Good

2gether NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RTQXX	2gether NHS Foundation Trust HQ	Evergreen House	GL53 9DZ
RTQXX	2gether NHS Foundation Trust HQ	Acorn House	GL1 3PX
RTQXX	2gether NHS Foundation Trust HQ	Marsburg House	GL5 2JP
RTQXX	2gether NHS Foundation Trust HQ	Linden Centre	HR1 2HU

This report describes our judgement of the quality of care provided within this core service by 2gether NHS Foundation Trust HQ. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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

Where applicable, we have reported on each core service provided by 2gether NHS Foundation Trust HQ and these are brought together to inform our overall judgement of 2gether NHS Foundation Trust HQ.

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?	Good
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 mental health services for children and young people as good because:

- There was good interagency partnership working with Action for Children, youth offending and substance misuse teams, children's services and paediatricians. Staff worked in a way, which was open and transparent and gave examples of when they had contacted children and young people and parents to discuss issues sensitively. All teams showed innovative practice and examples of this included a project with the military, the development of a reunification team and the functional family therapy team.
- Children and young people had access to a wide skill mix across all services .The skill mix in all teams included occupational therapists, nurses, nurse prescribers, art therapists, psychiatrists, psychologists, cognitive behavioural therapists and dialectical behavioural therapists giving children and young people access to a wide holistic service. Medical cover was good within the teams and there was access to a psychiatrist during the day and out of hours.
- All services had clear criteria for assessing referrals and signposted those that did not meet this. Missed appointments and reasons for cancellation explored and addressed where possible.
- Safeguarding processes were in place. All staff received training and were able to speak with confidence about making referrals. Service managers provided representation on safeguarding boards and gave regular updates in team meetings.
- Feedback from children and young people and families was extremely positive about the teams and the way they responded to individuals.

However:

- Staff did not always record that care plans were person centred, reviewed the risk assessments, put crisis plans in place or recorded physical healthcare consistently.
- There were no tier 4 inpatient beds available and children and young people had to be placed out of county often a great distance from home. In order to address this the trust had introduced the tier 3.5 service which was being further developed.
- Hereford clinic rooms were dull and not appropriately decorated or set up for use by children and young people.

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:

- Caseload management was good with use of a quarterly plan to moderate this. Bank staff covered for sickness and annual leave. Psychiatrist cover in all services was good and rotas were in place for out of hours.
- Assessments were completed using the choice and partnership approach a clinical services transformation model that ensured prompt completion of risk assessments. All teams responded to changes in children and young people's mental health using a duty or tier 3.5 worker.
- Safeguard training was good and all staff working with children and young people received level three training. Safeguarding was a regular item at team meetings in all services and meeting minutes reflected this.
- Mandatory training rates were high.
- Lone worker policies were robust and used by the teams.
- Serious incidents were low with two cases over the previous 12 months. An electronic reporting system was used to report incidents and managers used this appropriately with action plans for service development. Staff meeting minutes documented learning from incidents.
- Staff were aware of the duty of candour across the services and explained that they were encouraged to be open and honest with children, young people and families. Team meetings were used to feedback evidence of learning from any investigations.

However;

- Although the tier 3.5 and duty rotas responded well to changes in the needs of children and young people they were not robust relying on one worker on a rota from the tier 3 team. Plans to develop this were in place. There were no systematic processes in place for crisis plans and inconsistent use of these across all services. The criteria for incident reporting were unclear for staff.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments within the four week target and stored information securely on the electronic patient record system (RiO).

Summary of findings

- Children and young people had access to a wide range of professionals across all services, which included occupational therapists, nurses, nurse prescribers, art therapists, psychiatrists, psychologists, cognitive behavioural therapists, and dialectical behavioural therapists. Staff received a month's induction and had to undertake a period of shadowing before allocation of a caseload.
- Clinical audits took place at least four times a year and deadlines were set at the quality forum, which met monthly.
- Clinical and case supervision took place every four to six weeks and staff had received an annual appraisal. Team meetings took place on a weekly basis in Gloucestershire and fortnightly in Hereford. Performance management of individual staff was good and detailed in supervision records. Supervision addressed issues and concerns and a formal process implemented if there was no improvement.
- Interagency partnership working was good and teams liaised with a wide range of services.
- Induction covered mental capacity training but this was not mandatory.

However;

- Recording of care plans was not person centred or holistic. Physical health care recording was inconsistent and not recorded on the electronic recording system. A transition protocol was in place but all teams reported difficulties in moving young people to adult teams.
- Induction covered Mental Health Act training but this was not mandatory and regular training updates were not happening although staff had access to information from psychiatrists and staff with approved mental health professionals training. There was no systematic approach to mental capacity and consent to treatment and RiO did not show evidence that this was recorded.

Are services caring?

Good

We rated caring as good because:

- Staff treated children and young people in a kind and respectful way. They were sensitive to their needs and showed a good knowledge of the issues they faced.
- Eight children and young people spoken with said that staff were friendly and approachable.
- Consent to share information was on RiO and staff understood when and how to breach confidentiality, if needed

Summary of findings

- There was good participation from children and young people and carers in Gloucester with involvement of a participation worker from Action for Children and an active participation group.
- Children, young people, and carers said they were involved in care planning and decisions about treatment.

However,

- Although children, young people and carers reported that they were involved in care planning the electronic recording system did not show recording of this. The staff team did not record children and young people's consent to treatment and there was no written evidence that there had been consideration of Gillick competence.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The trust set clear criteria for accepting referrals, which were agreed with commissioners, and those that did not meet this were signposted to other agencies.
- Targets were set and achieved for assessment and referral to support from a tier 3 worker. Urgent referrals received a quick response using a duty or 3.5 rota. An assertive outreach worker in Gloucestershire offered short-term intervention for children and young people on the waiting list if needs changed.
- There was effective follow up for missed appointments and reasons for cancellations were investigated. Flexible appointments to meet needs of children and young people were available. The team only cancelled appointments when cover was unavailable.
- All buildings had disabled access including lifts and ramps where necessary. A wide range of information leaflets was on display and interpreters and people who could communicate in sign language for those who were deaf were available when required.

However;

- Level 3.5 and duty rotas were not robust. The Gloucestershire level 3.5 service duty rotas provided for minimal staffing and relied on one duty worker being rostered from the Gloucestershire tier 3 team on a daily basis. There were no tier 4 inpatient beds in the area and young people aged 16 plus were

Summary of findings

on adult mental health wards and under 16s on paediatric wards whilst waiting assessment from the team for out of county tier 4 beds. Admissions to out of county beds had happened in 25 cases in the previous 12 months.

- Waiting lists were long across all services except Marsburg House in Stroud. Children and young people didn't know how to make complaints and information was in an adult format in some areas although the trust had a children and young people's complaint leaflet.

Are services well-led?

Good

We rated well-led as good because:

- All services showed innovative practice and examples of this included the military project, reunification team and the functional family therapy team.
- Staff knew and agreed with the values of the trust and the teams' objectives reflected the values. Staff knew the names of senior managers of services and the trust executives who visited the sites and managers felt well supported by the senior team
- Ninety four percent of staff in Gloucestershire and 88% in Hereford had attended mandatory training. Team meetings, additional training, and the trusts quarterly newsletter updated staff on safeguarding. Staff showed a good understanding of safeguarding and could state when a referral was required
- Staff received both clinical and case management supervision. These happened every four to six weeks and all staff appraisals were up to date. There had been no cases of bullying and harassment of staff reported. Morale and job satisfaction were good and staff reported that they enjoyed and were committed to their work.
- Managers felt they had autonomy to make decisions and received support from senior managers. All staff knew about whistleblowing and said they felt they could do this if needed. They felt that the trust would manage this appropriately. Staff understood duty of candour.
- Staff felt they could feed into service development at a local level.
- The quality network for community CAMHS, commissioning for quality and innovation and peer reviews were used to monitor and review the quality of services.

However,

Summary of findings

- Staff were not consistently reporting incidents using the electronic reporting system and did not know the criteria list for its use.
- Eight children and young people said they did not know how to complain although 11 carers said they had received this information during their initial assessment. There had been 14 complaints in Gloucestershire but only seven in Herefordshire in the last 12 months.
- Mental Health Act training was covered in induction but updates were not mandatory.

Summary of findings

Information about the service

The specialist community mental health services for children and young people consists of children and young people's services (CYPS) which provide a range of services across Gloucestershire and child and adolescents mental health services (CAMHS) in Hereford.

CYPS in Gloucestershire provides a comprehensive range of services including tier 2 primary mental health workers responsible for assessment, tier 3 workers who provide specialist assessment and goal/outcome based interventions, and what is described as tier 3.5 services, which provide intensive short term packages of support. There is also a learning disability and parenting programme team. They sub contract to Action for Children who help to provide some services based in the same building.

Hereford provides a tier 3 service through a multidisciplinary team delivering mental health interventions to children and young people with complex moderate to severe mental health difficulties and a learning disability service. There is no tier 2 service for 0-10 year olds and support for looked after children is provided by a voluntary sector organisation who work closely with CAMHS.

Both CYPS and CAMHS use the choice and partnership approach, a clinical services transformation model that promotes collaborative working, goal setting, and demand and capacity flow management. They also use the children and young people improving access to psychological therapies project to improve the availability and effectiveness of mental health interventions for children and young people.

Our inspection team

The inspection team was led by:

Chair: Vanessa Ford, director of nursing standards and governance, West London Mental Health NHS Trust

Team Leader: Karen Bennett-Wilson, head of inspection for mental health, learning disabilities and substance misuse, Care Quality Commission

The team that inspected specialist community mental health services for children and young people consisted of four inspectors, one assistant inspector, and four nurses of which three had experience of working with CAMHS.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

Summary of findings

- Visited three locations in Gloucester and one in Hereford. At each location, we looked at the quality of the environment and observed how staff supported children and young people.
- Spoke with eight children and young people who were using the service and 11 carers and collected feedback from 26 children, young people and carers using comment cards.
- Spoke with the two interim service managers for child and adolescents mental health services (CAMHS) and three team managers.
- Spoke with 30 staff members including psychiatrists, nurses, clinical psychologists, CBT therapists, art therapists, occupational therapists, nurse prescribers, and administration workers.
- Attended and observed a review meeting between a psychiatrist and young person, a care planning phone conference, two multidisciplinary team meetings, and a CBT session.
- Looked at 33 treatment records of children and young people.

What people who use the provider's services say

We spoke with eight children and young people who were using the service and 11 carers.

Children and young people said they were able to trust the staff. They felt listened to and found staff to be friendly and showed understanding. Carers said that support was person centred and that they could speak to someone when they needed to. Carers spoke highly of the service and said staff were responsive. One carer said that the waiting lists for treatment were very long but 11 carers reported that once support was in place it was of good quality.

We collected 26 cards from comment boxes placed in the services before the inspection. Twenty four of the cards were positive responses and two were mixed. The positive comments said staff were respectful, provided age appropriate treatment and outstanding care.

Good practice

The children and young people's team in Gloucester provided the reunification project that supported the safe return of children and young people in care back to their families using a multi-agency approach.

Hereford CAMHS had been working with the local military base providing a prompt and responsive service to children of military personnel so that they could access support at the earliest opportunity.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should consider how it could improve recording on the electronic recording system and the quality of this across all specialist mental health services for children and young people. This would ensure care plans were person centred, crisis plans were completed, and consent for treatment is recorded.
- The trust should ensure children; young people and their carers know how to complain should they wish.
- The trust should improve access to suitable waiting areas in Hereford and ensure appropriate soundproofing to maintain confidentiality at Evergreen House and the Linden centre
- The trust should improve the Hereford clinic rooms, which were dull and not appropriately decorated or set up for use by children and young people.
- The trust should improve the management of waiting lists to reduce the number of children and young people waiting for the CYPS and CAMHS services.

Summary of findings

- The trust should offer advocacy to all children and young people receiving a service and train staff to understand why independent support is needed. The trust should work with commissioners and partners to address access to advocacy.

2gether 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
Evergreen House	2gether NHS Foundation Trust HQ
Acorn House	2gether NHS Foundation Trust HQ
Marsburg House	2gether NHS Foundation Trust HQ
Linden centre	2gether NHS Foundation Trust HQ

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.

- All staff received Mental Health Act training as part of their induction but regular updates were not mandatory. Psychiatrists gave updates to the teams. In Stroud and Hereford, a team member was an approved mental health professional so the team felt they would be able to access information if needed. Staff felt that they would benefit from regular updates so that they would have a better understanding of this if it needed.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act 2005 is not applicable to children under the age of 16. Gillick competence, which balances children's rights and wishes with the responsibility to keep children safe from harm, should be used for those under 16.
- Staff induction covered mental capacity and consent and all staff had received this. Staff felt that consent was the responsibility of the psychiatrists and they would discuss this with them if they needed to. Psychiatrists provided extra training on mental capacity and consent and gave information about the Children's Act in Hereford.

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

- Interview rooms in Acorn House were fitted with alarms. Handheld alarms were available at Evergreen House in Cheltenham and the Linden Centre in Hereford. However, staff did not always use these and, although there was no protocol in place about the use of alarms, staff felt they would use them if they felt there was a risk.
- Cleaning records were not displayed although all areas looked clean. As the building in Hereford was shared, the trust had no control over the cleaning contract and cleaning records were not available. The service manager had recently agreed to be the contact person for the building to resolve this issue. The staff cleaned and maintained the toys

Safe staffing

- Caseload management was good with use of a quarterly plan to moderate this. The average caseload was 40 per whole time equivalent and staff were expected to do 20 one-one appointments a week. Staff felt this was manageable. Quarterly planning sheets completed by staff and used in supervision to monitor workloads provided evidence of this. However, staff reported that issues with recruitment in Gloucestershire and Hereford had caused extra pressures and stress particularly with waiting lists and caseload management. In Gloucestershire, there was a vacancy rate of 19% and 24.01% in Hereford.
- Cover was good for sickness and annual leave using regular bank staff who had often worked in a permanent post within the service. They had knowledge of policies, processes, and gave a consistent service.
- Psychiatrist cover in all services was good and rotas were in place for out of hours. There were two nurse prescribers in Hereford and this role was being trialled in Gloucester.
- Mandatory training was good with 94% completed in Gloucestershire and 88% in Hereford. Staff reported that they were able to access additional role specific training such as dialectical behavioural therapy, family therapy, and eye movement desensitisation and reprocessing training. Hereford CAMHS was part of the CYP IAPT service transformation programme, which had given them good access to external training. This included evidence based practice in CBT, systemic family practice, supervision, use of routine outcome monitoring and support to develop participation.

Assessing and managing risk to patients and staff

- Risk assessments were completed during the initial assessment. All records that we looked at had been updated for risk. Staff reported that use of the electronic records system caused the most stress in their roles. We found that recording was inconsistent and often put in the section marked 'progress notes' rather than in the correct place. For example, physical health records were in progress notes and not in core assessment (where it was meant to go according to the contents list).
- There was no systematic process in place for using crisis plans and these were not recorded on the electronic records system or in paper records. Children and young people had contact phone numbers for helplines in the event of a crisis. They used a little red book in Gloucestershire and a card in Hereford but they did not receive a formal plan.
- All teams were able to respond to health deterioration using the duty or 3.5 worker who was on the rota from the tier 3 team and if a young person's mental health deteriorated whilst on the waiting list then an assertive outreach worker provided a six week intensive package of care in Gloucestershire. This was a new initiative and evidence as to its effectiveness was not yet available. The 3.5 and duty service consisted of one worker taken from the tier 3 team on a rota basis. Staff felt concerned about the level of responsibility due to the complex nature of some cases and the management of their tier 3 cases when on the rota. This was on Gloucestershire's internal risk register. It highlighted the lack of tier 4 beds, raised concerns about how robust this service was, and whether staff feel competent to deliver it. However, the trust was in the process of recruiting two new staff to the 3.5 duty service in Gloucestershire and in Hereford, the managers and psychiatrists were available to support the duty rota.
- Safeguarding training was good and all staff working with children and young people were trained to level 3.

Good

Are services safe?

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

Administration workers received level 2 training. Safeguarding was a regular item at team meetings and the minutes reflected this. Staff talked about safeguarding and demonstrated when to use it.

- Lone worker policies were robust and the trust was in the process of introducing lone worker personal alarms in Gloucestershire. The trust recognised that the centres closed at 5pm but some teams worked until 8pm. In Hereford the team used a system linked to an older adult unit at the Stonebow unit after 3pm. Details of visits were given to the ward and if an individual did not phone in or could not be contacted the police were called.

Track record on safety

- In Gloucestershire, two serious incidents had been reported over the previous 12 months. There were no cases in Hereford. They were able to show the use of serious incident recording and implementation of actions for an adverse event, which did not meet the requirements for serious incident reporting, but they felt needed this level of investigation. A detailed action plan from this was shared with Action for Children who were subcontracted to provide part of the service and across all teams.

Reporting incidents and learning from when things go wrong

- Incidents were reported using the electronic recording system and managers used this appropriately. However, not all staff knew the criteria for reporting or recording incidents. One staff member in Gloucestershire was analysing data from the system and this information will be used to promote learning from incidents and improve staff understanding of reporting.
- Staff understood the need to be open and transparent with children and young people and their carers. In an incident where staff sent letters out incorrectly they contacted the people involved to apologise. Team meetings used feedback from this for learning.

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

- Comprehensive assessments were completed within the four week target set by the trust. However, the care records were not personalised or holistic. The lack of a consistent approach to the electronic patient record system made information difficult for staff to locate. It was often stored in the wrong location and so care plans and risk information were not easily accessible. Record keeping on the electronic patient record system was on the CYPS risk register and monitored by the CYPS governance committee.
- Staff stored information securely on the electronic recording system. Gloucestershire did not use paper records. In Hereford, paper documents used for measuring outcomes were in locked rooms when not in use, and the keys kept in a locked cupboard.

Best practice in treatment and care

- The staff team offered a wide range of psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE) guidelines including family therapy, cognitive behavioural therapy, and dialectical behavioural therapy. In Hereford, nurse prescribers follow NICE guidelines including those for attention deficit hyperactivity disorder and they were able to give a clear description of how they used them in their daily practice.
- Clinicians considered children and young people's physical health care like weight, height, and blood pressure and basic equipment was available for this. However, they did not show this in 18 out of the 26 care records that we looked at in Gloucestershire. Physical health care and continued monitoring were recorded in the progress notes in Hereford in one case and not in the core assessment and in six records there was no evidence that physical health had been considered.

Skilled staff to deliver care

- There was a wide skill mix across all services including OTs, nurses, art therapists, CBT and DBT therapists and there was a focus on using therapy as an alternative to medication. Gloucestershire subcontracted to Action for Children who had a base at Evergreen House and they provided support workers and a participation worker.
- Staff received a one-month induction shadowing across all service areas before having a caseload allowing them to become familiar with the ethos of the team and delivery of services.
- Clinical and case supervision took place fortnightly and staff received annual appraisals. Supervision used the quarterly planner, a tool that recorded their weekly meetings, admin, and current caseload to moderate caseloads, explore performance issues and training needs. One team member was receiving supervision via skype with someone in America who was a specialist in their field.
- Team meetings took place on a weekly basis and addressed issues from incidents, complaints, and safeguarding. Meeting minutes recorded this information. It was mandatory for all members of the team to attend these meetings.
- Staff performance management was effective and evidenced in supervision records. Managers demonstrated how they addressed issues to affect staff performance positively.

Multi-disciplinary and inter-agency team work

- In Gloucestershire, interagency partnership was well developed as the trust subcontracted part of the tier 3.5 role to the voluntary organisation Action for Children. They also had two members of the team placed in the Gloucester City children and families social care teams who worked in small groups called pods. The two nurses worked alongside social workers, youth workers, and substance misuse workers, which had helped to develop this. The team in Marsburg house were moving to a shared building, with colleagues from adult services in order to strengthen their professional relationships. To raise the profile of CAMHS in Hereford good links were made with other services. This ensured the needs of children and young people were met. For example, the service manager was involved in the creation of the transformation plan for Hereford formed by the health and wellbeing board, sat on the safeguarding board, and had good links with voluntary sector organisations. This included the learning and development trust, a voluntary sector organisation which provided counselling for tier 2 patients.

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.

- The tier 3 care coordinator gave the 3.5 worker detailed information for out of hours support. The duty or 3.5 worker also liaised with the hospitals over urgent mental health admissions to both the adult and paediatric wards.
- A transition protocol was in place but staff stated there were difficulties in moving children and young people to adult mental health teams. Work took place to improve working relationships with adult teams however; these teams did not always accept referrals because children and young people did not meet the adult criteria or it was difficult to identify which team would take responsibility for a young person.

Adherence to the MHA and the MHA Code of Practice

- All staff received Mental Health Act training as part of their induction but regular updates were not mandatory. Psychiatrists gave MHA updates to the teams. In Stroud and Hereford, a team member was an approved mental health professional so the team felt they would be able to access information if needed. Staff felt that they would benefit from regular updates so that they would have a better understanding of this if it needed.

Good practice in applying the MCA

- The Mental Capacity Act 2005 is not applicable to children under the age of 16. Gillick competence and Fraser guidelines, which balance children's rights and wishes with the responsibility to keep children safe from harm, should be used for those under 16.
- Staff induction covered mental capacity and consent and all staff had received this. Staff felt that consent was the responsibility of the psychiatrists and they would discuss this with them if they needed to. Psychiatrists provided extra training on mental capacity and consent and gave information about The Children's Act in Hereford.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff treated children and young people in a kind and respectful way. Staff were sensitive to their needs and showed a good knowledge of the issues faced. Discussions during an observed cognitive behavioural therapy session and an appointment with a psychiatrist in Hereford showed staff to be compassionate and caring towards the children and young people.
- All children and young people that we spoke with found staff friendly and approachable. Parents and carers also confirmed this.
- Family and carers reported that services were flexible to individuals needs and that they were actively involved in planning of care and treatment for their child. One parent explained how appointments now took place at home, as her son had found the waiting area in Hereford stressful.
- Consent to share information was clearly recorded on the electronic recording system. Staff understood the criteria for breaching confidentiality to protect children and young people. Carers felt that they were well informed and able to ask questions when they needed clarification but also understood about when staff needed to maintain confidentiality.

The involvement of people in the care they receive

- There was good participation from children, young people, and carers in Gloucestershire. A participation worker from Action for Children worked as part of the team and there was an active participation group. Children and young people had helped to develop leaflets and reviewed forms. They made recommendations for the waiting area, such as music playing which were actioned. Children and young people's artwork was displayed in the corridors. Focus groups took place in Cheltenham and Gloucester and CYPS had an active children and young people's board. Children and young people were involved in staff recruitment. However, there was no participation group in Hereford but the service used ambassadors who were a group of children and young people who did not use CAMHS services to help them develop the service. The CAMHS team participated in local events for children and young people, for example, the 'shout out for wellbeing' conference.
- Children and young people and carers said they were involved in care planning although they were unsure whether they had a care plan. Records showed children and young people received a clinic letter rather than a care plan, which detailed the support they would receive. Recorded evidence of involvement in care planning was not on the electronic recording system. One parent said she could ask anything. Staff always treated her with respect.
- Feedback and comments boxes were in waiting areas and feedback boards were on display in Gloucestershire showing how the staff had addressed children and young people's ideas like having music in the waiting areas and artwork in the corridors.
- Access to advocacy was poor. The local authority commissioned these services and provided advocacy for a small number of groups like looked after children, those subject to child protection conferences, and disabled children aged 11-18 in Gloucestershire and looked after children and those subject to child protection conferences in Hereford. In Gloucestershire, staff did appear to understand why children and young people needed independent advocacy.
- There was no formal recording of consent to treatment on the electronic recording system but staff explained care and treatment in detail and assumed that if children and young people came to appointments that they agreed to undertake the care and treatment provided.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The trust's target for seeing children and young people for assessment following referral was four weeks and referral for treatment was 18 weeks. In Gloucestershire, they had 60 children and young people waiting for tier 3 support and 84 children and young people were waiting for the learning disability service following assessment. Staff said that the pressure to reduce the waiting lists meant that they had to move cases through the service more quickly and staff support felt rushed. In Hereford, they received an average of 80 referrals a month. To address this they ran evening clinics for a period of 12 weeks to provide assessments for low risk cases. Eight children and young people had waited longer than 18 weeks for treatment appointments although there were mitigating circumstances in these cases. For example, school assessments and changes in circumstances.
- Cases were looked at in weekly meetings and those that were urgent were allocated to a tier 3 worker. Allocations for other cases took place quarterly as set out in the choice and partnership approach. The teams could respond to urgent referrals quickly using a duty or 3.5 worker and these were usually seen on the day of referral. An assertive outreach worker in Gloucestershire offered short-term intervention for children and young people on the waiting list, if needs changed or allocated to a tier 3 worker.
- Criteria for accepting referrals were clear and those that did not meet the criteria were signposted to other services such as paediatricians or dieticians. An advice line for clinicians' wishing to make referrals in Gloucestershire had been set up to help ensure referrals were appropriate. Missed appointments were contacted and reasons for not attending explored to encourage future engagement with the teams. The teams were flexible and met the needs of children and young people by offering appointments at the home, schools, village halls, or a place of choice of the child or young person, as well as the centres.
- Staff rarely cancelled appointments and provided cover whenever possible. Psychiatrists booked appointments six months in advance and at times, these cancellations happened to allow for urgent cases. Staff contacted children and young people by phone when this happened. Appointments ran on time and children and young people and families informed if there were going to be any delays for any reason.

The facilties promote recovery, comfort, dignity and confidentiality

- Evergreen House had a wide range of rooms including a waiting room, art therapy room, clinic rooms, offices, conference, and MDT room, which were only used for these purposes and were set out to be friendly and inviting for children and young people. The building was converted for CYPS use and artwork belonging to children and young people was displayed throughout the building. There was a good display of information and leaflets. This included a small red book with contact numbers for crisis. The waiting area had child sized chairs and a play area. However, parents reported that they could clearly hear conversations taking place in the next room during sessions so expressed some concerns about whether information remained confidential.
- Interview rooms at Acorn House were soundproofed. They had a wide range of rooms including those for clinics, art therapy, interviews, and two large rooms for meetings. These rooms had appropriate decoration and were suitable for the purposes for which they were used. The waiting areas in Gloucestershire were welcoming, friendly and age appropriate with music, pictures, information boards and a fish tank. Leaflets included a self-harm helpline number and advice on keeping children safe.
- Marsburg House was due to move within a few days of our inspection from an old house with steep stairs to ground floor property with more space and better access. CAMHS would share the building with adult services although CAMHS would have their own entrance and facilities. The staff were looking forward to the move as this would provide better facilities and more space for children and young people accessing the service.
- In Hereford, services were delivered from a series of porta cabin type buildings used to deliver a variety of services, including sexual health and NHS emergency dental services. It had a shared waiting area downstairs and a lift to the upstairs rooms. Family's views on this were mixed. Some carers said they like the shared waiting area as it meant their child was not identified as

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Good

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a CAMHS service user whilst another said their child found it stressful and caused heightened anxiety. There was no waiting space upstairs and parents had to sit in the corridor when waiting for their child to complete a therapy session.

- Hereford clinic rooms were dull and not appropriately decorated or set up for use by children and young people. They were used for a range of therapies and storage space was limited for items such as art equipment. There were not enough rooms for clinics and groups to take place and staff shared overcrowded offices. The offices were extremely warm during our visit with limited ventilation. Conversations could be heard and it was difficult to maintain confidentiality. There had been a long-standing issue with cleaning not being done and no cleaning records, which the service manager had recently resolved by taking responsibility for this matter for the building, and engaging with the contractor.
- There was a CAMHS notice board in the downstairs reception and leaflets displayed upstairs by the lift. These included information about helplines, how to complain, carers support, and mediation.

Meeting the needs of all people who use the service

- Disabled access was good for all services with wide doors and accessible entrances and lifts. Car parking was an issue at Evergreen with limited spaces and families stated they found this frustrating as they had to park away from the centre.
- Wide ranges of information leaflets were available, which were translated to meet the needs of the community for example there is a large Polish community in Hereford and the trust newsletter had been translated for them. Interpreters and people who could communicate in sign language for those who were deaf were available when required. At Marsburg House, staff had set up a special email address so staff could support the deaf parents of a child when the child was moved to a tier 4 service out of the county.
- There were no tier 4 beds in the area and young people aged over 16 years were looked after on adult mental health wards and under 16s on paediatric wards whilst waiting for out of county tier 4 beds. The children and young people's team provided support to the wards until a bed was available. Within Gloucestershire the impact of managing/supporting children and young people placed out of area has been recognised and the service had developed an out of county liaison post. However, this post was vacant at the time of the inspection. Adult wards admitted twelve young people in the last 12 months; the longest stay was in Gloucestershire and was for 193 days on the Greyfriars PICU. A young person had been admitted to the ward shortly before their 18th birthday and in consultation with the young person and parents it was agreed that the young person should stay on the adult ward; an appropriate level of support was provided. Five children and young people in Hereford were on an adult wards in the last year with the longest stay reported as 3 days. Staff said that finding tier 4 beds could be difficult and they were often hundreds of miles away. This made continuity of care for children, young people, and families challenging. Staff tried to attend meetings for children and young people placed out of county in tier 4 services but the distances involved meant that they were away for a whole day, which affected service delivery.
- The tier 3.5 and duty rotas for dealing with urgent cases were not robust relying on one worker on a duty rota taken from the tier 3 team. Staff did not always feel confident in the level of responsibility this required. This service was on the children and young people's services risk register, recruitment for two new 3.5 workers was taking place, and the trust used the 3.5 system to solve the lack of tier 4 beds by providing support to children and young people on adult mental health and paediatric wards. In Hereford, psychiatrists and managers were available to support the duty worker.

Listening to and learning from concerns and complaints

- Eight children and young people said they did not know how to make a complaint and staff said they felt that more time should be spent explaining this process. Carers thought they had received this information during the initial assessment appointment. The Gloucestershire team had received no complaints in the last 12 months. However, staff understood how to respond to complaints if they did receive them and explained that they would direct the complainant to the patient, advice and liaison service (PALS) at the trust. The Hereford team had received seven complaints in

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the last year with three upheld. Including a complaint about information sent out addressed to a parent instead of a young person. The teams worked to resolve issues before they became formal complaints.

Are services well-led?

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Our findings

Vision and values

- Staff knew and agreed with the values of the trust and team objectives reflected the values and these were included in the appraisal paperwork.
- Staff knew the names of senior managers of services and the trust executives who visited the sites and managers felt well supported by the senior team particularly governance and human resources.

Good governance

- Ninty four per cent of staff in Gloucestershire and 88% in Hereford had attended mandatory training. Supervisions included both clinical and case management and happened every 4-6 weeks. Supervision was used to manage caseloads. Incidents were reported and learning used in team meetings to identify training needs.
- The team in Gloucester were working to the key performance indicators (KPIs) set by commissioning including targets for numbers supported and response times for assessment. These were embedded in care planning, record keeping and supervision. In Hereford KPIs were in the process of being set as part of the Hereford transformation plan through the mental health and wellbeing board. The service manager had actively participated in the formation of the plan. The number of complaints received was limited as children, young people did not know how to complain, and leaflets were in an adult format in Hereford.
- Managers felt they had autonomy to make decisions within their services and felt well supported by senior managers who they consulted with on a regular basis. Staff were able to submit items to the risk register at a local level and managers escalated these to the trusts risk register.

Leadership, morale and staff engagement

- There were no cases of bullying and harassment of staff reported in the last 12 months. All staff knew about whistleblowing and said they felt they could do this if needed. They felt that the trust would manage this appropriately.
- Morale and job satisfaction were good and all of the staff we spoke with enjoyed their work and showed a high level of commitment to the children and young people they supported. However, staff did report that they had felt pressured due to the need to reduce waiting lists and staff vacancies. Lack of an administration manager and difficulties in recruiting to this and 12 other vacancies placed extra pressure on the service manager in Gloucester. In Hereford, active recruitment for five vacancies was taking place and managers were spending more time in the offices with staff to understand the impact of vacancies on staff and waiting times.
- Staff understood duty of candour and demonstrated how to use it. They gave examples of being open and honest with children and young people and carers as soon as they realised an incident had occurred and gave them options for making a complaint or to provide feedback so that changes could be made.
- Staff felt they could feed into service development at a local level and said they felt the managers were approachable and listened to their suggestions. The nurse prescribers had suggested that carers would benefit from breakaway training. This was agreed and a suitable trainer identified to deliver the programme.

Commitment to quality improvement and innovation

- The quality network for community CAMHS, commissioning for quality and innovation and peer reviews which all support the improvement and development of services for children and young people were used to monitor and review the quality of services. The participation group was involved in reviewing the services in Gloucester using the 15-step method, which involved a young person making observations of the building during their first 15 steps from the entrance. Feedback helped to improve the reception and other areas of the building by putting in artwork and music.
- All services showed innovative practice. Examples of this included the reunification team, which supported the safe return of children and young people in care back to their families and the functional families team that offered short term strengths based therapeutic family intervention focussed on relationships. Hereford showed innovative practice through the military project where CAMHS staff had been working with the local

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military base to provide a prompt and responsive service to children of military personnel and de-escalation training for parents provided by a trained breakaway instructor.