

Requires Improvement**North Bristol NHS Trust**

Specialist community mental health services for children and young people

Quality Report

Trust Headquarters
Beckspool Road, Frenchay
Bristol
BS16 1JE
Tel: 0117 970 1212
Website: www.nbt.nhs.uk

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
South Gloucestershire community CAMHS team	RVJX4	Kingswood Hub	BS15 4EJ
North Bristol community CAMHS	RVJX4	Monks Park House	BS20 5NB
East and Central Bristol community CAMHS	RVJX4	Barton Hill Settlement	BS5 0AX
South Bristol community CAMHS	RVJX4	Osprey Court / Knowle Clinic	BS14 08L

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

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

Summary of findings

Where applicable, we have reported on each core service provided by North Bristol NHS Trust and these are brought together to inform our overall judgement of North Bristol 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 Specialist community mental health services for children and young people

Requires Improvement



Are Specialist community mental health services for children and young people safe?

Requires Improvement



Are Specialist community mental health services for children and young people effective?

Good



Are Specialist community mental health services for children and young people caring?

Good



Are Specialist community mental health services for children and young people responsive?

Good



Are Specialist community mental health services for children and young people well-led?

Requires Improvement



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Community Child and Adolescent Mental Health Services (CAMHS) provided services that were safe and all staff had a good understanding of their roles and responsibilities in relation to child protection and safeguarding children and young people. However, issues relating to the availability of suitably qualified and experienced staff in some teams and the pressure this was putting on existing staff had the potential, if not addressed in a timely manner, to put children and young people at risk. Existing staff may not always be able to respond to urgent referrals or maintain the safety of children and young people receiving services.

In addition, the lack of individual risk assessments and clearly documented care plans had the potential to put children and young people at risk of receiving unsafe or inappropriate care and treatment. It may be difficult for new staff or those unfamiliar with individual children and young people to identify what care and treatment had been agreed or should be provided.

Tier 3 CAMHS were provided by a wide range of professionals, were effective and there was evidence of mutually supportive, multidisciplinary working across all of the CAMHS teams. Teams used national guidance and best practice tools to ensure children and young people received an evidence-based, good practice service. Staff were supported by their team colleagues and peers, and had access to regular clinical supervision, training and continuing professional development opportunities.

Care was delivered by kind, compassionate and respectful staff who were passionate about their work and were committed to delivering high-quality services to children, young people and their families. Children, young people and their families said staff had a good understanding of their needs and involved them in decisions about their care. There was excellent partnership working with Barnardo's Helping Young People (Children and Families) Engage (HYPE) service and a clear ethos of engagement with and involvement of children, young people and their families in developing and delivering the services. A children's and young person's participation strategy (2014–2016) had been developed.

Children and young people were involved in developing information leaflets and media applications, and the recruitment and training of staff, and have created artwork to make the service environments feel more welcoming. Staff generally were aware of and understood the vision of the Community Children's Health Partnership (CCHP). However, some staff felt unsupported by operational management arrangements and undervalued, and that both service management and the trust did not listen to them. Most staff felt a connection to the CCHP and saw the benefits for effective service delivery.

Summary of findings

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

Are services safe?

All teams said they were understaffed and that posts had not been replaced when staff had left. Some teams had been operating with locum consultant psychiatrists for some time and some teams had staff on long term sick leave. Staffing issues were compounded by the Increasing Access to Psychological Therapies (IAPT) programme.

Funding was provided to backfill the posts of staff attending the programme but trust recruitment policies and practices meant that this had not happened in a timely manner and that posts were being backfilled by less experienced staff who could not take on complex cases.

Several members of staff said they felt stressed and were working much longer than their contracted hours to see urgent referrals and provide an appropriate level of service to children and young people.

Individual risk assessment were not always formally documented meaning that key risks were not easily identifiable to clinicians who might have to provide care to children and young people.

All teams delivered care and treatment from safe, child and young person friendly environments. The majority of staff were trained to the appropriate level in child protections and safeguarding and implemented statutory guidance around safeguarding.

Requires Improvement



Are services effective?

All teams consisted of a range of professionals offering a wide range of psychological therapies and care and treatment programmes. There was clear evidence of mutually supportive, multidisciplinary working across all of the Child and Adolescent Mental Health Services (CAMHS) teams.

There was evidence of the use of national guidance and best practice tools to ensure children and young people received a service based on good practice. Children and young people told us that they felt their needs were being met and that they were achieving the outcomes that they expected, as identified by the relevant clinicians involved in their care.

A single point of access for all 'choice and partnership approach' referrals was in operation, which enabled a consistent approach to triaging referrals to the correct teams and identifying those who needed urgent attention. All clinical staff said they felt supported by their teams and peers and had access to regular clinical supervision, training and continuing professional development opportunities.

Good



Summary of findings

Are services caring?

All staff across all of the teams were enthusiastic and passionate about their work and demonstrated a clear commitment to working with children, young people and their families.

We observed staff dealing with children and young people in a very kind, caring, compassionate and respectful manner and this was also conveyed in the way they spoke about their work.

All of the children, young people and families we spoke with felt they received good support from staff, were able to talk to them and felt comfortable with them during appointments. They felt they had been involved in making decisions about their care and treatment.

Good



Are services responsive to people's needs?

There was excellent partnership working with Barnardo's Helping Young People (Children and Families) Engage (HYPE) service and a clear ethos of engagement with and involvement of children, young people and their families in developing and delivering the services. A children and young person's participation strategy (2014–2016) had been developed. A specific Community Children's Health Partnership (CCHP) complaints and feedback service had been developed for children, young people and families. Concerns and complaints were dealt with promptly and were used to improve services.

All teams delivered care and treatment in clean, safe, suitable and young people friendly environments and although the North Bristol CAMHS team were based at Monks Park House, an old building in need of some updating, every effort had been made to ensure it was suitable for the care and treatment being delivered.

Good transition (from CAMHS to adult services) pathway arrangements existed between the CAMHS and Avon and Wiltshire Mental Health Partnership NHS Trust.

Good



Are services well-led?

There was uncertainty about whether North Bristol NHS Trust would continue to deliver CAMHS services (and all CCHP services) in the future. This was causing some concerns for staff about their future; it was evident that this was affecting staff morale.

Staff generally were aware of the vision and values of the CCHP, but the trust strategy and governance arrangement were not clear, other than to senior managers.

A large number of staff in all teams, except the South Bristol team, said they felt unsupported by the operational management arrangements for their team and within CCHP. Staff also said they

Requires Improvement



Summary of findings

felt that North Bristol NHS Trust did not understand their services and felt there was a lack of connection between CAMHS and the trust. However, staff generally felt a connection to the CCHP and saw the benefits for effective service delivery.

There was a clear commitment to the continuous improvement of services with the involvement of children and young people. A project to redesign CAMHS to improve responsiveness and integration was being progressed. Staff said they would like more input into this.

Summary of findings

Background to the service

North Bristol NHS Trust is an acute trust located in Bristol that provides hospital and community services to a population of about 900,000 people in Bristol, South Gloucestershire and North Somerset. It also provides specialist services such as neurosciences, renal, trauma and plastics/burns to people from across the South West and beyond. The trust has five main locations that are registered with the Care Quality Commission. It provides healthcare from Southmead Hospital, Cossham Hospital, the Frenchay Hospital site, Riverside and Eastgate House.

The trust provides community healthcare, including mental health care, for children and young people across Bristol and South Gloucestershire. This care is provided by the Community Children's Health Partnership (CCHP), which is part of North Bristol NHS Trust. In addition, the CCHP works with Barnardo's as partners to provide services.

The CCHP is part of the women's and children's health directorate of North Bristol NHS Trust. The vision of the CCHP is to build relationships with staff from Bristol City and South Gloucestershire Councils and other NHS partners to ensure children and young people receive integrated, accessible and equitable community services. CCHP includes health visiting school health nurses, community paediatricians, speech and language therapists physiotherapists, Occupational Therapy, Learning Disability Services, Specialist services. The service also operates multi-disciplinary CAMHS teams in the community and in the Riverside inpatient unit including psychiatrist, psychologist family therapists, CAMHS nurses psychotherapists. There were four community CAMHS teams delivering services across South Gloucestershire and Bristol; one for South Gloucestershire (based in Kingswood) and one for each of the Bristol areas: North (based at Monks Park House, Southmead Hospital), East and Central (based at Barton Hill) and South (based at Osprey Court, Whitchurch and Knowle – one team working out of two sites). The teams all deliver Tier 3 services (assessment and consultation services delivered by a multidisciplinary CAMHS team) covering a geographical area based in a local 'clinic', dealing with problems too complex for primary care workers. There was an emphasis on early intervention

and prevention across CCHP and the CAMHS teams used a set referral criteria, developed with joint commissioners, to ensure access to assessment and treatment for those children and young people who need it most, while making sure that other services had been tried when appropriate.

CAMHS community teams used a 'choice and partnership approach' for managing waiting times; if the referral was accepted into the service, then the waiting time for the first appointment should be within a few weeks. Urgent referrals could be seen on the same day or within a few days of the referral. The first appointment, the 'choice appointment', enabled an assessment of the needs of the child or young person and allowed decisions to be made about the most appropriate care and treatments that could be offered. Further appointments were called 'partnership appointments'. In addition, appointments were available with clinicians who offered specialist services, for example, dealing with trauma. In Bristol only health professionals can refer to the CAMHS team, whilst in South Gloucestershire staff from education are also able to refer to the CAMHS teams. A number of primary mental health specialists worked as part of the Tier 3 CAMHS team and helped primary healthcare professionals (such as GPs, health visitors) to work with children and young people to prevent referral to CAMHS and/or support appropriate referral.

Tier 3 CAMHS teams were made up of a number of different health professionals including:

- child and adolescent psychiatrists
- nurses (mental health and learning disability)
- clinical psychologists
- child and adolescent psychotherapists
- family therapists • primary mental health specialists
- primary infant mental health specialists (who see infants/children aged 0–3 years, and 4 years in preschool education)
- occupational therapists in some teams.

Summary of findings

In addition, CCHP (as part of North Bristol NHS Trust) had a number of specialist CAMHS teams (these teams were not included in this inspection) including:

- deliberate self-harm
- substance misuse
- learning disability

- ‘Thinking allowed’ (to support Looked After Children to express their thoughts about safety/safeguarding)

- ‘Be safe’ service which addresses sexually harmful behaviour

Riverside– inpatient unit (CQC inspected this service and a separate report is available).

Our inspection team

Our inspection team was led by:

Chair: Andy Welch, Medical Director, Newcastle upon Tyne Hospitals NHS Foundation Trust

Team Leader: Mary Cridge, Head of Hospital Inspection, CQC

The inspection team looking at the community aspects of the Child and Adolescent Mental Health Service (CAMHS)

(but not specialist CAMHS) included CQC inspectors and a variety of specialists including an expert by experience with experience of caring for a person who has used CAMHS, a senior nurse manager with experience of delivering CAMHS, and a senior nurse specialising in eating disorders in children and young people.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive acute hospitals inspection programme.

How we carried out this inspection

To get to the heart of people who use services’ experience 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?

Before visiting, we reviewed a range of information we hold about CAMHS at North Bristol NHS Trust and asked other organisations to share what they knew. These included the two local clinical commissioning groups, the NHS Trust Development Authority, the General Medical Council, the Nursing and Midwifery Council and the Royal Colleges.

We held a listening event in Bristol on 3 September 2014, when people shared their views and experiences. More than 35 people attended the event. People who were unable to attend the event shared their experiences by email or telephone. We carried out announced visits on 5, 6 and 7 November 2014. During the visits we held focus groups and interviews with a range of staff who worked within the service, such as nurses, doctors, therapists and managers.

We talked with children and young people who use services, who shared their views and experience of CAMHS. We observed how people were being cared for and talked with carers and/or family members and also reviewed care or treatment records of children and young people who use services.

Summary of findings

What people who use the provider's services say

During the inspection we spoke with children, young people and their families who use the services. The majority of people were very positive about their experiences of using services and felt that they had received support that was appropriate for their needs from caring, committed, skilled and knowledgeable staff. However, many felt that the referral and acceptance criteria for community CAMHS were too strict; many had

been referred a number of times before being accepted, by which time they felt their mental health had deteriorated or their issues escalated considerably. In addition, several children, young people and their families said that while the quality of service was good, there was just not enough of it. They felt that there was too much time between appointments, which meant the care being offered was not as effective as it might be.

Good practice

Our inspection team highlighted the following areas of good practice:

There was excellent partnership working with Barnardo's HYPE service and a clear ethos of engagement with and involvement of children, young people and their families in developing and delivering the services.

A children and young person's participation strategy (2014–2016) had been developed.

Children and young people were involved in developing information leaflets and media applications, and in the recruitment and training of CAMHS staff. They had also created a wide range of impressive artwork to make the services feel more welcoming.

A specific CCHP complaints and feedback service had been developed for children, young people and families. Concerns and complaints were dealt with promptly and were used to improve services.

The Bristol and South Gloucestershire infant mental health team offer a wide range of training to increase awareness of the importance of early years for children's psychological and emotional development and its impact on social and cognitive development. It also offered techniques that might be used for early intervention to promote the mental health and wellbeing of the infant population.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

- The provider must take action to address workforce issues across community CAMHS to ensure that each of the teams has an appropriate number of staff with the right level of skills and experience to meet the needs of local children and young people.
- The provider must ensure all children and young people have appropriate risk assessments and clearly documented care plans.
- The provider should ensure children, young people and their families are fully engaged in their care and are provided with a written plan of care that they agree to.

- The provider should improve individual patient record-keeping to ensure a consistent approach to records across CAMHS.
- The provider should take action to review the operational management arrangements across the community CAMHS teams to ensure arrangements are put in place to support all staff effectively.
- The provider should communicate more effectively and keep staff up to date with arrangements on the re-tendering for CCHP, including CAMHS.
- The provider should seek to actively involve staff much more in the redesign of CAMHS

North Bristol NHS Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Kingswood Hub	South Gloucestershire community CAMHS team
Monks Park House	North Bristol community CAMHS
Barton Hill Settlement	East and Central Bristol community CAMHS
Osprey Court / Knowle Clinic	South Bristol community CAMHS

Mental Health Act responsibilities

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

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards are not applicable to children under the age of 18 years.

Are services safe?

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

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

Summary of findings

All teams said they were understaffed and that posts had not been replaced when staff had left. Some teams had been operating with locum consultant psychiatrists for some time and had staff on long-term sick leave. Staffing issues were compounded by the Increasing Access to Psychological Therapies programme. Funding was provided to backfill the posts of staff attending the programme, but trust recruitment policies and practices meant that this had not happened in a timely manner and that posts were being backfilled by less experienced staff who could not take on complex cases. Several members of staff said they felt stressed and were working much longer than their contracted hours to see urgent referrals and provide an appropriate level of service to children and young people. Individual risk assessments were not always formally documented, meaning that key risks were not easily identifiable to clinicians who might have to provide care to children and young people.

All teams delivered care and treatment from safe, child and young person-friendly environments.

The majority of staff were trained to the appropriate level in child protection and safeguarding and implemented statutory guidance around safeguarding.

accommodated in an old building on the Southmead Hospital site which was in need of general updating. However, every effort had been made to provide a child and young person-friendly environment.

Incidents, reporting and learning

Staff within the community CAMHS teams learnt from incidents and this included incidents from other agencies and care providers. We were told how a serious incident that had occurred in one of the specialist CAMHS teams had been used to teach staff how to undertake root cause analysis and detailed investigations of incidents. Staff said that if incidents did occur they would use supervision sessions or team meetings to talk through them and explore whether the incident could have been prevented and whether it had been handled in the best way possible.

Safeguarding

Safeguarding policies and procedures were in place and staff had a very good knowledge of these. They were clear about their role in safeguarding children and young people and the need to take action over any concerns.

All children and young people received a safeguarding assessment at the initial appointment and any concerns were passed to the local authority safeguarding teams.

The South Gloucestershire team were based in the same building as the local authority and staff said this supported joint working when needed.

There was an overarching philosophy across all teams of engaging families and being open about safeguarding issues and responsibilities. The majority of staff had received general child protection training and virtually all clinicians had attended Level 3 child protection training (a requirement for clinicians working with children), except in the North Bristol team where only 70% of clinicians were up-to-date with their training.

Assessing and responding to patient risk

We looked at 30 individual patient records across all of the teams and the majority did not contain a risk assessment. A standard risk assessment tool had been developed; the related protocol recommended that CAMHS professionals use it but did not require its use. The protocol indicated that the risk assessment tool should be completed during the choice appointment/initial assessment and that this

Our findings

Track record on safety

In the last year there were no serious incidents requiring investigation in the community CAMHS teams and only a small number of other incidents, all of which resulted in no harm. Staff were confident in raising concerns and knew how to escalate them if necessary. All of the community CAMHS teams delivered care and treatment from safe environments; appropriate environmental risk assessments had been regularly undertaken and issue identified were managed appropriately. There were security alarms in all consulting rooms to protect staff, children, young people and their families. The North Bristol team were

Are services safe?

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

should be updated at the point of discharge, every six months or when a clinician considered it appropriate. However, on speaking to clinical staff responsible for undertaking the appointment sessions with the children and young people, it was clear that they had a good understanding of the risks of each of the individuals that they were seeing.

None of the teams had undertaken any audits of records, although they had identified inadequacies with records. There were plans to develop a CCHP-wide approach to CAMHS records. A standard operating procedure was under development and was due to be implemented imminently. However, a standard approach to organising paper records was proving difficult to establish because a number of clinicians across the teams had differing opinions as to how records should be set out and what should be included. We were told that the ambition was to move to an electronic patient record system and that an IT group was looking at systems that could be used. It was hoped that a decision could be made within the next three months.

Deprivation of Liberty Safeguards

Staff we spoke with had a clear understanding of the Mental Capacity Act 2005. Mental Capacity Act training was provided by the trust and also included training on the Deprivation of Liberty Safeguards; staff understood that this was not applicable for use with children and young people under the age of 18 years. Staff had a very good understanding of the Gillick competencies and Fraser guidelines.

Managing anticipated risks

Teams generally had difficulty identifying what their staffing establishment was meant to be. Staff we spoke with all said

they were understaffed and that posts had not been replaced when staff had left. Some teams had been operating with locum consultant psychiatrists for some time, although the trust had recently agreed to appoint to these posts on a permanent basis. Some teams also had staff on long-term sick leave. Staffing issues were compounded by the Increasing Access to Psychological Therapies programme. Although funding was provided to backfill the posts of staff attending the programme, the trust's recruitment policies and practices meant that this had not happened in a timely manner. The trust had taken a decision only to advertise the backfill posts on a fixed term contract; this had made it difficult to attract staff with the right level of clinical experience. In addition, referrals had increased because of increases in the population across the area. Staff said that this had not been taken account by the clinical commissioning groups and that there was a general shortfall in funding in relation to the amount of actual activity that the teams were undertaking.

Several members of staff in the North Bristol team told us that they felt stressed and were working much longer than their contracted hours to see urgent referrals and provide an appropriate level of service to children and young people. Staff from the East and Central Bristol team said that they could manage their workload as long as nothing went wrong and no one went off sick. South Gloucestershire team members said that they didn't always feel they were meeting the needs of children and young people and that current workloads were not sustainable. In contrast, staff from the South Bristol team said that, although there were some staff shortages, the team were positive about working flexibly to provide the service required.

Are services effective?

Good 

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

Summary of findings

All teams consisted of a range of professionals offering a wide range of psychological therapies and care and treatment programmes. There was clear evidence of mutually supportive, multidisciplinary working across all of the CAMHS teams. There was evidence of the use of national guidance and best practice tools to ensure children and young people received a service based on good practice. Children and young people told us that they felt their needs were being met and that they were achieving the outcomes that they expected, as identified by the relevant clinicians involved in their care. A single point of access for all 'choice and partnership approach' referrals was in operation, which enabled a consistent approach to triaging referrals to the correct teams and identifying those who needed urgent attention. All clinical staff said they felt supported by their teams and peers, and had access to regular clinical supervision, training and continuing professional development opportunities.

Our findings

Evidence-based care and treatment

A single point of access for all 'choice and partnership approach' referrals was in operation, which enabled a consistent approach to triaging referrals to the correct area teams and identifying those who needed urgent attention. Appropriate processes were in place to ensure urgent referrals were seen in a timely manner by an appropriate professional. A choice appointment was then offered with an appropriate clinician. At the choice appointment an assessment was made of the care needs and a range of options discussed with child or young person and their family, and the most suitable approach was selected. An appropriate clinician was identified and future partnership appointments arranged. We were told that the clinician undertaking the choice appointment would often continue with the partnership appointments providing they had the skills because they had already started to build the relationship crucial to effective therapeutic work and achievement of good outcomes.

From the examination of individual records it was difficult to identify exactly what care and treatment was being

offered, who was involved in the care and what plans for discharge from the service were. Very few contained formal care plans, although some clinicians identified a plan as a component of their notes of the sessions undertaken with children and young people.

Children and young people told us that they had not been given a copy of their care plan.

Although the majority of therapeutic sessions took place in each teams 'clinic' buildings, all teams could offer home visits, or visits in other establishments, such as schools, if needed.

A number of clinical pathways had been developed that were being used with children and young people with different needs, such as those with attention deficit hyperactivity disorder who might need input from a range of clinicians and professionals. The use of the pathway would ensure all their needs were addressed.

Approach to monitoring quality and people's outcomes

There was evidence of the use of national guidance and best practice tools to ensure children and young people received a service based on good practice.

Children and young people told us that they felt their needs were being met and that they were achieving the outcomes that they expected, as identified by the relevant clinicians involved in their care. A pilot project to evaluate CAMHS 'session by session' outcome measures had recently been launched; early feedback from both clinicians and children and young people was positive.

CAMHS at North Bristol NHS Trust are members of the Clinical Outcomes Research Consortium and as such routinely evaluated the outcomes of care using the consortium's models. We saw evidence that teams were achieving outcomes above the average for member organisations. Tier 3 CAMHS are members of the Royal College of Psychiatrists Quality Network for Community CAMHS. CAMHS services were working towards accreditation, with the South team having achieved this. This is the South West version of the Department of Health "Your Welcome standards".

Competent staff

All teams consisted of a range of professionals, resulting in a wide range of psychological therapies and care and treatment programmes being offered. Staff were highly

Are services effective?

Good 

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

skilled and competent in carryout their role. Staff were generally positive about training opportunities, although a number said they had to pay for attendance at conferences and some training courses themselves. North Bristol NHS Trust was supportive of staff attending the Increasing Access to Psychological Therapies programme; several members of staff had either attended the programme or were waiting to start the programme. Funding for three places for community CAMHS staff had been identified for 2015.

Staff were accessing statutory and mandatory training, although some felt that a good proportion of theses training courses were not relevant to their role and that time and resources would be better spent on training relevant to support them to do their job. The Barnardo's HYPE team ran participation training for all CAMHS staff, which was mandatory; 70% of staff had attended to date and plans were in place to ensure all staff would be trained by March 2015.

All staff spoke positively about the opportunities for peer support and reflective practice. All clinicians said they received clinical supervision but there were mixed accounts about managerial supervision. Some staff said they didn't have regular one-to-one meetings with their manager. The South Bristol team, in particular, were positive about having regular one-to-one meetings with their line manager and the support they received. The majority of staff that we spoke with had received an annual appraisal.

Information and record systems

The quality of record keeping was generally poor throughout the community CAMHS and needed improvement. Individual paper records did not follow a consistent format. It was difficult to identify what care and treatment was being offered, who was involved in the care and what the plans for discharge from the service were. In addition, notes had to be manually transported to different sites, depending on where children and young people attended for appointments. This was done using a number of transport systems, operated by different providers with different levels of reliability, and posed the risk of records not being available when required. We heard that access to activity information systems, the intranet and internet was a problem. The South Gloucestershire team often experienced long periods when they could not access the

system. It shared a server with the local authority and this regularly 'dropped out', causing significant disruption to work. However, all teams described difficulties due to incompatible information systems used in North Bristol NHS Trust and CCHP, resulting in information not being shared, lack of availability and the potential for information to be interpreted inaccurately or ineffectively. Staff said they were hopeful that there would be a move to using electronic patient records in the near future but no timescales for this had been communicated.

Multidisciplinary working and coordination of care pathways

There was clear evidence of mutually supportive, multidisciplinary working across all of the CAMHS teams. We heard of many examples of how teams worked in partnership with other clinicians, professionals and agencies. For example, work with community paediatricians through the attention deficit hyperactivity disorder clinical pathway, joint work and meetings with local authorities in respect of Looked After Children and the implementation of transition pathways (to adult services) with Avon and Wiltshire Partnership NHS Trust. Staff said that being part of CCHP encouraged multidisciplinary working across all services for children and young people and, although this did not always work as effectively as it might, they could see that, over time, being part of a wider partnership team could have significant benefits.

Consent to care and treatment

All children and young people were asked to consent to the sharing of information about their care and treatment with their parents, siblings, education and other health professions. We observed staff adhering to their wishes. Staff operated on a 'need to know' basis, so were selective about the information they shared outside of the clinicians directly involved in care. North Bristol NHS Trust had a clear policy relating to confidentiality and consent that was adhered to by the CAMHS teams. In waiting areas we saw posters about consent and confidentiality that were written with the input of children and young people. Information about confidentiality and consent was sent out to children, young people and their families before the choice appointment. Consent to care and treatment was obtained at the choice appointment and recorded in the individual records. All staff we spoke with had a good knowledge of the Gillick competency and Fraser guidelines.

Are services caring?

Good 

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

Summary of findings

Staff across all of the teams were enthusiastic and passionate about their work and demonstrated a clear commitment to working with children, young people and their families. We observed staff dealing with children and young people in a very kind, caring, compassionate and respectful manner and this was also conveyed in the way they spoke about their work. All of the children, young people and families we spoke with felt they received good support from staff, were able to talk to them and felt comfortable with them during appointments. They felt they had been involved in making decisions about their care and treatment.

Our findings

Dignity, respect and compassion

Staff across all of the teams were enthusiastic and passionate about their work and demonstrated a clear commitment to working with children, young people and their families. We spoke to 15 children, young people and their families, either at the time of their appointments or on the telephone, and all were very complimentary about the way they were treated by staff. Children and young people said staff listened to them, asked their views and didn't make judgements and so they were able to talk about their problems. Families said they also felt supported by staff.

We observed staff dealing with children and young people in a very kind, caring, compassionate and respectful manner, and this was also conveyed in the way they spoke about their work and was reflected in the written records that we read. However, some staff said they felt they could not always give their best and were worried that they may not always come across as caring as they would wish because of time pressures caused by staff shortages.

Patient understanding and involvement

There was excellent partnership working with Barnardo's HYPE service and a clear ethos of engagement with and involvement of children, young people and their families in developing and delivering the services. A children and young person's participation strategy (2014–2016) had been developed. Children and young people were involved

in developing information leaflets and media applications, and in the recruitment and training of CAMHS staff, and had created an impressive range of artwork to make the services feel more welcoming.

A Children's Charter had been produced by children and young people that identified the importance of them making choices about who they wanted to work with during their experience of using CAMHS. A number of young people had been involved in making a DVD demonstrating the support that could be provided for young people with mental health issues. This was used in the 'Mind Out' training delivered by the primary mental health specialist to professionals working with children and young people across Bristol and South Gloucestershire who have limited knowledge of CAMHS. The DVD had also been shown to the trust board.

All the children, young people and families we spoke with said they had been given adequate information about the services that CAMHS could provide as well as a wider range of health promotion and support services that they could access. The children and young people liked the fact that information was provided directly to them, so that they did not have to disclose to their parents or carers that they had this information.

Children and young people using community CAMHS had not been given copies of, or seen, their care plan. Some felt it would have helped to have a written plan of care so they could see what they were aiming for and could judge how well they were progressing.

Emotional support

All of the children, young people and families that we spoke with felt they received good support from staff and were able to talk to them and felt comfortable with them during appointments. They felt they had been involved in making decisions about their care and treatment in their 'choice' appointment and felt involved in decisions about what interventions were provided during 'partnership' appointments. However, the majority had not been given a copy, or seen, their plan of care.

A number of parent and carers said they had appreciated being offered separate meetings from their children, which provided support for them in dealing with their child's mental health issues. These sessions not only provided

Are services caring?

Good 

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

emotional support but also provided practical solutions on how to deal with difficult and challenging behaviour. One parent said these had “been invaluable in helping me cope between appointments”.

Are services responsive to people's needs?

Good 

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

Summary of findings

Referral guidelines for health professional had been developed; these also set out the criteria for acceptance to Tier 3 CAMHS. Approximately 75% of all referrals were accepted; there was consistency in acceptance rates across all the teams.

Team worked with a range of clinicians and professionals delivering services to children and young people team members liaised closely with schools. A key focus of care was to ensure that children and young people stayed in education whilst receiving services.

The teams work with marginalised and socially excluded children and young people and the East and Central team had developed a specific project to site services in the centre of the Somali community and two Somali workers had been employed in order to engage more effectively with the growing Somali population

Several children, young people and their families said that they felt the criteria for acceptance was too stringent. However, everyone we spoke to said that once they had been accepted into the service the quality of the care was excellent.

Some teams were experiencing difficulties meeting waiting times commitments for less urgent referrals, due staff shortages

Concerns and complaints were dealt with promptly and were used to improve services.

Good transition (from CAMHS to adult services) pathway arrangements existed between the CAMHS and Avon and Wiltshire Mental Health Partnership NHS Trust.

person. All teams held regular meetings two or three times a week to discuss referrals. The team would agree the most appropriate clinicians to take the referral and a letter would then be sent out asking that the children, young people or their families contact the service to book their choice appointment. Following the choice appointment, the clinicians would discuss with the team who would be best placed to progress work with the individuals and their families. These discussions included whether this should be a man or woman, and whether it should be based on a clinical model or who might best develop positive relationships with the individuals and their families.

As well as working with a range of other clinicians and professionals delivering services to children and young people, team members liaised closely with schools. A key focus of care was to ensure that children and young people stayed in education while receiving services. Weekly team meetings were held to discuss individual cases and care and treatment issues. Staff said these were essential in ensuring care and treatment was delivered in the right way to achieve the right outcomes.

Diversity of needs

The teams work with marginalised and socially excluded children and young people on a case by case basis and can offer visits to the home, school or other places of the child or young person's choosing to meet their needs. Staff identified that referral rates for black and minority ethnic groups were rising in line with black and minority ethnic group families moving into Bristol, although this was still low as a percentage of the population. The East and Central team had developed a specific project to locate services in the centre of the Somali community and two Somali workers had been employed in order to engage more effectively with the growing Somali population. The team had seen an increasing number of referrals for children and young people from this population.

Access to the right care at the right time

Several children, young people and their families said that they felt the criteria for acceptance were too strict. A number explained that they had been referred to the service several times before being accepted. One young person told us that they had a problem with self-harm (cutting) and on three previous occasions had been told that they had not been accepted because their self-harm was not serious enough, even though they had been admitted to an Emergency Department and it had been

Our findings

Service planning and delivery to meet the needs of different people

Referral guidelines for health professionals had been developed; these also set out the criteria for acceptance to Tier 3 CAMHS. Approximately 75% of all referrals were accepted; there was consistency in acceptance rates across all the teams. If the CAMHS teams were unable to accept a referral, a letter was sent to the referrer explaining why and giving pointers for managing the care of the child or young

Are services responsive to people's needs?

Good 

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

considered that they had deep lacerations that would result in permanent scarring. Some people told us that acceptance by the service had taken several years. However, everyone we spoke with said that once they had been accepted into the service the quality of the care was excellent, although a number said that they would have liked sessions closer together to gain maximum benefit.

Staff recognised that some teams were experiencing difficulty in meeting waiting time commitments for less urgent referrals because of staff shortages. All choice appointments should be offered within eight weeks of referral. The North team met this 60% of the time, East and Central 62% of the time, South Gloucestershire 80% of the time and the South team 91% of the time. The North team told us that last time the waiting list built up, the team worked extra hours, above their contracted hours, to reduce the waiting list. Other teams told us that they would work flexibly, including undertaking extra appointments, to reduce waiting lists.

Two commitment targets were measured for partnership appointments; the number seen within 10 weeks and the number seen within 18 weeks. Teams were meeting these commitments as follows: For 10-week partnership appointments, the North met the target 92% of the time, South Gloucestershire team 71% of the time, East and Central 94% of the time and the South team 94% of the time. For the 18-week partnership appointments, the North team met the target 71% of the time, South Gloucestershire team 64% of the time, East and Central 86% of the time and the South team 98% of the time. Several staff said they felt their caseloads were too large. They said this was

predominantly a result of the 'choice and partnership approach', although they recognised that there had been an increase in referrals in line with rises in the population. The system calculated that children and young people would need eight sessions, but many children and young people needed more sessions than this. Clinicians therefore took on more 'choice and partnership approach' appointments without discharging the equivalent number of children and young people, hence the caseloads continued to grow.

Good transition pathway arrangements (to adult services) existed between the Tier 3 CAMHS and Avon and Wiltshire Mental Health Partnership NHS Trust.

Complaints handling (for this service) and learning from feedback

A specific complaints and feedback service had been developed for children, young people and families. Concerns and complaints were dealt with promptly and were used to improve services. Teams took complaints seriously; these would be discussed at team meetings and used as learning opportunities to enable staff to reflect on practice and their approach to children, young people and families. The teams used an 'Experience of Service' questionnaire for parents and young people over the age of 11 years; this is an element of the Clinical Outcomes Research Consortium process. The questionnaire was given six months into their care and treatment or at discharge if sooner. Feedback was generally positive, although negative comments had been used to make improvements, including putting up a display board to provide information and providing feedback in a 'You said, we did' format.

Are services well-led?

Requires Improvement 

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

Summary of findings

There was uncertainty among staff about their future; it was evident that this was affecting staff morale. Most staff were aware of the vision and values of the CCHP, but the trust strategy and governance arrangement were not clear, other than to senior managers. The majority of staff we spoke with in the North Bristol team said they felt unsupported by the operational management arrangements for their team and within CCHP. Some staff in other teams, except the South Bristol team, echoed these comments. Staff also said they felt that North Bristol NHS Trust did not understand their services and felt there was a lack of connection between CAMHS and the trust. However, staff generally felt a connection to the CCHP and saw the benefits for effective service delivery. There was a clear commitment to the continuous improvement of services with the involvement of children and young people.

Our findings

Vision and strategy for this service

North Bristol NHS Trust had a clear vision and a strategy for achieving this vision. However, staff other than senior managers within the Tier 3 CAMHS team were not clear about how the vision and strategy related to them. They felt that the focus had been on developing the Brunel building at Southmead Hospital and the services delivered there, and that CAMHS had a low profile within the trust. Staff also said they felt that North Bristol NHS Trust did not understand their services and felt there was a lack of connection between CAMHS and the trust.

There was some uncertainty among staff about their future; it was evident that this was affecting staff morale. Staff generally were aware of the vision and values of the CCHP, felt part of the service and saw the benefit of being part of the partnership in the delivery of effective services. Staff were positive about the CCHP values of being child centred and of involvement and participation of children young people and families.

Guidance, risk management and quality measurement

Each team had their own governance arrangements, which were clear to team members. However, the teams operated

in isolation from one another, so arrangements had been developed to suit local teams; this meant that a considerable amount of sharing and learning about good practice was lost. The CCHP Board received regular reports about issues relating to clinical risk, including clinical activity reports showing clinical and non-clinical activity, information about complaints and staffing issues. The staffing and capacity issues had been escalated and were detailed on the trust-wide risk register. CCHP governance arrangements were not clear, other than to senior managers.

Leadership and culture of this service

Workforce redesign was being progressed to strengthen managerial lines of accountability and responsibility and ensure clear clinical leadership. Lead clinicians were being identified for each of the professions and nursing structures were being changed to create a robust nursing structure. In addition, plans were being developed to remodel CAMHS to bring about a more integrated model of care for children and young people. This would involve more integration between the specialist CAMHS and the community CAMHS teams. While staff said they felt these developments were positive, a number said there had been little discussion about developments and that these were happening without the engagement of clinicians, who could make a positive contribution.

Staff in the North Bristol team said they felt unsupported by the operational management arrangements for their team and within CCHP. Some staff in other teams, except the South Bristol team, echoed this. Some staff said they did not feel valued or listened to. The North team have had a vacant area manager post for 18 months. For some of this period a service manager has acted up and more recently the east and central area manager has provided cover. The South Bristol team were very positive about the local leadership and operational management of their team and service. However, there was a positive culture of collaborative working within teams and of supporting each other and working in partnership with other clinicians and professionals from other agencies. There was also a culture of meeting the individual needs of children and young people in a therapeutic and person-centred way.

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.

Public and staff engagement

Generally, staff felt that engagement from senior management within CCHP could be better and that engagement from North Bristol NHS Trust could be significantly improved.

Engagement with children and young people and families was excellent and there was a real commitment from Barnardo's HYPE team and CCHP to ensuring this was embedded across the service and all activities. Children and young people were involved in a wide range of developments, including the development of an overarching participation strategy setting out how engagement and participation would be achieved, improving the environment through art work projects, improving access by increasing the choice of venues where the services could be offered, developing self-referral pathways as part of the Increasing Access to Psychological Therapies programme, involving young people in the training of staff and recruitment and ensuring feedback about individual goals and how well therapy is going.

Innovation, improvement and sustainability

There was a clear commitment to continuous improvement with the involvement of children, young people and their families. Clinicians were committed to improving the experience and outcomes they achieved individually and all staff we spoke with, in all the teams, had a focus on improving services.

A number of activity performance targets were used to inform improvement, including: case-load sizes; time to 'choice and partnership' appointments; clinicians' job plan information; number of referrals; discharges; staffing information, including sickness and absence rates; attendance at training; and rates for when children and young people did not attend appointments. Service managers told us this provided valuable information to support team discussions about allocation of resources and how services could be maintained and improved. In addition, national benchmarking information and a small number of local audits were used to support improvements.

Compliance actions

Action we have told the provider to take

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

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities)
Regulations 2010 Staffing
The registered provider did not have suitable arrangements in place to ensure that sufficient numbers of suitably qualified, skilled and experienced staff were available at all times to meet the needs of children and young people.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities)
Regulations 2010 Care and welfare of people who use services
The registered provider did not have appropriate arrangements in place to protect children and young people from the risk of inappropriate care and treatment due to a lack of robust, documented, accurate, individual risk assessments.