Requires improvement

Black Country Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Black Country Partnership NHS Foundation Trust
Delta House
Delta Point
B70 9PL
Tel:0845 146 1800
Website: www.bcpft.nhs.uk

Date of inspection visit: 16-20 November
Date of publication: 26/04/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAJHQ	Trust Headquarters	Lodge Road CAMHS service.	B708NY
TAJHQ	Trust Headquarters	Sandwell Crisis and Intervention Team.	B708NY
TAJHQ	Trust Headquarters	Wolverhampton Key Team	WV6OUA
TAJHQ	Trust Headquarters	Wolverhampton Inspire Team	WV113PG
TAJHQ	Trust Headquarters	Wolverhampton Child and Family service	WV113PG
TAJHQ	Trust Headquarters	Wolverhampton Crisis and Home Treatment Team	WV113PG

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Black Country Partnership Foundation NHS Foundation trust.. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Black Country Partnership NHS Foundation NHS trust. and these are brought together to inform our overall judgement of Black Country Partnership NHS Foundation 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?	**Requires improvement** 
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

Contents

Summary of findings

Overall summary

We rated specialist community services for children and young people as requires improvement because:

- The trust did not ensure that all staff working with children and young people had disclosure and barring services (DBS) checks every three years as required in the 2014 trust disclosure and barring policy.
- Staffing vacancies at the Sandwell crisis team and Wolverhampton crisis and home treatment teams were high at63% and70% respectively. At the time of our inspection the Wolverhampton crisis and home treatment team had been placed on the Trust's risk register due to insufficient staffing. The CAMHS services had six consultant psychiatrists. This was below the recommendations by The Royal College of Psychiatrists for building and sustaining specialist CAMHS, (CR182) 2013.
- Interview rooms at the Lodge Road Child and Adolescent Mental Health Services (CAMHS) service did not have alarms fitted. Alarms had been removed and were stored in the administrative area of reception.
- Toys in use by young people were not regularly checked and cleaned across all services. Equipment used to monitor the physical health of young people using services was not always adequately maintained.
- The Sandwell CAMHS crisis team was on the trust risk register due to uncertainty about its funding as from March 2016. The child and family services team had placed themselves on the trust risk register due to increasing waiting times for appointments following initial assessment.
- There were inconsistencies in how the lone working policy was implemented.
- Incidents had occurred where dictation tapes had gone missing containing information on medication and risks for young people. All information needed to deliver care was not always stored securely and available to staff when they needed it.
- Of the 30 care records reviewed across the CAMHS service, 23% did not have a risk assessment present, 60% of risk assessments that were present were not completed to a required standard and 47% of care records did not contain a care plan. In records where care plans were completed these were found to lack the views of the young people using the service. There was not always evidence of personalisation or holistic care planning and care plans did not always contain the full range of needs of young people using the service. Care plans did not evidence the involvement of young people and their families. 91% per cent of care plans reviewed in the Sandwell CAMHS team, the Key team and the Wolverhampton child and family service had no evidence of the young person having been given a copy. Medical records did not always evidence parental responsibility.
- A child protection database was in use at Sandwell CAMHS service, of the eleven cases reviewed, 45% had no details completed for the named clinician.
- There had been no specific recent training for CAMHS staff regarding Gillick competence and staff understanding of this was variable. There was no evidence of assessment of Gillick competency within all files reviewed at Lodge road CAMHS service, or assessments of capacity and competence at the key team in Wolverhampton.
- The trust had a compliance target for mandatory training of 95%. All CAMHS clinical staff were required to attend safeguarding children level three training. The average attendance rate for this training across all teams was 50-80%. All staff did not receive yearly appraisals, 76% of staff across the teams visited had an appraisal in the preceding year.

Summary of findings

However:

- The Pierce suicide intent scale and the Health of The Nation Outcome Scale for Children and Adolescents (HoNOSCA) was being used within the CAMHS services to provide an outcome measure for rating the severity of needs and the effectiveness of treatment.
- The Sheffield Learning Disabilities Outcome Measure (SLDOM) was being used within the inspire service for children with learning disabilities
- A range of psychological therapies were available for children and young people and their families within the CAMHS service.
- Observations carried out during the inspection process showed that staff attitudes and behaviours when interacting with young people and their carers was respectful, responsive and provided appropriate practical and emotional support.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Interview rooms at the Lodge Road Child and Adolescent Mental Health Services (CAMHS) service did not have alarms fitted. Alarms had been removed and were stored in the administrative area of reception.
- Clinic rooms at the Gem centre had panic alarms but not all staff had a pin to use this or were able to describe how it worked.
- Socket covers were not always in place in rooms used by young people in the Inspire service at the Gem centre.
- Toys were not regularly checked and cleaned across all services.
- Cleaning records were not always available for staff to review or to check that areas had been cleaned at Lodge Road CAMHS service.
- Equipment used to monitor the physical health of young people using services was not adequately maintained.
- The CAMHS services had six consultant psychiatrists. This was below recommendations by The Royal College of Psychiatrists for building and sustaining specialist CAMHS, (CR182) 2013.
- The CAMHS team at Sandwell had high levels of staff sickness and vacancies that impacted on the services effectiveness.
- Staffing vacancies at the Sandwell crisis team and Wolverhampton crisis and home treatment teams were high at 63% and 70% respectively. At the time of our inspection the Wolverhampton crisis and home treatment team had been placed on the Trust's risk register due to insufficient staffing.
- The Sandwell CAMHS crisis team was on the trust risk register due to uncertainty about its funding in March 2016.
- The point of access for referrals into CAMHS had two members of staff. Staff within this service raised concerns that this was insufficient and did not allow for sickness or annual leave.
- Medical staff within the Lodge road CAMHS team had submitted incident reports to the trust detailing lack of secretarial cover for the last three months. Incidents had occurred where dictation tapes had gone missing containing information on medication and risks for young people.
- Disclosure and Barring Service (DBS) checks were not reviewed every three years, 73% of staff at the child and family service did not have current DBS checks.This was not compliant with the trust disclosure and barring policy.

Summary of findings

- Of the 30 care records reviewed across all services, 23% did not have a risk assessment present, 60% had a risk assessment but not completed to a required standard
- At CAMHS Lodge road, 50% of young people did not have a risk assessment whilst the remaining 50% had a risk assessment which was incomplete.
- Risk assessments completed by the key team were not always completed to the required standard.
- Crisis plans were not being used in the Key team.
- There were inconsistencies in how the lone working policy was implemented. A recent risk assessment of lone working at Lodge Road identified multiple gaps in assurance, control measures and best practice. This meant that staff's safety and wellbeing was not ensured.
- Bank staff were unable to use the trust datix system to report incidents. This was a concern as some bank staff had been working with the trust for a number of years.

However:

- Quality and safety meetings were held monthly as were CAMHS specialist mental health lead meetings for Wolverhampton and Sandwell. Lessons learnt from incidents were filtered down to team meetings.Debriefs were held formally within clinical or operational supervision. Staff were able to give us examples where lessons had been learnt as a result of incidents that had been reported and where changes in practice had taken place.
- Staff met with their manager on a regular basis to discuss their caseloads.
- Administrative staff at Lodge Road had received safeguarding children level 1 training in accordance with national guidance.
- The inspire team had evidence of the formulation of risk of the young people using the service and used outcome measures for risk reduction with regular review dates.
- The CAMHS service at Lodge Road had an allocated rota for clinicians to respond to urgent cases. This meant they were able to respond to sudden deteriorations in peoples health.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

Assessment of needs and planning of care

- The CAMHS teams did not routinely use care plans for young people. Thirty care records were reviewed across the services and 47% of these did not have a care plan within them.

Summary of findings

- A lack of consistent format to the care planning process meant that staff could not always be sure where to find information needed.
- All care plans did not have dates to evidence when they had been completed. This meant that staff were not always able to check when care plans required updating.
- All care plans had not been developed and personalised to reflect the individual young persons needs. This meant that staff may not always have person specific information available to provide good quality care, 63% of the records reviewed across the CAMHS services inspected had no evidence of personalisation of care plans, a further 20% had some evidence of this but not to the required standard.
- All care plans did not demonstrate a holistic approach to care planning. A full range of identified problems and needs of the young people receiving care from the CAMHS service were absent in 47% of the care plans reviewed and incomplete in a further 40%.
- Medical records did not always evidence parental responsibility.
- All information needed to deliver care was not always stored and available to staff when they needed it. Staff we spoke to told us that the track and trace system in place was not always effective and that records could be misplaced.
- A child protection database was in use at Sandwell CAMHS service, 45% of the eleven cases reviewed had no details completed for the named clinician.
- Not all staff received yearly appraisals, 76% of staff across the teams visited had received an appraisal within the last year, this was below the trust target of 95%. Within the Sandwell and Wolverhampton crisis teams, 50% of staff had appraisals in the previous year.
- The trust had a compliance target for mandatory training of 95%. All CAMHS staff had to attend safeguarding children level three training. The average attendance rate for this training across all teams was 50-80%.
- Bank staff working for the trust did not receive Mental Capacity Act (MCA) training. This was a concern as some members had been working full time with the trust as bank staff for a number of years.
- There had been no specific recent training for CAMHS staff regarding Gillick competence.As such, staff understanding of this was variable.
- There was no evidence of assessment of Gillick competency within all files at Lodge road CAMHS service, or assessments of capacity and competence at the key team in Wolverhampton

Summary of findings

However:

- Care plans at the Inspire team showed that young people received a high level of input from the team. Anger management booklets and pictorial care plans were used to promote the involvement of young people in their care.
- A range of psychological therapies were available for children and young people and their families.

Are services caring?

Good

We rated caring as good because:

Kindness, dignity, respect and support

- Staff treated young people and their carers with respect. They were responsive to their needs and provided appropriate practical and emotional support.
- Young people we spoke to told us that staff took time to understand them and to listen to their concerns.
- Staff knew the individual needs of the people they were working with and could explain how they adapted their practice to reflect this.
- Most staff we spoke to demonstrated a good awareness of the need for confidentiality in their clinical work.
- All care plans reviewed within the Inspire service had evidence of young people or their carers having a copy of their care plan.
- The child and family service had developed a feedback form for children. This used an emoticon key for children to give feedback about how friendly the staff were, how they felt about attending and whether they felt the service had helped them.
- Feedback from the carers of young people using the Key Team was very positive. Carers that we spoke to told us that they had received a variety of interventions including family therapy and that staff from the key team had maintained links with young people when they had been admitted to tier 4 CAMHS beds out of area.
- The Child and Family Services team had adapted the Commission for Health Improvement Experience of Service Questionnaire (CHI-ESQ) to include information on the ethnicity of people using the service. The team planned to review data received to identify any trends between ethnicity groups and their experiences with services.
- The CAMHS service at Lodge road had recently completed a CHI-ESQ for their service. There had been positive feedback from the families of young people about the support they had received from staff

Summary of findings

- Young people had been involved in the recruitment of staff to the Key team and the Inspire learning disabilities team.

However:

- Care plans did not evidence the involvement of young people and their families and 91% of care plans reviewed in the Sandwell CAMHS team, the Key team and the Wolverhampton child and family service had no evidence of the young person having been given a copy.
- We observed one young person having their height and weight taken in a corridor at the Sandwell CAMHS service. This could impact on patient confidentiality and the dignity of the young person.
- Concerns were raised by inspection staff regarding the content and type of language used in one set of clinical notes. This was brought to the attention of the manager of the service who was planning to investigate this further.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Staff we spoke to told us that information provided by the trusts oasis information governance system was not always reliable or valid.
- The child and family services and Sandwell CAMHS were not meeting their 18 week referral to treatment target.
- Sandwell CAMHS were not meeting their referral to assessment targets of 6-8 weeks.
- Carers reported high waiting times to gain access to services. The child and family services team had placed themselves on the trust risk register due to increasing waiting times for appointments following initial assessment.
- Staff at the single point of access (SPA) did not always have easy access to young people's care records.
- The crisis and home treatment team in Wolverhampton could not respond to crises at weekends or provide home treatment functionality due to low staffing. The team had placed themselves on the Trust's risk register due to low staffing levels.
- The lay out of the building at Lodge Road meant that patient confidentiality could be compromised. Carers of young people reported that they could over hear what they thought to be confidential conversations amongst clinical staff.

Summary of findings

However:

- The Child and Family services team were participating in the MILESTONE study. This was an international study looking at improving outcomes for young people who need to transition to adult services.
- Staff at the Key team were working with the young people to improve the decor following feedback that it looked tired.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- All staff were not aware of the trusts visions and values and reported that they had recently change
- The compliance with safeguarding adult level 3 training for the Sandwell CAMHS team and the Wolverhampton child and family services was 7%. The trust had identified this was a training need across all services and had put plans in place to mitigate this.
- Not all staff received yearly appraisals.
- Medical staff did not always have sufficient administrative support. This meant that clinical information was not reaching GP's and other stakeholders.
- Staff had reported to the trust that they were finding it extremely difficult to deliver the service in a safe and timely manner.
- Audits of clinical notes were carried out identifying missing information within care records. We did not see a plan in place to remedy this.
- Staff morale was low in most of the services that we visited. Low staffing levels coupled with high levels of sickness meant that they felt unable to deliver the service that children and young people and their families required.
- The CAMHS service was in the process of undergoing a transformation programme and staff were unsure how this would affect them.
- Some staff said they felt unable to cope due to increasing role demands and low staffing levels.

However:

- All staff we spoke to described good team working and being mutually supportive of each. Staff reported being proud of the quality of staff they worked with and the experience held within teams.

Summary of findings

- Staff were positive about the leadership provided from their service managers. Most staff were positive about the new senior management team although said that there had been many changes which had impacted on consistency from senior management level in the trust.
- Duty of candour was evident in the responses from services to people who had complained.

Summary of findings

Information about the service

- The Key team provides intensive support for children and young people with severe emotional and behavioural disorders. The Key Team is a multi-agency service with professionals from health, social care and education working together in an integrated approach around the family. It is a specialist (Tier 3.5) child and adolescent mental health service (CAMHS).
- The Sandwell CAMHS service assesses and treats severe behaviour and mental health disorders in children and young people aged 5 to 18 and offers support and guidance to families, carers and parents and stakeholders. They implement the choice and partnership approach, (CAPA) model for demand management.
- The Sandwell CAMHS crisis Assessment and Intervention Team (CAIT) was started as a pilot in December 2014. The service operates 7 days a week, 8am -8pm, 365 days a year. Its aim is to provide a timely service, able to respond both quickly and intensively to children. young people and their families and carers who require a tier 3+ approach.
- The Wolverhampton crisis and home treatment team is a tier 3 + service. The service operates 7 days a week, 8am -8pm, 365 days a year. The overall aim of the team is to reduce the frequency of tier 4 admissions, keeping children and young people at home with their families, where they are able to receive a specialist, intensive CAMHS support. The team aims to provide short term interventions up to a maximum of 6 months in duration.
- The Wolverhampton child and family service provides a multi-disciplinary approach to the assessment, diagnosis and treatment of any child or adolescent up to 18 years of age with psychological disturbance of behaviour, emotions and/or development of psychiatric disorders. The assessment considers the child or adolescent within the context of their family and wider community. The Service is provided in close collaboration with Inspire, the community learning disabilities team for children and adolescents, the Key team and the crisis and home treatment service.
- The Inspire team provides targeted and specialist support for children and young people with mild, moderate or severe learning disabilities and mental health problems.

Our inspection team

Our inspection team was led by:

Chair: Dr Oliver Shanley, Deputy CEO & Executive Director of Nursing, Hertfordshire Partnership University NHS Foundation Trust

Team Leader: James Mullins; Head of Hospital Inspection (mental health) CQC

Inspection Manager: Kenrick Jackson

The team consisted of two CQC inspectors, a psychiatrist, a nurse, a psychologist, a mental health act reviewer, a social worker and an expert by experience who had experience of using mental health services.

The team would like to thank all those who met and spoke to inspectors during the inspection, and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust. They had prepared for our visit by gathering relevant information and requesting availability of staff and service users to meet or speak with us.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- Visited two teams in Sandwell and four in Wolverhampton, looked at the quality of the environment, and observed how staff supported children and young people.
- Spoke with eight young people who were using the service and twenty one carers.
- Spoke with the managers of the six teams visited.
- Spoke with thirty one other staff members; including psychiatrists, nurses, clinical psychologists, CBT therapists, art therapists, occupational therapists, nurse prescribers and administration workers
- Attended and observed three review meetings between psychiatrists and young people, a care planning approach (CPA) meeting, a choice assessment, a home visit, two family therapy sessions and a music therapy session. The team also attended a sex education session, a nurture group for foster carers of looked after children and a cooking group with young people using services at the Key team.

We also:

- Looked at 30 treatment records of young people.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with eight young people and twenty one carers of people using the service. Most people we spoke to were happy with the care they received and fed back that staff were respectful, kind and had a good understanding of the needs of the young people under their care. Concerns were raised by some carers of young people regarding lengthy waiting times to access services.

Good practice

- Development of a sensory processing group within Sandwell CAMHS service. This was developed by Occupational therapists as a result of long waiting times for OT interventions.
- A psychologist at the Child and Family services was in the process of putting forward a study for ethical approval. The proposed study was the perception of ability and confidence of UK mental health clinicians working with young people with gender dysphoria. This research was based on the increasing referrals of young people to the Tavistock centre in London.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all relevant care records contain a risk assessment and that this risk assessment includes detailed and consistent information about the people that use their services.
- The provider must ensure that where toys are available for the use of young people attending services that those toys are regularly cleaned and records are maintained of this process.

Summary of findings

- The provider must ensure that the care plans completed for the people who use their services are personalised and recovery oriented with the persons strengths and goals evident within them.
- The provider must ensure that a persons relative or carer's involvement in the care planning/management plan process is evident within care records where appropriate.
- The provider must ensure that services have adequate staff to function fully, including out with normal working hours.
- The provider must ensure that all documentation is stored securely and adequate systems are in place to minimise the loss of clinical records.
- The provider must ensure that consent to care and treatment and consideration to Gillick competency is consistently recorded within the care records of people using services.
- The provider must ensure that staff receive well structured appraisals on an annual basis.
- The provider must ensure that statutory and mandatory training compliance is monitored regularly and that outstanding areas of non-compliance are addressed.
- The provider must ensure that all staff receive three yearly disclosure and barring service checks as per their 2014 policy.

Action the provider SHOULD take to improve

The provider should ensure that all staff are aware of the trust lone working policy and adhere to the guidance within this.

Black Country Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust was able to provide data for Mental Capacity Act training compliance across all services in Sandwell and Wolverhampton as 56% compliant. The trust did not provide data for the CAMHS services specifically.
- Bank staff working for the trust did not receive MCA training. This was a concern as some members had been working full time with the trust as bank staff for a number of years.
- The MCA would apply only to 16 and 17 year olds. There was no record that any young person had required a best interest's assessment.
- There had been no specific recent training for staff regarding Gillick competence. Overall, staff understood the test for Gillick competency, for young people under 16 years of age. They knew the age range of young people where such an assessment may be appropriate. However, some staff did not have an understanding of Gillick competence.
- There was little evidence concerning capacity in young people's clinical records.
- There was no evidence of assessment of Gillick competency within any of the records seen at Lodge road CAMHS service, or assessments of capacity and competence at the key team in Wolverhampton. We observed a member of the medical staff confirming consent with a young person and their family as part of a medication review. It was unclear whether the young persons competency to consent to their treatment had been established.

Detailed findings

- The inspire team at the Gem centre used easy to understand consent sheets for young people and these had been completed.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- Interview rooms at the Lodge road CAMHS service did not have alarms fitted. Alarms had been removed from interview rooms and were stored in the admin area of reception. Staff informed us that this was because there was no procedure in place to respond should the alarms be activated. Staff advised us that personal attack alarms were available for individual use if required but acknowledged that these may not be heard in all rooms. This meant that staff were at increased risk of harm.
- Clinic rooms at the Gem centre had inter-call panic alarms but not all staff had a pin to use this or were able to describe how it worked.
- Socket covers were not consistently in place in rooms used by young people in the inspire service at the Gem centre.
- There was no evidence of a rota or audit system to ensure that toys in use by young people were cleaned regularly across all services visited. Staff at the Gem centre told us that toys were cleaned on an ad hoc basis;this was an infection control risk. Staff also informed us that toys were checked annually and broken toys removed. This mean that young people were at increased risk of injury. Toys in use at Lodge Road appeared old and in poor condition. Foreign objects were found in one toy box in use by a young person during our inspection. The toy box also contained broken toys and scraps of paper. This was brought to the attention of the manager immediately by a member of the inspection team.
- The walls within some of the rooms being used by children and young people at Lodge road were bare and had no child centred displays.
- Cleaning records were not always available for staff to review or to check that areas had been cleaned at Lodge road CAMHS service.
- The services had weighing scales to weigh young people. This equipment was important for young people with eating disorders and for medication monitoring. The weighing scales in use by the Inspire team at the Gem centre were in the consultants rooms and were due to be tested in 2013. Staff at Lodge road were unable to locate audits for the calibration of equipment used to measure height or weight. This meant that equipment in use in these services could be providing incorrect measurements.

Safe staffing

- The Royal College of Psychiatrists have produced staffing level indicators for CAMHS services. For the population size, the CAMHS services should have had 12 consultant psychiatrists. This was the staffing level indicated for CAMHS at Sandwell and Wolverhampton. The CAMHS services had six consultant psychiatrists. Medical staff we spoke to told us that their case loads were high and that the staffing level did not take into account other roles they performed which included teaching. One doctor that we spoke to was also the clinical director for the CAMHS service which meant that his role and capacity was stretched.
- Staff within the CAMHS team at Sandwell reported high levels of staff sickness and vacancies that impacted on the services effectiveness.The trust reported that staff sickness for the previous twelve months had been 14%. Staff sickness for the months of April to July averaged 28%. Staff vacancies were 10% at the time of the inspection.
- Staffing vacancies at the Sandwell crisis team and Wolverhampton crisis and home treatment teams were high at 63% and 70% respectively. Staff we spoke to told us that bank staff had been used to fill vacancies but that it was having a significant impact on the crisis teams ability to respond when required. Staff told us that at weekends the Wolverhampton crisis and home treatment team was only able to offer a telephone response service due to insufficient staff and that they were unable to offer home treatment functionality. At the time of our inspection the Wolverhampton crisis and home treatment team had been placed on the trusts risk register due to insufficient staffing
- Staff told us that that there was no recognised tool used for estimating staffing requirement within the

community teams. Staff within the child and family services at the Gem centre reported that the staffing level of the team had halved in the previous four years although referrals to the team had increased by 20% in the last year.

- The newly set up point of access for referrals into CAMHS had two full time members of staff within its establishment. Staff within this service raised concerns that this was insufficient and did not allow for sickness or annual leave.
- Most staff across all the services visited reported staffing levels across the professional disciplines were too low. Medical staff within the Lodge road CAMHS team had submitted recent incident reports to the trust detailing lack of secretarial cover for the last 3 month, this had led to delays in communication between the CAMHS service and local GP's.
- Staff across all services told us that there was access to a psychiatrist when required. Staff in the crisis team at Sandwell had access to 24 hour CAMHS consultant cover via the on call duty system. This included weekends.

Assessing and managing risk to patients and staff

- Risk assessments for young people using the services were not always completed. Risks were identified when a referral was received and during an initial assessment. Urgent appointments were available when a young persons' risks were considered to be high. However, following the initial assessment young people did not always have a risk assessment completed.
- At CAMHS Lodge road, 50% of young people did not have a risk assessment whilst the remaining 50% had a risk assessment which was incomplete. One risk assessment for a young person had a review date of 2017, whilst another had detailed information regarding the risk history of a young person but with limited information on how to manage this. A risk assessment reviewed had risk of suicide and deliberate self harm to a young person rated as high however the risk assessment had errors in the fields completed, no relapse plan or a record of who had a copy of the risk management plan. One set of file notes recorded significant concerns about the wellbeing of a young person on discharge from hospital but there was not an updated risk assessment found.
- At the key team and inspire team, most young people had a risk assessment although 58% of these were found to be present/done but to a less than required standard.
- Within the key team, we found one file where reference had been made to risk of violence in the young persons initial assessment. This was not reflected in the risk screening tool. In two files, there was no formulation of how to manage risk after the initial assessment and in a further three files there was no detail of the nature of risks identified.
- The inspire team had evidence of the formulation of risk of the young people using the service and the use of outcome measures for risk reduction with regular review dates.
- There was no evidence of crisis plans in use in the key team
- A recent risk assessment of lone working at Lodge Road identified multiple gaps in assurance, control measures and best practice, these included failures of staff to respond within fifteen minutes of a clinician not making contact, staff not informed what to do in an emergency and inadequate staffing levels for clinicians to work in pairs, in particular out of core working hours. This meant that staff's safety and wellbeing was not ensured.
- Staff within all the teams visited were able to describe the lone working policies they followed. This included the use of a buddy system, Staff providing services out of core hours maintained contact with the switchboard at Penn hospital. There were inconsistencies in how the lone working policy was implemented. One team we visited used a code word to alert staff if they required assistance whilst another team did not.
- Most staff within all the CAMHS teams were up to date with annual mandatory training.
- Not all staff within the CAMHS crisis team at Sandwell and the crisis and home intervention team at Wolverhampton were up to date with safeguarding children level 3 training. The average in both teams was 50%. The average compliance rate for this training in the Sandwell core CAMHS team and the child and family services in Wolverhampton was 80%. This was below the trust identified compliance target of 95%. Most staff knew who the safeguarding lead was for the trust and how to contact them if required.

Requires improvement

Are services safe?

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

- The compliance with safeguarding adult level 3 training for the Sandwell CAMHS team and the Wolverhampton child and family services was 7%. The trust had identified this was a training need across all services and had put plans in place to mitigate this.
- Administrative staff at Lodge road had received safeguarding children level 1 training in accordance with trust guidance.

Track record on safety

- Between July 2014 and June 2015 there were 3 serious incidents recorded across the trust which related to services for children and young people. One of these was related to the CAMHS services and was related to data loss.

Reporting incidents and learning from when things go wrong

- Quality and safety meetings were held monthly as were CAMHS specialist mental health lead meetings for Wolverhampton and Sandwell. Lessons learnt from these meetings were filtered down to team meetings.
- Incidents had occurred where dictation tapes had gone missing containing information on medication and risks for young people. Staff also reported that due to a reduction in medical secretary provision there were delays in correspondence from the team reaching GP's and other stakeholders and they were finding it extremely difficult to deliver the service in a safe and timely manner.
- Debriefs following incidents were held formally within clinical or operational supervision. There had been 7 severe incidents reported via the national reporting and learning system (NRLS) in the year prior to our inspection. Staff were able to give us examples where lessons had been learnt as a result of incidents that had been reported and where changes in practice had taken place. Table top reviews had happened with learning identified for school and social care colleagues around the mental health act and use of section 136 for children.
- Bank staff were unable to use the trust datix system to report incidents. Staff we spoke to told us they would ask a colleague to complete the datix foms on their behalf. Bank staff did not receive training on how to use the datix system. This was a concern as some bank staff had been working with the trust for a number of years.

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

- Young people within the CAMHS teams and the key and inspire teams did not all have a care plan. This meant that different staff members may not be aware of the young persons needs or treatment plan.
- Of the 30 care records reviewed across the services inspected, 47% had no care plan present, 43% of records reviewed had a care plan present but the information contained within it was of a less than required standard or was incomplete.
- There was no consistent format to the care planning process across the CAMHS services. Care plans within individual services had differing versions of care plan formats. This meant that staff could not always be sure where to find information needed to inform the care planning process.
- All care plans did not have dates to evidence when they had been completed. This meant that staff were not always able to check when care plans required updating, 53% of the care plans reviewed had not been dated when completed.
- Of the 30 care records reviewed, 63% of the records had no evidence of personalisation of care plans. A further 20% had some evidence of this but not to a required standard. There was also limited evidence of family and carer involvement in the care planning process, some care plans had evidence of family involvement, other care plans and records had no details recorded of address or contact details for carers and family.
- All care plans did not demonstrate a holistic approach to care planning. A full range of identified problems and needs of the young people receiving care from the CAMHS service were absent in 47% of the care plans reviewed and incomplete in a further 40%.
- Care plans were not always recovery orientated, 60% of the care records reviewed for the CAMHS services had no evidence of the strengths and goals for the young person identified.
- There was evidence within care plans at the Inspire learning disabilities team of young people receiving a high level of input from the team. Records reviewed also showed evidence of behavioural support plans written clearly and demonstrating the young persons involvement in their care. Anger management booklets and pictorial care plans were being used to promote the involvement of young people in their care.
- There was minimal evidence available in the medical records reviewed of the identification of parental responsibility. Parental responsibility has been set out in the children's act 1989 and means the legal rights, responsibilities and authority a parent has for a child and the child's property. Parental responsibility includes the ability to consent to treatment for a child who is not legally competent or has not had competency established. The lack of parental responsibility identified within care records reviewed meant that staff could not always be sure who was legally able to consent to treatment on the young persons behalf and could lead to treatment being provided unlawfully.
- Paper records were in use in the services we inspected. Staff told us that the trust were planning to implement electronic patient records in the coming year. All information needed to deliver care was not always stored and available to staff when they needed it. Staff told us that records could be stored in multiple locations and we were made aware of a reported incident where a paper file had been missing earlier in the year and was subsequently found on top of a filing cabinet. Staff we spoke to told us that the track and trace system in place was not always effective and that records could be misplaced.
- A child protection database was available for review at Sandwell CAMHS service however 45% of the eleven cases reviewed had no details completed for the named clinician. 82% of the records did have details completed for the young persons social worker, however the remainder of the database sections including supervision and case conference dates were blank.

Best practice in treatment and care

- A pathway for young people with self harming behaviour had been developed and was in use at the Gem centre. This pathway had been developed in a yellow coloured format to differentiate it from other paper notes and identified suicidal ideation alongside static and dynamic risk factors. This was in accordance

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.

with NICE guidance for self harm (longer term management (CG133) and the short term physical and psychological management and secondary prevention of self harm in primary and secondary care NICE guidelines (CG16).

- The Pierce suicide intent scale and the Health of The Nation Outcome Scale for Children and Adolescents (HoNOSCA) was being used within the CAMHS services to provide an outcome measure for rating the severity of needs and the effectiveness of treatment.
- A range of psychological therapies were available for children and young people and their families within the CAMHS service. These included cognitive behavioural therapy and dialectical behavioural therapy in accordance with NICE guidance.
- A nurturing attachment training programme was being provided by the Looked After Children Team (LAC) team at the Gem centre and focussed on enabling parents to be more effective foster carers and adopters. The group was evidence based and required participants to work together to share their experiences. Participants told us that they were very pleased with the service offered.
- NICE guidance for challenging behaviours and continence was being used by the inspire team working with young children with learning disabilities.
- Evidence was available that audits of clinical notes were carried out. A recent trust audit of ten sets of clinical notes was reviewed at Lodge Road CAMHS service, 20% of the records within the audit did have a current risk assessment or evidence of a review whilst 10% of records did not have a care plan. We did not see evidence of an action plan as a result of this audit.
- The positive parenting programme (Triple P) was available to support carers. This was in accordance with NICE guidance. Staff within the CAMHS inspire team had developed their own model of practice based on this.
- We observed CAMHS consultants carrying out medication reviews. Physical health monitoring was included as part of this process. A shared care protocol was in place between Sandwell CAMHS and local GP practices. Young people prescribed medication for mood disorders and Attention Deficit Hyperactivity Disorder (ADHD) received physical healthcare monitoring from their GP.

Skilled staff to deliver care

- Teams had a range of staff from different disciplines to enable them to care for children and young people. This included Occupational Therapists, counselling psychologists, clinical nurse specialists and consultant child and adolescent psychiatrists. There was a nurse prescriber working within the Sandwell crisis team.
- Staff received a trust wide induction although not a locality specific induction
- Not all staff received yearly appraisals, 76% of staff across the teams visited had received an appraisal within the last year, this was below the trust target of 95%. Within the Sandwell and Wolverhampton crisis teams, 50% of staff had received an appraisal in the previous year.
- Managers we spoke to told us that staff received supervision regularly but were not always able to provide tracking tools to demonstrate this was the case.
- Promoting safe and therapeutic services (PSTS) training was available and the staff compliance with this training was 95%.
- Staff were able to access necessary specialist training for their role although they said that this had become more difficult recently due to lack of funding by the trust. Training that staff had attended included the Autistic Diagnostic Observation Scale (ADOS) and mindfulness training.

Multi-disciplinary and inter-agency team work

- Staff told us that they had access to a range of regular multi-disciplinary meetings.
- Sandwell CAMHS provided a parent and family solutions group in partnership with the local authority and the CAMHS team. The format of the group was as a multi agency meeting with the local authority to provide focussed working with families who had children that may need to be taken into care.
- Staff attended weekly referral meetings, monthly business meetings and monthly governance meetings. The monthly business meeting provided feedback to the teams from higher level trust meetings.
- A recent event where a young person had absconded from the care of a member of the key team was

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.

reviewed. Outcomes of this were that a core group meeting was activated with input from social services. Risk reduction plans were put into place following a review by staff with multi agency input. The young persons risk assessment had been updated following this meaning all staff were aware of changes in the management of care.

- Staff in the Sandwell crisis team had daily handover meetings with the psychiatrist attached to the team who also carried out weekly assessments of new referrals.
- We observed a home visit where the care of a young person was transferred from the crisis team to a psychologist within the Sandwell CAMHS team. Notes reviewed as part of this demonstrated joint working between the crisis team and early intervention services. Family members were supported through the transition of care and were complimentary of the care received from the crisis team. The family we spoke to said that the thoroughness of the handover between clinicians meant that the young person had not become anxious or concerned by the change.

Good practice in applying the Mental Capacity Act

- The trust was able to provide data for Mental Capacity Act training compliance across all services in Sandwell and Wolverhampton at 56%. The trust did not provide data for the CAMHS services specifically.
- Bank staff working for the trust did not receive MCA training. This was a concern as some members had been working full time with the trust as bank staff for a number of years.
- The MCA would apply only to 16 and 17 year olds within CAMHS. There was no record that any young person had, or had required, a best interest's assessment.
- There had been no specific recent training for staff regarding Gillick competence. Staff understanding of the test for Gillick competency for young people under 16 years of age was varied.
- There was limited evidence concerning the assessment of capacity in young people's clinical records. There was no evidence of assessment of Gillick competency within all files at Lodge road CAMHS service or assessments of capacity and competence at the key team in Wolverhampton. We observed a member of the medical staff confirming consent with a young person and their family as part of a medication review. It was unclear whether the young persons competency to consent to their treatment had been established
- The inspire team at the Gem centre had easy to understand consent sheets for young people and these had been completed.

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

- Observations carried out during the inspection process showed that staff attitudes and behaviours when interacting with young people and their carers was respectful, responsive and provided appropriate practical and emotional support.
- We observed one young person having their height and weight taken in a corridor at the Sandwell CAMHS service. This could impact on patient confidentiality and the dignity of the young person.
- Young people we spoke to told us that staff took time to understand them and to listen to their concerns.
- Concerns were raised by inspection staff regarding the content and type of language used in one set of clinical notes, this was brought to the attention of the manager of the service who was planning to investigate this further.
- During the inspection we had the opportunity to observe cooking and music groups at the key team. These groups provided young people with the opportunity to engage in either skill or vocational based activities. Staff and patients told us that they made efforts to integrate therapies into young peoples educational commitments at school. This included members of staff picking young people up to ensure they attended valued activities.
- Staff we met with and who led individual and group sessions with young people were able to discuss with us the individual needs of the people they were working with and how they adapted their practice to reflect this.
- Most staff we spoke to demonstrated a good awareness of the need for confidentiality in their clinical work. The key team had adopted a system of young people and families being allocated a numerical reference for use instead of names on confidential patient information. This was to mitigate the risk of breaches of confidentiality as young people regularly visited the team base.

The involvement of people in the care that they receive

- Young people and their families told us that they actively participated in care planning and participated in their care programme approach (CPA) reviews. This was not evidenced within care plans however and 91% of care plans reviewed in the Sandwell CAMHS team, the key team and the Wolverhampton child and family service had no evidence of the young person having been given a copy. All care plans reviewed within the Inspire service had evidence of young people or their carers having a copy of their care plan.
- The child and family service had developed and were using a feedback form for children. This used an emoticon key for children to give feedback about how friendly the staff were, how they felt about attending and whether they felt the service had helped them.
- Carer feedback from young people using the key team was very positive. Carers that we spoke to told us that they had received a variety of interventions including family therapy and that staff from the key team had maintained links with young people when they had been admitted to tier 4 CAMHS beds out of area. Carers we spoke to told us that the key team had helped to represent their family at meetings. One person said “considering the journey we have been on as a family, it is the best service we have ever used”, another family said that if they hadn’t had help from the key team “we wouldn’t be where we are now, I’d recommend them to anyone, if you need help, they are the people you need”.
- The Child and Family Services team had adapted the Commission for Health Improvement Experience of Service Questionnaire (CHI-ESQ) to include information on the ethnicity of people using the service. The team planned to review data received to identify any trends between ethnicity groups and their experiences with services.
- The CAMHS service at Lodge road had recently completed a CHI-ESQ for their service. Concerns had been raised by respondents regarding the waiting times to access services. There had been positive feedback from the families of young people about the support

Good

Are services caring?

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

they had received from staff. One carer fed back that the team listened and got relevant agencies involved, another carer reported that the team were fantastic in helping their son.

- Young people had been involved in the recruitment of staff to the key team and the inspire learning disabilities team.

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

- Staff we spoke to told us that information provided by the trusts oasis information governance system was not always reliable or valid.We were shown an example of the waiting list for the Sandwell CAMHS service. Information provided by the trust showed that there were nine young people waiting in the 16-18 week period for a choice appointment. Seven of these referrals had already been seen, one person had cancelled and rearranged their appointment and one young person was now under the care of the crisis team. One referral was showing as currently breaching the eighteen week referral to choice assessment although they had been discharged from the service in 2012.
- Young people were on waiting lists for assessment or interventions for long periods. Whilst waiting times were monitored, there was no active monitoring of young peoples' risks. Carers were told that if they had concerns they should contact the services or attend accident and emergency if required,
- Sandwell CAMHS used the choice and partnership approach (CAPA) model for service provision. The operational policy for the team identified 6-8 weeks for the initial choice assessments for standard, ie, non urgent referrals. Data received from the trust for the period of April to October 2015 was that referral to first contact waiting times for the service was 11.8 weeks. This was outside the target set in the operational policy. Carers of young people using this service had raised concerns regarding lengthy waiting times for appointments.
- The CAMHS service at lodge road had an allocated rota for clinicians to respond to urgent cases. This meant they were able to respond to sudden deteriorations in peoples health.
- Service inclusion/exclusion criteria was available for the Sandwell and Wolverhampton CAMHS team within their operation policies.
- The trust was not commissioned to provide a tier 4 CAMHS service. Placements for young people requiring admission were found using out of area trusts or independent providers. In the year prior to inspection, one child had been admitted to the 136 place of safety suite in Wolverhampton
- Data provided by the trust showed that one hundred and nine referrals were registered as waiting over eighteen weeks for the Sandwell CAMHS team. The Child and Family services team in Wolverhampton had 37 referrals registered at over 18 weeks. Staff we spoke to said that they did not feel these figures accurately reflected the performance of their teams. The child and family services reported that they saw all referrals within eleven weeks.
- The trust had recently introduced a point of access for people requiring CAMHS services. This was co-located with the Multi Agency Safeguarding Hub (MASH). Staff within the point of access said that they were unable to access CAMHS notes which impacted on their ability to effectively risk assess and manage referrals from young people who had previously used the CAMHS services.
- Carers we spoke to reported high waiting times to gain access to services. Carers did say however that services were good once young people had been accepted onto the teams caseload. One young person had waited for a year for a replacement counsellor to be allocated due to staff sickness.
- The child and family services team had placed themselves on the trust risk register due to increasing waiting times for appointments following initial assessment.
- The crisis and home treatment team in Wolverhampton could not respond to crises other than by telephone at weekends, or provide home treatment functionality due to low staffing numbers. Staffing levels should be four whole time equivalent WTE staff. The team had less that one WTE member of staff with a substantive post. Staff from the child and family team said they often worked over their core hours to cover vacancies in the home treatment team.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a range of rooms and facilities across all services visited to support treatment and care.

Are services responsive to people's needs?

Requires improvement

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

- Clinic rooms were not in use due to the nature of the services provided. Consultant rooms within the child and family service had height and weigh scales available for physical examination. The weighing scales had not been calibrated recently and should have been checked in 2013. The equipment for measuring height was due to be checked in December 2015.
- Staff at Lodge road raised concerns about the privacy and confidentiality for staff and people using services due to the proximity of the administrative area to the waiting room. Feedback on the service from a carer of a young person was that they often overheard what sounded like they should be private conversations. This meant that confidentiality for the people using services could be compromised.
- There was a range of information leaflets available in all services. This included information on support groups for carers of young people, how to access advocacy services and female genital mutilation and honour based violence support services. Leaflets were available in a variety of languages and in accessible formats for children and young people at the Gem centre although we did not see them in other services. Staff told us they could print off leaflets in alternate languages if required.

Meeting the needs of all people who use the service

- Evacuation chairs were available at the Gem centre in case of emergency.
- The buildings we visited all had disabled access with parking available, Toilet facilities were also available for people using the service who had disabilities. Baby changing facilities were available at the Gem Centre.
- Most staff we spoke to said they could access interpreting services though the trust if required. The key team were able to give an example of where they had sought alternative provision for an interpreter to avoid the possibility of stigma within the local community for the child and family they were supporting.

Listening to and learning from concerns and complaints

- Seven complaints were received across the services we visited from May to October 2015. Two of these complaints had been upheld. No complaints had been referred to the Parliamentary Health Service Ombudsman (PHSO).
- Most carers and families we spoke to said they knew the process for raising concerns and complaints and felt able to do so. We saw evidence within the CAMHS services at Lodge Road of feedback about the service being collated from young people and their families.
- Young people at the Key team had raised concerns that the décor was tired. As a result of this a project had been started to paint the walls with murals of trees and each leaf was completed by a young person with their thought for the day. This was observed during the inspection process and the young people involved fed back to us that they felt valued and listened to.
- Most staff knew how to handle complaints appropriately and what the process was. A patient and liaison services (PALS) box was present at the reception at Lodge Road CAMHS services for feedback from people using the service.
- Staff demonstrated learning from service user feedback. Young people that used services were involved in the decoration of their environment at the Key team. The child and family services and Inspire teams had developed child friendly feedback forms for their services. The CAMHS service at Lodge road and the child and family team at the Gem centre were both using the Commission for Health Improvement Experience of Service Questionnaire (CHI-ESQ)to gain feedback from young people and their carers about how the service was performing.

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

- All staff were not aware of the trusts visions and values and reported that they had recently changed.
- Senior management staff had visited the services we inspected. Most staff said they felt positive about recent changes within the senior management team although some staff felt that continuity was lacking within the CAMHS service and unsure how the proposed transformation programme would affect them.

Good governance

- Disclosure and Barring Service (DBS) checks were not reviewed every three years, 73% of staff at the child and family service were without up to date DBS checks. This was not compliant with the trusts disclosure and barring policy implemented in 2014.
- All staff records reviewed had at least two references received from previous employers.
- Not all staff within the CAMHS crisis team at Sandwell and the crisis and home intervention team at Wolverhampton were up to date with safeguarding children level 3 training. The average in both teams was 50%. The average compliance rate for this training in the Sandwell core CAMHS team and the child and family services in Wolverhampton was 80%, this was below the trust identified compliance target of 95%.
- Promoting safe and therapeutic services (PSTS) training was available and the staff compliance with this training was 95%.
- The compliance with safeguarding adult level 3 training for the Sandwell CAMHS team and the Wolverhampton child and family services was 7%. The trust had identified this was a training need across all services and were in the process of providing training for staff.
- Not all staff received yearly appraisals, 76% of staff across the teams visited had received an appraisal within the last year, this is below the trust target of 95%. Within the Sandwell and Wolverhampton crisis teams 50% of staff had received an appraisal in the previous year.
- Managers we spoke to told us that staff received supervision regularly but were not always able to provide tracking tools to demonstrate this was the case. Staff told us they met with their manager on a regular basis to discuss their caseloads as part of the supervision process.
- Incidents that should be reported were reported via the trusts datix system.
- Team managers did not always feel they had sufficient authority and administrative support. Medical staff had raised concerns with the trust via the datix system that due to lack of administrative support, clinical information was not reaching GP's and other stakeholders. Staff had reported to the trust that they were finding it extremely difficult to deliver the service in a safe and timely manner. One member of staff told us that at Lodge road CAMHS service, administrative and clerical staff were pushed to their limit. Staff described feeling worn down and concerned about taking leave due to the workload they would return to.
- Key performance indicator (KPI) dashboards were in use across all services we visited. Staff were able to demonstrate how they were used to monitor rates of non attendance, waiting times and appointments across the services. Staff were also able to evidence feedback given to the trust if these performance indicators were not met. This included regular meetings with senior staff and the implementation of improvement plans

Leadership, morale and staff engagement

- Staff morale was low in most of the services that we visited. Most services reported low staffing levels coupled with high levels of sickness. This meant that they felt unable to deliver the service that children and young people and their families required.
- The Sandwell CAMHS crisis team was on the trust risk register due to uncertainty about its funding in March of 2016. Staff told us that this uncertainty about the future of the crisis team funding had been a constant issue. Staff were unsure about the impact the CAMHS transformation programme and the creation of a single crisis team would have on staffing levels.
- The CAMHS service was in the process of undergoing a transformation programme and staff were unsure how this would affect them.

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.

- There had been uncertainty regarding the funding of the Key team in Wolverhampton who had previously been told they would be disbanded, this uncertainty regarding funding was still an issue.
- Funding for the Sandwell crisis team had initially been for three months and was then renewed. The service was funded until March 2016, staff were unsure about what would happen after that
- Staff In management roles said they felt unable to cope due to increasing role demands and low staffing levels.
- All staff we spoke to described good team working and being mutually supportive of each. Staff reported being proud of the quality of staff they worked with and the experience held within teams.
- Staff were positive about the leadership provided from their service managers. Most staff were positive about the new senior management team although said that there had been many changes which had impacted on continuity for staff
- At the time of our inspection there were no grievance procedures being pursued and there were no allegations of bullying or harassment.

Commitment to quality improvement and innovation

- CAMHS community services had recently been inspected as part of the West Midlands Quality Review Service. The West Midlands Quality Review Service (WMQRS) is a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based quality standards, carrying out developmental and supportive quality reviews - often through peer review visits and producing comparative information on the quality of services.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients were not provided with care which was personalised specifically for them. Care plans were missing or incomplete. Patients' capacity and ability to consent to be involved in the planning, management and review of their care and treatment was not routinely established. This was a breach of regulation 9 (3) (b,c,d,e,f)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not maintain accurate, complete and detailed records in respect of each person using the service. Risk assessments for people receiving care were absent or did not contain detailed information. This was a breach of regulation 12 (2) (a, b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not operate a cleaning schedule appropriate to the care and treatment being delivered from the premises.Toys in use by young people were not regularly cleaned or replaced when broken. Cleaning audits were not always available to be reviewed. This was a breach of regulation 15 (1) (a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not maintain securely an accurate complete and contemporaneous record in respect of each service user. Records were incomplete and stored in multiple locations within services and dictation tapes had been reported missing. This was a breach of regulation 17 (2) (c,d).
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure there were sufficient staff for services to function fully. One crisis and home treatment team was on the trust risk register due to low staffing, this team were also unable to provide the home treatment function they had been commissioned for. Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs This was a breach of regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

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.