Sheffield Children's NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

Sheffield Children's NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. It provides integrated healthcare for children and young people from the local population in Sheffield and South Yorkshire, as well as specialised services to children and young people nationally.

We inspected the trust between 14 and 17 June 2016. We undertook an unannounced inspection at the Emergency department on 30 June. We previously inspected the Sheffield Children's Hospital in May 2014 and rated it as good overall. The mental health services and community services were not inspected at that time. We have not inspected the Embrace service.

This inspection was to inspect the mental health and community services. We also undertook a focused inspection in areas within Sheffield Children's Hospital that were identified as requiring improvement at the previous inspection. These were areas of emergency and urgent services, neonatal services, surgical services, medicine and critical care.

In the inspection in May 2014, we identified that the trust must ensure the hospital cover out of hours was sufficiently staffed by competent staff with the right skill mix, particularly in the Emergency department. We also identified the trust must ensure consultant cover in critical care was sufficient and that existing consultant staff were supported while there were vacancies in the department and that the process for ongoing patient review for general paediatric patients, following their initial consultant review, must be reviewed to ensure there were robust processes for ongoing consultant input into their care. We found that at this inspection, all these specific areas had been addressed.

At this inspection, we rated services that had not previously been rated and also the specific areas we inspected. However, we did not review the overall rating for the trust as the inspection was focused on specific areas only.

We rated children's, young people and families services within the community services as good. Child and adolescent mental health wards, child and adolescent mental community services and transition services required improvement.

Our key findings were as follows:

- The trust had taken action to address areas identified at the inspection in May 2014. However, the trust had made insufficient progress in developing transition services since our last inspection. The trust directors recognised there was further work to do.
- There was an open culture within the organisation. Challenge was encouraged by executives and non-executive directors. However, the trust was not fully compliant with the Duty of Candour regulation.
- There were some staff shortages; the Board had approved additional posts in principle and recruitment was underway.
- Incidents were reported and investigated and lessons learned, although there were some concerns about the reporting of restraint in mental health services. The trust was planning to introduce an electronic incident reporting system which would improve capability to analyse themes.
- Infection prevention and control policies were effective. There had been no cases of MRSA reported since 2008. All reported cases of Clostridium difficile between April 2015 and March 2016 were unavoidable.
- Feedback from people who used the services we inspected and those who are close to them was mostly positive about the way staff treated people.
- There was evidence of public engagement, however it was recognised by the trust, that there needed to be a more systematic approach; there was no patient and public involvement strategy in place.
- There were no mortality outliers at the trust.
- There was a lack of robust monitoring and governance in some areas, for example use of the Mental Health Act and equality and diversity.
- Staff did not always take a proactive approach to safeguarding, particularly in the emergency department and within mental health services.

Summary of findings

- Within mental health services, staff used restrictive practices, some of which met the definition of seclusion. However, these were not recognised as such and were not dealt with in accordance with trust policy.
- The trust was in the process of building work to provide new accommodation for some of the wards and outpatients. The aim was to provide an environment to better meet the needs of children, young people and their families.

We saw several areas of outstanding practice including:

- The CAMHS service had been successful in securing NHS England and local clinical commissioning group funding for a child and adolescent mental health service schools link pilot scheme. The aim of this was to improve joint working between child and adolescent mental health service and schools. The project arose from the 'Future in Mind' Department of Health document and the transformation plan to improve early access to mental health support for young people. The scheme consisted of a number of tier three child and adolescent mental health professionals working within 10 schools. The project had been positively received by the funders and organisations involved.
- The trust had established paediatric palliative care simulation training.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure compliance with the Duty of Candour (regulation 20).

Child and adolescent mental health wards

- The trust must ensure that practices used by staff to manage behaviour such as time out and seclusion are used and recognised correctly. Staff should follow applicable procedures for the use of these practices with clear rationale and evidence documented.
- The trust must ensure that informal patients are aware of their rights, and any restrictions, and understand these when they consent to their admission and treatment. Staff should not use the threat of detention in order to prevent patients from leaving where this is not a justifiable and required intervention.
- Staff must ensure that incidents involving abuse between patients are referred as safeguarding concerns where necessary. Evidence of safeguarding considerations must be documented accordingly.
- The trust must ensure that there is consistency between staff about what incidents are reported and what the threshold is for reporting physical interventions.
- The trust must ensure there are appropriate systems in place at service level in order to effectively assess and monitor the service and how it operates. This should include the ability to identify and monitor staff training requirements and that staff supervisions are undertaken in accordance with policy.
- The trust must ensure there are effective systems and processes in place to monitor medicines management and infection control practices. These should be able to identify and highlight shortfalls in practice which must be addressed as necessary.
- The trust must ensure that policies in place in relation to the Mental Health Act appropriately reflect current practice and legislation.
- The trust must ensure that relevant staff receive appropriate training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The trust must ensure that there is appropriate oversight of the application of the Mental Health Act and any breaches of this within the service.

Specialist community mental health services for children and young people

- The trust must ensure that environments are assessed in order to identify and mitigate risks that may be present to people using the service.
- The trust must ensure that lone working procedures are risk assessed as necessary and lone working processes are suitably robust to maintain safety.
- The trust must ensure there are appropriate systems in place at service level in order to effectively assess and monitor the service and how it operates. This should include the ability to identify and monitor staff training requirements and that staff supervisions are undertaken in accordance with policy.
- The trust must ensure that clinic room equipment is safe and suitable for use. There must be effective systems and processes to monitor infection control practices. These should be able to identify and highlight shortfalls in practice.

Summary of findings

- The trust must ensure staffing levels are sufficient to enable young people to access treatment within timescales set out in trust and NHS national targets.

Transition care

- The trust must ensure that there are effective governance systems in place to capture, respond, and learn from transition related complaints and incidents.
- The trust must ensure that sufficient numbers of staff have appropriate training in the Mental Capacity Act 2005.
- The trust must ensure that there is an effective clinical audit system in place to monitor transitional care provision.

Urgent and emergency care

- The trust must ensure all children are appropriately assessed for safeguarding risks.

Medical care

- The trust must ensure that staff undertake and document appropriate risk assessments to promote safe care.
- The trust must ensure all staff disciplines have safeguarding training.

Community health services for children, young people and families

- The trust must ensure that electronic record systems enable staff to identify and assess risks to the health, safety and welfare of people who use the service.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Sheffield Children's NHS Foundation Trust

Sheffield Children's NHS Foundation Trust provides acute and community provides services for children and young people in Sheffield and South Yorkshire, as well as specialised services for patients further afield.

The trust operates from one main acute hospital site, Sheffield Children's Hospital, as well as inpatient Child and Adolescent Services at the Becton Centre and respite care provided at Ryegate House. In addition, care is provided to children and young people in their own homes and at clinics across the city.

The trust has 284 beds, which included 18 critical care beds.

The trust employs 2667 staff:

- 336 medical
- 1059 nursing
- 1270 other

The trust financial position was:

- Revenue (2015): £169,630,869
- Full Cost (2015): £168,741,422
- Surplus (2015): £889,447

We previously inspected the Sheffield Children's Hospital in May 2014. The mental health services and community services were not inspected at that time. This inspection was to inspect the mental health and community services. We also followed-up areas identified as requiring improvement at that inspection.

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott

Head of Hospital Inspections: Julie Walton, Head of Inspection

The team included CQC inspectors and a variety of specialists: including consultants, specialist children's nurses, health visitor, school nurse, allied health professionals and an expert by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, 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?

The inspection team inspected the following community health and mental health core services:

- Children, young people and families
- Community end of life
- Child and adolescent mental health inpatient services
- Child and adolescent mental health community services

In addition, the inspection team inspected the following core services at Sheffield Children's Hospital that were rated at the inspection in May 2014 as requires improvement or not rated (due to the methodology at that time):

- Urgent and emergency care – safe and effective
- Medical care – safe, responsive and well-led
- Surgery - safe
- Critical care – well-led
- Neonatal - effective

Summary of findings

• Transition – safe, effective, caring, responsive and well-led.

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning

group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held a stall in the trust on 7 June 2016 and spoke with young people and their families and received written comments in our comments boxes. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. During the inspection we attended a Young Healthwatch meeting to gain the views of young people who had experience of the services provided. The team would like to thank all who shared their experiences.

Focus groups were held with a range of CAMHS staff and community staff including nurses, doctors, health visitors, school nurses, specialist nurses and allied health professionals. Drop-in sessions were held at Sheffield Children's Hospital. We also spoke with staff individually as requested.

We talked with children, young people and their families in the hospital, Becton Centre, Ryegate House and in community settings. We observed how children and young people were being cared for, talked with

carers and/or family members, and reviewed personal care and treatment records.

We carried out an announced inspection on 14 to 17 June 2016 and an unannounced inspection on 30 June 2016.

What people who use the trust's services say

The Friends and Family Test results for May 2015 to February 2016 were consistently below the England average and the average for specialist children's trusts. In February 2016, the percentage of people recommending the trust to friends and family was 74.2%. The trust were aware of specific data collection issues with their friends and family data collection and were implementing and piloting alternative methods of data collection.

The latest survey of children and young people published in July 2015 showed all responses were about the same as other trusts with one response regarding parent's views on pain management being better compared with other trusts. This was based on information about 261 children and young people who received care during July, August and September 2014 at Sheffield Children's NHS Foundation Trust.

Facts and data about this trust

Sheffield Children's Hospital NHS Foundation Trust had the following activity for the period 1 April 2015 to 29 March 2016:

- 32,685 inpatient admissions
- 132,812 outpatient (total attendances)
- 56,029 Accident & Emergency (attendances)

The trust provides services for children and young people in Sheffield and South Yorkshire, as well as specialised services for patients further afield. Three of the four districts within South Yorkshire (Barnsley, Doncaster and Rotherham) have a lower than average proportion of Black, Asian and Minority ethnic (BAME) residents. Sheffield has a similar ethnic make up to the England average. However, there is a higher percentage of residents from 'other ethnic groups' (2.2% compared to an England average of 1%).

The four districts making up South Yorkshire (Barnsley, Doncaster, Rotherham and Sheffield) all lie within the first quintile in the index of deprivation meaning they are four of the most deprived districts in England.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? At the previous inspection in May 2014, we rated the trust as requires improvement for safe. This was a focussed inspection; we inspected safe in children, young people and family services and child and adolescent mental health services for inpatients and the community. We also inspected safe as part of a follow-up to our previous inspection in urgent and emergency care, medical care, surgery and transition. We have not reviewed the rating for safe at the trust as the inspection was focused on specific areas only. We found: • Sufficient improvements had been made in medical care and surgery following our previous inspection. • Although some improvements had been made in urgent and emergency care and transition, these were not sufficient. • A nursing establishment review had been completed. There were some staff shortages, however the Board had approved additional posts in principle and recruitment was underway. • The trust monitored sepsis as part of a CQUIN target. However, there was no sepsis screening documentation in place for staff to use. • Incidents were reported and investigated, although there were some concerns about the reporting of restraint in mental health services. Lessons were learned and changes made in practice, where indicated. Staff knew about the need to be open and honest with patients and their carers. However, we also found: • Staff did not always take a proactive approach to safeguarding, particularly in the emergency department. It was not always clear that incidents involving patients were referred as safeguarding concerns where they met the criteria within mental health services. • Within mental health services, staff used restrictive practices, some of which met the definition of seclusion. However, these were not recognised as such and were not dealt with in accordance with trust policy.	

Summary of findings

Are services at this trust effective?

At the previous inspection in May 2014, we rated the trust as good for effective.

This was a focussed inspection. We inspected effectiveness in children, young people and family services and child and adolescent mental health services for inpatients and the community. We also inspected effectiveness as part of a follow-up to our previous inspection in transition. Effectiveness in urgent and emergency care and neonatal care were also inspected as we were not rating them at the time of the previous inspection. We have not reviewed the rating for effectiveness at the trust as the inspection was focused on specific areas only.

We found:

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. However, in mental health services, there was no evidence of how staff had assessed young people as being competent to make their own decisions.
- Information about care and treatment, and their outcomes, was monitored. Outcomes for people who used services were positive, consistent and met expectations.

However, we also found that:

- Mental Capacity Act training was not mandatory and not all staff had completed this.
- The service did not monitor application of, or record any breaches of, the Mental Health Act.
- There was a lack of audit in mental health services and transition to monitor the effectiveness of the service.
- Some policies in relation to the Mental Health Act were still awaiting ratification and referred to out of date information.

Are services at this trust caring?

At the previous inspection in May 2014, we rated the trust as good for caring.

This was a focused inspection. We inspected caring in children, young people and family services and child and adolescent mental health services for inpatients and the community. We also inspected

Summary of findings

caring as part of a follow-up to our previous inspection in transition as this was not previously rated. We have not reviewed the rating for caring at the trust as the inspection was focused on specific areas only.

We found:

- People were involved and encouraged to be partners in their care and in making decisions, although it was recognised this could be improved in mental health services.
- People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.
- Feedback from people who used the service and those who are close to them was mostly positive about the way staff treated people.

Are services at this trust responsive?

At the previous inspection in May 2014, we rated the trust as good for responsive.

This was a focussed inspection. We inspected responsiveness in children, young people and family services and child and adolescent mental health services for inpatients and the community. We also inspected responsiveness as part of a follow-up to our previous inspection in medical care and transition. We have not reviewed the rating for responsive at the trust as the inspection was focused on specific areas only.

We found:

- Services were planned and delivered to meet the needs of people.
- Complaints and concerns were taken seriously, responded to in a timely way and listened to. Improvements were made to the quality of care as a result of complaints and concerns.
- Children and young people with complex needs and/or learning disabilities were usually well-known to the teams. Where admission to hospital was planned, the Patient Advice and Liaison lead developed a plan in conjunction with the child or young person and their family.

However, we also found that:

- We reviewed the complaints files for five complaints. There was no clear recorded investigation report. Within community settings, there was no information displayed in clinical areas to inform people how to make a complaint.

Summary of findings

- Some young people in the generic mental health services had to wait significant amounts of time for treatment. These timescales exceeded the trust's own target and NHS referral to treatment time scales. Community paediatrics were not meeting the target that people with a referral from a GP should start their treatment within 18 weeks.
- There was no provision for multi-specialty clinics, meaning some young people had to attend hospital on multiple occasions to see different specialties.

Are services at this trust well-led?

At the previous inspection in May 2014, we rated the trust as good for well-led.

This was a focussed inspection. We inspected well-led in children, young people and family services and child and adolescent mental health services for inpatients and the community. We also inspected well-led as part of a follow-up to our previous inspection in medical care, critical care and transition. We also inspected well-led at trust level.

We have not reviewed the rating for well-led at the trust as the inspection was focused on specific areas only.

We found:

- The trust had taken action to address most areas identified at the inspection in May 2014. However, the trust had made insufficient progress, particularly in developing transition services since our last inspection. The trust directors recognised there was further work to do.
- There was an established set of values and vision at the trust. Staff across the organisation were aware of these.
- There were service specific strategies that aligned with a trust strategy.
- There was an open culture within the organisation. Challenge was encouraged by executives and non-executive directors.

However, we also found:

- No mental health activity was reported to board level which meant there was no oversight by the trust about use of the Mental Health Act.
- There was a lack of robust monitoring and governance regarding equality and diversity.
- Although there was evidence of public engagement, it was recognised by the trust, that there needed to be a more systematic approach; there was no patient and public involvement strategy in place.

Overview of ratings

Our ratings for Sheffield Children's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	N/A	N/A	N/A	N/A
Medical care	Good	N/A	N/A	Good	Good	N/A
Surgery	Good	N/A	N/A	N/A	N/A	N/A
Neonatal services	N/A	Requires improvement	N/A	N/A	N/A	N/A
Transitional services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Sheffield Children's NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Requires improvement	Good	Good	Good	Good	Good
Overall Community	Requires improvement	Good	Good	Good	Good	Good

Overview of ratings

Our ratings for Mental Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Specialist community mental health services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall for service	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

We previously inspected the Sheffield Children's Hospital in May 2014 and rated it as good overall. The mental health services and community services were not inspected at that time. At this inspection, we rated services that had not previously been rated and also the specific areas we inspected. However, we did not review the overall rating for the trust as the inspection was focused on specific areas only.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had established paediatric palliative care simulation training.
- The CAMHS service had been successful in securing NHS England and local clinical commissioning group funding for a child and adolescent mental health service schools link pilot scheme. The aim of this was to improve joint working between child and adolescent mental health service and schools. The project arose from the 'Future in Mind' Department of Health document and the transformation plan to improve early access to mental health support for young people. The scheme consisted of a number of tier three child and adolescent mental health professionals working within 10 schools. The project had been positively received by the funders and organisations involved.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure compliance with the Duty of Candour (regulation 20).

Child and adolescent mental health wards

- The trust must ensure that practices used by staff to manage behaviour such as time out and seclusion are used and recognised correctly. Staff should follow applicable procedures for the use of these practices with clear rationale and evidence documented.
- The trust must ensure that informal patients are aware of their rights, and any restrictions, and understand these when they consent to their admission and treatment. Staff should not use the threat of detention in order to prevent patients from leaving where this is not a justifiable and required intervention.
- Staff must ensure that incidents involving abuse between patients are referred as safeguarding concerns where necessary. Evidence of safeguarding considerations must be documented accordingly.
- The trust must ensure that there is consistency between staff about what incidents are reported and what the threshold is for reporting physical interventions.
- The trust must ensure there are appropriate systems in place at service level in order to effectively assess and monitor the service and how it operates. This should include the ability to identify and monitor staff training requirements and that staff supervisions are undertaken in accordance with policy.
- The trust must ensure there are effective systems and processes in place to monitor medicines management and infection control practices. These should be able to identify and highlight shortfalls in practice which must be addressed as necessary.
- The trust must ensure that that policies in place in relation to the Mental Health Act appropriately reflect current practice and legislation.
- The trust must ensure that relevant staff receive appropriate training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The trust must ensure that there is appropriate oversight of the application of the Mental Health Act and any breaches of this within the service.

Specialist community mental health services for children and young people

- The trust must ensure that environments are assessed in order to identify and mitigate risks that may be present to people using the service.
- The trust must ensure that lone working procedures are risk assessed as necessary and lone working processes are suitably robust to maintain safety.
- The trust must ensure there are appropriate systems in place at service level in order to effectively assess and monitor the service and how it operates. This should include the ability to identify and monitor staff training requirements and that staff supervisions are undertaken in accordance with policy.

Outstanding practice and areas for improvement

- The trust must ensure that clinic room equipment is safe and suitable for use. There must be effective systems and processes to monitor infection control practices. These should be able to identify and highlight shortfalls in practice.
- The trust must ensure staffing levels are sufficient to enable young people to access treatment within timescales set out in trust and NHS national targets.

Transition care

- The trust must ensure that there are effective governance systems in place to capture, respond, and learn from transition related complaints and incidents.
- The trust must ensure that sufficient numbers of staff have appropriate training in the Mental Capacity Act.
- The trust must ensure that there is an effective clinical audit system in place to monitor transitional care provision.

Urgent and emergency care

- The trust must ensure all children are appropriately assessed for safeguarding risks.

Medical care

- The trust must ensure that staff undertake and document appropriate risk assessments to promote safe care.
- The trust must ensure all staff disciplines have safeguarding training.

Community health services for children, young people and families

- The trust must ensure that electronic record systems enable staff to identify and assess risks to the health, safety and welfare of people who use the service.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Within CAMHS inpatient services: • Medicines were not always managed in a proper and safe way. • Some medicines, which had reduced expiration on opening, did not contain the dates of when they were opened. • Staff did not record details of medicines that patients brought back to the service on return from leave. • There were discrepancies in information on some drugs charts in relation to allergies and abbreviations, which had potential to cause errors. Within community CAMHS services: • Care and treatment was not always provided in a safe way. • The environment at both services had not been suitably assessed to identify and mitigate any risks that may be present to young people. • Lone working risk assessments were not carried out in accordance with trust policy. • Some equipment was not fit for purpose as it was out of date and had not been currently serviced.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Within CAMHS inpatient services: • Staff used restrictive practices, which involved use of quiet rooms to de-escalate behaviour. Patients were not always able to freely leave. Staff did not recognise or treat these episodes in accordance with policy and follow necessary seclusion practice where required. • It was not always evident from staff reports what forms of restraint and restrictive practices had taken place and for what duration of time. As such, we could not establish that such interventions were proportionate and necessary where they had occurred. • Informal patients were not aware of their rights and able to leave the service at their own will. • Where incidents had occurred involving abuse between patients, there was no evidence that safeguarding referrals had been made or considered. Within the emergency department: • There were missed opportunities to undertake risk assessments and documentation to prompt assessment of safeguarding needs and sharing of information with other agencies.
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Within CAMHS inpatient services: • There was no set structure for the service as to what specialist training each staff group was required to have in order to perform their roles. • There was no effective system to identify and monitor staff training and supervisions and ensure that these took place as required. • There were no systems to monitor adherence to effective medicines management and infection control practices.

This section is primarily information for the provider

Requirement notices

- The service did not monitor and have oversight of application of the Mental Health Act including any breaches of the Act. Several policies in relation to the Mental Health Act were not current and some policies did not contain reference to the Act where necessary.
- The system to monitor and assess the service was not robust. Information from incident reports was not sufficiently detailed or being used to analyse themes and trends.

Within community CAMHS services:

- There was no set structure for the CAMHS service as to what specialist training each staff group was required to have in order to perform their roles.
- There was no effective system to identify and monitor staff training and supervisions within CAMHS and ensure that these took place as required.
- There were no robust systems to monitor and assess infection control practice and clinical equipment within CAMHS.
- The system to monitor and assess the service was not robust. Information from incident reports was not sufficiently detailed or being used to analyse themes and trends.
- Effective governance systems were not in place to capture, respond, and learn from transition related complaints and incidents. There was not an effective clinical audit system in place to monitor transitional care provision.

Within children young people and families community services:

- There was no consistency across the trust with regards to records. There was a risk that practitioners did not have access to information in a timely manner to minimise risks.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Within community CAMHS services: • Sufficient amounts of staff were not deployed in order to meet the requirements of the service. • The waiting times from initial referral to actual treatment were lengthy. They exceeded the trust's own target and the timescales set out in the NHS constitution.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** • There was no provision for multi-specialty clinics, meaning some young people had to attend hospital on multiple occasions to see different specialties. • There was no single clear, structured education programme or guidance for young people or carers around the transition planning process.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met:** • Staff we spoke with told us that they had limited understanding or training on the Mental Capacity Act, or how it could apply to transitional care. • There were clinic letters that continued to be directed to the parents of young people transitioning into adult care and contained confidential patient information. We saw no documentation to confirm that this was what had been requested by the patients in question.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

- Written notification was not provided following notifiable safey incidents.