Requires improvement

Dorset Healthcare University NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Tel:
Website:

Date of inspection visit: 23-25 June 2015
Date of publication: 16/10/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RDYNM	Sentinel House	CAMHS community teams	BH17 0RB

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Overall summary

We gave an overall rating for specialist community mental health services for children and young people of **requires improvement** because:

• In two of the CAMHS services we visited we found that there was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.

• Two of the community CAMHS teams were unable to provide a service to children and young people within target waiting times due to vacancies and staff sickness.

• We were told by the staff and service managers that caseloads were reviewed regularly at the weekly multi-disciplinary meetings. We reviewed the minutes of the multi-disciplinary meetings for May 2015 and could find little evidence that caseloads had been reviewed at these meetings in two of the teams we visited..

• Insufficient numbers of staff were up to date with their mandatory training. The trust had a target of 85% of staff to have completed mandatory training. No CAMHS team had reached 85% for all mandatory training and there were some mandatory training courses with very low levels of attendance.

• Fourteen of the 26 care records we reviewed did not contain up to date care plans.

• There were backlogs in administrative work in one service which had delayed referrals of young people to other services.

• Staff shortages and vacancies prevented the CAMHS community services from delivering all the psychological therapies recommended by NICE.

• The community CAMHS services did not meet their waiting list targets for assessment or treatment.

• The trust could not provide us with detailed information regarding the number of young people waiting for tier two assessment or treatment or how long they had waited.

• Feedback we received from local stakeholders was critical of the wait for treatment that young people had to experience after referral to community CAMHS and was also critical of delays in the crisis service responding to urgent assessments.

• Four of the seven parents of young people who used the community CAMHS services we spoke with told us that they were not satisfied with the amount of time their child had to wait for assessment and treatment after the initial referral.

• There were not effective systems in place to ensure staff received mandatory training, to manage the waiting lists and to ensure there were sufficient staff.

• There was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.

• There was not an effective system in place to ensure consistency in standards and work processes across the different community CAMHS teams.

However:

- safeguarding was good and we saw clear evidence of learning from incidents. All staff we spoke with received regular supervision. There were weekly team meetings and multi-disciplinary meetings. The community CAMHS teams and children's learning disabilities team had built very good working relationships with the local schools. The consultant psychiatrist at the children's learning disability service carried out regular joint clinics with a consultant paediatrician. The trust is part of Reading University's CYP-IAPT (children and young people's improving access to psychological therapies) programme. The North Dorset community CAMHS team had set up a CAMHS advisory telephone service for professionals in North Dorset. Nine of the eleven young people or carers we spoke with said the staff they worked with were supportive. The three parents of young people who used the North Dorset service we spoke with gave us extremely positive feedback regarding the service. They praised the team psychiatrist and support workers and told us that both their children's and their own support needs had been met by the service. The

Summary of findings

staff we spoke with spoke respectfully of the young people and their carers and were able to give us many examples to demonstrate their understanding of the individual needs of the young people who used the service. The trust produced age appropriate and accessible information leaflets. Toys and books were available in waiting rooms. The multi-disciplinary leadership teams at the children's learning disability service and at North Dorset community CAMHS worked very well and enabled those teams to deliver high service standards. Staff generally were positive and engaged. The trust responded very positively and quickly when we raised concerns about the risk assessment process for cases on the waiting lists following our visits. The trust took prompt action to review and reduce the highest risks and has drawn up an action plan to review all the waiting lists, caseloads and the risk assessment process.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- In two of the CAMHS services we visited we found that there was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment. Because of these findings we were concerned that in these services staff did not assess, monitor or manage risks for young people waiting to use the service. This meant that opportunities to prevent or minimise harm could be missed.
- Two of the community CAMHS teams were unable to provide a service to children and young people within target waiting times due to vacancies and staff sickness. This meant that some children and young people who needed treatment were not receiving it within an acceptable timescale.
- We were told by the staff and service managers that caseloads were reviewed regularly at the weekly multi-disciplinary meetings. We reviewed the minutes of the multi-disciplinary meetings for May 2015 and could find little evidence that caseloads had been reviewed at these meetings in two of the teams we visited. Therefore we could not be assured that all risks, communications and updated information for children and young people were being reviewed regularly by the multi-disciplinary team.
- Insufficient numbers of staff were up to date with their mandatory training. The trust had a target of 85% of staff to have completed mandatory training. No CAMHS team had reached 85% for all mandatory training and there were some mandatory training courses with very low levels of attendance. This meant that insufficient numbers of staff had received the training the trust considered to be mandatory for their positions.
- safeguarding was good and we saw clear evidence of learning from incidents.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Fourteen of the 26 care records we reviewed did not contain up to date care plans.
- There were backlogs in administrative work in one service which had delayed referrals of young people to other services.

Summary of findings

- Staff shortages and vacancies prevented the CAMHS community services from delivering all the psychological therapies recommended by the National Institute for Health and Care Excellence (NICE).

However:

- all staff we spoke with received regular supervision. There were weekly team meetings and multi-disciplinary meetings. The community CAMHS teams and children's learning disabilities team had built very good working relationships with the local schools. The consultant psychiatrist at the children's learning disability service carried out regular joint clinics with a consultant paediatrician. The trust is part of Reading University's children and young people's improving access to psychological therapies (CYP-IAPT) programme. The North Dorset community CAMHS team had set up a CAMHS advisory telephone service for professionals in North Dorset.

Are services caring?

Good

We rated caring as **good** because:

- Nine of the eleven young people or carers we spoke with said the staff they worked with were supportive.
- The three parents of young people who used the North Dorset service we spoke with gave us very positive feedback regarding the service. They praised the team psychiatrist and support workers and told us that both their children's and their own support needs had been met by the service.
- The staff we spoke with spoke respectfully of the young people and their carers and were able to give us many examples to demonstrate their understanding of the individual needs of the young people who used the service.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** because:

- The community CAMHS services did not meet their waiting list targets for assessment or treatment.
- The trust could not provide us with detailed information regarding the number of young people waiting for tier two assessment or treatment or how long they had waited.

Summary of findings

- Feedback we received from local stakeholders was critical of the wait for treatment that young people had to experience after referral to community CAMHS and was also critical of delays in the crisis service responding to urgent assessments.
- Four of the seven parents of young people who used the community CAMHS services we spoke with told us that they were not satisfied with the amount of time their child had to wait for assessment and treatment after the initial referral.

However:

- the trust produced age appropriate and accessible information leaflets. Toys and books were available in waiting rooms.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- There were not effective systems in place to ensure staff received mandatory training, to manage the waiting lists and to ensure there were sufficient staff.
- There was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.
- There was not an effective system in place to ensure consistency in standards and work processes across the different community CAMHS teams.

However:

- the multi-disciplinary leadership teams at the children's learning disability service and at North Dorset community CAMHS worked very well and enabled those teams to deliver high service standards. Staff generally were positive and engaged. The trust responded very positively and quickly when we raised concerns about the risk assessment process for cases on the waiting lists following our visits. The trust took prompt action to review and reduce the highest risks and has drawn up an action plan to review all the waiting lists, caseloads and the risk assessment process.

Summary of findings

Information about the service

The children's learning disability service is based at Seastone House, Bournemouth and provides a service across the county of Dorset. The service offers support for children and young people (up to 18 years old) with a learning disability who require specialist medical care or nursing care, as well as offering support and advice to their families.

There are six community child and adolescent mental health service (CAMHS) teams based across Dorset: Bournemouth and Christchurch; Poole; East Dorset; Weymouth and Portland; West Dorset; and North Dorset.

The CAMHS services offer assessment and treatment to children and young people aged up the age of 18 years (and their families/carers) who are suffering significant mental health difficulties, which have not responded to intervention at primary care, and prevention and early intervention level.

The community CAMHS teams offer services divided into tier two and tier three work. Tier two services offer targed services for mild to moderate emotional wellbeing and mental health problems. Tier three services offer specialist services for young people with moderate and severe mental health problems that are causing significant impairments in their day-to-day lives. The community CAMHS teams also offer crisis and out-of-hours services.

Our inspection team

The team that inspected this core service was comprised of: two inspectors from CQC, three specialist advisors with experience of working in and managing community mental health services for chidren and young people and a Mental Health Act reviewer.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information. We also sought feedback from people who use services and carers at focus groups across the county.

During the inspection visit, the inspection team:

- visited the community mental health services for children and young people in Bournemouth and Christchurch (Shelley Clinic); in Weymouth and Portland (Lynch Lane); in North Dorset (Blandford Hospital); and the children's learning disability service

Summary of findings

at Seastone House in Bournemouth. We looked at the quality of the clinic environment and observed how staff interacted with young people who use services and carers;
- spoke with four young people who were using the service;
- spoke with seven parents of young people who were using the service;
- spoke with the managers or acting managers for each of the services we visited;
- spoke with 18 other staff members; including doctors, nurses, social workers, psychologists and administrative staff;
- interviewed the divisional director with responsibility for these services;
- attended and observed one multi-disciplinary meeting.
- looked at 26 treatment records of patients;
- 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

Four of the parents of young people who used the community CAMHS services told us that they were not satisfied with the amount of time their child had to wait for assessment and treatment after the initial referral. All four parents were very satisfied with the quality of treatment their child was receiving at the time we spoke with them.

The young people who used the community CAMHS services had mixed views regarding the service they had received. One young person in the east of the county told us that at first they had been referred to adult services mistakenly and that the CAMHS service needed more staff, more organisation and better communication. Another young person who used the East Dorset service told us that the support they received was very good. A young person who used the North Dorset service told us that they were reasonably happy with the service they received but that they would like more individual therapy rather than group therapy.

The three parents of young people who used the North Dorset service gave us extremely positive feedback regarding the service. They praised the team psychiatrist and support workers and told us that both their children's and their own support needs had been met by the service.

Two parents told us that they had experienced problems with the service their child had received initially but the service had improved considerably since the initial problems. One parent told us they did not always get support from out of hours services when they called them.

The parent of a young person who used the children's learning disability service told us they were very positive about the quality of care and the staff in the service.

At the end of the inspection we collected comment boxes from the community services. We received 21 comment cards from the children's learning disability service at Seastone House. Of the 21 comments, 18 were positive about the service and 3 were negative. The positive comments included praise for the professionalism of the staff, the quality of care provided, the support given to children and young people and their families, the flexibility of the staff and the clean, welcoming and calm environment.

Good practice

- The children's learning disability service won an innovation award from the Royal College of Psychiatry in 2014 for "Developing Parenting Groups as an Initial Intervention."
- The children's learning disability service provided a very flexible service. The service was able to see children and young people within 24 hours for urgent referrals and offered evening and Saturday appointments.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that a consistent risk assessment process is put in place for all cases of children and young people waiting for assessment or treatment.
- The trust must ensure there are sufficient numbers of suitably skilled staff employed in the specialist community mental health services for children and young people.
- The trust must ensure that staff are up to date with their mandatory training.

Action the provider SHOULD take to improve

- The trust should ensure that caseloads are reviewed regularly to ensure that they are manageable and young people receive appropriate treatment.
- The trust should ensure the action plans they produced following our visit to the community CAMHS teams are implemented without delay.
- The trust should ensure that all care plans are up to date.
- The trust should ensure that correspondence to carers and young people relating to their treatment plans is sent to them promptly.
- The trust should ensure that correspondence referring children and young people to other services is sent promptly without delaying their treatment.
- The trust should ensure it has systems in place to deliver greater consistency in the standards and working practices across the different community CAMHS teams.

Dorset Healthcare University 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
Shelley Clinic – Bournemouth and Christchurch community CAMHS.	Sentinel House
Lynch Lane – Weymouth and Portland community CAMHS.	Sentinel House
Blandford Hospital – North Dorset community CAMHS.	Sentinel House
Seastone House - Children's learning disability service	Sentinel House

Mental Health Act responsibilities

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

The Mental Health Act was rarely used by the specialist community mental health services for children and young people. The North Dorset community CAMHS service had recently given whole team training and produced training guidance on the Mental Health Act and Code of Practice relevant to CAMHS. All clinical staff we spoke with said they had received training in the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act only applies to young people aged 16 years and over. All staff we spoke with at the children's learning disability service had a good understanding of the Mental Capacity Act and how it applied to relevant young

Detailed findings

people. The North Dorset community CAMHS service had recently given whole team training and produced training guidance on the Mental Capacity Act and Code of Practice relevant to CAMHS.

The deprivation of liberty safeguards apply only to people aged 18 and over.

Inadequate

Are services safe?

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

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

Summary of findings

We rated safe as **inadequate** because:

- In two of the CAMHS services we visited we found that there was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment. Because of these findings we were concerned that in these services staff did not assess, monitor or manage risks for young people waiting to use the service. This meant that opportunities to prevent or minimise harm could be missed.
- Two of the community CAMHS teams were unable to provide a service to children and young people within target waiting times due to vacancies and staff sickness. This meant that some children and young people who needed treatment were not receiving it within an acceptable timescale.
- We were told by the staff and service managers that caseloads were reviewed regularly at the weekly multi-disciplinary meetings. We reviewed the minutes of the multi-disciplinary meetings for May 2015 and could find little evidence that caseloads had been reviewed at these meetings. Therefore we could not be assured that all risks, communications and updated information for children and young people were being reviewed regularly by the multi-disciplinary team.
- Insufficient numbers of staff were up to date with their mandatory training. The trust had a target of 85% of staff to have completed mandatory training. No CAMHS team had reached 85% for all mandatory training and there were some mandatory training courses with very low levels of compliance. This meant that insufficient numbers of staff had received the training the trust considered to be mandatory for their positions.

However:

- safeguarding was good and we saw clear evidence of learning from incidents.

Our findings

Safe and clean environment

- All areas of the clinics and therapy rooms we saw were clean and appeared well maintained. We saw the cleaning records were up to date.
- None of the interview rooms we saw were fitted with alarms. The staff we spoke with told us that they felt there had never been a need for alarms to be fitted because they did not feel at risk using the interview rooms. There had been no incidents recorded in the interview rooms.

Safe staffing

- The community CAMHS teams employed a range of professionals including psychiatrists, psychologists, occupational therapists, nurses, support workers and administrative staff. The staff we spoke with (excluding those in the children's learning disabilities service) all told us that there were at the time of our inspection, or in the preceding 12 months, key posts were vacant or affected by staff sickness or training. They told us that their ability to provide a service to children and young people had been impacted by the number of vacancies and staff sickness.
- The staffing data provided by the trust informed us that there were, in total, 81 substantive staff employed by the trust in the specialist community mental health services for children and young people (at 31 May 2015). Also, 9 substantive staff (11%) had left the service in the last 12 months.
- The trust informed us that there was a 3.3% total staff vacancy rate in CAMHS services (including inpatient services) at 31 May 2015. However, the vacancy rate varied considerably between the individual services. The highest vacancy rates were for tier three services for Bournemouth and Christchurch (10.2%), tier 2 services for North Dorset (10%) and the children's learning disability service (9.9%).
- Key posts within community CAMHS teams were vacant which impacted on the lengths of time that young people had to wait for assessment and treatment. All

Inadequate

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staff we spoke with at Shelley Clinic (Bournemouth and Christchurch team) said they were under-resourced. In addition to their tier three vacancies, two full-time members of the team were undertaking further professional training which meant they were each not available to work in the service two days per week. The manager told us that these sessions were not filled by other staff so the service ran without two members of staff two days per week. At the Weymouth and Portland service all staff we spoke with said they were concerned about recruitment and retention of staff, particularly psychiatrists and psychologists. The service did not have a permanent consultant psychiatrist and their clinical psychologist was due to leave the trust in August 2015. Both the Bournemouth and Weymouth services did not meet their waiting list targets.

- Between 1 March and 31 May 2015, 418 shifts had been filled by bank or agency staff to cover sickness, vacancies and absence in the trust's specialist mental health community services for children and young people. The Bournemouth and Christchurch service had the highest usage of bank or agency staff with 178 shifts filled in this period for both tier two and tier three work. The children's learning disability service had the lowest usage of bank or agency staff with five shifts filled in this period.
- The trust senior managers told us that there had been a skill review process for community CAMHS teams in 2013 which had set the resource levels and staff skill mix for each service. The local managers told us that they thought there should be a further review to update resource levels and skill mix in response to changing need in the past two years.
- Caseloads per case worker in the six community CAMHS teams were very similar. East Dorset had the highest team average caseload of 53 and Weymouth and Portland had the lowest at 47. The number of cases awaiting allocation to a care coordinator at the time of our inspection varied from zero in North Dorset and Weymouth and Portland to eight in the Poole team. There were 20 cases awaiting allocation to a care coordinator in total across the services. The cases awaiting allocation to a care coordinator were held by crisis workers until a care coordinator could be allocated.
- We were told by the staff and service managers that caseloads were reviewed regularly at the weekly multi-disciplinary meetings. We reviewed the minutes of the multi-disciplinary meetings for May 2015 and could find little evidence that caseloads had been reviewed at these meetings. A small number of cases were discussed at these meetings where there were particular issues such as a need for medical input and there was some discussion recorded of assessments that had taken place that week. At the Bournemouth and Christchurch meetings in May, between 19 and 21 cases had been discussed at each meeting, most of which were young people who were receiving inpatient treatment and newly assessed cases. At the Weymouth and Portland meetings in May, between 2 and 7 cases had been discussed at each meeting, these were all cases where there were updates noted. At the North Dorset meetings in May, between 7 and 14 cases had been discussed at each meeting. Again most of these cases were highlighted as needing medical input or were new assessments. There was no specific discussion about caseloads recorded in any of the multi-disciplinary meetings minutes we reviewed.
- The local managers could not give us figures for the numbers of their staff who had completed mandatory training. They told us they thought that not all staff were up to date with mandatory training. The local managers advised that this information was held centrally in the trust. All staff confirmed to us that new staff received mandatory training as part of their induction in the trust. The data the trust gave us for mandatory training showed that there was a significant variance across the teams and across different elements of mandatory training with regards to how many staff were up to date with their mandatory training. The trust has a target of 85% of staff to have completed mandatory training. Only information governance mandatory training met the trust's target across all CAMHS teams. We were concerned that there was a systemic failure to provide basic life support mandatory training because only one community mental health team for children and young people had met the target for this training. The Weymouth and Portland service, the West Dorset service and the Poole service had particularly low percentages of staff who had completed the training. None of the Weymouth and Portland tier two staff and only 25% of tier three staff had completed the basic life support

Inadequate

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training. One-third of West Dorset tier two staff and 75% of tier three staff had completed the basic life support training. In the Poole service, 20% of tier two and 50% of tier three staff had completed the basic life support mandatory training.

Assessing and managing risk to patients and staff

- We reviewed 26 care records in total during our visits to the specialist children's and young people's community mental health service teams. Of the 26 care records we reviewed, 25 had risk assessments recorded. The risk assessments we reviewed at the Weymouth and Portland service and the Bournemouth and Christchurch service were not well recorded. Nine of the 15 care records we reviewed in these two services had basic risk assessments and only five of the 15 records had fully updated risk assessments. However the risk assessments we reviewed at the North Dorset community CAMHS team and at the children's learning disabilities team were detailed, up to date and had been updated regularly where appropriate.
- All teams apart from the children's learning disability service had waiting lists for children and young people to be assessed and to receive treatment. We asked the service managers how they risk assessed the waiting lists. The local managers told us that risks were assessed when the cases were triaged, at the full assessment and then they should be periodically reviewed at least once every six months but more frequently if they had been assessed as high risk or if new issues were raised. Although all the local service mangers were able to describe this process we were concerned about the effectiveness of the systems in place in the Weymouth and Portland service and the Bournemouth and Christchurch service. We found that in these services there was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment. At the Bournemouth and Christchurch service we reviewed the notes for one young person who had been referred to the service in July 2014 and had been assessed in September 2014. The young person was waiting for treatment at the time of our visit but there was no record that a further risk assessment had taken place in the nine months the young person had been waiting for treatment. We also reviewed the notes for one young person who had been referred and assessed in August 2014. The young person had then started to receive treatment in May 2015. There was no updated risk assessment recorded between 14 August 2014 and 7 May 2015, a period of over eight months. At the same service we saw the notes for one young person who had been referred to the service in December 2014 and risk assessed on 16 February 2015. The young person was assessed as high risk. This young person was waiting for tier three services at the time of our visit but there was no record that a further risk assessment had taken place in the four months the young person had been waiting for treatment.

At the Weymouth and Portland service we reviewed the notes for one young person who had been risk assessed as high risk of self harm when they were initially assessed in 2014.In the young person's notes it was recorded in May 2015 that the young person had self-harmed but no updated risk assessment was present in the notes. We also reviewed the notes for one young person whose notes stated that on 1 April 2015 the young person was low in mood and suicidal.There was no updated risk assessment recorded for this young person but the young person had been referred to the duty crisis team.

The trust told us that the waiting lists were reviewed by the local teams in the weekly multi-disciplinary team management meetings. We requested the minutes of the community CAMHS multi-disciplinary team management meetings for May 2015. The minutes of the meetings for May 2015 provided by the trust had no records of any clinical reviews of the waiting list cases by the Weymouth and Portland service team or the Bournemouth and Christchurch service team.

Because of these findings we were concerned that in these services staff did not assess, monitor or manage risks for young people waiting to use the service.This meant that opportunities to prevent or minimise harm could be missed.

- Following our visit to the local community CAMHS teams we informed the trust of our concerns straight away. The trust took immediate action to review the waiting lists. The trust lead consultant for CAMHS and the head of mental health and clinical risk lead for CAMHS examined in detail all cases waiting for tier three treatment. They identified 97 young people on the tier three waiting list, risk-rated the cases and prioritised those that needed action taken urgently. They produced an action plan to

ensure all cases of young people on the tier two waiting list were reviewed by 31 July 2015, to ensure all caseloads in the community CAMHS teams are reviewed and to improve waiting list management, particularly ensuring risk assessment is robust. The trust has been keeping us informed of the progress to these actions.

- However, in the North Dorset CAMHS team the local managers there clearly talked us through their processes for monitoring risk for the children and young people on the waiting list. We saw in the records we reviewed at North Dorset that their processes were being followed and workers regularly contacted the referring agency and/or family or service user whilst children and young people were waiting for assessment or treatment to review.
- All staff we spoke with in the services knew about the trust's safeguarding policy and could tell us how to make a safeguarding alert and when it would be appropriate to do so.
- The trust had a lone working protocol which was available in all of the specialist community mental health services for children and young people. The staff we spoke with were aware of the protocol and could explain how they followed it.

Track record on safety

- There were no serious incidents recorded in the last 12 months for specialist community mental health services for children and young people in Dorset.
- The team managers told us they discussed with their teams learning from incidents that had occurred in the community CAMHS services and in other services within the trust. We saw recorded in the multi-disciplinary meeting minutes that learning from incidents had been discussed at the meetings.

Reporting incidents and learning from when things go wrong

- There were 44 minor incidents reported in the community CAMHS services and 25 minor incidents reported in the children's learning disability service.
- The service managers and other staff members we spoke with told us that they knew how to report incidents. We saw information posters and sheets in the services regarding incident reporting. We saw that incident reporting had been discussed in multi-disciplinary meetings.
- The minutes of multi-disciplinary team meetings recorded that the teams had discussed learning from incidents within CAMHS services and from incidents in other services within the trust.
- The clinical governance newsletters for Dorset CAMHS/ learning disabilities services which were produced quarterly for all staff in the CAMHS and children's learning disabilities services contained a section on learning from critical incidents.
- The team managers at the North Dorset community CAMHS service told us there had been an intervention meeting following one incident which had led to a change in practice within the trust. A bed manager had been recruited to the CAMHS inpatient service following an incident involving issues with the community CAMHS team trying to get an out of area bed for a young person in crisis.

Are services effective?

Requires improvement

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

Summary of findings

We rated effective as **requires improvement** because:

- Fourteen of the 26 care records we reviewed did not contain up to date care plans.
- There were backlogs in administrative work in one service which had delayed referrals of young people to other services.
- Staff shortages and vacancies prevented the CAMHS community services from delivering all the psychological therapies recommended by NICE.

However:

- all staff we spoke with received regular supervision. There were weekly team meetings and multi-disciplinary meetings. The community CAMHS teams and children's learning disabilities team had built very good working relationships with the local schools. The consultant psychiatrist at the children's learning disability service carried out regular joint clinics with a consultant paediatrician. The trust is part of Reading University's CYP-IAPT (children and young people's improving access to psychological therapies) programme. The North Dorset community CAMHS team had set up a CAMHS advisory telephone service for professionals in North Dorset.

Our findings

Assessment of needs and planning of care

- We reviewed 26 care records on the electronic patient record system. Comprehensive assessments were documented in each of the 26 care records we reviewed and had been carried out at the young person's first appointment. Out of the 26 care records we reviewed, we could not find up to date care plans in 14 of the records. The eight care records that were up to date were in the North Dorset and children's learning disability services.
- The quality of record keeping in the North Dorset team and the children's learning disabilities team was higher than in the other community CAMHS teams we visited. Caseworkers and clinicians in these two services ensured that the electronic records were updated promptly following appointments; that letters were sent out promptly following appointments; and that referrals to other services and agencies were made swiftly.
- The Bournemouth and Christchurch service had a backlog of letters to be typed and the electronic care records were not fully up to date. For example, one of the records we reviewed related to a young person who had been assessed in May 2015. The electronic care record stated that the young person would be referred to a different service. However, there was no record that the referral had taken place. The young person's parent had rung the following week to query what action was being taken and it was recorded that they were told that they would be sent a copy of the referral letter but there was a typing backlog. We asked the service manager to check the case during our visit and they confirmed that the letter had now been typed but a copy had not yet been uploaded to the electronic care record. At this point it was four weeks after the young person's appointment which meant the young person's referral to a different service was delayed by four weeks.

Best practice in treatment and care

- The services carried out audits to check they were following NICE guidance when prescribing medication to the children and young people.
- Staff in the three community CAMHS teams we visited told us that they were not able to offer all the psychological therapies recommended by NICE because of staff shortages. For example, the North Dorset team had a vacancy for an occupational therapist and the Bournemouth and Christchurch team had a vacancy for a family therapist. Two members of staff in the Weymouth and Portland team told us that there was a need for more staff trained to deliver cognitive behavioural therapy (CBT).
- The community CAMHS services were using outcome measures to rate severity and outcomes for young people, for example, revised children's anxiety and depression scale (RCADS), outcome rating scale (ORS), mood and feelings questionnaire (MFQ) and Yale-Brown obsessive compulsive scale (Y-BOCS).
- The trust is part of Reading University's children and young people's improving access to psychological therapies (CYP-IAPT) programme. Reading University ran

Are services effective?

Requires improvement

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

a training session to all CAMHS staff on the use of outcome measures. The CAMHS services submit their outcome measures data to the CYP-IAPT project every quarter.

- The children's learning disability service used learning disability appropriate outcome scales such as goal based outcomes and aberrant behaviour checklist (ABC).
- Clinical staff participated in clinical audit. For example, in May 2015 the CAMHS community services participated in the prescribing observatory for mental health (POMH-UK) audit of prescribing for attention deficit hyperactivity disorder (ADHD) in children, adolescents and adults.

Skilled staff to deliver care

- The community CAMHS teams and the children's learning disability service staff establishment included a full range of mental health disciplines including nurses, occupational therapists, psychologists, social workers and psychiatrists. There were vacancies in some key posts, for example a consultant psychiatrist post at Weymouth and Portland, an occupational therapist post at North Dorset and a family therapist at Bournemouth and Christchurch.
- All staff we spoke with had attended an induction course when they joined the trust which included mandatory training.
- All staff we spoke with said they received appropriate specialist training for their roles. Two of the nurses we spoke with had received in-house CBT training to enhance their therapy work. All crisis workers attended two-day dialectical behavioural therapy (DBT) skills training in July 2015.
- 90% of non-medical staff in the specialist community mental health services for children and young people had received an appraisal in the last 12 months.
- The trust is part of Reading University's children and young people's improving access to psychological therapies (CYP IAPT) programme.
- All the staff we spoke with received regular supervision, both clinical and managerial.

Multi-disciplinary and inter-agency team work

- Each service had a multi-disciplinary meeting every week and a team meeting every Wednesday morning.
- The community CAMHS teams had good working relationships with the trust's CAMHS inpatient unit, Pebble Lodge. The out-of-hours community CAMHS service was run out of the inpatient unit and there was daily communication and handover between the inpatient and community CAMHS services.
- The community CAMHS teams and children's learning disabilities team had built very good working relationships with the local schools. Many of the community CAMHS appointments were held in schools so that young people's education was not disrupted by their treatment.
- The community CAMHS teams were working on building closer links with school nurses and health visitors.
- The consultant psychiatrist at the children's learning disability service carried out regular joint clinics with a consultant paediatrician.
- The North Dorset community CAMHS team had set up a CAMHS advisory telephone service for professionals in North Dorset. The telephone service offered support in identifying whether a referral to CAMHS was appropriate. Information on the telephone service had been sent to all schools, children's centres and GP practices in the North Dorset area.

Adherence to the MHA and the MHA Code of Practice

- The Mental Health Act was rarely used by the specialist community mental health services for children and young people.
- The North Dorset community CAMHS service had recently given whole team training and produced training guidance on the Mental Health Act and Code of Practice relevant to CAMHS.
- All clinical staff we spoke with said they had received training in the Mental Health Act.

Are services effective?

Requires improvement

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

Good practice in applying the MCA

- The Mental Capacity Act only applies to young people aged 16 years and over. All staff we spoke with at the children's learning disability service had a good understanding of the Mental Capacity Act and how it applied to young people.
- The North Dorset community CAMHS service had recently given whole team training and produced training guidance on the Mental Capacity Act and Code of Practice relevant to CAMHS.
- All clinical staff we spoke with said they had received training in the Mental Capacity Act.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** because:

- Nine of the eleven young people or carers we spoke with said the staff they worked with were supportive.
- The three parents of young people who used the North Dorset service we spoke with gave us extremely positive feedback regarding the service. They praised the team psychiatrist and support workers and told us that both their children's and their own support needs had been met by the service.
- The staff we spoke with spoke respectfully of the young people and their carers and were able to give us many examples to demonstrate their understanding of the individual needs of the young people who used the service.

Our findings

Kindness, dignity, respect and support

- There were few children and young people at the services on the days we visited. All of the interactions we saw between young people and carers and the staff members were respectful and supportive.
- Nine of the young people or carers we spoke with said the staff they worked with were supportive.
- The three parents of young people who used the North Dorset service we spoke with gave us very positive feedback regarding the service. They praised the team psychiatrist and support workers and told us that both their children's and their own support needs had been met by the service.
- All teams ran workshops for parents to provide information and support. For example, the trust community CAMHS services ran a seven-week programme for supporting parents with children with anxiety. Also, the community CAMHS services ran CBT-based parenting programmes for managing children who self-harm.

The involvement of people in the care they receive

- Care plans recorded on the electronic patient record system were not very personalised. The care plans we saw that were recorded in letters sent to young people and their carers were personalised and showed understanding of the individual needs of the young people who used the service.
- The staff we spoke with spoke respectfully of the young people and their carers and were able to give us many examples to demonstrate their understanding of the individual needs of the young people who used the service.
- The parent of a child who used the children's learning disability service told us that they worked with the service to develop their child's care plan together.
- Young people who used the community CAMHS services participated in the CYP-IAPT film project. The community CAMHS teams worked with Healthwatch and Birmingham University to develop short films with young people with lived experience of CAMHS.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

We rated responsive as **requires improvement** because:

- The community CAMHS services did not meet their waiting list targets for assessment or treatment.
- The trust could not provide us with detailed information regarding the number of young people waiting for tier two assessment or treatment or how long they had waited.
- Feedback we received from local stakeholders was critical of the wait for treatment that young people had to experience after referral to community CAMHS and was also critical of delays in the crisis service responding to urgent assessments.
- Four of the seven parents of young people who used the community CAMHS services we spoke with told us that they were not satisfied with the amount of time their child had to wait for assessment and treatment after the initial referral.

However:

- the trust produced age appropriate and accessible information leaflets. Toys and books were available in waiting rooms.

Our findings

Access and discharge

- In May 2015 77% of tier three referrals to all community CAMHS services met their four week target between referral and assessment. 55% of tier two referrals to all community CAMHS services met their eight week target between referral and assessment. 69% of tier two and tier three referrals met their 16 week target between referral and treatment.

Waiting times varied between different local teams. The children's learning disability service did not have a waiting list. The North Dorset community CAMHS team had an average wait of eight weeks for tier two assessments and four weeks for tier three assessments. The Bournemouth and Christchurch community CAMHS team had an average wait of 17 weeks for tier two assessments and seven weeks for tier three assessments.

We asked the trust how many young people were waiting for assessment or treatment, what type of treatment they were waiting for and how long was the longest wait. We were concerned that at the time of our visit the trust could not provide us with this information which showed that effective monitoring was not in place. Following our visit and after we raised concerns the trust reviewed all the waiting lists and provided us with updated information. The table below shows the numbers of young people waiting for tier three treatment in each community CAMHS service, the longest wait and the average wait time.

	Total number of cases waiting for treatment	Longest wait (weeks)	Average wait (weeks)
West Dorset	**8**	**26.6**	**14.6**
East Dorset	**14**	**7.1**	**10.1**
North Dorset	**5**	**21.1**	**15**
Weymouth and Portland	**31.9**	**15.9**	**35**
Bournemouth and Christchurch	**86**	**19.5**	**33.4**
Poole	**20**	**12**	**Total**
	97		

The trust produced an action plan following our visit to ensure all cases of young people on the tier two waiting list were reviewed by 31 July 2015, to ensure all caseloads in the community CAMHS teams are reviewed and to improve waiting list management.

Are services responsive to people's needs?

Requires improvement

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

- Feedback we received from local stakeholders was critical of the wait for treatment that young people had to experience after referral to community CAMHS and was also critical of delays in the crisis service responding to urgent assessments.
- Four of the seven parents of young people who used the community CAMHS services we spoke with told us that they were not satisfied with the amount of time their child had to wait for assessment and treatment after the initial referral.
- However the children's learning disability service provided a very flexible service. The service was able to see children and young people within 24 hours for urgent referrals and offered evening and Saturday appointments.
- The community CAMHS teams included crisis workers who responded to urgent referrals and held cases that were waiting to be allocated to a case worker.
- The community CAMHS teams contacted young people who did not attend appointments. Anyone high risk who did not attend was followed up by a telephone call from a support worker. All others were followed up by a letter.
- When appointments had to be cancelled support workers contacted the young person and/or carer to explain and to re-arrange the appointment.

The facilties promote recovery, comfort, dignity and confidentiality

- The waiting rooms contained information leaflets regarding local services, medication and how to make complaints.
- The community CAMHS teams used a range of different therapy rooms across the county. Some were in the community CAMHS teams' offices and some were shared community facilities.
- Not all of the therapy rooms were sound proofed. Three members of staff told us they would like better sound proofing in the therapy rooms at Bournemouth and Christchurch, Weymouth and Portland and in the North Dorset service.

Meeting the needs of all people who use the service

- All of the community CAMHS services had disabled access.
- Information leaflets about CAMHS were provided by the trust in three formats, one for under 13 year olds, one for over 13 year olds and one for parents and carers. Age appropriate information was contained in the leaflets. Information about how to contact advocacy and how to make a complaint were included in the older children's leaflet and the leaflet for parents and carers.
- The children's learning disability service had a sensory room and had toys and books appropriate to the needs of young people with learning disabilities.
- The children's learning disability service provided accessible information booklets regarding health issues and conditions and produced accessible care planning information for young people with learning disabilities.
- Interpreters and signers were available to staff.
- The waiting rooms contained toys and books for children and young people to play with. The toys and books were appropriate for younger children. There was very little provided for older children.

Listening to and learning from concerns and complaints

- There were 28 complaints in total received by the trust in the last 12 months about specialist mental health services for children and young people. Of these 28 complaints, 11 were upheld by the complaint investigation.
- Feedback on the outcome of investigations of complaints was provided to staff in team meetings and multi-disciplinary meetings. We saw recorded in the team meeting minutes the actions the teams agreed to improve their processes following the feedback. For example, providing more DBT training to staff.

Are services well-led?

Requires improvement

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

Summary of findings

We rated well-led as **requires improvement** because:

- There were not effective systems in place to ensure staff received mandatory training, to manage the waiting lists and to ensure there were sufficient staff.
- There was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.
- There was not an effective system in place to ensure consistency in standards and work processes across the different community CAMHS teams.

However:

- the local multi-disciplinary leadership teams at the children's learning disability service and at North Dorset community CAMHS worked very well and enabled those teams to deliver high service standards. Staff generally were positive and engaged. The trust responded very positively and quickly when we raised concerns about the risk assessment process for cases on the waiting lists following our visits. The trust took prompt action to review and reduce the highest risks and has drawn up an action plan to review all the waiting lists, caseloads and the risk assessment process.

Our findings

Vision and values

- The staff we spoke with knew the trust's values.
- The staff we spoke with knew who the most senior managers in the organisation were and could tell us who had visited their services, for example the chief executive.

Good governance

- There was not an effective system in place to ensure there was sufficient suitably skilled staff in post to deliver the community CAMHS services. However, many shifts had been covered by bank staff.
- There was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.The trust senior managers clearly expressed to us the systems they believed were in place to risk assess young people whilst they were waiting for assessment or treatment. However, in practice, we found that only the North Dorset service could demonstrate to us that these systems were consistently implemented. We could not find any evidence that checks were carried out centrally in the trust to ensure that risk assessments were being carried out in line with trust policies and procedures.
- A senior manager had been appointed in April 2015 to review the performance of the community CAMHS services. The senior CAMHS manager had worked with each team to produce action plans to improve the services. These action plans had only been in place for a few weeks prior to our inspection so it was too early to judge whether the actions identified would improve the service provided to children and young people.
- The trust had developed scorecards to gauge the performance of the community CAMHS teams. The scorecards were on the trust's computer system and were accessible in the local services.
- The multi-disciplinary leadership teams at the children's learning disability service and at North Dorset community CAMHS worked very well and enabled those teams to deliver high service standards.
- There was a significant variance in the performance standard and work processes between the different teams. There was not an effective system in place to ensure consistency in standards and work processes across the different community CAMHS teams.
- However, the trust responded very positively and quickly when we raised concerns about the risk assessment process for cases on the waiting lists following our visits. The trust took prompt action to review and reduce the highest risks and has drawn up an action plan to review all the waiting lists, caseloads and the risk assessment process.

Leadership, morale and staff engagement

- The staff we spoke with sounded passionate about their work. All staff told us they enjoyed working in their teams and were well supported by peers and their manager. Non-medical staff told us they had a good relationship with the consultant psychiatrist for their

Are services well-led?

Requires improvement

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team (where there was one in post) and felt well supported clinically. Staff did raise issues regarding the staff shortages and high waiting lists but were very positive about team morale.

- Staff told us there was not a bullying or harassment culture in the community CAMHS teams. Staff knew how to raise concerns and felt they could do so without fear of victimisation.

Commitment to quality improvement and innovation

- The children's learning disability service won an innovation award from the Royal College of Psychiatrists in 2014 for "developing parenting groups as an initial intervention."

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. Staff were not compliant with mandatory training requirements. This was a breach of regulation 12 (1) (2)(c).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not ensure that the risks to the health and safety of service users of receiving care and treatment had been assessed and had not done all that was reasonably practicable to mitigate any such risks. In the Bournemouth and Christchurch service and the Weymouth and Portland service we visited we found that there was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment. This was a breach of regulation 12 (1)(a)(b).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust did not ensure there were sufficient numbers of suitably qualified, competent, and skilled staff to meet the needs of the people using the service. In the Bournemouth and Christchurch service and the

This section is primarily information for the provider

Requirement notices

Weymouth and Portland service we visited they were unable to provide a service to children and young people within target waiting times due to vacancies and staff sickness.

This was a breach of regulation 18 (1).