Good

Oxford Health NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNU10	Trust Head Quarters	Bath and North East Somerset CAMHS,Temple House, Keynsham	BS31 1HA
RNU10	Trust Head Quarters	Melksham CAMHS, Melksham Hospital, Melksham	SN12 7NZ
RNU10	Trust Head Quarters	South Buckinghamshire CAMHS, Orchard House, High Wycombe	HP12 4BF
RNU10	Trust Head Quarters	Swindon CAMHS, Marlborough House, Swindon	SN1 4JS
RNU10	Trust Head Quarters	Banbury CAMHS, Orchard Health Centre, Banbury	OX16 2EZ
RNU10	Trust Head Quarters	CAMHS Learning Disability Service, Saltway Centre, Swindon	SN5 5TD

Summary of findings

RNU10	Trust Head Quarters	Oxford CAMHS, Boundary Brook House, Oxford	OX3 7LQ
RNU10	Trust Head Quarters	Witney CAMHS, Child & Family Clinic, Witney	OX28 4BE
RNU10	Trust Head Quarters	Abingdon CAMHS, The Clockhouse, Abingdon	OX14 5SW
RNU10	Trust Head Quarters	Salisbury CAMHS, Salisbury District Hospital, Salisbury	SP2 8BJ

This report describes our judgement of the quality of care provided within this core service by Oxford Health 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 Oxford Health NHS Foundation Trust and these are brought together to inform our overall judgement of Oxford Health 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?	Outstanding
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:

- Young people and their families and carers who used the service were effusive in their praise for the staff. The outstanding caring by staff for young people and their families and carers was observed by our inspection team and commented on by other agencies who worked with the services.
- The overall positive culture we observed was all the more remarkable given the size of the child and adolescent mental health services that the trust provides.
- The services were responsive, designing and delivering interventions appropriate to young people's needs.
- The trust was creative in the way it developed services in response to young people's needs, typified by the creation of apprenticeships for young people who have used the service which aim to help them engage with the job market.
- The trust had comprehensive crisis support for young people with a very positive assertive outreach service.
- Services were well led with dynamic leadership at a local and senior level.
- There was very good learning from incidents.
- We saw evidence of excellent multiagency working.

However:

- There had been such a focus on addressing waiting lists that caseloads had become very high in some areas putting the quality of care and patient safety potentially at risk.
- The quality of risk assessments was variable across the services. In particular we were concerned about the risk assessments in Melksham, Swindon and Oxford central. However we did see staff considering risk with young people and their families/carers at all times.
- Mandatory training rates were low. We were particularly concerned about Mental Capacity Act training and staff knowledge surrounding this.

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:

- We were concerned at the quality of rrecording of risk assessments in the Melksham, Swindon and Oxford Central teams. Although we saw good examples of risk assessments in the other services, especially in the specialist outreach services for children and adolescents.
- We were concerned at the size of caseloads that some clinicians held particularly in Salisbury and Oxford Central teams which could impact on the safety of young people using the service and staff wellbeing. The focus on addressing waiting lists meant that caseloads had become high in some areas potentially putting the quality of care and patient safety at risk.
- Some of the environments that the trust used for the CAMHS teams had areas of concern including toys not being cleaned, leading to an infection control risk. There was a lack of risk assessment at Melksham which shared its site with adult services and not all bases had alarm systems.
- Mandatory training rates were low, although we saw some work to address this.

However:

- We found that staff in all the CAMHS services considered risk in a clear and coherent way, discussing it with young people and their families and with other professionals. Teams were good at sharing the risk. This included those teams where the recording of their risk assessments was not to a good standard.
- We found that all the services learnt well from incidents and shared that learning across all teams in what was described as a no blame culture.

Are services effective?

Good 

We rated effective as good because:

- The teams had excellent multiagency working with good relationships with external agencies.
- Different disciplines in the teams worked effectively and respected each other's views putting the young person's needs at the centre of the work that they did.

Summary of findings

- We consistently found evidence of best practice in delivery of care, for example the staff in the outreach service for children and adolescents (OSCA) were trained in dialectical behaviour therapy.

However:

- Recording of care planning was variable across the services. This appeared to be linked to the implementation of the new electronic records system with some teams being more confident in its use than others.
- Staff knowledge of the Mental Capacity Act and how it applied to children and young people aged 16 and above was not consistent nor was the recording of capacity and consent to treatment in the care notes. We were concerned at the quality of the training on capacity and consent staff received.

Are services caring?

We rated caring as outstanding because:

Outstanding 

- The workforce were positive about the young people and their families at every stage, even when dealing with difficult and challenging issues.
- Young people and their families and carers who used the service were effusive in their praise for the staff.
- Staff were highly motivated to offer care that met what young people wanted. Relationships between people who use the service and their families and carers and staff were very positive.
- We observed consistently positive interactions with young people and their families. This was reflected in how staff spoke about young people and their situations when they were not present as well.
- Other agencies who worked with the services commented on the positive nature of staff.
- Young people were involved in their care and also the design of service delivery and were valued for their voice by staff.
- The overall positive culture we observed was all the more remarkable given the size of the child and adolescent mental health services that the trust provides.

Are services responsive to people's needs?

We rated responsive as good because:

Good 

Summary of findings

- The trust had comprehensive crisis support for young people. Young people in crisis received a robust and safe response with excellent links into other agencies.
- Young people and their families and carers were accessing services within statutory time limits. The services considered discharge when appropriate and had good systems in place for transition to adult services even in areas where the trust did not provide those services.
- In the majority of sites we visited we saw that young people had been involved in the features of the buildings to make them appropriate.
- There was good learning from formal complaints.

However:

- Some of the environments where CAMHS was delivered from were not as welcoming as they could be. Although a lot of work had been done on the majority of the reception areas, this had not always been continued through to the therapy rooms where young people and their families/carers were seen. The environment at witney was very poor.
- Informal complaints were not recorded or monitored for trends.

Are services well-led?

Good

We rated well-led as good because:

- Leadership within CAMHS services at both a senior and local level was robust and enthusiastic with a clear vision for child and adolescent mental health services.
- Morale in the service was good in the majority of services.
- There were good governance systems in place, particularly on learning from incidents with staff in Wiltshire and Buckinghamshire being able to relate learning from the same incident.
- There were good relationships in place with key stakeholders including commissioners.

However:

- We were concerned that the level of caseloads and the pressure this placed on staff was not understood in all areas, in particular in Oxford central. This affected morale in this service.

Summary of findings

Information about the service

Oxford Health NHS Foundation Trust is commissioned by five different clinical commissioning groups to deliver child and adolescent mental health services (CAMHS) across a wide geographical area and 13 locations. The trust provides services to Oxfordshire, Buckinghamshire, Swindon, Wiltshire and Bath and North East Somerset. These included services from Aylesbury to Salisbury.

The services are commissioned differently in each area. For example some services had integrated learning disability services whilst others had separate learning disability teams. Some areas have commissioned specialist services such as regional forensic CAMHS across Oxfordshire Buckinghamshire and Berkshire and the child and adolescent harmful behaviour service across Oxfordshire and Buckinghamshire.

However, all the areas provided tier three child and adolescent mental health services and delivered the same out of hour's model coupled with an assertive outreach service known as OSCA (outreach service for children and adolescents). The trust also provided tier two (or primary) CAMHS across the counties with the exception of Swindon where tier two provision was provided by the local authority.

Our inspection team

The inspection team was led by:

Chair: Professor Jonathan Warren

Head of Inspection: Natasha Sloman, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

Team Leader: Serena Allen, Inspection Manager, Care Quality Commission

The inspection team that inspected specialist community mental health services for children and young people consisted of one CQC inspection manager, one CQC inspector, one CQC policy advisor, six specialist advisors including two consultant psychiatrists, nurses and a social worker all experienced in working in child and adolescent mental health services. We were also joined by an expert by experience who was a mother of a young person who used services.

On the first day of the inspection, a CQC head of hospital inspection and two inspectors joined us. On the third day we were joined by a CQC inspection manager, and four specialist advisors including a consultant psychiatrist, a psychologist and two nurses who were all experienced in working in child and adolescent mental health services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information.

Summary of findings

During the inspection visit, the inspection team:

- Visited ten locations across the five counties the trust provides services in
- Spoke to 20 young people who used the services
- Spoke to 29 family members or carers of young people who used the services
- Reviewed 74 care records
- Spoke to 96 staff and 23 managers working in the services
- Spoke to nine external stakeholders
- Held two focus groups with staff working in child and adolescent mental health services
- Attended 18 meetings including multidisciplinary team meetings and meetings with other agencies and providers
- Observed 28 episodes of care both in clinics and in the community, including vistis to young peoples homes, schools and other settings.

Although we were not able to visit every location providing child and adolescent mental health services we did speak to young people and families/carers who used the services we did not visit. We also spoke to staff in these services and sampled records from them.

What people who use the provider's services say

We spoke to 20 young people who used services and 29 family members/carers. Comments about the services were overwhelmingly positive. Staff were described as caring. However four families expressed concern that although the service was very good, they had to wait a long time before they were seen.

We also received 14 comment cards, 13 were from people using Swindon CAMHS and one from a user of Aylesbury CAMHS. The comments cards were generally positive with only three responses that were mixed. The comment cards stated that staff cared about their patients, that concerns were listened to and the services were always available. However, there was concern on three of the cards about long waiting times to access the services

Good practice

Good Practice

- The trust had introduced apprenticeships for young people who had used services and engaged with their participation program. This aimed to assist young people to get work experience to aid them in entering the job market following their treatment.
- The trust had effective out of hour's provision for young people who may be in crisis. This had CAMHS clinicians, psychiatrists and managers all on call. Young people and their families or carers knew to call the out of hours GP service on 111 as part of their crisis plans who would triage calls and contact the service. Local agencies including GP's emergency departments, duty social workers and police were aware of how to contact the service for advice out of hours. The clinicians would initially offer telephone consultation and arrange emergency appointments held by each tier three team every day, or if necessary would arrange an immediate assessment.
- Managers used routine outcome measures in clinician's caseload supervision to ensure the clinicians were making progress with each case and provide assistance if they were not.
- The trust worked well with other agencies in the youth offending service in Oxfordshire running an innovative cannabis clinic. The police gave warnings on possession and the CAMHS staff triaged young people for developing mental health concerns and provided education on the risk of illicit substance misuse to mental health.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must address the variable quality of risk assessments to ensure that all risks to young people are properly recorded and managed.
- The provider must review the caseloads in the CAMHS teams and the impact on safe patient care.

Action the provider SHOULD take to improve

- The provider should ensure that they meet their targets for mandatory training.
- The provider should ensure that all toys are cleaned regularly and pose no risk to infection control.
- The provider should ensure that the use of care planning is consistent across the services on the electronic records system.
- The provider should look at the recording of capacity and consent and the application of the Mental Capacity Act in the care records and staff training for how the act applies to children's services.
- The provider should consider having a formalised risk assessment for the premises at Melksham. This is because young people attend a shared site with adult services. .

Oxford Health 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
Bath and North East Somerset CAMHS	Temple House, Keynsham
Melksham CAMHS	Melksham Hospital, Melksham
South Buckinghamshire CAMHS	Orchard House, High Wycombe
Swindon CAMHS	Marlborough House, Swindon
Banbury CAMHS	Orchard Health Centre, Banbury
CAMHS Learning Disability Service	Saltway Centre, Swindon
Oxford CAMHS	Boundary Brook House, Oxford
Witney CAMHS	Child & Family Clinic, Witney
Abingdon CAMHS	The Clockhouse, Abingdon
Salisbury CAMHS	Salisbury District Hospital, Salisbury

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.

Detailed findings

- Staff we spoke to told us they had received training in the MHA and code of practice. Most of the staff were confident in the codes specific guidance on children and young people under the age of 18.
- Psychiatrists in the service all received section 12 training and although the use was infrequent as would be expected in CAMHS. The doctors displayed good knowledge and described the support and training in the Mental Health Act as meeting their needs.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a variable level of detailed knowledge around the Mental Capacity Act in the staff we spoke with. All the staff understood what the Act was, however the majority told us it was mainly the psychiatrists who would lead on the Mental Capacity Act. We were concerned when one manager informed us that the Mental Capacity Act did not apply to them as they worked in children's services. The Mental Capacity Act is relevant to young people aged 16 and over.
- The Mental Capacity Act does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the patients where possible in the decision making regarding their care.
- There was evidence of consent to treatment and consent to share information being recorded in the majority of the records we reviewed however it was lacking in some services such as all six of the records we reviewed in Melksham and six of the records we viewed in Swindon and Oxford Central which was half of the records we viewed in those services.
- However we did see staff engage in discussions about consent with young people and their families in all the clinical observations we conducted including those teams.
- Where capacity and consent was recorded we saw that these had been updated and checked when decisions needed revisiting regarding consent.
- Mental Capacity Act (MCA) training was included in the trusts mandatory corporate induction programme and the trust informed us that it was offered as part of the MHA refresher training. However staff told us that Mental Capacity Act training was only given once when they first joined the organisation and that they had not received updates.

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

- The quality of the different team bases differed greatly.
- The premises used by the South Oxford CAMHS team in Abingdon were in poor condition. The environment was small; there was a leak in the roof, which had led to substantial water damage in particular in the tier two PCAMHS staff area, and along various corridors leading to an unpleasant working and clinical environment. Heaters had been set up to dry the walls in those areas. We discussed this with the service manager who told us this had been the case for approximately 18 months. This was on the local risk register. Work had begun to address this at the time of our inspection and the trust reported that it was completed in November 2015.
- In Salisbury there had been problem with damp in the offices and clinical space on one side of the building and we saw remnants of mould which had been growing up the walls due to poor ventilation. The estates department had provided yearly upkeep and painted over it. The windows however had recently had extra ventilation put in to tackle the damp problem and staff felt that it should solve the problem.
- All services we visited were very clean and cleaners we spoke with felt that they had sufficient time to complete their work which was evident in the environments we viewed. However across the majority of sites there was no cleaning rota for toys, either in waiting areas or those used for therapy. The cleaners were not aware that they should be cleaning them. In some sites we were told it was the individual clinician's responsibility for their therapy room however we saw no evidence that this was being carried out. This was acknowledged by the trust and immediate action was taken when we raised it.
- Some sites had well-equipped clinic room with the necessary equipment to carry out physical examinations such as Boundary Brook house in Oxford. The environments and clinic rooms were acceptable in South Bucks and Oxford North teams, both in private areas and well equipped. However teams often linked in with general practitioners to complete physical health monitoring. In Melksham, height and weight were originally done in a dedicated room, however young people fed back they found it small and claustrophobic so the equipment was moved into the normal consulting rooms. In the Oxford South team in Abingdon the clinic room had no examination couch, with the scales used outside the room due to lack of space. This was on the local risk register.
- We saw hand gel available in all services and in some services in Oxfordshire and Buckinghamshire staff also carried it with them.
- We were concerned that there was no formalised risk assessment for the premises at Melksham considering young people who attended the service on their own. The premises were in a community hospital on a shared site with adult services that young people had to walk through.
- South Bucks, Oxford North, Oxford South, Oxford Central and Melksham teams all used personal alarm systems (PIT). All staff we spoke to were confident in their use. We saw they were tested regularly. There were no alarms in the Bath and North East Somerset base in Keynsham, nor the Salisbury, Witney or Swindon base but personal alarms were available in all but the Witney base.
- PAT testing was variable with some equipment in date and others not. Sometimes this could be in the same room, for example at Boundary Brook House some equipment had been tested in 2015 and some had not been tested since 2013. In the Oxford South team some equipment had not been tested since 2014.

Safe staffing

- The majority of services were at or near full staffing. However all services were facing increased demand for services. Four of the five children's commissioners in the local clinical commissioning groups stated that was the biggest challenge facing the services.
- However in South Bucks CAMHS, staffing numbers were identified as a challenge. The transition from the tier model and crisis service to a pathway model was being managed carefully. Staff had been consulted as to what

area they would prefer to work in. During this process managers had been able to identify the total vacancies to fill across the new OSCA service was 29% which was being managed by robust recruitment. This equated to four vacancies out of 13.5 whole time equivalent posts. . In order to ensure a safe transition to the new model additional experienced locum staff on a six month contract had been recruited. All staff members we spoke to told us the locum staff were skilled, knowledgeable and considered part of the team.

- In the Salisbury team the staffing was 15 whole time equivalent posts with 3.2 vacancies. The trust had recruited to one post with a further two staff recruited on fixed term contracts. Due to the increase in waiting times and caseloads, senior managers had agreed to a locum for 12 weeks to support the caseload management.
- We were concerned that clinicians' caseloads were high, for example in Salisbury the average caseload was 64. However, there was also pressure in the teams where staffing was at or near full complement, in Oxford central the caseload per tier three practitioner was 60.
- There seemed to be a particular issue in the consultant psychiatrists' caseloads. In the north Oxford team for example consultants were holding cases of 120 people. In Swindon consultants reported caseloads of 110. When we asked a manager in the Oxford central team what their highest caseload was they stated that over the summer when two doctors were off work one doctor had a caseload in the seventies. When we checked the psychiatrist's caseload on the records system, it was 188. The Royal College of Psychiatrists recommended level for consultants is 80. A psychiatrist on a phased return from sick leave had a caseload of 82. Senior managers were aware of the large medical caseloads in some areas and had begun work to address this. However the caseloads of all consultants was not understood.
- There was a perception by staff we spoke to that the focus on the waiting lists had resulted in higher caseloads and a pressure to allocate care co-ordinators more quickly, which led to higher stress and pressure on the teams. Staff told us they did not believe young people were at risk and the majority felt they were achieving good outcomes. However where there were high caseloads in the Oxford Central team and Salisbury team staff felt under much higher pressure and were concerned at potential increased risk.
- This had meant a need for creative management of caseloads, for example we were shown how groups had been set up for people to access instead of one to one interventions in PCAMHS and also smarter triage of referrals (telephone consultations) to reduce travel and face to face time. Where appropriate, some young people would use video calls with their care coordinator, which helped with the capacity management and the large distances that the staff in rural areas such as Wiltshire had to manage.
- The Oxford north team in Banbury and Oxford south team in Abingdon were planning on restructuring their services in the future. This aimed to make services more integrated. Staff and managers believed this would reduce waiting times.
- We were shown how caseloads were managed in the North and South Oxford teams. We found that in these services the team managers were efficient at monitoring caseloads and maintaining communication with team members around management of caseloads. Supervision records showed that staff were supported to discuss caseload management. A RAG rating to determine risk (red, amber, and green) was applied to the caseload management spreadsheets, which also identified when care programme approach reviews were due. Caseloads for tier three practitioners here were high at an average of 45, but lower than other areas of the trust.
- The children and young people's directorate compliance for mandatory training was 82% against a target of 87%. However, within child and adolescent mental health services compliance was lower such as CAMHS Buckinghamshire OSCA team where 64% completed mandatory training. This was echoed elsewhere with tier two CAMHS Buckinghamshire South 66% completed, Oxford tier three 67% completed, Oxford Central 69% completed and Oxford North 68% completed. However Oxford South tier two had exceeded the target with 90% completed.
- Staff expressed concern that a lot of mandatory training was provided in Oxford, which meant long travel times

Requires improvement

Are services safe?

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particularly for those in Wiltshire and Bath and North East Somerset. We did see however that the trust was making efforts to deliver training for staff more locally with some mandatory training being delivered in the community bases. Some community staff were being trained as trainers, for example a practitioner based in Melksham was training to be a trainer in life support.

Assessing and managing risk to patients and staff

- We were concerned at the variability of recording risk assessments in the services. In Melksham the six records we sampled all had either no or poorly completed risk assessments. For example, one record had a part completed risk assessment that had been started in 2014 and not been updated since. In Oxford Central four of the five records we viewed also had the same problems. In Swindon three of the six records we viewed were poor. However in other areas of the service we saw that risk was being recorded more accurately. Out of the care records viewed in the Oxford north, Oxford south and Buckinghamshire south and Bath and north east Somerset services, we found that all had a risk assessment on initial triage, a full risk assessment on admission to the caseload and risks were reviewed regularly. Risks identified were translated into the plans of care for all the records we saw and crisis plans were in place. Quality of records was not totally consistent in these services. For example, in Salisbury we reviewed ten care records and although nine were good, one was poor. There were variations in the quality and detail of the risk assessments. For example one crisis plan contained 'all agencies to collaborate together' but did not give details about how this would happen or who the agencies would be. We saw a number of very basic risk assessments. However it was clear that risk was a high priority and staff were skilled in identifying and managing risks even if this was not reflected in the records. The staff we spoke to and clinical meetings attended demonstrated a very high skill and knowledge around risk management. In clinical appointments we observed we saw staff skilfully addressing risk with young people and making good assessments of their needs.
- In all of the outreach services for children and adolescents (OSCA teams) which provided intensive assertive outreach to higher risk young people we saw consistently excellent risk assessments and plans for managing them.
- We attended multidisciplinary team meetings in Swindon and Melksham and clinical discussion meetings with the Oxfordshire OSCA team, the Bucks OSCA team and clinical handovers in the North and South Oxford teams. During all these clinical meetings we saw very high level discussions around risk management demonstrating very skilled teams. In all meetings a number of cases were discussed at length and within them we saw the risks were high and complex. Teams supported each other, offering clinical challenge, ideas and shared the risk. During the handovers current risk factors and changes in risk were communicated with clarity and updated in the clinical records. We noted there was a high level of clarity in planning around risk management.
- We raised our concerns with the trust around the quality of the risk assessments at the time of our visit. The trust immediately undertook an audit which according to the trust 'confirmed the variability of risk assessment entries'. The trust has put in place an action plan to address this. This includes includes sharing examples of good practice across teams.
- All staff we spoke to were able to clearly describe the safeguarding procedures, including how to make an alert. Team meeting minutes recorded in depth discussions of safeguarding issues. We saw this in the meetings we observed. There was clear evidence of good liaison with both the trust and local safeguarding teams within the case records. One of the trusts named safeguarding nurses visited each team for six weekly safeguarding supervision. We also saw good leadership and support from the named doctor for safeguarding which was valued by the teams. We saw a case where there had been disagreement between agencies involved where the named doctor had visited that service and chaired a meeting with all professionals and agencies involved to make sense of the differences and agree a strategy.
- All the teams we visited had good lone worker systems and staff we spoke to were confidently able to tell us what they were. For example, in South Bucks, where the

Requires improvement

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service is over a 24 hour period, details of workers were linked to the switchboard at Aylesbury and Oxford. Staff members always worked in pairs for out of hours visits. All the teams had a buddy system and outlook diaries were kept updated and monitored by both buddy and administrative staff throughout the day. Clinicians were very positive about the support that the administrative staff provided in checking diaries and supporting them in lone working.

Track record on safety

- There was one serious incident requiring investigation (SIRI) in the last 12 months. This involved a ligature in one of the community sites. We observed good learning from this incident which had improved safety in the service. The trust had made physical alterations to the site. The learning from this incident had been shared across all the community CAMHS teams provided by Oxford Health. Staff across the services were able to tell us about the incident and some told us how the actions and recommendations had been put into practice including the introduction of ligature cutters and how they had practiced their use in team meetings.
- We were also aware of the death of a young person who was open to this service which occurred earlier this year. The coroner had not held their hearing at the time of our inspection, so we were not able to comment on this in our report.

Reporting incidents and learning from when things go wrong

- There was good knowledge around reporting incidents. Staff we spoke to knew the systems and the procedure for reporting. We were told there was good feedback locally from incidents and learning points were discussed in team meetings and individually in supervision. We saw examples of this in team meeting minutes.
- Staff told us they felt supported around incidents and that they felt there was an open and honest culture including and involving young people and carers.
- We were given examples of where incidents had prompted a change in practice. One involved improvement of lone working procedures and another following a breach in confidentiality. We saw that risks around these were reduced since the improvements, and more robust systems were in place.
- Staff were also able to describe trust wide incidents outside of CAMHS, through the trust's quality improvement newsletter called "The Bulletin." Where appropriate this was also discussed in staff team meetings, for example the clinical team manager in the Swindon learning disability CAMHS team was able to show us how they screened the bulletin for relevant learning and discussed the outcomes and impact on practice in their team meeting.
- Staff we spoke to described a "culture of learning" within the organisation and that there was a no blame culture regarding incidents, which were always used as learning points. We also saw evidence of staff having appropriate support following incidents including debriefs. In a meeting with police in Wiltshire we saw the service discussing recent incidents in crisis care for young people and looking at lessons learnt.

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

- All referrals coming into the CAMHS services were subject to initial triage and screening prior to formal assessment.
- In the majority of areas a normal tier 2 and tier 3 model was in place although tier 2 services in Swindon were provided by the local authority.
- The South Buckinghamshire CAMHS team in High Wycombe and North Buckinghamshire CAMHS team in Aylesbury were developing a new model of care. They were moving away from the traditional tier two and three CAMHS to an integrated pathway model in partnership with Barnardo's and Beat (third sector provider with expertise in eating disorders). From October 1st all referrals would come in via a single point of access (SPA) in the North Buckinghamshire CAMHS team in Aylesbury, where skilled clinicians would assess the level of treatment needed.
- We looked at care records from all the services, and found the assessments to be comprehensive and holistic. The day to day records of care young people had received were all of good quality. These were all recorded onto the electronic records system.
- There was variation in how care plans were recorded. Some areas recorded the care plan in more traditional CAMHS format of a letter to the young person or parents/carers. Other services used care plans and letters. All the plans of care reflected the views and involvement of the young person and/or their carer where appropriate. We saw the planning of care was of a high standard and very person centred, clearly reflecting the needs and wishes of the young person. In all of our observations of care we saw that young people and their carers were consulted on their care. We were also told this was the case by all the young people and families we spoke to. Where formalised, care plans had clear outcomes and it was documented that young people and their carers had been given copies of their plans.
- The CAMHS teams had experienced the process of migrating records from one electronic system (RiO) to another (Care notes) which was causing some frustration and concern within the teams. Despite this, we found the records were transferred over safely and were managed well.
- The electronic records system (CareNotes) required staff to use its diagnosis codes within the system. We were concerned to note this meant that staff were having to use the diagnosis of 'mental retardation' in the learning disability teams. Staff in those services had put in more respectful formulation and diagnosis of the young person's needs in free text boxes underneath. Staff were very unhappy at having to use this term in the young person's records and had raised it previously with the trust. It was not used clinically in letters or discussions with children and families.

Best practice in treatment and care

- The services provided a wide range of psychological interventions including multi-family therapy, cognitive behaviour therapy and dialectical behaviour therapy.
- Physical healthcare had been considered in the records and addressed if there were any concerns. The records we looked at reflected good liaison with the young person's general practitioner, who held responsibility for their overall physical health management.
- At the time of our inspection, outcome measures being used were ROMs (routine outcome measurements) which included strengths and difficulties questionnaire (SDQ) and social communication questionnaire (SCQ). The SDQ was being completed periodically throughout the treatment period, however it was paper based and the return rate was poor. Due to this, an electronic application for the iPads used by the teams was developed to be used starting mid-October which would capture real-time results with ease of use for young people and their families and carers. Commissioners had raised concern about the difficulty in capturing outcome data, however the new system appeared to be robust enough following its trials and managers were confident in its roll out.
- We looked at a random selection of active cases within the services we visited. Complex cases were being monitored and managed well by multi-agency teams. Young people who needed support outside of the CAMHS teams were signposted to alternative support, the CAMHS team maintained contact.

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.

- We observed an outreach service for children and adolescents (OSCA) clinical referral meeting and looked at a sample of case notes within the OSCA services. The skill level and experience of the professionals in these teams was very high, this was apparent when very complex cases were discussed in particular. The team worked closely with the crisis service. We heard examples of creativity with difficult to engage young people, staff willing to meet the young people in cafes and other areas away from clinics in order to support them. These were arranged at times that suited the young person's waking or sleeping habits.
- All of the OSCA teams, including support workers, were trained in dialectical behaviour therapy. This was considered best practice for the high level of needs the young people using the service presented with, for example self-harm or eating disorders.
- We attended a family therapy group which consisted of five professionals, psychiatrist, family therapist, social worker, mental health practitioner and psychotherapist. Throughout the session staff paid very good attention to the young person and their carers. We also observed a parents educational group, set up by North Oxford PCAMHS in Banbury to support parents in recognising and managing anxiety and panic in their children. This was led by caring and knowledgeable staff. Evaluation sheets were used at the end of the sessions with a rating of one to five. However it didn't state whether one was good or five was good. When we fed this back it was immediately acted upon so people could feed back clearly with a clear scale.
- In Witney there was a regular group for the management of anxiety for parents of young people who use the service. In the last 18 months there had been five groups of six parents helped in this way, by providing cognitive behavioural therapy.
- Across all the teams staff were being released for training to deliver children and young people's improving access to psychological therapies programme (CYP IAPT) which was then being consistently delivered.
- In the youth offending team in Oxfordshire, CAMHS staff worked jointly with other agencies in a cannabis clinic. Police gave young people a warning whilst the CAMHS staff saw them for triage. This meant that staff could pick up early signs of developing mental illness and provide education to young people about the risks of illicit drug use to their mental health.
- In all the episodes of care we observed that conversations were goal focussed for the young person and their carers.
- Clinical staff regularly engaged in clinical audit. For instance, there was a quarterly care programme approach audit; a review of information shared with GPs and an audit looking at the quality of assessments under the Mental Health Act 1983. An attention deficit hyperactivity disorder audit that had been set up to check for improvements against previous national audit.

Skilled staff to deliver care

- All the services employed highly skilled and experienced staff, which included nurses, consultant psychiatrists, psychologists, primary mental health workers, family therapists, cognitive behavioural therapists, social workers, child and family support workers and occupational therapists. The teams also had experienced and supportive management teams with appropriate clinical backgrounds.
- All staff received a comprehensive induction programme on joining the trust. In addition within the new Buckinghamshire service, specialist training had been provided in conjunction with Barnardo's. Barnardo's supplied a staff team of 30 specifically recruited to work within the new model. These staff would provide the 'buddy' role. At the time of our visit they were in week four of the induction, however some employees had fed back that they did not feel confident in some areas and extra training had been planned following this feedback.
- Teams we visited were enthusiastic and skilled. For example in North Oxford CAMHS team in Banbury and South Oxford CAMHS team in Abingdon staff were able to clearly talk to us about their roles, had received training appropriate for their roles and had all received supervision regularly. We saw in team meeting minutes that training needs and skills were discussed. We also saw this within staff supervision records.

Are services effective?

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- Services for children with learning disabilities varied depending on local commissioning priorities. In some areas, such as Swindon there was a very skilled team well led by a clinical manager and a child and adolescent psychiatrist specialising in learning disabilities. In other areas we saw learning disability professionals working in virtual teams integrated in the tier 3 CAMHS services. Staff in both models shared learning and best practice with each other.
- We saw where there had been concerns about a clinician's performance that the managers supporting that individual were taking appropriate action to address their needs.

Multi-disciplinary and inter-agency team work

- We observed multi-disciplinary team meetings in Wiltshire, Swindon, Salisbury, High Wycombe, Banbury and Abingdon and reviewed the minutes of other teams. These were well attended by all staff from different disciplines and teams in each region. The meetings were well conducted and effective. We saw that the staff regularly brought more concerning cases to the meetings and risk was shared amongst the team rather than sitting with individual clinicians. Case discussion was robust and challenging, but at all times was respectful with a genuine care for young people and their carers. The meetings also had a business component where any corporate business including incident feedback, training, and caseload management issues could be discussed.
- External agencies including the police, head teachers and local authority staff were positive about the service's approach to multiagency working. They described the trust's CAMHS services as extremely responsive with a very good knowledge of safeguarding and able to challenge appropriately and ask difficult questions. Commissioners in the clinical commissioning groups described multiagency working as one of the CAMHS services strengths.
- We also observed several high level clinical meetings, including pre-assessment, assessment and debrief meetings.
- We observed a regular meeting between the Wiltshire police mental health liaison officer and the CAMHS service manager for Wiltshire. There was clear evidence of this being an effective means of ensuring good liaison to address crisis care issues for young people where the police were involved. The meeting addressed issues regarding section 136 and also discussed young people who were frequently high risk where the CAMHS team had provided care plans for the police to follow which were held on police systems.
- We also observed a neurodevelopmental forum in Wiltshire which consisted of paediatricians, speech therapy, educational psychology, and the CAMHS team. This showed excellent working with other services including discussion of complex young people to ensure the best possible outcome for them.
- We attended and observed a school in reach session provided by the North Oxford CAMHS team in Banbury. We observed excellent working relationships and good examples of multi-agency working to support the young person to remain in school. We saw that the team members shared expertise and supervision.
- We observed outreach service for children and adolescents (OSCA) clinical meetings with the South Buckinghamshire CAHMS team in High Wycombe and the Oxford Central team. The teams present had high level and skilled discussions around not only risk management, but discussed creative ways of engaging the young person through joint working with external agencies, for example local authority safeguarding, schools, council and voluntary sectors. We saw examples of when young people wished to transfer to another team and the communication levels between the teams was good.
- We also observed discussions around the involvement of the young person and potential transition to adult services. This included meetings set up with adult services, including in those areas such as Wiltshire and Bath and North East Somerset, where the trust was not the provider of adult services.

Adherence to the MHA and the MHA Code of Practice

- Staff had received training in the Mental Health Act and code of practice. Most of the staff were confident in the codes specific guidance on children and young people under the age of 18.
- Psychiatrists in the service all received section 12 training and although the use was infrequent as would

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be expected in CAMHS, the doctors displayed good knowledge and described the support offered by the trust and the training offered in the Mental Health Act as meeting their needs.

Good practice in applying the MCA

- There was a variable level of detailed knowledge around the Mental Capacity Act in the staff we spoke with. All the staff understood what the Act was, however the majority told us it was mainly the psychiatrists who would lead on the Mental Capacity Act. We were concerned when one manager informed us that the Mental Capacity Act did not apply to them as they worked in children's services.
- The Mental Capacity Act does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the patients where possible in the decision making regarding their care.
- There was evidence of consent to treatment and consent to share information being recorded in the majority of the records we reviewed however it was lacking in some services such as all six of the records we reviewed in Melksham and six of the records we viewed in Swindon and Oxford Central which was half of the records we viewed in those services.
- However we did see staff engage in discussions about consent with young people and their families in all the clinical observations we conducted including those teams.
- Where capacity and consent was recorded we saw that these had been updated and checked when decisions needed revisiting regarding consent.
- Mental Capacity Act training was only given once when staff first joined the organisation with no updates or refreshers.

Outstanding ☆

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

- We rated caring as outstanding as we observed staff who were positive in their interactions with young people and their families and respectful of their needs even when they were not present, for example in multidisciplinary team meetings.
- Families and young people we spoke to were universally positive about staff and the way they interacted with them. One parent who used the learning disability service in Swindon described their clinician as someone who helped them unpick and find the solution as the parent rather than telling them what to do. We had previously observed in a clinical session with that parent the clinician skilfully getting the parent to come to conclusions for herself and then offering meaningful choices about future care pathway options whilst valuing the parent's views.
- In all the conversations we had with 20 young people who used services and 29 family members/carers and the 14 comment cards we received, there were no adverse comments about staff. They all reflected that staff valued young people and treated them with kindness, dignity and respect. This was reflected in the experience of service data that the trust collected and we reviewed.
- Families were also very positive about the administrative staff and receptionists, stating they were always calm and respectful, even when they called in distress. One parent described a team administrator as 'Mary Poppins' in the way that they resolved things swiftly and ensured that clinicians were available when she called.
- All young people and carers spoke positively about how responsive staff were. We were told by young people and families that if they called in a distressed state the staff always assisted and listened and helped even if they did not personally know them.
- We observed numerous interactions with young people and their carers; some informally in the waiting rooms and others during clinical therapy sessions both in the sites and the community. At all times we saw the behaviour and manner the staff acted in was polite, friendly, warm and respectful.
- We observed a young person and their carer joining two therapists for a session within the South Oxford PCAMHS team in Abingdon. We saw that throughout the entire session the young person and their carer was involved in the process and treat with dignity and respect. The carer told us after the session the staff were extremely professional and patient.
- Another carer who we spoke to in the North Oxford CAMHS team in Banbury told us they always felt welcomed and 'looked after' whilst helping them with their problems. They told us they were happy with the service and they had seen a positive change in their child. They were confident in the care they received and were always treated with dignity and respect.
- A young person we spoke to in the South Buckinghamshire CAMHS team in High Wycombe also reflected this. We were informed that they had been very scared when they had first used the service and 'out of control', that staff at first had 'used a lot of long words' that they didn't understand at first. However they said that staff quickly made them feel very comfortable and safe. They told us they were provided with leaflets they could understand so they didn't have to talk to their parent about what they were feeling if they didn't want to. They said that all the staff were very friendly and welcoming, even when they are just passing them in the waiting room.
- In another intervention we observed in the Family Assessment and Safeguarding Service in Oxford we saw that the clinicians presented sensitive information in a way that the parents could understand and digest whilst being respectful and empathetic at all times.
- Another young person we spoke to in the waiting room in the North Oxford CAMHS team base in Banbury told us they had received very helpful information before their appointment. That everyone had been very polite and genuinely had wanted to help. Despite feeling initially anxious and nervous, the staff had helped them

Are services caring?

Outstanding ☆

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to relax and feel safe and comfortable to manage their problems. They told us they were very happy with their therapist, who was very caring and professional and gave good feedback and support to carer too.

- We spoke with a young person in North Oxford CAMHS team who told us there was a good system to access the service initially through the school, that staff were 'absolutely' respectful and trustworthy at all times. They told us the teams were very caring and considerate and they felt secure in their care. They told us their case worker made sure they were always engaged in decisions every session, and that although their family wasn't involved at first, as treatment went on the young person decided to involve their family as their confidence increased. They told us there were good feedback systems after each therapy session.
- Throughout all of our observations of direct clinical care and meetings we noted that staff were extremely knowledgeable about the individual needs of their service users whilst also displaying a genuine warmth and concern for their circumstances and welfare.
- A senior manager in one of the local authorities told us that the staff they worked with worked incredibly hard and always had the family and child at the centre of everything they did.
- We saw that confidentiality was maintained. In multidisciplinary team meetings we observed there was clear discussion on information sharing and what should be shared with other agencies. There was a good understanding of the boundaries between safeguarding and patient's rights to privacy. We saw in our observations of care that young people were involved in how and when the information could be shared.

The involvement of people in the care they receive

- We saw clear involvement of young people in decisions about their treatment and care. Young people and their families were given genuine choice on the future pathway of their care in the majority of cases. Where there were not alternative options this was explained appropriately to the young person and their carers.
- Across all services they all had received support and guidance from the staff. We found numerous examples where staff acted as advocates to the young people and their families and carers in aiding them to access other statutory and voluntary services.
- The trust facilitated a group called the "Article 12 council" within the Oxfordshire CAMHS services. This was named after article 12 of the United Nations Convention on the Rights of the Child which is "respect for the views of the child when adults are making decisions that affect children". Throughout the services we visited we saw that the article was fulfilled by all levels of staff and management in the organisation who were clear that children have the right to say what they think should happen and have their opinions taken into account.

The "Article 12 council" consisted of young people who used services and were involved in service improvement. Over 35 young people participated in this facilitated by three participation workers. Work had included the re-commissioning of the service in Buckinghamshire as well as being involved in interviewing staff with their own questions.

- The Article 12 council also supported the teams in design of facilities, information provided and offered challenge to the way services for young people are delivered. All the staff and management we saw spoke about the group with enthusiasm and pride.
- We found that the staff and the trust valued the young people so much they had created innovative new apprenticeships for young people who have used services, partly to help them gain meaningful employment. This meant that they could be helped into the job market as part of their recovery.
- The service regularly took feedback from young people and families and carers using the services in a variety of formats including questionnaires and apps on ipads. We saw evidence of "you said, we did" in all the reception areas we visited.

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 CAMHS services aimed to see emergency referrals within 24 hours, with different targets for urgent and routine referrals depending on where they were commissioned. A routine referral would enter the single point of access where a clinical team leader would triage to ascertain appropriate pathways. This was done in conjunction with the team manager so a decision could be made whether the referral sat within PCAMHS or CAMHS. A care co-ordinator would then be allocated dependent on the skills required.
- At the time of our inspection there were variable waiting times to access services across the trust. In Bath and North East Somerset access to both tier two and tier three services was only four weeks. However in Wiltshire tier three services had a wait of 16 weeks for the Salisbury team whilst other tier three services in Melksham and Marlborough were for four weeks.
- The trust gave the waiting times as follows:
- Oxon South tier two PCAMHS six weeks
- Oxon North tier two PCAMHS nine weeks
- Oxon central tier two PCAMHS 12 weeks
- Oxon South tier three CAMHS 15 weeks
- Oxon North tier three CAMHS 12 weeks
- Oxon central tier three CAMHS 13 weeks
- Buckinghamshire North tier two PCAMHS four weeks
- Buckinghamshire South tier two PCAMHS six weeks
- Buckinghamshire North tier three CAMHS two weeks
- Buckinghamshire South tier three CAMHS 15 weeks
- Swindon tier three CAMHS between 8 to 12 weeks
- Wiltshire Melksham tier two PCAMHS six weeks
- Wiltshire Salisbury tier two CAMHS 12 weeks
- Wiltshire Marlborough 22 CAMHS 12 weeks
- Wiltshire tier three CAMHS Melksham four weeks
- Wiltshire Marlborough tier three CAMHS four weeks
- Wiltshire Salisbury tier three CAMHS 16 weeks
- Bath and North East Somerset tier two PCAMHS four weeks
- Bath and North East Somerset tier three CAMHS four weeks
- The most serious concern was the waiting time in Salisbury. When we visited the service, the local team had figures which contradicted the trust figures above. Locally the team reported they had a waiting list of 24 weeks, however the trust assured us this figure was for a small number of young people. There was an active review looking at the caseload in Wiltshire with assistance coming from the other CAMHS teams in Marlborough and Melksham. New staff had been appointed to address this, including the trust agreeing to locum staff to assist with the waiting list, although staff were concerned this was only for a short period.
- There was a perception by staff we spoke to that the focus on the waiting lists had resulted in higher caseloads and quicker allocation of care co-ordinators, which led to a little higher stress and pressure on the teams and higher caseloads. Staff told us they did not believe young people were at risk and the majority felt they were achieving good outcomes. However where there were high caseloads in the Oxford Central team and Salisbury team staff felt under much higher pressure and were concerned at potential increased risk.
- We did note that from June 2015, the North Oxford CAMHS team in Banbury and South Oxford CAMHS team in Abingdon had reduced their waiting times from over 30 weeks.
- Commissioners in all the clinical commissioning groups told us that the pressure on waiting times and access to the service was their main concern. This was a key feature in discussions about the service, although many of them acknowledged that the services were coping with increasing demand across all their areas.
- The services considered discharge when appropriate and had good arrangements in place for transition from children to adult services, even in areas where the trust did not provide those services. This included regular monthly meetings with adult services.

The trust had comprehensive crisis support for young people which was provided across all of its services. Young people who were assessed as needing urgent care were seen promptly and without delay. The trust operated an on call system that had a senior mental health practitioner able to respond within each county. They were supported by a clinical team manager and on call CAMHS psychiatrist who could be called if required. The telephone numbers for who was on call were distributed to the 111 telephone call service, GP's, emergency departments and social services.

Are services responsive to people's needs?

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Families as part of their crisis plans were advised to call 111 who would then notify who was on call. The service would offer a phone consultation but also urgent assessment when necessary. The on call psychiatrist could be called if the mental health practitioner felt it was required. The service ran a duty system each working day with two emergency slots for assessment at 10am and 2pm in each of the tier three CAMHS teams. The mental health practitioner on call could book into those slots for the next day or they could be used if families or other agencies contacted the service with urgent concerns. The system was robust and used appropriately and met the needs of young people in crisis.

- The trust took active steps to engage with young people who found it difficult or were reluctant to engage with mental health services. In all five counties the trust ran an OSCA service (outreach service for children and adolescents) which engaged with young people who would not engage with a clinic based service. We observed numerous examples of effective interventions by this service. One young person was met in a garden centre café. Although we were initially concerned about the confidentiality of this environment, the young person explained that they would not visit the CAMHS service base for fear of being seen by peers and did not want home visits for the same reason. It was explained to us that there was little chance of her teenage friends going into a garden centre café. This made her feel secure and therefore able to engage.
- The staff working in the OSCA service including mental health practitioners and support workers, provided lots of innovative ways to engage the young people. This included using text and video calls which proved effective with the distances they had to travel and provided face to face contact with distressed young people when they needed it. We also saw them visiting young people in their homes including providing meal time support to young people with eating disorders.
- We saw guidelines for management and assessment of young people following self-harm. It detailed management of someone presenting to the emergency department and identified the process including medical care, psychosocial assessment, social concerns, safety issues, complex cases, criteria and discharge. All staff we spoke to knew these guidelines. This included other agencies that may come into contact with the young person for example care plans being jointly developed with police and emergency departments.
- Following work with commissioners and the start of a new contract, the South Buckinghamshire CAMHS team in High Wycombe and North Buckinghamshire CAMHS team in Aylesbury were in the process of developing a new model. This meant moving from the traditional tier two and three CAMHS to an integrated pathway model. When this was rolled out fully, it would provide a single point of access to appropriate help.

The facilities promote recovery, comfort, dignity and confidentiality

- The environments that we saw were very mixed in terms of being appropriate for the needs of young people and their families. The Oxford central team had one of the best reception areas we have seen for young people with clear involvement of young people in its design, including funky flooring and a large plasma screen with information provided in age appropriate ways. However the walls in the clinic areas were bare with few pictures. This also applied to the Swindon base where the reception area was also well designed with young people's involvement but few pictures on the walls in the consulting rooms and corridors leading to a sterile environment except for two rooms used by another team. However Swindon, along with North and South Oxford and Buckinghamshire South had electronic terminals for patient feedback in the waiting area.
- The building used by South Buckinghamshire CAMHS team in High Wycombe was in disrepair. Plans were in place to move to health premises in December 2015 as the current building was owned by the local authority. The team had made a lot of effort to improve the facilities with artwork and furnishings. The waiting room had a large provision of leaflets and information, accessible in different languages, and was made welcoming for the young people. We did note however, the consultation rooms were not entirely soundproofed.
- The building used by North Oxford CAMHS team base in Banbury had its own entrance which was clearly marked and accessible. The reception office was at the door entrance with one person facing the reception desk and able to observe who was at the door. We saw a large

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amount of leaflets however some were out of date by up to a year. There was good artwork displays and the environment was warm and welcoming. We saw there was a good selection of age appropriate books and games available and comfortable sitting area.

- The Bath and North East Somerset service in Keynsham was well appointed with comfortable facilities in a bright and modern décor with age appropriate resources. This service also had a large TV screen providing information about services. Young people from the participation group had arranged the design of this presentation.
- We found that despite the difficulties in the environment at Abingdon the team had done their best to protect privacy and dignity. However the weighing scales were out in the corridor (in a low traffic area) outside an extremely small clinic room with no examination couch. The service manager described to us the limited options of managing this in the small space and that position was the only one possible. We saw that it was also on the team risk assessment with actions around ensuring confidentiality. However the entrance and waiting area was warm and welcoming, with a lego wall in the reception room. We saw there was a lot of recent thank you cards displayed with appreciative messages and a TV screen with advice about the services and team contacts. Privacy was protected around the environment with privacy blinds at consultation room windows and a well-equipped play room with toys, books and games.
- In Melksham the staff had engaged with service users to make it as child friendly as possible, all of the clinic rooms had chalk boards mounted to the walls for young people to use. The service had been responsive to young people's needs, for example when a young person noticed there were two clocks visible in one room with slightly different times which he found difficult to process, one was removed. The service was running a competition for young people at the time of our visit for new art work for the walls.
- However the environment at Witney was very poor. In the reception area a chalkboard had been put up but there were no chalks available. The large television with the information animations designed by the young people that had been introduced elsewhere had been put up in a corridor. However, it was not visible to people waiting in reception. The service had no age appropriate toys. Pictures on the wall were peeling.
- In all of the waiting rooms we saw that radios had been provided that played local radio stations. We were told that this had been introduced following feedback from families in particular parents and carers who found waiting in silence difficult if they didn't accompany the young person into their appointment.

Meeting the needs of all people who use the service

- All staff had access to interpreters when required and we saw evidence in the care records of staff being respectful and meeting of young people's cultural needs.
- The outreach service for children and adolescents (OSCA) was open to all children and young people. Children with learning disabilities who needed assertive outreach were also able to access the support and interventions the service offered with joint working with the learning disability teams.
- There were no concerns regarding disabled access at any of the sites we visited. However in the Keynsham base all the staff offices were up the stairs in a building with no lift. Although this would not affect patients it would limit any professional visitors or staff members who had a disability. There was a similar situation in the office at High Wycombe, however in that base, designated office space on the ground floor had been prepared if anyone required it.
- All of the leaflets the trust provided had a statement on the back of them which read "If you need the information in another language or format please ask us". This statement was then repeated in seven different languages and scripts.

Listening to and learning from concerns and complaints

- All young people and their carers we spoke with told us they knew how to complain. They were able to describe the complaints procedure and all said they felt confident that this would be acted upon if needed. None of the people we spoke to said they had anything they wished to complain about in their services at the time of our visit.

Are services responsive to people's needs?

Good

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- Staff we spoke with were able to describe the complaints procedures and felt that the services were very open with families, bringing any issues to their attention in a timely way. Family members and carers we spoke with told us they felt the teams were open with them and felt they could discuss any concerns with the staff should they need to.
- We saw evidence in care notes of informal complaints being dealt with swiftly by local service managers. However we were told by managers that they did not collate the informal complaints to analyse any trends.
- There were ten formal complaints in the last year, of which six were upheld. One was referred to the ombudsman. The most common theme was difficulties with communication with families. We saw evidence of learning in relation to formal complaints. For example, in one complaint there was a concern that the CAMHS team had failed to respond to a request that had come from a school. The investigation accepted that there had been issues around communication of the closure of the request from the school, noting that neither the family nor GP were informed of this. We saw that changes had been made and communication was good with schools during our visits.

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

- All the staff we spoke with were able to tell us the vision and values of the organisation as well as the ethos and values of their individual teams. We saw there was an excellent sense of pride within the teams around the services they provided and staff told us they felt respected and supported by local management.
- We were told that managers within the team and senior managers were very visible, approachable and creative. We saw that staff felt able to challenge management decisions without recrimination.
- Members of the executive team had visited a number of the CAMHS services and we heard numerous times that staff in CAMHS felt that the chief operating officer was a positive champion of their services. Staff told us they felt that the chief operating officer understood the challenges they faced and was very supportive.
- The vision of the service to engage with young people with the most complex needs was evident in their engagement with commissioners in delivering a robust out of hours and crisis service. This was coupled with an assertive outreach model for children and young people which was very good.
- The creativeness of the leadership was evident in the development of apprenticeship roles by managers in the service. These aimed to continue to harness the skills and experience of young people who had used the service, whilst giving them the experience to help them engage in the jobs market through the apprenticeship.

Good governance

- All staff received appraisals and regular supervision in line with trust policy. Staff we spoke with all felt they were supported through supervision, could raise issues and discuss caseload management. We looked at three random supervision records from teams we visited and these were completed and detailed, with clear goals and targets set. Some of the teams had started using the routine outcome monitoring tools as part of caseload supervision by managers. These were the outcome tools in patient's clinical notes and they were being used to help the clinician in supervision about the patient's progress. Where this had been introduced we saw that it had a positive impact on the caseloads as staff were focussed on outcomes. We were told of plans to roll this out to all teams.
- Clinical audit across the services and plans for future audits were in place and discussed in team meetings.
- Incidents were reported through the electronic system (Ulysses). All staff we spoke with understood the system and knew how to report incidents. They also felt they received good feedback from incidents and received good debriefs from their team and management. We saw numerous examples of very good learning from incidents and complaints. Staff told us of a culture of learning in the organisation and that they would always feel comfortable in raising a concern in what they felt was a "no blame culture".
- There had been problems with the implementation of the new electronic record system and staff found it difficult at times to use all of its functionality.
- The team risk registers for all the services we visited were comprehensive, relevant and up to date with detailed actions. The managers we spoke with demonstrated how they had submitted information from the risk register and told us they had good communication with the senior management teams around any updates around actions and plans.
- There was good learning from formal complaints but we saw no evidence of monitoring of informal complaints that were dealt with locally.
- However we were concerned at the level of mandatory training amongst the CAMHS teams. Staff complained that too many courses were held in Oxford which made them difficult to travel to, especially if they were in Wiltshire or Bath and North East Somerset. Staff acknowledged that the trust had recently become more responsive to their needs in training. Some mandatory training had been delivered in local team bases with the training department travelling to them to deliver it. We also saw that some staff were being trained to be trainers to deliver mandatory training in their locality.

Leadership, morale and staff engagement

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.

- We saw strong local leadership within each of the teams. Staff felt supported by their managers and were positive, although we did note concerns within the Oxford Central team at Boundary Brook House.
- We saw that there was clear and effective leadership within the senior team in the children's directorate who had a shared vision for CAMHS and the trust and authority from the executive team to carry that out. There was respect for that leadership in the staff we spoke to.
- We spoke at length with all the service managers in all the services we inspected. Without exception they were committed, proud of their service and teams, creative and supportive and extremely knowledgeable and enthusiastic about the services they provided. They described the trust as being a positive place to work, with senior leadership that liked to work cleverly and creatively.
- We saw further evidence of the good leadership that we found throughout the inspection in the way that the trust responded to the difficult circumstances faced by one team in particular which included support from the trust board and chief executive.
- Staff were positive about the young people and the services they delivered whilst being honest about the challenges they face in the increasing demand and caseloads. We were pleased to note this was also true of the team that had faced the most significant challenges given the difficulties that they have faced.
- Children's commissioners in the five different clinical commissioning groups told us that the trust was good to work with and responsive to their requests. Commissioners felt that senior managers within CAMHS were always open to challenge and willing to look at any issue that needed to be raised. They also told us that the trust could be very innovative in how it delivered services, shown by the development of effective specialist services and ways to engage hard to reach young people. However there was some concern that the level of innovation the trust showed meant that it did not always focus on core service delivery. The confidence that the commissioners had in the trust was shown in the way two of the clinical commissioning groups had just extended their contract with the trust by two years and another had just recommissioned services from them.
- There were had been some very difficult challenges faced around reduction of waiting lists which had meant changes in work processes. Some staff told us they had been resistant to this and were feeling under some pressure, however with support of their line manager and service managers they understood the direction of the service. When we asked the managers and service managers how they managed this transition, all were able to give us good appropriate and supportive responses. However the impact on caseloads following this work needs to be addressed.
- In the large geographical areas that the trust provided CAMHS, we were told by staff that there had been a tendency for the trust to be too focussed on Oxford. An example of this was a member of staff in Wiltshire being told they had to attend the IT department to sign for a new mobile phone, which would have taken a day out of their work and considerable a 160 mile round trip. Although this was resolved we heard other examples of this. However there had been moves to address this by the trust, for example, recent innovations from occupational health visiting teams to hold clinics and consultations for managers and arranging to visit teams to deliver flu vaccinations in their bases.

We were concerned that staff in the Oxford central team felt that management within the trust were trying to manoeuvre our inspection so that we would not see the challenges they faced. This raised questions about the dynamics of this team which was an exception to all the other services that we visited where staff were positive and complimentary about management. A new service manager had been appointed less than two months prior to our inspection, who was enthusiastic about taking things forward

- Consultants within the service were very positive about the model and their role in it and were well respected in all areas and fully integrated into the teams. However there were issues with the consultant workforce in Wiltshire who felt under pressure coupled with some staffing issues. We saw clear plans in place to address this with senior managers having a full understanding of the issues we found.

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.

- Sickness and absence was not an issue in any of the core services we inspected. We also found that staff we spoke with felt confident to raise concerns and would not hesitate to raise a whistleblowing concern if they needed to.
- The NHS staff survey in 2014 showed that 79% of staff in the trust worked more than their contracted hours which was higher than the national average. Staff in the CAMHS services we spoke to reflected this, given their high caseloads.
- We asked staff if they had ever felt bullied or harassed within their roles. In one of the services we were told by some staff there had previously been a culture of bullying which they were now confident had been managed well. Nobody felt they couldn't raise a concern around bullying if they needed to. We could see that all the staff in the teams we visited were assertive, confident and very supportive of each other. This was also reflected by the managers and service managers who told us they encouraged positive challenge within the teams and were very sensitive and aware of the stress and pressure their teams could be under.
- There was a high level of pride and job satisfaction in the staff we spoke with, including managers and service managers. We observed that morale had been affected by changes in service model and pressure to reduce waiting times; however staff had retained their sense of pride and empowerment whilst supporting each other through the changes.

Commitment to quality improvement and innovation

- The service was one of the early adopters and pilot sites of children and young people's improving access to psychological therapies programme (CYP IAPT).
- Staff in the service had looked at unexpected deaths and impact on the service and how to support colleagues resulting in a paper published in the journal of psychology.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Regulation 17 (2) (c)** Records relating to the care and treatment of each person using te service must be kept and be fit for purpose. The provider must address the variable quality of risk assessments to ensure that all risks to young people are properly recorded and managed.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Regulation 17 (2) (b)** Providers must have systems and processes that enable them to identify and assess risks to the health, safety, and/or welfare of people who use the service. The provider must review the caseloads in the Tier 3 CAMHS teams and the impact on safe patient care.