head of Inspection: Natasha Sloman, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission;

Team Leader: Louise Phillips, Inspection Manager, Care Quality Commission.

The inspection team that inspected this core service comprised: two CQC inspectors, plus three senior nurses and one occupational therapist as special advisors.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information they held about the service.

During the inspection visit, the inspection team:

- Visited five of the community locations in Newbury, Reading, Wokingham, Maidenhead and Slough and looked at the quality of the environment.
- Observed the treatment of two patients on the attention deficit hyperactivity disorder (ADHD) care pathway.
- Spoke with five young people who were using the specialist CAMHs services.
- Spoke with 12 parents of young people using the services.
- Collected feedback from 26 children and young people and parents and carers using comment cards.
- Looked at 20 treatment records of children and young people.
- Spoke with four managers, one clinical lead and the operational manager for CAMHS.
- Spoke with 20 other staff members; including therapists, psychologists and nurses.
- Attended and observed three multi-disciplinary meetings which included allocation and waiting list risk management.
- Observed a handover meeting at the common point of entry service in Wokingham. Observed a service involvement meeting in Reading.
- Looked at 20 staff personnel files.
- 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

We spoke to five young people and 12 parents involved in their care.

Parents expressed satisfaction with the service their child was receiving. However, some parents and carers were not aware of how to access help and support for themselves. Five parents we spoke with told us that they whilst they were satisfied with treatment their child was receiving they needed more support for themselves, but were not clear how to access help or receive a carer's assessment.

We received 26 comment cards. The comments cards were mainly positive about the service. However, five responses that were mixed and four were negative in their content.

Of the comment cards received, 17 described how caring and supportive staff were and that children and young people felt listened to and cared for. However, there were concerns on seven of the mixed and negative cards about the long waiting times to access the services.

Good practice

The trust had appointed a dedicated service user facilitator to support and develop an active user and carer participation group. The group had made improvements to service design such as, community buildings so that they were more accessible and welcoming to young people. Young people were also

Summary of findings

involved in the development of a support, hope and recovery online network specifically for young people.

This was a younger person's version of the established web based forum providing additional online peer support between appointments through a secure and supported social networking site.

Areas for improvement

Action the provider MUST take to improve

The provider must improve waiting times from referral to treatment for all pathway and specialist services.

Action the provider SHOULD take to improve

The provider should consider arrangements for personal alarms and alarms in treatment and interview rooms.

The provider should ensure that all environmental risk assessments, including ligature risk assessments are routinely shared with staff teams.

The provider should ensure the quality of risk assessments in individual care records.

The provider should ensure that care plans are always recorded and up to date and accessible.

The provider should ensure that supervision records are accurately kept in line with trust policy.

The provider should ensure access to independent advocacy.

The provider should ensure clear signposting to carer's information and support.

Berkshire Healthcare NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
West Berkshire CAMHS (Newbury)	Lower Henwick Farm House, Turnpike Road, Thatcham, Newbury, RG18 3AP.
West Berkshire CAMHS (Reading)	3 – 5 Craven Road, Reading, RG12 5LF
East Berkshire CAMHS (Slough)	Fir Tree House Upton Hospital, Albert Street, Slough, SL1 2BL.
Central Berkshire CAMHS (Wokingham and Bracknell	Wokingham Community Hospital 41 Barkham Road, Wokingham, RG41 2RE.
CAMHS Common point of entry (CPE)	The Old Forge 2nd Floor 45 – 47 Peach Street Wokingham RG40 1XJ
East Berkshire CAMHS (Windsor, Ascot and Maidenhead)	1st Floor, Nicholsons House, Nicholsons Walk, Maidenhead, SL6 1LD

Mental Health Act responsibilities

- Community CAMHS staff had attended training related to understanding of the Mental Health Act 1983.
- Staff within the service were aware of how to access support and guidance within the trust if necessary.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were familiar with Gillick competency and engaged young people in discussions about consent.

Staff had received training related to the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

- The service was commissioned to see children and young people in community premises. We visited community premises in Slough, Newbury and Wokingham and saw that clinic rooms were equipped with the necessary equipment to carry out physical examinations. Equipment, such as weighing scales and blood pressure monitors were calibrated regularly. Portable electrical appliances had up to date safety checks.
- There were no alarms in interview rooms. Staff told us that they assessed young people and their parents and carers individually as to whether to take a personal alarm into interview rooms. If an alarm was taken a buddy system was in place to respond to help when the alarm was activated. In Newbury, hearing what the alarm sounded like was part of the induction checklist for new staff to complete.
- All areas we inspected were visually clean. However, cleaning records were not consistently in place. Some rooms had cleaning records on the back of doors, for example at Newbury and Maidenhead where each clinician had responsibility for a clinical or interview room.
- It was not always clear whether the toys were regularly cleaned. There were cleaning wipes and reminder signs in Slough where we also saw that reception staff cleaned toys at the end of the day. However, we did not see a cleaning rota to support this. Clinical wipes with a sign to keep out or reach of children were left in the patient area at Wokingham and Maidenhead, although these were removed by staff during our visit.
- Most buildings were well maintained and Wokingham community building had been newly refurbished. However, the Newbury building had damp walls in some rooms and some carpets and chairs were stained and worn. On the ground floor the carpeted floor was uneven, although there were signs displayed about this to warn people. We were told that there were plans to improve the environment and that this was carried out by estates department, although we did not see these plans.
- We were told by staff that regular work place assessments of the community buildings were carried out by the estates department. However, staff were not aware of what actions there were from these site checks and reports were not kept on site.
- Buildings were not purpose built and had been adapted for use for the community teams. Each community site we visited had multiple ligature risk and hazards, such as door hinges and window fittings. There have been no known ligature incidents in any of the trust's community sites. Staff were not aware of ligature risk assessments but informed us that risk was mitigated by children and young people never being left unaccompanied and reception areas were manned and had CCTV in the waiting areas.
- The trust had carried out recent ligature risks assessments at community offices and had identified some high ligature risk areas. However, staff and managers we spoke with were not aware of the trust risk assessments and had not seen the outcome of community building risk assessments, including plans to reduce ligature risks.
- Staff adhered to infection control principles and there were hand wash signs in bathrooms and hand gels and signs in the clinical rooms.
- We reviewed records and saw that staff were compliant with infection control training.

Safe staffing

- Funding had been agreed for 28.4WTE new posts and the trust was in the process of recruiting staff to posts in order to manage and reduce the waiting lists on the referral pathways. East Berkshire had fully recruited and there were a number of new staff in the process of induction. However some areas, such as rural west Berkshire and central Berkshire were harder to recruit to, where 75% of the posts had been recruited to and advertising was on-going. The trust was also recruiting

Good

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to posts where staff had left. Turnover was higher in West Berkshire and Wokingham and 17 staff had left in the last twelve months. Overall staff turnover was 15% in the last year.

- There were interim cover arrangements for vacancies through the employment of agency and locum staff. Temporary staff were on block contracts in order to improve consistency and mitigate risk. However, in Wokingham 50% of the staff were locum or agency staff, which had impacted negatively on the stability of the team. There was 19 WTE agency staff in post to cover the vacancies overall.
- Caseloads were managed and reassessed regularly through individual supervision and during weekly allocation meetings and fortnightly business meetings. Team profiles had been recently undertaken to ensure safe staffing levels for caseloads. West Berkshire were trialling a caseload management tool with weighting, such as caseload complexity. However, caseload management tools were not in yet in place for the whole service.
- Routine outcome measures were used in the anxiety and depression pathway which enabled staff to manage caseloads more clearly with a focus on outcome measures.
- Management of the waiting list was undertaken by clinical staff which included a system of triage and face to face contact in order to manage the waiting list safely. However, this had impacted on time with existing caseloads and some staff reporting feeling under pressure.Waiting lists were a particular concern in the ASD diagnostic team where there were more than 1400 young people on the waiting list.
- The common point of entry service for all referrals had recently increased their hours from Monday to Friday 9am to 5pm week to a 12 hour service per day covering 8am to 8pm on each weekday. This meant that staff could assess more patients each day. However, there were concerns from staff and management about the robustness and stability of the new rota due to staff vacancies and some recent staff sickness.
- There was rapid access to a psychiatrist when required. There were designated duty workers in each locality and a rota of duty clinicians for patients who were assessed as high risk.
- We reviewed training matrices and saw that staff were compliant with the appropriate statutory and mandatory training, such as safeguarding and equality and diversity. Training rates were 85% compliant. Managers received fortnightly training reports and reminders on a red, amber and green rated report. Staff and managers also received reminders when training renewal was due. There was a process in place to ensure that agency staff were also up to date with statutory training. We reviewed a sample of these records and saw that this included safeguarding and infection control. However, we spoke with two agency staff who had not received recent training, although we did not see records to substantiate this.

Assessing and managing risk to patients and staff

We reviewed 20 care records and saw that there was some variation in the quality and detail of the risk assessment records. For example, in Wokingham we reviewed seven records and saw that there were risk assessments in place, but three of the records had not been updated monthly or at the last appointment. However, we observed clear risk planning in each of the three multidisciplinary meetings at Newbury, Slough and Wokingham. We saw an example where staff responded promptly to a change in the young person's risk assessment, when there had been deterioration in the young person's mental health.

There were safety plans for patients with advice for young people and families on how to keep safe and also how to get help out of the service working hours.

- Staff undertook a risk assessment of children and young people at initial triage. Staff actively monitored patients on the waiting list to detect any change in the level of risk. There was a traffic light system rated waiting lists where patients were assessed as red, amber or green. Each of the team's risk registers were actively managed by a clinician and this was reviewed each week.
- Staff, including agency staff were trained in safeguarding and staff we spoke with were confident in how to make a safeguarding alert. Staff were familiar with trust protocols and there were safeguarding flow charts and protocols clearly displayed. There was a named safeguarding nurse assigned to CAMHS that staff described good links with.
- The service was not commissioned to provide home treatment and services were offered at clinics across the

Good

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county. However, when staff needed to visit a patient at home, for example if the patient was unable to travel, then the safety protocol was to work in pairs and inform the staff of their whereabouts.

- Personal alarms were not consistently used and most clinic rooms did not have an alarm. Staff told us that there was the option to carry a personal alarm and have a buddy system with another staff member which was used on an individual basis if staff had any concerns about their safety.

Track record on safety

- There were no serious incidents (SIRIs) in last 12 months.

Reporting incidents and learning from when things go wrong

- Staff we spoke with across the service knew how and when to report and there was an open culture of reporting and learning from incidents. Incidents were reported on the electronic incident reporting system and the outcomes were discussed at fortnightly business meetings,
- There were action plans and evidence of change following incidents, for example in West Berkshire record keeping improvements were made following an incident, which included an improved template to follow at weekly allocation meetings.
- Staff told us that they were always de-briefed and supported after an incident.

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

- We looked at 20 care records in total and saw that plans of care mainly reflected the views and involvement of the young person and/or their carer where appropriate. Children, young people and carers were given a care plan sheet to take away with identified goals, agreed risks and a signed joint agreement of what CAMHS and the young person has agreed. Young people and their parents or carers we spoke with were clear about what their care plan was and what had been jointly agreed.
- There were some good examples of jointly agreed care plans in East Berkshire and the attention deficit hyperactivity disorder pathway which demonstrated up to date, personalised and recovery orientated plans. There were also good examples of assessments and care plans at West and East Berkshire, although there was some variation in how care plans were recorded overall. Some were recorded in a more traditional CAMHS format of a letter to the young person or parents/carers. Other services used a combination of care plan agreements and letters which had been all been uploaded onto the trust electronic system.
- We reviewed seven records in central Berkshire CAMHS at the Wokingham site and found that although progress notes and risk assessments were in place, five of the seven records had no care plans in either electronic or paper format. We checked with staff who also could not locate care plans for the five records. Following the inspection the trust advised us that all except one care plan was in place, but had been misfiled and a care plan had been completed for the remaining record without a care plan.
- All information on each site was stored securely on electronic and paper based systems.

Best practice in treatment and care

- Staff followed NICE guidance and we saw examples in records, such as in prescribing medicines for patients on the ADHD care pathway.
- The services provided a wide range of psychological interventions for children and young people in Berkshire by a team of therapists, including family therapy, art and dance therapy. Treatments included psychotherapy and cognitive behaviour therapy. Children, young people and their carers commented positively on the treatment available. However, staff reported that they were not fully compliant with National Institute for Health and Care Excellence (NICE) guidelines as could not always provide the level of cognitive behaviour therapy as recommended by NICE on the ADHD pathway.
- Staff undertook physical health checks for smoking and all young people over 16 were checked in order to offer smoking cessation. Managers and staff confirmed that routine physical health monitoring was generally carried out by the patient's general practitioner, who held responsibility for their overall physical health management. There was liaison with GPs and primary care but did not see evidence of routine annual physical health checks in the records we reviewed. The ADHD pathway team had recently recruited a school nurse to support physical health monitoring.
- Staff used outcome measures to rate severity and outcomes, such as routine outcome measurements which included the strengths and difficulties questionnaire and social communication questionnaire.
- Staff participated actively in a range of clinical audits and there was an annual audit programme in place. This included auditing of adherence to NICE guidance for assessment of depression and NICE guidance for prescribing for patients on the ADHD pathway.

Skilled staff to deliver care

- The teams across Berkshire had a range of psychiatrists, psychologists and therapists providing a rich mix of disciplines to support patients with specialist mental health treatment. Following the recent additional funding to increase capacity and reduce waiting time the trust were in the process of recruiting a number of positions including band 5 and 6 nurses. This had been agreed to support succession planning and career development for staff.
- Most staff were experienced and well qualified. Some newly recruited staff were still receiving an induction and teams were being supported by agency and locum staff, particularly in central Berkshire, where recruitment had been more challenging.

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.

- We reviewed 20 staff records and looked at induction and mandatory and statutory training plans. Staff received a full induction, including shadowing staff across the CAMHS service with shadowing opportunities across the three care pathways.
- Staff were supervised regularly with a combination of team and individual supervision. Staff received an annual appraisal. Staff told us that they felt supported by the trust and their managers, although staff in Wokingham reported feeling under pressure due to the high percentage of non-permanent staff.
- We saw that staff had access to regular team meetings and there were fortnightly business meetings, which included clinical and business components on the agenda.
- All staff we spoke with confirmed that they received the necessary specialist training for their roles. Staff had the opportunity for development training and three staff described the trust as very supportive with developmental training.
- Staff confirmed that they had received a recent appraisal and a review of records confirmed this.
- Staff told us that they received regular supervision including group and external clinical supervision. We reviewed staff records which showed that most staff were supervised regularly, although there were some gaps and some staff records showed that staff were not supervised as per the trust policy.
- Managers confirmed that they had dealt with poor staff performance promptly through the supervision structures.

Multi-disciplinary and inter-agency team work

- There were regular and effective multi-disciplinary meetings across Berkshire. We observed three of these multi-disciplinary team meetings in Newbury, Slough and Wokingham, which were held each week. The meetings were well attended by all staff from different disciplines within the teams in each region. Staff showed a clear understanding of the children and young people on their caseload, with clinicians providing appropriate clinical advice on the cases discussed.
- We observed a handover meeting at the common point of entry service in Wokingham and we saw that this was well conducted.
- There were good discussions between teams within the trust. For example, we observed a shared care meeting between East Berkshire CAMHS and the early intervention in psychosis service.
- All the meetings we observed were well conducted and the case discussions were robust and challenging but at all times was respectful with a genuine care for young people and their parents and carers.
- The community teams had links with teams external to the trust, such as primary care and schools and there were some good examples of external inter agency working. For example, the monthly CAMHS/social care meetings to discuss complex cases across Berkshire and joint working with the youth offending service.

Adherence to the MHA and the MHA Code of Practice

- The service was compliant with mandatory training related to understanding of the Mental Health Act.
- Staff we spoke with were aware of how to access support and guidance at the mental health office in the trust, if necessary.
- There was no direct access to independent mental health advocacy and staff and managers advised that they would speak to mental health act administration or patient advice and liaison service (PALS) for access to mental health advocacy.

Good practice in applying the MCA

- The Mental Capacity Act (MCA) does not apply to young people aged 16 and under. For children and young people under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.
- The staff we spoke to were conversant with the principles of Gillick and used this to include the children and young people where possible in the decision making regarding their care.
- All permanent staff had received training related to the Mental Capacity Act and Deprivation of Liberty Safeguards, which was part of the induction. It was also a requirement for agency and locum staff.

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.

- Staff routinely engaged in discussions about consent with young people and their families in all the clinical observations we conducted. Children and young people and their parents and carers we spoke with confirmed that consent was checked at each appointment. There was evidence of consent to treatment and consent in the majority of records we viewed. These had been updated and checked when decisions needed revisiting regarding consent.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We spoke with five young people and twelve parents about the care that they or their child had received. Each patient and carer we spoke with expressed satisfaction about the treatment provided. They told us that staff were kind and caring and always treated them with dignity and respect.
- Families told us how all staff including reception staff were very understanding and caring.
- We observed episodes of care or therapy across the service and discussions of care in multidisciplinary meetings.
- Staff worked flexibly to support the patients' individual needs.For example, if a patient wanted their parent with them or if a patient needed to be seen at home rather than a community location.
- Reports by young people and their parents supported our observations and feedback of how staff helped them were mainly positive. However, five of the parents and carers we spoke with expressed frustration at the length of time they had had to wait to get into the CAMHS service. This was also a theme on seven of the 26 comments cards expressing dissatisfaction about the long waits.

The involvement of people in the care they receive

- We observed care, therapy and treatment options being discussed with young people and families. Children and young people told us that they felt involved in their care or therapy. One patient told us that they knew what to expect and what the next steps were. However, we did not always see that young people had been given a copy of their care plan clearly documented in the clinical records. Four children and young people were not sure if they had a care plan.
- Most parents and carers we spoke to told us that there was appropriate involvement and provision of support for the young person. However, some carers told us that there was a lack of information for carers. Five parents we spoke to in East and West Berkshire were unclear how to get carers support or a carer's assessment to support them.
- The trust had made recent improvements in carer information, such as the mental health carer's campaign group carers training to involve carers more fully.
- There was no direct access to advocacy groups. Staff told us that they directed children and young people and carers to the patient advice and liaison service for signposting to advocacy and this information was displayed on each site we visited.
- People were encouraged to give feedback on the care they received. The service regularly took feedback from young people and families and carers using the services in a variety of formats including questionnaires and apps on electronic devices. Suggestion boxes and results of participation group findings and actions were on each site we visited. There was evidence of "you said, we did" in all the reception areas we visited. Examples of how the service had responded to feedback such as development of photo boards of staff in response to feedback were on display in waiting areas.
- There was a participation lead for user and carer participation and information was displayed inviting young people to join the user and carer participation group in each site we visited. We observed a monthly countywide facilitated user and carer involvement group which took place at Reading. P

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- The trust worked closely with the clinical commissioning groups to manage waiting times from referral to treatment. There had been a 30% increase in referrals from young people and the service was not meeting the existing or projected increase in demand for CAMHs community services. This had resulted in longer than acceptable waits for some young people.
- Referral rates across Berkshire particularly high in some pathways, such as the autistic spectrum disorder (ASD) diagnostic pathway where there were 1400 patients on the waiting list. A reduction in the waiting lists was a key target for the trust and its commissioners.
- At the time of our inspection the trust was in the process of a service redesign and had implemented recent improvements to waiting times and the safe management of the waiting list in order to mitigate the risk of waiting times. This had been supported by new investment from the clinical commissioning groups (CCGs). However, it was too early to see the impact of these improvements on the waiting lists across Berkshire.
- We observed multidisciplinary allocation meetings in Newbury, Wokingham and Slough and observed the team working actively with monitoring the waiting list. The lists were well managed, and included face to face contact with children and young people who were assessed as a red risk. There was ongoing assessment and monitoring of referrals. Referrals were re-assessed according to individual risk each week and if assessed as red, then a safety plan and regular monitoring, including face to face contact was put in place.
- Waiting lists were managed by a clinician on a daily basis and waiting list management meetings took place with the multi- disciplinary team with a weekly and monthly reporting to the executive team.However, waiting lists were long and at the time of our inspection the majority of referrals were waiting more than 12 weeks, with the longest waits in the ASD diagnostic pathway. Some children and young people had waited on the diagnostic pathway for more than two years.
- There were some geographical differences in the waiting times, for example, the longest waits were in central and west Berkshire where there were more referrals and vacancies have been harder to recruit to.
- In November 2015 the trust reported that:-
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  334 patients were waiting longer than 12 weeks on the attention deficit hyperactivity disorder (ADHD) pathway
- 1216 patients were waiting longer than 12 weeks on autistic spectrum disorder (ASD) diagnostic pathway
- 133 patients were waiting longer than 12 weeks for specialist community therapy.
- All children and young people were triaged and assessed by the team to ascertain the appropriate pathways.
- The trust had set targets for all common point of entry referrals to be telephone assessed by the next working day and care documentation triaged for any risks before being assigned to a pathway. In order to increase the effectiveness of the common point of entry /urgent care team hours of work had recently been increased to 8am-8pm. The common point of entry service received an average of 130 referrals per week.
- Each team responded promptly to children and young people who phoned in and there were duty workers allocated each day to manage this. There were duty plans with clinicians allocated each weekday to respond to and call children and young people and their parents.
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  - Children and young people were offered some flexibility with appointments, for example, young people could have a choice of location and flexibility of times was offered. The service was not commissioned to provide home treatment but offered individual flexibility to visit young people at home. Staff gave examples of this such as a patient who was reluctant to engage and preferred to be seen at home would be offered home appointments.
  - The teams also took a proactive approach to re-engaging with people who did not attend (DNA) their planned appointments. There was a policy of two DNAs before a young person was referred back to their GP. However, the teams we spoke with took an individual approach to DNAs in order to understand

Are services responsive to people's needs?

Requires improvement

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why the person had not attended and re-engage children and young people. There was a significant amount of clinical time placed on telephoning and writing to young people and their family in order to remind about appointments or to enquire regarding non-attendance, to then re-book. The current DNA rate was around 10%.

- Appointments were only cancelled when absolutely necessary, such as unexpected staff sickness. Children and young people and their parents or carers were kept informed by the administration staff if patient's appointments were running late.

The facilities promote recovery, comfort, dignity and confidentiality

- We looked at the environments at the Newbury, Slough and Wokingham community buildings. There were therapy rooms and clinic rooms to support treatment and care. We did note that the consultation rooms were not entirely soundproofed; however, they were positioned so that conversations could not be overheard from the reception areas in order to maintain confidentiality.
- None of the buildings were purpose built and varied in terms of comfort and appropriateness for younger people. There were good examples of appropriate materials and information for younger people displayed at eye level at Fir Tree House in Slough with a 'starlight' child friendly TV and DVD in the waiting area.
- Posters and displays, such as, positive affirmation statements, were on display in each service which had been agreed which had been requested by children and young people at the participation group. The participation group had also co-ordinated the display of children's and young person's arts and crafts.
- However, the building at Newbury had some old fashioned furnishings that were tired and worn in places and at Wokingham some of the treatment rooms were based in the adult unit.
- There were age appropriate leaflets for children on each site, such as information on treatments, local services and how to comment and complain.

Meeting the needs of all people who use the service

- Each building had disabled access; however, at the Newbury site wheelchair access was through the staff entrance at the back of the building.
- We did not see the full range of information leaflets available in languages spoken by people who used the service, but staff confirmed that these were easily accessible.
- Staff told us that there were a number of new leaflets in the process of design by the participation group.
- Staff confirmed that there was easy access to interpreters and/or signers through a local contractor. Information in braille and easy read leaflets could be accessed quickly, although we did not see these leaflets.

Listening to and learning from concerns and complaints

- The trust aimed to foster an environment where staff were confident to raise concerns about patient safety and learn with respect to errors, incidents, near misses and complaints across the organisation. We found that this was the culture within the community CAMHS teams and staff were confident to raise concerns and to learn from incidents.
- The total number of complaints received over the last 12 months was 33 of which 13 were upheld. There were no complaints that were referred to the ombudsmen in the last 12 months.
- Young people and their parents and carers felt informed about how to complain. Parents and young people expressed frustration about the length of waiting time to be seen. One young person said they did not intend to comment until they had finished their therapy but felt informed about the process.
- There were comments and compliments boxes on the sites we visited for children and young people and their carers to give feedback. This could be posted anonymously. However, we saw that young people would have to ask at the reception desk for a form to comment on the service before they posted their comment at the Newbury site.
- There were display boards which included information on how to complain at each site.

Are services responsive to people's needs?

Requires improvement

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

- There were "'you said, we did" boards on each site, which showed improvements that had been made as a result of feedback and engagement. Improvements included a photo board of all staff at the Newbury site and an area for younger people at Slough.
- Staff were confident in how to handle complaints appropriately. We found that the services were open to complaints and comments and learning from these. Complaints and compliments were discussed at fortnightly business meetings and were on the standing agenda of business meetings on each site.

Are services well-led?

Good

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 were aware of the trust core values of caring, commitment to good quality and working together. These were integral within the value based appraisal process.
- At West and East Berkshire staff had developed their own team objectives that reflected the organisations values and objectives.
- Staff we spoke with knew who the senior managers in the trust were and confirmed that senior managers had regularly visited the community buildings.

.Good governance

- We observed robust governance structures for monitoring waiting list management. Waiting lists of CAMHS community services was a key quality concern and was monitored by the Board and regular monitor meetings were held with each of the commissioning groups. CCGs remain concerned about the waits but felt satisfied with the communication from trust. The improved structures and staffing had led to improvements in monitoring of the waiting list but it was too early to see any significant reduction in the length of waits.
- There were good systems in place to ensure that staff received mandatory and statutory training and staff appraisals, although the systems were not robust enough to identify the gaps in supervision or supervision recording.
- The trust's open culture to incident reporting had encouraged staff to report and learn from incidents, including safeguarding.
- Each team manager had administrative support and managerial support from the service manager. Managers felt they had sufficient authority to carry out their role effectively, although there were pressures due to the waiting list and capacity issues.
- Staff submitted items to the local risk register and key risks such as waiting lists were then submitted to the trust risk register.

Leadership, morale and staff engagement

- Most staff told us that they were satisfied and enjoyed their work, but felt under pressure with the waiting lists.
- Overall, morale and job satisfaction was mixed across the service. In East Berkshire where there was a full complement of staff, morale was high. In Wokingham community teams and the common point of entry service where there were staff vacancies, this had adversely affected staff morale. Sickness and absence rates were below five per cent despite the pressure on staffing across the service.
- Managers reported that there were no recent bullying and harassment cases although one staff member expressed that bullying had taken place.
- Staff we spoke with were confident in how to whistle blow including in cases of bullying and/or harassment. Staff told us that they would be happy to raise concerns without fear of victimisation.
- Two of the three managers we spoke with in East, West and central Berkshire were in interim management posts. All managers had benefited from leadership training and were enthusiastic about the leadership and management skills opportunities that had been provided by the trust. In addition to the highly regarded management programme there were also opportunities for professional development and two staff we spoke with were being supported by the trust to develop their clinical skills by undertaking master's programmes.
- Staff and managers told us that there was always opportunity to give feedback. The trust had offered the opportunity to give feedback on services through the trust wide 'Listening in Action' group) which had been in place since 2012.

Commitment to quality improvement and innovation

- The trust had invested in the ADHD pathway as commitment to quality improvement. They used a quantitative behaviour test which was an evidence based best to support in the diagnosis of ADHD.

The trust was in the early stages of leaflet and website development with young people and their carers. This included the development of a web based social networking peer support forum to support mental health recovery.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983 **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: 17(2)(a) Assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of experience of service users in receiving those services).** The provider must address the long waiting lists for patients to access services. This is a breach of Regulation 17(2)(a)