Good

Surrey and Borders Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

18 Mole Business Park
Randalls Road
Leatherhead
Surrey KT22 7AD
Tel: 0300 55 55 222
Website: sabp.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXXHQ	Trust Headquarters	CAMHS Community East Team, Kingsfield Centre	RH1 4DP
RXXHQ	Trust Headquarters	Primary Mental Health Team, Kingsfield Centre	RH1 4DP

Summary of findings

RXXHQ	Trust Headquarters	Children and Young People's Learning Disability Service Team, Kingsfield Centre	RH1 4DP
RXXHQ	Trust Headquarters	CAMHS Community North Team, Ashford Hospital	TW15 3AA
RXXHQ	Trust Headquarters	Primary Mental Health Team North, Ashford Hospital	TW15 3AA
RXXHQ	Trust Headquarters	Children and Young People's Learning Disability Service Team, Berkeley House	GU7 1QU
RXXHQ	Trust Headquarters	CAMHS Community SouthTeam, Ridgewood Centre	GU16 9QE
RXXHQ	Trust Headquarters	Primary Mental Health Team South, Ridgewood Centre	GU16 9QE

This report describes our judgement of the quality of care provided within this core service by Surrey and Borders Partnership 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 Surrey and Borders Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Surrey and Borders Partnership NHS Foundation 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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated specialist community mental health services for children and young people as good because:

Services were caring and effective at matching therapies or treatments to people's presenting needs.

Patients were able to be involved in service development, including recruitment and training of staff. This had a positive impact on the experience of people using the service.

Managers were good at developing services to respond to the needs of the local population.

However:

Risk assessments for many patients were incomplete, absent or hard to access. This could have led to poor care for patients. Risk assessments that were there were hard to find.

Staff and managers were not always following the lone working policy and this has the potential to put staff at risk.

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:

- Risk assessments for many patients were incomplete, absent or hard to access. This could have led to poor care for patients.
- Staff and managers were not always following the lone working policy. Patients experienced breaks in service due to a lack of cover for long term staff absences.

However:

- All four sites were clean and well maintained.
- Staff levels were being monitored and reassessed as part of the ongoing restructure of services in order to maintain safe staffing levels.
- Reporting of incidents and learning from incidents was good and improving.

Monitoring and managing of risks associated with anti-psychotic medicines was good.

Are services effective?

Good

We rated effective as good because:

- Staff had a wide range of assessment tools that they used skilfully to identify patient's needs.
- There was a range of National Institute for Health and Care Excellence approved therapies available to patients and these were well matched to patient needs.
- Work between teams was effective and a lot of partnership working was taking place with primary mental health workers based in external teams such as education, youth work and criminal justice settings.
- Teams had access to staff skilled in working with the Mental Health Act when this was needed.

However:

- Some services such as occupational therapy and speech and language therapy were hard for staff to access, especially during school holidays.

Are services caring?

Good

We rated caring as good because:

- Patients felt cared for and very secure in working with staff, especially the team that worked with patients who had suffered sexual trauma.

Summary of findings

- There was a high level of patient involvement in design and development of services through the CAMHS Youth Advisors (CYA) group.
- The service had many routes through which patients could give opinions and ask questions. The provider demonstrated that they were listening to patients in feedback.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Access to services was promoted through easy read literature, interpreters and a translation service.
- The service worked with CAMHS Youth Advisors team to reach hard to engage patients
- Out posted workers from primary mental health services carried out preventative work and raised awareness of mental health issues with partner agencies.
- The service had an ongoing project to provide outreach to the gypsy/Roma/traveller community.

However:

- Many professionals in the service expressed frustration at the lack of CAMHs inpatient beds in Surrey. This resulted in sending children and young people out of area or placing them in adult wards when they were acutely ill.
- Patients experienced breaks in service due to a lack of cover for long term staff absences.

Are services well-led?

Good

We rated well-led as good because:

- The trust had a clear vision for services and the staff reflected these in their work.
- A good range of training was available to staff and managers were able to monitor uptake of mandatory training.
- The service had a risk register that staff could access. This worked effectively in highlighting problems and escalating unsolved problems to board level.
- Managers were monitoring key performance indicators (KPIs) and using these to inform service development.
- Two of the three CAMHS teams had achieved accreditation with Quality Network for Community CAMHS (QNCC).

However:

- Rates of staff appraisals were low.

Summary of findings

- The SystemOne electronic care record was difficult to use and created extra work for managers and admin staff, especially with regard to KPIs.

There was a lack of commitment among senior staff to carry out clinical audits.

Summary of findings

Information about the service

The service for children and young people provides mental health support for under 18 year olds across Surrey. They operate three child and adolescent mental health service (CAMHS) community teams, across eight locations with integrated primary mental health teams (PMHT) at eight locations.

They operate two children and young people's learning disability service (CYPLD) teams across six locations.

Additionally they provide county wide CAMHS teams for children in care and leaving care, specialist groups for sexual trauma and recovery (STARS), parent infant mental health, eating disorders and interventions for patients with higher, more intensive support needs (Hope day services).

The trust was last inspected in July 2014. At that time we found that staff were not reporting incidents that affected the quality of the service people received and were not being made aware of the findings of previous incident reports. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated activities) regulations 2010.

We asked the trust to address this and at this inspection we found that incident reporting and learning from incidents had improved in this core service to a standard that met the requirements of the regulations.

Our inspection team

The team inspecting this core service was comprised of: a Care Quality Commission inspector, a specialist paediatric psychiatrist, a specialist children's mental health nurse and a children's social worker specialising in mental health.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- Visited two children and young people learning disability (CYPLD) teams and three child and adolescent mental health service (CAMHS) teams at four sites.
- Spoke with six patients and seven parents or carers of patients who were using the service.

Summary of findings

- Spoke with the managers or acting managers for each of the teams.
- Spoke with 20 other staff members; including doctors, nurses and social workers.
- Spoke with the divisional director with responsibility for these services.
- Observed four patient consultations and one support group session.
- Attended and observed three hand-over meetings.
- Looked at 12 treatment records of patients.
- 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

Patients told us that the service was good, but there can be a long wait to be seen. They told us that once they are being seen by the service, then transition between teams and therapists is smooth.

Patients said that they trusted staff and were able to discuss freely their mental health problems and traumatic experiences. They felt confident that staff would listen and they felt safe to do this.

Some people told us that some admin staff were unfriendly or unhelpful at times.

Good practice

Children's community services had built an excellent relationship with an independent organisation, the CAMHS Youth Advisory service, to promote patients' involvement in service development including building design, staff training and recruitment.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

The trust must ensure that risk assessments are completed and easy to access.

The trust must ensure that staff follow the lone workers policy. The policy was not enforced or reviewed by team managers.

The trust must ensure that staff supervision and appraisals are conducted regularly.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

The trust should ensure that they are committed to service improvement through internal and external clinical audits to monitor the effectiveness of their work.

The trust should ensure that children and adult patients should have separate waiting areas. This was not available at the Redhill Children with Learning Disabilities team.

Surrey and Borders 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
CAMHS Community East Team, Kingsfield Centre, RH1 4DP	Trust Headquarters
Children and Young People's Learning Disability Service East Team, Kingsfield Centre, RH1 4DP	Trust Headquarters
CAMHS Community North Team, Ashford Hospital, TW15 3AA	Trust Headquarters
Children and Young People's Learning Disability Service West Team, Berkeley House, GU7 1QU	Trust Headquarters
CAMHS Community SouthTeam, Ridgewood Centre, GU16 9QE	Trust Headquarters

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.

Team members did not regularly apply the Mental Health Act in their day to day work because the CAMHS and CYPLD services treated children and young people in the community who were not subject to the formal processes

of the Mental Health Act. Compliance with mandatory training on the Mental Health Act was good and awareness of the principles of the Act among team members was good.

There were sufficient staff within the service with experience and skills to support and advise the teams when they needed to apply the Mental Health Act. The urgent care pathway team provided support to arrange inpatient admissions under the Act.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.

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Mental Capacity Act and Deprivation of Liberty Safeguards

Although compliance with training was good, knowledge of the Mental Capacity Act was inconsistent across the service. We saw that the CYPLD teams were good at working with patients and carers to promote and develop capacity to understand and consent to treatments. CYPLD teams were also good at assessing capacity.

Care plans for the use of anti-psychotic medicines for children contained assessments and regular reviews of Gillick competence for under 16 year olds and mental capacity for over 16 year olds.

However many care plans and treatment plans did not contain assessments of mental capacity or Gillick competence when these would have been appropriate. Some care plans contained consent forms signed by carers on behalf of patients over 16 years, who may have either have given their own consent or should have been subject to a mental capacity assessment.

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

- Three of the sites we visited were dedicated community services and the fourth was based in Ashford hospital. All four sites were clean and well maintained. We saw maintenance logs for the buildings that showed timely responses to reported faults.
- The community based teams did not have panic alarms in their consulting rooms. We discussed this with staff who told us this had not been an issue. The children and young people's learning disability service (CYPLD) service only saw people at the team base for initial assessments, with all subsequent visits being carried out at home. Initial assessments were usually conducted by more than one team member, which would be a mitigating factor for personal safety. The community based teams did not have clinic rooms for physical health checks, as these checks were carried out by GPs or school health teams at the request of children and adolescent (CAMHS) staff.
- The Ashford hospital based team shared facilities with a paediatric outpatient ward. The paediatric team had a clinic room that the CAMHS team was able to use if needed. This was well maintained and the maintenance log showed that equipment was regularly checked.
- The Ashford paediatric outpatient ward had panic alarms in the consulting rooms. However we observed that staff from both services answered the intercom and that they did not always ask visitors to state the purpose of their visit before unlocking the door. We also noticed that the reception desk, from which staff operated the intercom, did not have a clear line of sight to the door. Staff did not always look too see who had come on to the ward. This meant that staff from either service could not be sure who was on the ward at any given time.

Safe staffing

- At the time of our inspection the CAMHS teams were preparing for the service to be remodelled in order to add new care pathways and services. This had resulted in a high turnover of staff and new establishment figures were being estimated and recruited against.
- Managers told us that the establishment figures had been appropriate but in some teams clinicians believed caseloads were becoming unsafe. They expected this situation to be addressed with the funding for new care pathways.

Assessing and managing risk to patients and staff

- The assessment and management of risk were inconsistent. Staff told us that a new electronic care records system had been introduced and the risk assessment tool on the new system did not prompt staff to consider risks as broadly as the previous system. We reviewed 12 initial assessments which incorporated the risk management plan. Of these, six records did not have risk information detailed in the assessment. The initial assessment tool used on SystemOne only asked three key questions in respect of risk to others, risk from others and risk to self. There were no other prompts in this tool that might enable staff to review risks in more detail. The impact of this meant that risk were not always adequately recorded and easy to locate as there was no separate risk assessment in all cases.
- Some care records did not have multidisciplinary risk assessments when this was appropriate. For example, one patient seen by the primary mental health team was known to his lead worker to be at risk of suicide or self-harm but this was not recorded on the risk assessment domain of his care plan. This meant that other workers and services who accessed the electronic care record, for example at an acute hospital, would not be fully aware of the risks to the patient.
- However, many records contained good risk assessments and risk management plans, particularly where children and young people were prescribed anti-psychotics. Risk management included monitoring of physical health and good quality information on potential side effects for parents and carers. Risk records were updated at each visit and when appropriate the lead worker discussed risks further with the multidisciplinary team. We found that more experienced staff continued to record and manage risk effectively despite the fact they stated that the online tools were less effective.
- Lone worker safety was not well addressed by any of the teams we visited. There was a lone worker policy in

Requires improvement

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place but this was not enforced consistently. Staff did not have access to personal alarms or devices for letting teams know when they had completed visits. Visiting workers' diaries were available to managers but we observed they were not always updated by the workers and there was no system in place for managers to review or enforce the lone worker policy.

Track record on safety

- In the twelve months prior to our inspection the children and young people's services had reported one serious incident requiring investigation as defined by the NHS Commission Board Serious Incident Framework 2013. One manager we spoke with was involved in investigating this with the clinical commissioning group (CCG). Most staff we spoke with said they had been told of the findings but a few said that they did not receive feedback on learning from incidents.

Reporting incidents and learning from when things go wrong

- At our previous inspection we found that not all staff knew how to report incidents and were not aware of learning from serious incidents. We asked the provider to take action to improve this.
- At this inspection incident reporting had improved and the staff we spoke with were aware of the wide range of incidents that they were required to report. Most staff were able to tell us about reports relating to serious incidents in their teams and in other parts for the trust. Outposted workers, based in education or other settings, were able to report incidents but did not know of the outcomes of learning from incidents. One change we were told about was that clinicians were now reporting incidents of persistent self-harm by patients more consistently. These had not always been reported in the past and the team were worried that the behaviour might be becoming "normalised" within the therapeutic relationships that patients had with their clinicians.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We found that staff used a wide range of assessment tools appropriate to the needs of the patients. The initial assessments were comprehensive and for most patients were completed within the first two appointments. Assessments covered social, educational and general health needs as well as mental health in order make the team's intervention as effective and holistic as possible.
- Following initial assessment, patients or their carers were provided with a letter containing a detailed plan for care and support from the team. This included contingency plans for any deterioration in the patient's mental health and contact details for the lead professional within the team and out of hour's contacts.
- Care records were updated following every appointment or other contact with the team. Clinical assessment tools were scanned and uploaded to System One, the electronic patient record. As this tool was new, some staff still had difficulties accessing care records and there was some inconsistency in how interventions and assessments were recorded. For example, risk assessments and history were often not in the "risk" domain of the record and staff were not able to find them in a timely manner.
- The CAMHS team had more difficulty with accessing records than the CYPLD team. CAMHS had many outposted workers who did not use SystemOne as their main recording system. These workers told us that they had more difficulty keeping up to date with the weekly changes to System One. Initial referrals and information often came through to the team from outposted workers and their difficulties with the system might have contributed to the problems in accessing information.

Best practice in treatment and care

- The CAMHS and CYPLD teams provided a wide range of psychological therapies. These were discussed with the patient and/or carer at initial assessment, and then decided on at post assessment multidisciplinary meetings. Therapies were mainly National Institute for Health and Care Excellence (NICE) recommended courses related to cognitive behaviour therapy (CBT) but also included therapies for trauma such as eye movement desensitisation reprocessing (EMDR). A quality management group within the trust met monthly and included NICE guidance on therapies as part of their regular agenda.
- The psychiatrists and the nurse prescriber in the service had good systems in place to monitor the use of anti-psychotic medicines for children. We found that psychological therapies were explored in depth before anti-psychotics were considered and when prescribed, effective monitoring was in place.
- Only one team, based at Ashford hospital, was able to directly monitor the physical healthcare of patients. The other teams relied on GPs or health teams at schools for special educational needs to carry out these checks. Some psychiatrists told that they found it frustrating waiting for GPs to carry out tests, particularly blood tests, when reviewing children's medication.
- Psychiatrists and therapists used a range of outcome measures specific to the interventions to assess how effective people's treatments were.
- We found little evidence of organised clinical audit for the effectiveness of services. Some managers were unenthusiastic when discussing them. One staff member told us they had not been involved in a clinical audit for five years.
- However we found that plans were in place as part of the restructuring of services to introduce a range of clinical audits with a person assigned to take on that work.

Skilled staff to deliver care

- The multidisciplinary team consisted of psychiatrists, nurses, psychologists, psychotherapists and social workers who had a dual role and qualification as therapists. Therapists included art therapists, a music therapist, drama therapists, family therapists and child and adolescent psychotherapists.
- There was one nurse prescriber for the CYPLD service. Occupational therapy, physiotherapy and speech and language therapy were commissioned separately by the clinical commissioning group and provided through schools.
- Most staff had received a timely induction after starting with the teams. However a few had experienced a delay of up to four months in receiving their corporate induction. This had an impact on their work role as they

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were expected to carry a caseload, but unable to use SystemOne to update patient notes while waiting for their induction. This created extra work for other members of the team.

- Staff had access to a wide range of supervision depending on their role. For example, outposted workers received training from their CAMHS manager, their "host" manager and their relevant clinical supervisor. However not all staff received this level of supervision Records provided by the trust showed that only 50% of staff had received supervision in a three month period leading up to the inspection. This fell below the trust's own target of 75%.
- The trust also gave us information which showed that only 67% of non-medical staff had received an appraisal in the 12 months before the inspection.
- Specialist staff we spoke with told us they were able to access the training they needed it. The trust had a system in place for professionals to request funding for training they identified as contributing to their role and to the service.

Multi-disciplinary and inter-agency team work

- The CAMHS teams used pre-assessment and post assessment multidisciplinary team meetings to discuss referrals. These established which professional and which model of therapy were best for the patient. The patient's own views were discussed at the initial assessment and taken to the post assessment meeting by the assessor. The lead worker was then able to discuss the patient with members of the team on a less formal basis as treatment progressed.
- The CAMHS service had many partner agencies that it signposted people to. We discussed with patients how they moved between service in the voluntary sector and the CAMHS team. They told us that it was quite smooth, once they were known to CAMHS, to get referred back by the partner agency if their needs changed.
- There was effective partnership working with other agencies via outposted workers who were employed by CAMHS but worked in other settings such as education, criminal justice and youth work. Social workers based in CAMHS teams had specific time dedicated to referrals from the local authority. However many team members expressed frustration with the arrangements for accessing occupational therapy, physiotherapy and speech and language therapy. As they were provided through schools, teams had little access to them, for example CYPLD had access to occupational therapy for two hours per month including school holidays.

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

- We found that there was a core group of staff with sufficient knowledge of the Mental Health Act (MHA) to support the teams with patients who may be subject to the Act. The CAMHS service provided an urgent care pathway for patients who may need inpatient care. The people allocated to this team could support other staff in accessing Mental Health Act assessments and discussing the patient's needs. 71% of staff had up to date training on the Mental Health Act.
- The CAMHS team also provided the Hope team in partnership with the local authority. This was aimed at preventing admission of young people to inpatient services or minimising the length of stay if they were admitted.
- During the inspection, a CAMHS community patient was admitted to a health based place of safety and subsequently to an adult ward following a Mental Health Act assessment. This was because there were no adolescent beds commissioned locally by NHS England. The Hope team arranged for admission to an adolescent unit within a day of admission to the acute ward. We reviewed the management of this and found that the trust put the necessary safeguards in place to protect the young person until the right bed was found.

Good practice in applying the Mental Capacity Act

- The trust had clear policies on understanding and assessing mental capacity and Gillick competence, and 81% of staff in the service were up to date with Mental Capacity Act training. However we found that teams were inconsistent in applying them. The children and young people's learning disability staff we observed were very competent at assessing mental capacity, as described in the Mental Capacity Act, and records were thorough. There was evidence of discussion between professionals and families about the patients' capacity and/or Gillick competence.
- We saw evidence of work to develop interventions for people, for example, taking blood from children with learning disabilities. This was used to reduce the need for restraint where patients found the intervention

Are services effective?

Good

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difficult or distressing, but the practitioner judged that it was in their best interests. We saw individual plans to promote each patient's understanding of the process and improve their competence in giving consent to treatment.

- However, within the CAMHS teams, the understanding of the MCA was not as good. There was some evidence of assessing Gillick competence in prescribing medicines, but many staff we spoke with did not understand the legal principles of the Mental Capacity Act for over 16s or Gillick competence for under 16s. For example, parents were asked to sign consent forms for 16 and 17 year olds to receive treatment. It was not clear to staff when the patient had a right to say if their medical details should be shared with their parents. This meant that young people were being denied their right to autonomy and privacy.

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

- Patients and carers we spoke with described staff as supportive and understanding. Staff were responsive to the emotional and social needs of patients and carers and understood the presenting mental health problems.
- Patients we spoke with told us that therapists were good at discussing consent with them, including if they wanted their parents or carers present for consultations. Patients who accessed the STAR team, which specialised in sexual trauma, told us they felt very secure in talking to therapists. They felt that their privacy was respected and that they could talk freely and confidently about their experiences. Parents of children using the STAR service reported that their children seemed very confident and were impressed at the way that the therapists enabled their children to open up and talk about traumatic experiences.
- However some patients and carers reported that admin staff could be unfriendly and appeared uncaring at times. This had a negative impact on what was a generally positive relationship with the teams they dealt with.

The involvement of people in the care that they receive

- The trust had developed a very effective partnership with an independent patient-led organisation, the CAMHS Youth Advisors (CYA). This organisation provided mandatory training for staff on the patient experience of using services. They also provided patient representation for interview panels and were consulted on building designs for the new restructured children's and young people's services. They had been consulted on the design of waiting areas for existing buildings.
- CYA also made awards to staff which was based on patient experiences. Managers we spoke with said that this had a good impact on staff morale and contributed to positive relationships with patients.
- We looked at a visitors' book in the waiting room of the South CAMHS team. Many patients had written comments on the service, both positive and negative. All comments had received a written response from the team so that patients were aware that their comments were being read and addressed by staff. We were able to observe examples of information provided and changes to the environment that were a response to patient comments.
- Patient experience forms were offered by staff after each visit or consultation with patients. Some staff were able to offer this on a tablet device, and touch screens were available in some reception areas for patients to complete these forms. However it was not clear how the data from these forms was used to inform service delivery.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The trust had a target of 28 days from referral to assessment. Figures provided by the trust showed that all teams had higher than average waiting times than this. One team, CAMHS East, had an average waiting time of 75 days. We observed in people's notes that the target was not always met. More recent referrals showed an improvement in waiting times. A waiting time recovery plan had been in operation in the service since September 2015. Each service monitored the numbers waiting for treatment and waiting for assessment. Any young person on the waiting list was triaged and risk assessed. Waits for treatment following assessment averaged four weeks across the CAMHS services.
- One team, CAMHS North, had created an action plan to address waiting times. This team kept records of waiting times for initial assessment and beginning of treatment and these were reviewed monthly. This showed a month by month improvement in numbers of people waiting more than four weeks for assessment and more than nine weeks for treatment. For example in the February waiting list for assessment had 85 people, of which three had waited more than 28 days. This compared to 32 out of 79 who waited more than 28 days when the action plan was introduced in September 2015.
- Patients and their carers told us that waiting times could be an issue, and that administration errors could be a problem in getting a first appointment. For example, one patient received a letter offering an appointment the next day, which was not enough notice for the carer to arrange to take the patient. This resulted in a delay of two weeks in getting a new appointment.
- Managers told us that funding was not available to cover long term absences such as maternity leave. These meant cases were reviewed and closed when the team could not cover the absent workers' caseload. Some parents told us that it could be difficult to get support for their child if the named worker was absent. One parent told us that their child was not seen by the team for over a year because the named worker had been absent. The parent told us that there had been a deterioration in the young person's mental health which required more significant intervention than would have been the case if they had been seen regularly.
- We saw that long term absences of staff were discussed at team meetings and the case loads of absent staff were reviewed and prioritised by team managers.
- Teams had a policy for "Did not attend" patients to promote uptake of appointments. This included looking at administration errors as part of incident reviews to ensure that people were offered appointments they were more likely to attend.

The facilities promote recovery, comfort, dignity and confidentiality

- Facilities at all sites were good, though at the Cedar House site patients had to go through the older person's community team area to access the CAMHS team. However patients and carers did not report any issues with this.
- Waiting areas at four of the five teams we visited were only for children and their carers However the CYPLD waiting area at Kingsfield Centre was shared with the adult learning disability team. This site was only used for initial assessments as the team policy was to carry out home visits once the patient was known to the team. The waiting area was staffed by reception staff at all times patients were present and this mitigated against any risk of discomfort to the child if they needed to share the waiting room with a vulnerable adult patient.
- The CAMHS South team at Cedar House had used furniture to create a discrete secluded spot in their waiting area as some patients did not like being "on view" to other people waiting for appointments, and this allowed them more privacy.
- Consultation rooms were available in a range of sizes at the different sites to allow for a range of consultations, from one to one to family therapy. Toys and other activities were available for younger children to use while their carers spoke to therapists.

Meeting the needs of all people who use the service

- Physical access to facilities was good. We spoke to some patients with mobility issues who told us they had no issues with access to services. The CYPLD teams were able to provide literature in easy read format using in-house resources. The trust had a contract with a translation and interpreting service. Staff that had used this told us the interpreting service was good, but that the translation service could be slow in delivering requested literature.

Are services responsive to people's needs?

Good

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

- The service used primary mental health outposted workers extensively to reach people that may need support, but were not aware of how to access the service. They also worked extensively with schools, criminal justice and make other services and professionals aware of the service.
- The service worked in partnership with the CAMHS Youth Advisors (CYA) to develop groups for people that services found hard to engage. This helped to promote positive relationships with the CAMHS service or monitor their mental health while disengaged from services.
- The CAMHS service had carried out an extensive project to engage with a large local gypsy/Roma/traveller community. This had been successful and the staff who took part in the project were raising awareness of the project and carrying out training with other parts of the trust.
- The Hope team worked in partnership with the local authority children's service to work with children who were refusing to attend school, as well as working to prevent or minimise hospital admissions.
- Staff expressed frustration at the lack of local inpatient beds for CAMHS patients. No inpatients CAMHS beds were commissioned by NHS England in Surrey and so only private beds or out of area placements were available. The Hope team had developed good links with private providers, but the lack of properly commissioned beds made placement difficult. For example, a CAMHS patient required admission during our inspection and was placed in a local adult acute ward temporarily as the nearest CAMHS bed was in Sheffield.
- Staff told us that as part of the planned restructure of CAMHS, there would be access to two social care beds via the Hope team. However, these would not meet the needs of patients with acute mental health needs requiring hospital admission for assessment and treatment.

Listening to and learning from concerns and complaints

- In the twelve months prior to the inspection the service received twelve complaints, of which two were fully upheld and seven were partially upheld. Mangers were aware of the themes of these complaints, which were mainly related to postponed appointments and continuity of care where there had been changes to the young person's named therapist or doctor.
- Carers we spoke with who had made complaints were satisfied with the way the complaints had been handled. Patients we spoke with were aware of the complaints procedures, though none had made direct complaints about their care or treatment.
- Staff we spoke with were knowledgeable about the complaints policy and most were able to give examples of feedback the team had received about the resolution of complaints relating to their client group.

Are services well-led?

Good

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

- Staff we spoke with were clear about the values of the trust and the work of the teams reflected the goals of the trust. The service was in process of restructure and training was taking place on the values and the goals for the new care pathways.
- Staff told us that there had been some instability in senior management in the year before our inspection, but the current management were clear on setting the goals of the service. Senior managers had held events where staff were consulted and briefed on changes to the service.

Good governance

- Most staff told us they were able to prioritise patient contact time over administration tasks. However the introduction of SystemOne had created more administration tasks, particularly for managers. For example managers were expected to monitor and report on key performance indicators (KPIs) relating to their teams but SystemOne did not allow managers to generate reports on KPI data and so a lot of management and admin time was spent reviewing cases in order to generate the reports. This was particularly difficult for the CYPLD team as they had no allocated admin workers and so managers and staff had to spend more of their time on this task.
- The team leader for CYPLD services told us that admin staff would be recruited for the team as part of the restructure.
- Mandatory training was planned and monitored, so that managers knew when staff were required to update their training. Staff take up of mandatory training was quoted as 71%, but this included some courses that were not mandatory for community staff, such as food hygiene.
- A system was in place for staff to receive annual appraisals, however only 67% of non-medical staff had received an appraisal in the year before the inspection. Figures were lowest in the CYPLD teams, where only 41% of non-medical staff received an appraisal.
- Managers were reviewing key performance indicators such as waiting times from referral to assessment and treatment in order to target team resources more effectively. However some psychiatrists and therapist told us they were under pressure to close cases earlier than they thought appropriate in order to see new referrals.
- The service had an effective risk register. Staff were able to ask for items to be put on the risk register and received feedback on progress. For example a staff member noticed that a secure door was not closing properly when leaving the unit in the evening. This was reported to maintenance. When the out of hour's maintenance team did not respond, the concern was escalated further until it reached the board risk team, known as the "safety huddle." The board team ensured that the repair was carried out but also looked at the reasons for the lack of response to the original request. The timescale for all actions to be completed and feedback to be given to the team was four days.

Leadership, morale and staff engagement

- Records provided by the trust showed that staff turnover was high in the year leading up to the inspection, with16% of staff having left the service. The CYPLD service had no turnover of staff. Managers attributed the high turnover to the restructure of services, which some staff were not happy with.
- Most staff we spoke with were happy with the development of the service, but acknowledged that other staff had left due to the restructure. There were no reported complaints within the service of bullying and harassment and no staff raised this as a concern with the inspection team.
- Staff we spoke with were positive about professional development through specialisation, though there were limited opportunities for promotion due to the stability of the management team.

Commitment to quality improvement and innovation

- Two of the CAMHS teams, North and South, had achieved accreditation with the Quality Network for Community CAMHS. Managers told us that the West team expected to complete this the following year, but they were waiting for the restructure to be completed before starting the process.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12: Safe care and treatment The provider was not always assessing the risks to the health and safety of service users and not always doing all that was reasonably practicable to mitigate such risks. This is breach of Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18: Staffing People employed by the provider were not receiving appropriate supervision and appraisal as necessary to enable them to carry out the duties for which they were employed to perform. This is a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.