Requires improvement

Solent NHS Trust

Specialist community mental health services for children and young people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1CF2	St James Hospital	Portsmouth CAMHS	PO4 8LD
R1CD1	Adelaide Health Centre	Southampton CAMHS	SO16 4XE

This report describes our judgement of the quality of care provided within this core service by Solent NHS 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 Solent NHS Trust and these are brought together to inform our overall judgement of Solent NHS 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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Summary of findings

Overall summary

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

- The performance of the Southampton team was of concern in many areas which was in contrast to the Portsmouth team.
- Risks assessments were not completed for all young people and there was not an effective system in place to assess the risks to young people. The staff team had not met all the recommendations from an investigation into a serious incident in July 2015 about review assessments and the introduction of crisis plans. Environmental risks to young people in the clinics were not always considered.
- In Southampton CAMHS, there were limited improvements or learning made following the serious incident involving the suicide of a young person in July 2015.
- There was no consistent approach to caseload management to assist access and discharge. The community CAMHS services did not meet all their targets for assessment or treatment in all areas. Waiting times for children on the autism pathway and cognitive behavioural therapy were long. Staff did not 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.
- We found no evidence to show that young people were involved in decisions about the service including being able to recruit staff. Few young people had an advocate and both services stated this was an area for further development.
- Record keeping was inconsistent. In Southampton, 12 of the 23 care records we reviewed did not contain up to date care plans. In Portsmouth, all the seven reviewed did contain care plans. Staff members were inconsistent about the storage of the plans on the electronic records system so they were not easy to find. Information about a young person being under the care of the local authority or subject to safeguarding procedures was not clearly highlighted or readily accessible.
- Staff shortages and vacancies prevented the CAMHS community services from delivering all the psychological therapies recommended by National Institute for Health and Care Excellence. Not all young people had access to timely psychology input. Following recent integration of services, staff were expected to work with children of all ages. Staff trained in adolescent work did not feel competent to work with young children under the age of ten and vice versa. Training had not been provided for this change in roles.

However:

- All young people we spoke with said the staff they worked with were supportive. The foster carers and parents of young people who used the service gave us positive feedback regarding the service. The staff we met spoke respectfully of the young people and their carers and understood the individual needs of the young people who used the service.
- Comprehensive assessments were documented in each of the 30 care records we reviewed and had been carried out at the young person's first appointment. In Portsmouth CAMHS, risk assessment, care plans and crisis plans were comprehensive and assisted staff deliver safe care and treatment to young people and children.
- There was good team working with regular meetings, supervision and work with outside agencies such as the community CAMHS teams and children's learning disabilities team had built very good working relationships with the local schools.
- 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 high and medium risks and developed a crisis plan. They developed a new risk assessment format and an

Summary of findings

action plan to review all the waiting lists, caseloads and the risk assessment process. We saw immediate improvements evident when we visited unannounced eight working days after our formal inspection ended.

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 Southampton CAMHS, risks assessments were not consistently completed for all young people and there was not an effective system in place to assess the risks to young people. The staff team had not met all the recommendations from an investigation into a serious incident in July 2015 about review assessments and the introduction of crisis plans.
- In Southampton CAMHS, there were limited improvements or learning made following the serious incident involving the suicide of a young person in July 2015.
- Environmental risks to young people were not always considered. Young people and children had access to knives in the unlocked kitchen in Southampton CAMHS and access to the photo copying cupboard and equipment in the doctor's interview room in Portsmouth CAMHS. In Southampton CAMHS, there was not a system in place to ensure cleaning of toys in the waiting room.
- In Southampton CAMHS, there were not sufficient staff to ensure young people's assessed needs were met.

However:

- In both services, all areas of the clinics and therapy rooms we saw were clean and appeared well maintained.
- In Portsmouth CAMHS, risk assessments, care plans and crisis plans were comprehensive and assisted staff to deliver safe care and treatment to young people and children.

Are services effective?

Requires improvement

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

- In Southampton 12 of the 23 care records we reviewed did not contain up to date care plans and in Portsmouth seven of the seven reviewed did contain care plans.
- Staff members were inconsistent about the storage of the plans on the electronic notes system so they were not easy to find.
- Staff shortages and vacancies prevented the CAMHS community services from delivering all the psychological therapies recommended by NICE. Not all young people had access to timely psychology input or autism assessments.

Summary of findings

- Information about a young person being under the care of the local authority or subject to safeguarding procedures was not clearly highlighted or readily accessible.
- Not all staff received training specific to their role. Following recent integration of services, staff were expected to work with children of all ages. Staff trained in adolescent work did not feel competent to work with young children under the age of ten and vice versa. Training had not been provided for this change in roles.

However:

- Comprehensive assessments were documented in each of the 30 care records we reviewed and had been carried out at the young person's first appointment.
- 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.

Are services caring?

Good

We rated caring as **good** because:

- All young people we spoke with said the staff they worked with were supportive.
- The foster carers and parents of young people who used the service gave us positive feedback regarding the service.
- The staff we met spoke respectfully of the young people and their carers and understood the individual needs of the young people who used the service.

However:

- We found no evidence to show that young people were involved in decisions about the service including being able to recruit staff.
- Few young people had an advocate and both services stated this was an area for further development.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

- The community CAMHS services did not meet all their targets for assessment or treatment in all areas. Waiting times for children on the autism pathway and CBT were long with an average 56 weeks from initial assessment from a general team to seeing the specialist clinician. There were 136 families on this waiting list.
- Caseload management was not robust. Staff and managers felt it was not working and meant that capacity to work with children and young people was affected. Staff reported they felt they did many assessments with less time treating patients.

However:

- The trust produced age appropriate and accessible information leaflets. Toys and books were available in waiting rooms.
- All staff spoken with across both services told us they know how to handle complaints appropriately

Are services well-led?

Requires improvement

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

- There was not an effective system in place to ensure consistency in standards and work processes across the different community CAMHS teams, including how the teams assessed the risks to young people whilst they were waiting for assessment or treatment.
- There were not effective systems in place to ensure staff received mandatory training, to manage the waiting list, to ensure there were sufficient staff or that recommendations from serious incidents had been implemented.

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 high and medium risks and developed a crisis plan. They developed a new risk assessment format and an action plan to review all the waiting lists, caseloads and the risk assessment process.

Summary of findings

Information about the service

St James Hospital and Adelaide Health Centre are the registered locations from where Solent NHS Trust provides its child and adolescent mental health services (CAMHS) for the people residing in the City of Portsmouth and in Southampton. Southampton CAMHS includes the building resilience and strength (BRS) team that is part of the integrated family assessment and intervention service. Young people also had access to the Jigsaw service which is an integrated health and social care provision for children with moderate and severe learning disability plus complex family circumstances or enduring complex health conditions.

The CAMHS service is a multi-disciplinary service providing a range of assessments, treatment and support for children and young people in the community where there are concerns about their mental health. Types of conditions include depression, psychosis, eating disorders, self-harm, obsessive compulsive disorder and neuro-developmental disorders. The two CAMHS services work independently of each other. They have different commissioners and work in different ways.

In 2014 we inspected the CAMHS. The service was fully compliant with no requirements. However there were two recommendations from the inspection:

- The trust should ensure analysis of outcome measures across CAMHS to inform service development. At this inspection in 2016, we found that this recommendation had been met.
- The trust should ensure a high standard of record keeping across all CAMHS sites and ensure consistency. At this inspection in 2016, we found that this recommendation had not been met.

Our inspection team

The inspection team was led by: Joyce Frederick, Head of Hospital Inspection.

The team was comprised of: two CQC Inspectors and one specialist advisor who was experienced in working in children's mental health services.

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?

During the inspection visit, the inspection team:

- Visited the community mental health services for children and young people in Portsmouth and Southampton. We looked at the quality of the clinic environment and observed how staff interacted with young people who use services and carers; we also visited the behaviour resource service in Southampton.
- Spoke with six young people who were using the service.
- Spoke with four parents of young people who were using the service.

Summary of findings

- Spoke with four foster carers.
- 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.
- Collected feedback from four patients using comment cards.
- Looked at 30 treatment records of patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

We also completed an unannounced inspection of Southampton CAMHS on the 12 July 2016 to follow up on concerns surrounding risk assessments.

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 foster carers were very satisfied with the quality of treatment young people were receiving at the time we spoke with them.

We spoke with six young people who were using the service who said they were overall happy with the service and said they found it useful.

At the end of the inspection, we collected comment boxes from the community services. We received four comment cards all of which were positive about the service.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure risks assessments are completed for all young people and there is an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.
- The provider must ensure crisis plans are completed for all young people who are assessed as requiring them to keep them safe.
- The provider must ensure care records contain up to date care plans to support staff to care and treat young people safely.
- The provider must ensure all staff receive training specific to their role. In Southampton, assessments were being completed by clinicians who did not have sufficient training to do so.
- The provider must ensure that young people and children do not have access to knives in the unlocked kitchen in Southampton CAMHS and access to the photocopying cupboard and doctor's interview room in Portsmouth CAMHS.
- The provider must ensure their governance systems are effective. Systems should ensure consistency in standards and work processes across the different community CAMHS teams; manage the waiting lists; ensure there are sufficient staff to care and treat young people; ensure recommendations from serious incidents are met and systems are in place to assess the risks to young people whilst they were waiting for assessment or treatment.

Action the provider SHOULD take to improve

- The provider should ensure staff members are consistent about the storage of the care plans on the electronic care records system so they are easy to find.
- The provider should ensure there is a system in place to routinely clean toys in the waiting room.
- The provider should ensure all young people and children have access to timely psychology (CBT) input and access to services for children with autism.

Summary of findings

- The provider should ensure information about a young person being under the care of the local authority or subject to safeguarding procedures is readily accessible to staff members.
- The provider should ensure that all young people are involved in decisions about the service, including being able to recruit staff.
- The provider should ensure CAMHS teams meet all their targets for assessment or treatment in all areas. Waiting times for children on the autism pathway and CBT were too long.
- The provider should ensure a consistent approach to caseload management to assist staff to manage access and discharge effectively.

Solent NHS 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
Southampton CAMHS	Adelaide Health Centre
Portsmouth CAMHS	St James Hospital

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. All clinical staff we spoke with said they had received training in the Mental Health Act 1983.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act only applies to young people aged 16 years and over. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the patients where possible in the decision making regarding their care.

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 people. The community CAMHS service had recently had training 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

Our findings

Safe and clean environment

- In both services, 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. We reviewed cleaning records for the past three weeks prior to the inspection and all were up to date, complete and filled in correctly. However in Southampton there was no records relating to the cleaning of toys in waiting room.
- We asked for environmental risk assessments but these were not available on site as they were not completed by the service managers. However, managers knew their content.
- All of the interview rooms we saw were fitted with alarms. There had been no incidents recorded in the interview rooms.
- In Southampton CAMHS, the door to the staff kitchen was open when the inspection team visited. Therefore, domestic knives were easily accessible if a young person became agitated and left one of the interview rooms and entered the kitchen. In Portsmouth CAMHS, the photocopying cupboard was also open and in the open doctors interview room there were scissors. Young people had easy access to these areas. We raised this with the trust during the inspection and saw a new lock installed immediately in the kitchen and plan in place for a key pad to be installed.
- Staff adhered to infection control principles including hand-washing. There was signage explaining hand-washing techniques in both Portsmouth and Southampton premises.

Safe staffing

- There was an overall 11% total staff vacancy rate in CAMHS services. However, the vacancy rate varied considerably between the two teams.
- In Southampton, there were 20% staff vacancies of a 43 staff total. Staff told us key posts were vacant due to 14 staff leaving in 2015 because of either promotion, concerns about the merge, retiring or taking new positions. Staff told us that their ability to provide an effective service to children and young people had been impacted by the number of vacancies as they had lost a wealth of experience. Three new staff had been recruited to the team, including a nurse team lead and a nurse, who were starting in august 2016; an advert was going out for another band 6 post. A locum CBT therapist had recently started work for 4 months.
- However, Portsmouth CAMHS was well staffed with a 2% vacancy rate. For example, the Portsmouth CAMHS single point access team was fully staffed apart from one vacancy which was being recruited to. The current staff complement was nine staff members. These included four band six staff, nurses and social workers. Two new crisis posts were being recruited to reduce hospital admissions and facilitate step down from inpatient facilities, which would be reviewed after 12 months. These included a band six and a nurse prescriber. In the extended team (the extended team offered assessment and intervention for children and young people aged 0-18 years and their families/support networks who had moderate to severe mental health disorders. It was a multidisciplinary team) there were 15 working time equivalents (WTE) with19 staff members, plus specialist and foundation doctors. The team composition included the clinical team lead, full-time and part-time psychologists, systemic therapist, psychotherapist and two psychology assistants. There were also three full time doctors and one part time doctor. The learning disability team was also fully staffed.
- In Portsmouth, there were clear arrangements for cover arrangements for sickness, leave, vacant posts to ensure patient safety. In Southampton, there was a recruitment drive in place and agency staff were used where appropriate.
- In both Portsmouth and Southampton CAMHS, there was rapid access to a psychiatrist when required.
- The average cases loads in Southampton and Portsmouth were between 30 to 50 young people each. Team managers recognised the need to ensure all

caseloads in the community CAMHS teams were reviewed to improve waiting list management because in Southampton there was inconsistent practice across the team.

- In Southampton, staff members told us they were not clear how decisions were made about the allocation of patients, how many cases they should have on their caseloads or how this figure was reached. This also meant they were unclear on how the decision for which treatment the young person would be offered was made as it was dependent on individual clinician's skills. They told us they had monthly clinical supervision where they looked at caseloads but it felt inconsistent and was dependent on personality of the supervisor, strengths and acuity of current caseloads. However, in Portsmouth, caseloads were reviewed regularly and staff caseloads were an average of six to seven patients per day worked, with 12 new cases allocated across the team monthly off the waiting list.
- The overall score for staff completion on mandatory training across both services was 85% against a trust target of 87%. In Southampton CAMHS they achieved 73% compliance, scoring 72% or below for six of the 13 training courses they were eligible to attend. The average attendance safeguarding adults for the team in February 2016 was 67%.
- In Portsmouth mandatory training was higher at 95%.They also included training on risk, ADHD, audit of transition, care plans, discharge and NICE guidelines on baseline assessments.

Assessing and managing risk to patients and staff

- In Southampton CAMHS, staff did not undertake a risk assessment of every patient at initial triage/ assessment and update this regularly. Staff did not use the risk assessment documents held on the trusts electronic recording system to formulate patients risk information.
- In the 23 files we looked at in Southampton CAMHS, none had clearly defined risk assessment and or risk management plans. The deputy manager advised that risk staff reviewed and updated risk assessments twice weekly, on Monday and Wednesday via clinical MDT meetings. They recorded these discussions in a paper folder and administrative staff members were responsible for updating the patient's records. This, however, was not evidenced in all of the 23 records. Staff were not able to show an example of any recording of risk discussion in any of the 23 records viewed. For example, in one young person's file a young person had taken an overdose of medication but there was nothing in their records to say how high the current risk was, how it was to be managed or how family should manage risk. The staff member whose case it was said that this had been discussed at the high intensity meetings but there were no records on file.
- The trust had been aware that risk assessments were a concern in Southampton CAMHS prior to the inspection. Following a serious incident in Southampton in July 2015 involving the suicide of a young person, the investigation recommendations were that the trust review risk assessments by March 2016. An additional recommendation was that collaborative crisis plans should be introduced that could be accessed by young people, families and teams. This was also due to be introduced March 2016, and was not in place at the time of our inspection. We brought these issues to the attention of the senior staff in the trust including the clinical director who formulated an immediate action plan. The plan included a new format and process for risk assessments and staff training.
- On our unannounced inspection on 5 July 2016, the service there was evidence that staff were starting to implement the action plan. For example, staff members had started completing the new risk assessment on the electronic care records system for all new assessments and the plan was to update all other files at young people's reviews. Staff members made a judgement if the risk level was high or medium. If the risk was medium or high, staff had to complete a crisis plan.The staff team had worked hard and had completed 79 risk assessments and senior managers told us it had been embraced by the staff team. Other actions completed included an email to all team members with an invitation to meet with the head of children's services to discuss the new format and a development meeting planned on the sixth of July. The deputy manager had sent screenshots of the new risk assessments and risk assessment policy to all staff. The new electronic care records system risk assessment was completed by 30 June and was rolled out on 04 July 2016. There was also electronic care records system training on site.

Inadequate

Are services safe?

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

- However, in Portsmouth CAMHS crisis plans were completed and well integrated into their work. In the seven files looked at in Portsmouth we saw crisis plans when required. The information included current issues and risk, plan of contact, plan of medication, plan for family participation, plan for young person's participation, plan for managing changes to mental or physical state out of hours, indications for hospital admission and plan to reduce management of risk.
- Southampton and Portsmouth CAMHS also worked differently in relation to the management of risk for young people on their waiting lists. In Southampton CAMHS, therewas not an effective system in place to assess or monitor the risks to young people whilst they were waiting for assessment or treatment. For example, if a patient was assessed by the duty access team as routine then the case was discussed at the Friday allocation meeting. Risks were reviewed at allocation meeting if additional information came in to the service. The average waiting time was 10 weeks from referral to face to face meeting. There was no proactive contact with the child or young person following referral and prior to initial assessment. The team relied on contact from parents or professionals to inform them of any increasing risk. If a young person were not involved with family and professionals, for example, not at school, just under the care of their GP this did not trigger any more proactive monitoring. This system put at greater risk young people with limited support or families that were hard to engage or had limited confidence about contacting the service. The consultant explained they might get a call about the child or young person but not yet seen them. They told us they could not manage risk for a patient that the team haven't seen. The deputy manager told us staff actively telephoned patients on the waiting lists. However, in the files reviewed we saw showed us this was not always the case.
- In Portsmouth CAMHS, there was a clear system to assess the risks to young people whilst they were waiting for assessment or treatment. The single point of access team had a'care of waiters' programme which reviewed patients risk weekly. Any changes to risk were recorded in case notes. There was also a separate self-harm referral procedure. The most risky cases requiring crisis plans were seen within one to two weeks by the extended team. In Southampton they worked in collaboration with Sussex Partnership NHS Foundation Trust to deliver a service.
- All staff spoken with in both CAMHS teams 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. However, the electronic care records system did not highlight young people who were subject to a child protection plan to alert staff.
- 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 four serious incidents recorded 4 December 2015 and 3 July 2015 for both services. Three incidents were about of breach confidentiality in Portsmouth and one was about the unexpected death of a young person in Southampton.

Reporting incidents and learning from when things go wrong

- In Portsmouth CAMHS we saw evidence of improvements in safety as a result of the serious incident about confidentiality.We saw recorded in the multi-disciplinary meeting minutes that learning from incidents had been discussed at the meetings. We also attended the team meeting for the single point of access team and the learning disability teams where the teams discussed learning about increased confidentiality. This included the use of photocopiers and storage and transport of sensitive information. We observed team members discuss ideas of how they could put it into practice in their team and further improve practice.
- In Southampton CAMHS there had been no improvements made following the serious incident involving the suicide of a young person in July 2015. The investigation recommendations due to be completed by March 2016 had not been completed. For example, the investigation recommended the service defined the CAMHS risk summary format and its location within the electronic care records system so it could be easily located. They stated that the use of record systems

should be standardised to promote consistency. The only action completed by 31 March 2016 was that the report was shared and there was an action plan for completion by the clinical governance group. The group had formulated a plan to meet the recommendation but they had not completed the work.

- The service managers and other staff members we spoke with demonstrated that they knew how to report incidents. We saw information posters in the services regarding incident reporting. We saw that incident reporting had been discussed in team 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. Incidents included those around safe storage of information.However,learning from incidents was not always shared across the two services due to the way they operated independently of each other.
- The clinical governance minutes for Portsmouth and Southampton CAMHS contained a section on learning from critical incidents. The team meeting agenda in Portsmouth CAMHS was pre-populated with recent incidents from within the service and the trust. The managers at the Portsmouth CAMHS service told us there had been a change in practice within the trust in relation to the information where an appointment letter had been sent to the wrong patient. As a result, there was a change of practice cascaded down to teams via Information governance structure.
- We were told by staff that following any serious incidents staff were offered support and debrief sessions. Staff members from both services told us they found this useful.

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.

Our findings

Assessment of needs and planning of care

- Comprehensive assessments were documented in each of the 30 care records we reviewed and had been carried out at the young person's first appointment.
- At the 2014 inspection, we recommended that the trust should ensure a high standard of record keeping across all CAMHS sites and ensure consistency. This recommendation had not been met. We reviewed 30 care records on the electronic patient record system and found inconsistent practice across the two CAMHS services. In Southampton CAMHS 12 of the 23 records had short plans included at the end of the initial assessment summary, or in some instances embedded in daily recordings or progress notes. These were in narrative format and failed to evidence discussion with either patients or carers, or to reflect the patient's views, discussions of best practice, treatment options or NICE guidance. They did not contain sufficient information to assist safe care for young people and children. None of the plans viewed were signed either by the patients or their relatives carers. Staff members told us they didn't use care plans in Southampton CAMHS and they felt this inconsistent with colleagues from adult mental health Service.
- In Portsmouth, care plans were of a higher standard. In all of the seven records reviewed in Portsmouth, we saw up to date care plans. In one care plan we saw the care plan template covered: immediate hopes, who were involved, risk issues, who to contact in crisis, current difficulties, therapy goals and types of interventions. There was also evidence staff followed NICE guidelines, for example for those for treating depression in young children and young people 2005. In the files of two young people who were looked after by the local authority, we saw each had an action plan, developed with the child and they get a copy, this was confirmed in the care records. In the extended team, we reviewed one care plan that contained sufficient information to assist the staff team care and treat the young person safely. It was goal orientated with actions.
- However, staff members across both services were inconsistent about the storage of the plans on the electronic record system so they were not easy to find. For example, if the staff member created the care plan via the template it was saved as "care plan" however, if the staff member had saved the template in a word document and had uploaded it could be saved under a different name. This created confusion and meant staff could not easily access the care plan. Staff members told us this was systemic of the new electronic care records system.
- The trust had recently introduced a new electronic care records system. Staff told us that their previous system was more compatible with the work they did in relation to risk, assessments and care planning. The trust introduced additional training to use the system more effectively following our inspection. All information was kept on the computer secured via password protection. Following serious incidents about confidentially the trust had circulated learning about information governance which we saw was discussed in team meetings and followed by staff teams.

Best practice in treatment and care

- The CAMHS teams followed NICE guidance when prescribing medication. Evidence seen in young people's records in Southampton and Portsmouth confirmed that staff followed NICE guidelines in relation to psychosis and schizophrenia in children and young people. These included: recognition and management NICE (2013); depression in children and young people; identification and management in primary community and secondary care NICE (2015).
- Staff in the Southampton CAMHS team told us that they were not able to offer all the psychological therapies recommended by NICE because of staff shortages. For example, In Southampton they had 0 .4 psychologist. The learning disability team had two part time psychologists with each giving one whole session a week. Two members of staff in the team told us that there was a need for more staff trained to deliver CBT (cognitive behavioural therapy). In order to address a CBT therapist started the week before the inspection, this halved the waiting list from 52 to 26 weeks. Following the inspection the trust informed us that they also had 3.5 working time equivalents (WTE) in post at the time of the visit. This included the staff at the BRS, Jigsaw and the autism assessment service.

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.

- In both Southampton and Portsmouth CAMHS, staff did not monitor young people's physical health care unless the patient had an eating disorder or the young person had attention deficit hyperactivity disorder (ADHD) and was prescribed medication. Any other physical health monitoring was met through the patient's GP.
- Portsmouth CAMHS had implemented the recommendation of the 2014 inspection report that the trust ensures analysis of outcome measures across CAMHS to inform service development. Portsmouth staff used outcome rating scales (ORS) and session rating scales (SRS). The ORS is a simple, four-item session by session measure designed to assess areas of life functioning known to change as a result of therapeutic intervention and to encourage a collaborative discussion of progress with young people. The ORS and SRS gave young people and carers a voice in treatment as it allows them to provide immediate feedback. At Southampton CAMHS, mental health practitioners spoken with didn't know if they used outcome ratings scales.The deputy manager told us this was an area for development.
- Clinical staff in both CAMHS teams participated in a variety of clinical audits. For example, in Portsmouth CAMHS clinical staff completed audits in risk assessment, self-harm, transitioning young people from CAMHS into adult services, care plans, discharge and audit eating disorders. In Southampton, two audits were completed by junior doctors in relation to management of referrals received in the last six months. They were now going to analyse information for improvements.

Skilled staff to deliver care

- Both CAMHS teams included a full range of mental health disciplines including nurses, advanced nurse specialists, occupational therapists, art psychotherapists, clinical child psychologists, social workers and psychiatrists. There were vacancies in some key posts. For example in Southampton, the learning disability team had two part time psychologists with each giving a one whole session a week. This led to long waiting lists for CBT.
- Staff in Portsmouth were experienced and qualified for their roles. Staff in Southampton said whilst they were experienced and qualified in CAMHS, staff members who formally worked in the adolescent service were new to assessments of younger children and vice versa for clinicians from the young children service. When the services amalgamated, experienced staff left the service and were being replaced by less experienced staff. Following the amalgamation in Southampton, staff had not received training for their new roles of assessing all ages.
- All new staff attended a trust induction. In Southampton staff told us they attended the trust's one day induction, and then have a service induction that involved learning the house keeping of the service and then a gradual induction over a few weeks shadowing clinicians. In Portsmouth, staff had one day a week for four weeks in the single point access team. The induction was four weeks where new staff shadowed other clinician's dependant on experience. All staff members confirmed that the induction prepared them for the roles they undertook.
- Southampton staff told us there were positions coming up for IAPT training; this was aimed at all staff. One mental health practitioner said she had completed deliberate self harm training. Four staff spoken with at Southampton were concerned regarding lack of training and told us they had brought it to development days but had no resolution.
- All the staff we spoke with received both clinical and managerial supervision and data from the trust showed that 100% of staff had received supervision and appraisal in the last year. In Portsmouth, there was a variety of supervision opportunities. These included peer supervision that was specific to treatments offered for CBT, DBT and family therapy. There was also individual line management every five weeks where safeguarding was a standing agenda item. There was a supervision spread sheet on shared drive that was updated by managers, facilitators or individual clinicians/supervisees. The supervision model was currently being shared with other children services teams in the trust. In Southampton, supervision was between four to six weeks. As of February 2016, 85% of staff had completed their annual appraisal. Both services had a weekly team meeting.
- There were no staff subject to staff performance issues at the time of the inspection.

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.

Multi-disciplinary and inter-agency team work

- Each CAMHS service had regular multi-disciplinary meetings (MDT). For example, in Southampton there were high intensity meetings where a range of clinicians discussed the needs of young people for whom there were increased concerns. We observed a MDT neurological development meeting in Portsmouth that included psychologists and the clinical director discussion the management of cases. They discussed alternative strategies and treatments for the young person in detail in a kind, professional and informed manner.
- Both multidisciplinary teams worked well as a team.
- The community CAMHS teams had good working relationships with the nearest CAMHS inpatient unit in another trust.

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

- The Mental Health Act was rarely used by the specialist community mental health services for children and young people.
- The community CAMHS service had recently had training guidance on the Mental Health Act and Code of Practice relevant to CAMHS.
- All clinical staff we spoke with confirmed they had received training in the Mental Health Act. The average attendance across both teams was 71%. This was below the trust target of 87% but a rolling programme of training was in place and we saw staff identified as having not completed this training were booked onto it.

Good practice in applying the Mental Capacity Act

- The Mental Capacity Act only applies to young people aged 16 years and over. The Mental Capacity Act only applies to young people aged 16 years and over. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the patients where possible in the decision making regarding their care. Records confirmed that Gillick competency was always considered.
- 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 people. For example, in Portsmouth CAMHS no capacity assessments were completed if children under 16 attended the initial assessment with parents and the parent signed a consent form. If child was over 13 years old they could attend a drop in without a parent and were sometimes seen in school clinics without parents. Staff would then complete a capacity assessment.
- 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.

Our findings

Kindness, dignity, respect and support

- All of the interactions we saw between young people and carers and the staff members were respectful and supportive.
- All young people or carers we spoke with said the staff they worked with were supportive and caring. The four foster carers and four parents of young people who used the service gave us positive feedback regarding the service.
- The staff we met 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. In Portsmouth, we observed a neuro-developmental assessment interview with a young person's mother and grandfather. The clinician spoke to each family member separately. They explored detailed developmental and physical health history from mother's pregnancy to current presentation, covering early developmental and school history, family composition, mental health history. We saw the clinician treated the family with respect.

The involvement of people in the care that they receive

- In Portsmouth CAMHS feedback received from two foster parents, and parents of a child who was looked after by the local authority, told us that they worked with the service to develop the child's care plan together. In Southampton, four carers spoken with said they didn't know what a care plan was but stated there was some discussion at the face to face meetings with staff about the plans for their child.
- Where possible, patients were involved in care planning and we saw evidence to show that this was the case. In Southampton, patients and their representatives did not receive a copy of their care plan. In Portsmouth CAMHS, the care plans were personalised and records indicated parents were sent a copy. The care plans we saw 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.
- Advocacy information was displayed in both Portsmouth and Southampton waiting rooms. For example, for looked after young people the council provided an advocacy service that the young person could self-refer to. The advocacy service in the city was available to few 17/18 year olds who were in receipt of tier three services. Tier 3 services are usually multi-disciplinary teams or services working in a community mental health setting or a child and adolescent psychiatry outpatient service, providing a service for children and young people with more severe, complex and persistent disorders. Advocates could attend meetings if families agreed. There was no separate advocacy service set up for young people. Few young people had an advocate and both services stated this was an area for further development.
- We found no evidence to show that young people were involved in decisions about the service including being able to recruit staff. The managers at both Portsmouth and Southampton stated this was an area for development.
- Young people and their families were able to give feedback on the care they receive via comments or compliments sent to the service. Both services were developing a young people's survey. In Southampton, young people were invited to comment on the design and name of the new service with feedback forms seen in the waiting rooms.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- Southampton and Portsmouth CAMHS had different commissioners and were set up differently. In Southampton, all referrals were triaged on a daily basis by the duty clinician. All urgent cases were contacted and an initial appointment/assessment was arranged. All referrals that had been triaged as routine were allocated at the weekly multi-disciplinary meeting. In Portsmouth, referrals were via the single point of access. Consequently, young people did not have a consistent service across CAMHS.
- Waiting times varied between different waiting lists at each service. Portsmouth and Southampton CAMHS teams monitored and mostly met their key performance indicators (KPIs). For example in Southampton, the deputy manager told us that the waiting time from referral to a face to face appointment was on average seven to 12 weeks. In June 2016 the average wait was seven weeks. The KPI was for patients to start treatment within 18 weeks of referral. The managers at both services used the data analysis team dashboard to monitor performance. In Portsmouth waiting times and client satisfaction met KPIs with 85% of patients happy with length of time they had to wait for a service.
- However, waiting times for children on the autism pathway, CBT and neuro development was long. For children with a potential diagnosis of autism in Southampton the longest wait was currently 56 weeks from initial assessment from a general team to seeing the specialist clinician. There were currently 136 families on this waiting list. Staff told us that the waiting list for children with autism had steadily grown since the amalgamation in November of 2015 when it had been three months. The management team told us that the new service model was commissioned based on an assumption at the commissioning stage that the service would expect to see 250 cases per annum with the reality being that in 2015/16 there were 350 cases requiring an autism assessment. In order to reduce the waiting times the service had attempted to secure agency staff to work within the service but has only been able to secure one day per week of a psychologist that has not had a significant impact. However, the deputy manager told us that patients waiting for CBT were active cases and were receiving other interventions by the team while waiting for CBT. In addition, a new CBT worker had just started work at Southampton.
- In Portsmouth CAMHS, they introduced neuro development clinics for young people to optimise the number of patients clinicians could see and this had reduced waiting lists. The key performance indicator) for neuro-development to see young people was three months. Neuro developmental cases had a 'care of waiters' programme after initial assessment which involved psycho-education, school observations and information gathering. There was an eight-month wait for final assessment and diagnosis. The routine neuro development cases wait times had come down from 24 weeks to 13 weeks.
- In Southampton the deputy manager stated that in addition to the auditing of waiting times, there was still work to be done on caseload management and discharge planning to reduce waiting times because it varied greatly between clinicians and the data on the IT system was often unreliable. Staff members told us that caseload management was inconsistent. Patients on waiting lists were given the name of the staff member who would be offering them a service. However, staff said this work was often time consuming and then impacted on their ability to work face to face with patients.
- Staff reported they felt they did many assessments with less time treating patients. Time was taken up finding what was available for younger children if previously they worked with adolescents. Staff felt committed but under pressure. Managers felt there were signs the service was adapting to the new integrated model but it would be some time before the service could offer an equivalent service to Portsmouth or the service prior to the amalgamation.
- In Portsmouth, the system was much more defined and organised. The referral was accepted by the single point of access team, who telephoned the parent, or other services, to get more information. If the referral was appropriate for the service, an initial assessment appointment was offered, using an allocations priority rating scale to decide the urgency of appointment. This meant they had a range of waiting times based on priority. The initial assessment was within four weeks

Are services responsive to people's needs?

Requires improvement

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

and then patients were seen within 13 weeks to meet the 18-week guidance. Staff saw an average of six to seven patients per day worked, 12 new cases were allocated across the team monthly off the waiting list. Staff members across the service had clear expectations about caseload management.

- In both teams, urgent referrals were seen quickly within 48 hours. Both teams met the KPI that 95% patient referrals were triaged within two days. Young people who had been assessment may be placed on an internal waiting list and were seen by a clinician within 12 weeks.
- Both teams took some steps with patients who found it difficult or were reluctant to engage with mental health services. In Portsmouth, there was more consistent one to one contact with patients if the risk to young people increased. They had an assertive outreach approach to assist young people who may otherwise find our services difficult to access. Both CAMHS teams contacted young people and their GP who did not attend appointments. Staff in both Portsmouth and Southampton CAMHS told us when appointments had to be cancelled staff members contacted the young person and/or carer to explain and to re-arrange the appointment.

The facilities promote recovery, comfort, dignity and confidentiality

- In both Portsmouth and Southampton CAMHS patient waiting rooms contained information leaflets regarding local services, medication and how to make complaints. They were both comfortable and decorated in a child friendly way.
- The CAMHS teams used a range of different therapy rooms in their bases. These included art therapy and family therapy rooms. Each were well equipped.
- Both waiting rooms had toys and books appropriate to the needs of young people and children. In Portsmouth there were computer games young people could use.
- Therapy rooms in both Southampton and Portsmouth CAMHS were sound proofed to ensure patients privacy.

Meeting the needs of all people who use the service

- All of the community CAMHS services had disabled access and toilets for young people with a disability.
- Information leaflets about CAMHS were provided by the trust in age appropriate formats Information included how to access counselling and substance misuse services, contact advocacy and how to make a complaint.
- Portsmouth 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. The Portsmouth learning disability team was well resourced and well run. It was integrated in both schools and the wider community and it offered a wide range of services. However, there was no dedicated team for young people with learning disabilities in Southampton that had long waits for those young people. Young people had access to the Jigsaw service which is an integrated health and social care provision for children with moderate and severe learning disability plus complex family circumstances or enduring complex health conditions.
- In both teams interpreters and signers were available to staff. Staff in both Portsmouth and Southampton had accessed these services for young people for whom English was not their first language.

Listening to and learning from concerns and complaints

- All patients spoken with, across both services, told us they knew how to make a complaint. In Southampton, complaints were tracked online via the 'children service line complaints summary'. The summary form 1st April 2015 to 31st March 2016 detailed complaints included, clinical waiting times, quality and safety of care, lack of clinical input, communication and staff attitude. All complaints were recorded on an action tracker via a traffic light type system. For example, green indicated complaints had been completed and the complainant informed of outcome, an amber case is on-going and white not yet addressed.
- There were seven complaints in total received by the trust in the last 12 months about specialist mental health services for children and young people. Of these three fully upheld and two partially upheld. No complaints were referred to the ombudsman.
- All staff spoken with across both services told us they know how to handle complaints appropriately. For

Are services responsive to people's needs?

Requires improvement

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example, in Southampton we observed a carers group with five foster carers attended with two children and two staff members. All the foster carers and staff told us they knew how to handle complaints.

- Feedback on the outcome of investigations of complaints was provided to staff in team meetings and multi-disciplinary meetings. In Portsmouth, business meetings shared team briefings about a range of governance issues including complaints. We saw recorded in the team meeting minutes the actions the teams agreed to improve their processes following the feedback from a complaint. 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.

Our findings

Vision and values

- The staff we spoke with knew the trust's visions and values. They were displayed on the walls in each service.
- 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 had visited both sites.

Good governance

- The community CAMHS service was managed by the clinical director and the head of children's services in Portsmouth, south east and the head of children's services Southampton, south west. The deputy head of service, programme leads, clinical governance, a quality lead and a lead clinician reported to the clinical director and head of service. The head of services were responsible for the `better care` managers in Portsmouth and Southampton, clinical leads and locality teams.
- There was not an effective governance system in place to ensure consistency in standards and work processes across the different community CAMHS teams. For example, at the last inspection in 2014 we found shortfalls in record keeping and recommended that the trust should ensure a high standard of record keeping across all CAMHS sites and ensure consistency." This recommendation was not completed. Portsmouth and Southampton CAMHS, although part of the same trust worked independently of each other. This was reflected when staff attended our focus groups and told us they came to find out what the other service was doing.
- There was no effective governance to ensure staff implemented recommendations and learning from the incidents. In Southampton CAMHS there had been limited improvements made following the serious incident involving the suicide of a young person in July 2015.
- The managers used KPIs and other indicators to gauge the performance of the team. The team's performance against trust targets were on the trust's computer system and were accessible in the local services.
- The managers from both services told us that they felt they had sufficient authority and administration support. The managers across the service stated that stated they could submit items to the trust risk register.
- The managers across both CAMHS teams ensured the overall score for staff completion on mandatory training across both services was 80%.Staff members across both services received appraisal and managerial and clinical supervision to enable them care and treat young people and children safe.
- The CAMHS teams undertook audits to ensure they were following NICE guidance when prescribing medication to the children and audits young people.
- The trust responded very positively and quickly when we raised concerns about the risk assessment process for high and immediately reviewed the risk assessment processes and put in place an action plan to implement and monitor changes.

Leadership, morale and staff engagement

- In Southampton CAMHS three significant events happened in 2015 which contributed to the current shortfalls in provision. The adolescent service and the service for younger children aged nought to 14 years were merged. The trust sold the building where the adolescent service was based and staff members were moved over to Adelaide health centre. Finally, a new IT (system one) was installed. Staff felt they had not been engaged in the service redesign. Staff did not feel they had sufficient training in the complexities of the assessments of nought to 18 year olds. A large number of staff left the service taking with them and wealth of experience and knowledge. Morale in the service was low.
- In order to address the concerns raised by the staff team the new `better care` deputy manager was designated to be solely responsible for the CAMHS service in Southampton. In addition, an independent company was brought in to help address staff morale issues. Staff told us they welcomed this but morale remained low. However, during this difficult transition, the staff team did not address the findings of the investigation in relation to a serious incident in 2015 and young people were put at risk.

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.

- All staff in Southampton CAMHS, managers including the clinical director had been very open and honest about the current position and the difficulties they encounter with the new IT system. However, it remains the case that the overall governance of the situation, for a variety of reasons, was not well managed at the time and this has impacted on service provision.
- Both services had a yearly staff survey. In Portsmouth, the results of surveys were predominately positive. In Southampton, the results reflected the staff morale following the merger. The trust commissioned an independent company to establish what staff concerns were and put a plan in place to resolve issues. They correlated staff responses at recent staff away days and the average staff satisfaction score was four out of 10. Staff comments included concerns about lack of communication, structure, the IT, lack of strong leadership and inconsistent referrals, no lockers, hot-desking and loss of sense of team. Staff spoken with at the inspection recognised the work from the managers to resolve the situation but stated that staff morale was mixed. They recognised that the trust invested a lot of time in identifying their concerns but they were anxious for a resolution.
- Across both services sickness and absence rates were in line with the national average of 4%. The Bradford scale was used to monitor sickness via team leads. The Bradford scale is a formula used in human resource management as a means of measuring worker absenteeism. Staff also had access to health and wellbeing support via occupational health at the trust.
- 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.
- Staff we spoke with told us that they knew how to use the whistle-blowing process and that they would use it of they had concerns without fear of victimisation.
- In Portsmouth, the staff we spoke were passionate about their work. All staff told us they enjoyed working in their teams and were well supported by peers and their manager. In Southampton, staff morale was mixed. Staff at our focus group prior to the inspection felt that the amalgamation of the teams was not well thought out and they lacked training in assessments that left them feeling disempowered. All staff we spoke with told us that they were proud of the care that they delivered and that they had a real sense of purpose and achievement. Staff described good team working between their immediate team members and wider professional groups.
- Staff members across both services had opportunities for secondment and leadership development.
- Overall, staff we spoke with understood the term duty of candour. They gave us examples of being open and transparent with patients and explained when things have gone wrong.
- Staff were offered the opportunity to give feedback on services and input into service development and staff surveys and development days. Although staff in Southampton had concerns about the impact of the amalgamation, they felt able to express their views but a significant number did not feel they were listened to.

Commitment to quality improvement and innovation

- In Portsmouth, patients had access to a staff member who helped them bridge the gap between the CAMHS service and the voluntary sector.
- Portsmouth has been a member of the Quality Network for Community CAMHS (QNCC) since 2006. They achieved CAMHS accreditation for 2014 to 2017 and CAMHS LD Accreditation with Excellence for 2015 to 2018.

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 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 Southampton CAMHS, we found that there was not an effective system in place to assess the risks to young people. 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 trained to complete assessments of young people and children. The trust did not ensure that young people and children did not have access to dangerous items in the unlocked kitchen and interview rooms. The trust did not ensure crisis plans were completed for all young people who were assessed as requiring them to keep them safe. This was a breach of regulation 12 (1) (a) (b) (d) 12 (2) (b) (c).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure there is an effective system in place to ensure consistency in standards and work processes across the different community CAMHS teams to manage the waiting lists, to ensure there were sufficient staff, to ensure recommendations from serious incidents are met and assess the risks to young people whilst they were waiting for assessment or treatment. This was a breach of regulation 17 (2) (a) (b).
	The trust did not ensure that all young people had care plans. This was a breach of regulation 9.