Inadequate

North Staffordshire Combined Healthcare NHS 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)
RLY00	Trust Headquarters	CONNECT CAMHS and First Steps (Stoke) CONNECT CAMHS and First Steps (Newcastle under Lyme) CAHMs ASD CAMHS Disability Paediatric Psychology	ST6 5JJ and ST3 3BS ST5 1AZ ST1 5UR ST1 5UR ST3 3BS

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

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

Summary of findings

Where applicable, we have reported on each core service provided by North Staffordshire Combined Healthcare NHS Trust and these are brought together to inform our overall judgement of North Staffordshire Combined Healthcare NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive?	Inadequate
Are services well-led?	Inadequate

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 North Staffordshire Combined Healthcare NHS Trust as inadequate because:

- Staffing levels in most services were not safe. There were not enough consultant psychiatrists, nurses, psychologists, therapists or administrators. Young people waited too long to receive non-urgent assessments, diagnostic assessments or treatment. The Royal College of Psychiatrist have published a college report entitled 'Building and sustaining CAMHS to improve outcomes for children and young ' CR182 (November 2013). This report provides an update of guidance on workforce, capacity and functions of specialist child and adolescent mental health services (CAMHS) in the UK. It aims to give a 'rule of thumb' tool that can be applied to any region in any jurisdiction of the UK.
- There was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.
- The number of fixed-term additional staff was insufficient. They had minimal, if any, impact on some waiting times.
- Risk assessments for young people were not always completed. When risks were assessed young people did not always have a risk management or safety plan.
- In CONNECT and First Steps services, on some days, there was no allocated duty worker. Services could not ensure that urgent matters were dealt with in a timely manner.
- Safeguarding children training was not undertaken by all staff. Not all clinical staff were required to undertake level three safeguarding training.
- In almost all services, staff morale was low.
- Not all young people had a care plan. Where young people did have a care plan, the majority were not specific, detailed or personalised. Some care plans did not address young peoples' identified needs. Young people and carers' views were not recorded. A clinical audit of care plans had not led to improvements.
- There was no shared care protocol regarding the physical health of young people with eating disorders. This was not in accordance with NICE guidance. Weighing scales in services were not calibrated regularly.
- In CONNECT CAMHS and First Steps services, there was no regular communication with general practitioners.
- There was no psychiatrist in, or attached to, CAMHS ASD service. This was not in accordance with NICE guidelines. There was a lack of psychiatric input into CONNECT and First Steps services.
- The clinical records of some young people were transferred between services, sometimes regularly. There was a high risk that some young peoples' clinical records would not be complete, or always be available for staff that needed them.
- Outcome measures, to assess services effectiveness, were not used consistently in all services
- The buildings in which services were based were not suitable but there was a programme of improvement to improve services
- There was no effective system for monitoring feedback, or concerns, of young people or carers. Possible themes or trends were not always identified.
- There was a lack of robust governance systems in CAMHS community services to underpin safe and high quality care. Key performance indicators were limited in CAMHS community services.
- The plan to reduce the waiting lists was not comprehensive. It only addressed some of the difficulties, and was time limited. The plan did not have the level of impact required.
- The service managers, and their deputies, managed all of the CAMHS community services. They had limited capacity to drive quality improvement and service development.
- Plastic toys in waiting areas and interview rooms were not disinfected regularly. This was an infection control risk.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as inadequate because:

- Staffing levels in most services were not safe. There were not enough consultant psychiatrists, nurses, psychologists, therapists or administrators.
- Risk assessments for young people using the services were not always completed. When young people did have a risk assessment and identified risks, they did not always have a risk management or safety plan.
- The risk assessment form used by CAMHS community services was designed for adults. It was not suitable for use in CAMHS community services.
- There was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.
- Both CONNECT and First Steps services had a 'duty worker' system. On some days, within both services, there was no allocated duty worker. Services could not ensure that urgent matters were dealt with in a timely manner.
- Reception and administration staff were not required to undertake safeguarding children training. Not all clinical staff were required to undertake level three safeguarding training.
- Plastic toys in waiting areas and interview rooms were not disinfected regularly. This was an infection control risk.
- Weighing scales were not calibrated regularly. This equipment was particularly important for young people with eating disorders.

However:

- Staff were open and transparent with young people and their carers. When mistakes were made, managers were aware of what action should be taken.
- Incidents across all CAMHS services were discussed in team meetings. Staff discussed how learning might take place.

Are services effective?

Inadequate

We rated effective as inadequate because:

- Not all young people had a care plan. Where young people did have a care plan, the majority were not specific, detailed or personalised. Some care plans did not address young peoples' identified needs. Young people and carers' views were not recorded.

Summary of findings

- In CONNECT CAMHS and First Steps services there was not regular communication with general practitioners. This was also the case concerning young people with eating disorders. This was not in accordance with NICE guidelines.
- There was no shared care protocol regarding the physical health of young people with eating disorders. This was not in accordance with NICE guidance.
- There was no psychiatrist in, or attached to, CAMHS ASD service. This was not in accordance with NICE guidelines. There was a lack of psychiatric input into CONNECT and First Steps services.
- CAMHS Disability and CONNECT and First Steps services used outcome measures, but not consistently. Some staff members used different outcome measures. This meant the effectiveness of some services could not be assessed.
- The clinical records of some young people would be transferred between services, sometimes regularly. There was a high risk that some young peoples' clinical records would not always be available for staff that needed them.
- In CAMHS ASD there was no record of staff attending supervision.
- Most appraisals lacked detail. Staff members' progress, development and performance was not always recorded.
- There was little evidence concerning capacity in young people's clinical records.

However:

- A range of psychological therapies were provided by the services to meet the needs of young people.
- All services had regular team meetings, and staff attended these.
- Staff were able to undertake specialist training, including autism, theraplay, eating disorders and systemic family therapy.

Are services caring?

Good

We rated caring as good because:

- The way staff communicated with children and young people was thoughtful and respectful.
- The majority of young people and carers were very positive regarding staff. Young people could trust staff and felt listened to. Carers felt that staff had a real interest in their child or young person.
- Staff demonstrated a thorough understanding of young people and their families' needs.

Summary of findings

- Staff had undertaken evening and weekend work in order to reduce waiting lists. They were not required to do this.
- Young people were always included on interview panels during staff recruitment.
- Young people and carers had been involved in developing the new care pathways for the services. They were also being recruited to join the CYP directorate management meetings.

However:

- A small number of young people and carers had a negative view of staff. Young people and carers were not consistently asked to provide feedback on services. It was not clear if changes were always made as a result of young peoples' and carers feedback.

Are services responsive to people's needs?

Inadequate

We rated responsive as inadequate because:

- Young people waited three to four months to receive a non-urgent initial assessment.
- Following assessment, young people waited a year for partnership appointments.
- The waiting lists for school observations and the CAMHS ASD service were a year or more.
- Many young people first received treatment well over a year after the initial referral.
- The buildings in which services were based were not suitable but there was a programme of improvement to improve services.
- The majority of carers said that they did not know the complaints procedure. Staff did not consistently tell young people or carers how to complain.
- There was no system for monitoring concerns of young people or carers. Possible themes or trends were not always identified.

However:

- The findings from complaints investigations were discussed in team meetings. Staff also received individual feedback from complaints and learnt from this.

Are services well-led?

Inadequate

We rated well led as inadequate because:

- In almost all services, staff morale was low.
- There was a lack of robust governance systems in CAMHS community services to underpin safe and high quality care.

Summary of findings

- There was no overall system for monitoring that NICE guidance was followed.
- A clinical audit of care plans had not led to improvements.
- The providers' key performance indicators were limited in CAMHS community services.
- Outcome measures were not used consistently, so service effectiveness could not be assessed.
- The service managers, and their deputies, managed all of the CAMHS community services. They had limited capacity to drive quality improvement and service development.
- Insufficient additional staff had been employed to reduce waiting times. The plan to reduce the waiting lists was not comprehensive. It only addressed some of the difficulties, and was time limited. The plan did not have the level of impact required.

However:

- There was a strong sense of team cohesion and staff provided mutual support to each other.
- Service managers and their deputies were aware of their responsibilities when mistakes were made with regards to duty of candour.
- Managers in the CYP directorate had attended the Aston leadership programme.
- Staff were positive regarding the new management in the CYP directorate.
- The new management team were clearly committed to improving the quality and safety of services.

Summary of findings

Information about the service

The children and young people's directorate (CYP) in the Trust provides a number of different Child and Adolescent Mental Health Services (CAMHS) for young people in Stoke-on-Trent and North Staffordshire.

Adoption psychology – based in Stoke-on-Trent, provides specific psychological support to young people and their carers. The young people would be in care, adopted, or living with members of their extended family.

CAMHS Autistic Spectrum Disorder Service (CAMHS ASD) – a specialist assessment and diagnosis service. The service also provides time-limited support following a diagnosis of autism.

CAMHS Disability- provides specific support for young people with developmental delay or a learning disability. Young people may also have physical health needs. A dedicated service is also provided to some specialist schools.

CONNECT CAMHS and First Steps (CONNECT and First Steps) – A multi-disciplinary service providing support for young people and their carers. Young people would require support with their mental health, behaviour or emotions. The service includes an Improving Access to Psychological Therapies (IAPT) service. The service is provided in Newcastle under Lyme - CONNECT and First Steps (Newcastle), and from two locations in Stoke-on-Trent – CONNECT and First Steps (Stoke).

Paediatric psychology – provides specific psychological assessment, advice and support for young people and their carers. These young people would have an acute or chronic illness, or have had a traumatic injury. In addition to general paediatric psychology, the service provides specialist support for young people with certain illnesses. This support is for young people who have cancer, diabetes, gastric illnesses, or breathing difficulties. The service also provides support for young people who have been in intensive care or are receiving end of life care.

Sustain – based in Newcastle-under-Lyme, provides specific psychological support to young people and their carers. The young people would be in care or adopted.

Yellow House – provides specific psychological and social support to young people, their carers and their parents. The young people and carers would be in small group homes or foster care.

Youth offending service – Staff from CAMHS also work in the youth offending teams in North Staffordshire and Stoke-on-Trent.

These services had not been inspected previously.

Our inspection team

The team that inspected the core service consisted of a CQC inspector and 8 specialist advisors. These included two consultant child and adolescent psychiatrists, a specialist CAMHS nurse, a social worker and a psychologist. All of whom had experience of 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.

Summary of findings

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the five services and looked at the quality of the environment and observed how staff were caring for young people using the service
- visited the CAMHS community referral hub
- spoke with three young people who were using the service
- spoke with 11 carers of young people using the service
- spoke with the service managers or deputy service managers for the services
- spoke with 38 other staff members; including doctors, nurses, psychologists, play and parenting specialists, therapists, administrators, a medical secretary and a social worker.
- looked at 63 clinical records of young people using the services
- looked at 6 clinical records of young people on the waiting list for the services
- looked at 5 staff appraisal records
- interviewed the clinical director with responsibility for these services
- attended and observed three appointments between staff members and young people
- attended and observed a staff team meeting, a multidisciplinary case discussion and a psychology advisory group
- collected feedback from 17 young people and carers using comment cards.
- 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

Young people said they were able to trust the staff. They felt they were listened to. Carers reported that they felt staff showed real interest in the child or young person. Carers spoke highly of the service and the staff'. Most carers said that the waiting lists for assessment or treatment were very long.

We collected 17 cards from comment boxes placed in the services before the inspection. Twelve of the cards were positive, three were mixed and two were negative. The positive comments concerned the caring and compassionate approach of staff. The negative comments related to staff skills and training and not understanding a carer's needs.

Good practice

- The waiting list for the specialist paediatric psychology services was short. Young people were seen within two weeks. Sometimes young people were seen the same day.
- Staff had undertaken evening and weekend work to reduce waiting lists. They were not required to do this.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there are sufficient numbers of staff employed in CAMHS community services.
- The provider must ensure that all staff who provide care and treatment are suitably skilled and experienced for their role.
- The provider must ensure that weighing scales are calibrated regularly.
- The provider must ensure that staff are able to access a psychiatrist at all times.
- The provider must ensure that all children and young people have a risk assessment. When risks are identified they must have a risk management or safety plan. Risk assessment forms must be appropriate for CAMHS community services.
- The provider must ensure that CAMHS CONNECT and First Steps services operate an effective duty worker system. The system must ensure that a duty worker is available to deal with urgent matters.
- The provider must ensure that all staff in CAMHS community services have safeguarding children training. Staff providing care or treatment must have level three safeguarding children training.
- The provider must ensure that all young people have a care plan. Care plans must be specific, detailed and personalised. They must address all of the young person's needs and record the views of young people and/or their carers.
- The provider must ensure that young people have one set of clinical records. These records must be comprehensive and complete. Clinical records must always be available to staff who need them.
- The provider must ensure that outcome measures are used consistently so that the effectiveness of services can be assessed.
- The provider must ensure that a psychiatrist provides dedicated input into all services (with the exception of paediatric psychology).
- The provider must ensure that all young people are able to have an assessment and access to diagnostic or treatment interventions, in a timely manner.
- The provider must ensure that concerns from young people and carers are monitored to identify themes and trends.
- The provider must ensure that all buildings operating CAMHS services are suitable for their use.
- The provider must ensure they operate effective governance systems to ensure the quality and safety of services. These systems should incorporate clinical standards and guidance. The systems must include risks relating to the service, environment and infection control.

Action the provider SHOULD take to improve

- The provider should ensure that there is an effective system in place to assess the risks to young people whilst they are waiting for assessment or treatment.
- The provider should ensure that there is a record of the date and content of staff supervision in the CAMHS ASD service.
- The provider should ensure that all appraisals record staff members' progress, development and performance. A detailed development plan should be recorded.
- The provider should ensure that CONNECT CAMHS and First Steps services communicate regularly with young people's general practitioners.
- The provider should ensure that young people's capacity to consent to care and treatment is recorded in clinical records. Where parental or carer consent is provided this should be clearly documented.
- The provider should ensure that feedback from young people and carers, in all services, is co-ordinated and ongoing.
- The provider should review the management capacity required to drive quality and service improvements in CAMHS community services.

North Staffordshire Combined Healthcare NHS Trust

Specialist community mental health services for children and young people

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CAMHS CONNECT and First Steps (Stoke)	Trust Headquarters
CAMHS CONNECT and First Steps (Newcastle under Lyme)	Trust Headquarters
CAMHS ASD	Trust Headquarters
CAMHS Disability	Trust Headquarters
Paediatric Psychology	Trust Headquarters

Inadequate

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 interview rooms at CONNECT and First Steps (Newcastle) had alarms. Staff did not have access to personal alarms.
- The front doors to the services were locked, with entry controlled by the receptionist. At the CAMHS ASD and Disability services, this was the only locked door. Inside there was unrestricted access to the building and this posed a potential risk of an incident.
- All areas were clean and well maintained. The cleaning contractor undertook regular audits.
- In the waiting rooms in services, there were plastic toys. At CONNECT and First Steps (Stoke) the toys had been cleaned ten months ago. At CAMHS ASD, Disability and CONNECT and First Steps (Newcastle), the toys were cleaned twice a year. The frequency with which toys were cleaned was an infection control risk. No infection control audits were in place.
- The services had weighing scales to weigh young people. This equipment was important for young people with eating disorders. CAMHS ASD and Disability services shared a building, and shared the weighing scales. These weighing scales were last calibrated in 2011. At CONNECT and First Steps (Newcastle) they had been calibrated almost 18 months previously. This meant the scales in these services could be providing incorrect measurements. The four blood pressure machines in CAHMS ASD and Disability services had all been calibrated recently.

Safe staffing

- Staffing levels in most services were not safe. There were not enough consultant psychiatrists, nurses, psychologists, therapists or administrators. The Royal College of Psychiatrists have produced staffing level indicators for CAMHS services. The CAMHS services had two consultant psychiatrists. The clinical director of CAMHS services also worked two days per week as a consultant psychiatrist. Each of the consultants had a caseload of over 100 young people.
- The Royal College of Psychiatrists provide indicators for other staff providing care and treatment. This would include nurses, psychologists and therapists.
- There were approximately 63 staff in all services, including service managers and deputy service managers. This lack of clinical staff had a major impact on almost all of the waiting lists.
- The administrators in the services also staffed the reception areas. This included taking regular phone calls from carers of young people on the waiting lists. In CONNECT and First Steps (Newcastle) there was one administrator for three days of the week. Whenever they left the reception area phones would not be answered. This also meant young people and carers could not be let into the building.
- The number of children and young people needing CAMHS services had been assessed using a validated tool.
- There were 344 young people waiting for a partnership assessment.
- Staff met with their manager on a regular basis to review their current caseloads.
- Staff on maternity leave or long term sickness were not replaced by locum or agency staff.
- The child and adolescent psychiatrists were based in one office. This was where the CAMHS ASD and CAMHS Disability teams were based. Staff at the CONNECT and First Steps services accessed a psychiatrist by telephone. The CAMHS Disability service had a dedicated consultant psychiatrist for one and a half days per week. There were plans for psychiatrists to be based in different community services.
- Staff undertook a range of mandatory training. Almost all staff were up to date with mandatory training.

Assessing and managing risk to patients and staff

- Risk assessments for young people using the services were not always completed. Risks were identified when a referral was received and during an initial assessment. Urgent appointments were available when a young persons' risks were considered to be high. However following the initial assessment young people did not always have a risk assessment. At CONNECT and First Steps (Stoke) 51% of young people did not have a risk assessment. Ten young people had identified risks

which had not been assessed. Some of these young people had very serious, or multiple risks identified. For six young people there was no record that any risk areas had been explored. Four young people had a risk assessment. Three of these identified significant risks, but none had a risk management or safety plan. At CONNECT and First Steps (Newcastle) 50% of young people did not have a risk assessment. Two of these young people had multiple and serious risks. There was no record that potential areas of risk had been explored for four young people. In CAMHS Disability we reviewed four clinical records. There was no risk assessment for three young people. A risk assessment specifically for that service was in development. At CAMHS ASD 47% of the clinical records did not contain a risk assessment. There was no record that potential risks had been explored. The risk assessment for one young person identified the risk of violence. No other sections of the assessment were completed. It was unclear if those areas had been explored. This was not in accordance with NICE guidance.

- The risk assessment form used by CAMHS community services was designed for adults. Some areas specifically related to risks 'as an adult'. There was minimal space to record dates of incidents, severity, contributing factors and the young persons' view.
- Young people were on waiting lists for assessment or interventions for long periods. Whilst waiting times were monitored, there was no active monitoring of young peoples' risks. Carers were told that if they had concerns they should contact the services.
- Both CONNECT and First Steps services operated a 'duty' system. This involved a staff member being available to deal with urgent situations. The staff member on 'duty' also had their usual work, including appointments to attend. On some days, within both services, there was no allocated duty worker. Another member of staff would deal with urgent issues when a duty worker was unavailable. On occasions, there was no member of staff available and the manager or their deputy would deal with the issue. The 'duty' system was not sufficiently robust. Services could not ensure that urgent matters were dealt with in a timely manner.
- Reception and administration staff were not required to undertake safeguarding children training. Not all clinical staff were required to undertake level three safeguarding training. Two clinical staff had only undertaken level one safeguarding children training. This did not follow national guidance. All of the staff in the CAMHS Disability services had undertaken level three safeguarding training. There had been 13 safeguarding children referrals in the six months prior to inspection. In the same time period there had been no safeguarding adult referrals. As the services usually worked with families, this was a concern.
- Staff in services undertook very few home visits, with the exception of CAMHS Disability service. There was a system throughout CAMHS community services for lone working.

Track record on safety

- There had been a serious incident some months prior to the inspection. The community safety partner had referred this to a multi-agency learning review. There had been no other serious incidents in the services in the previous year.

Reporting incidents and learning from when things go wrong

- Staff were aware of incidents that required reporting. However, some incidents were not reported. Thirty-two incidents had been reported in the services in the previous six months. There were no incident reports regarding staffing. There were only four incident reports of violence/assault. This did not match what we heard in services, and verbal abuse was under-reported.
- Staff were open and transparent with young people and their carers. Staff provided clear information regarding waiting times. When mistakes were made, managers were aware of what action should be taken.
- Incidents across all CAMHS services were discussed in team meetings. This included incidents on the CAMHS wards. Staff discussed how learning might take place. Staff knew about the Trusts' 'learning lessons' events.
- When any incidents occurred, staff received support and a de-briefing.

Are services effective?

Inadequate

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

- There was a delay in routine assessments occurring. Overall the assessments of young people were comprehensive and thorough.
- Not all young people had a care plan. This meant that different staff members may not know the young persons' needs or their treatment plan. Forty per cent of young people at CONNECT and First Steps (Newcastle) did not have a care plan. One young person had a care plan but their name was not on it. Two care plans were not signed by a staff member. This meant it was not possible to identify who had written the care plan. At CONNECT and First Steps (Stoke) 22% of young people did not have a care plan. Where young people did have a care plan 75% of them were poor. Care plans generally indicated what intervention should be undertaken. They were not specific, detailed or personalised. Some care plans did not address young peoples' identified needs. Most care plans appeared to be written for staff rather than young people or carers. Medical abbreviations were frequently used. At CAMHS ASD service two young people did not have care plans. One young persons' care plan was very brief. This was not in accordance with national guidance. The care plan forms had no space for young people or their carers to write their views. In CAMHS Disability service all young people had a care plan. The care plans were specific, personalised and comprehensive.
- All of the services maintained and kept a set of clinical records for each young person. The psychiatrists for the services were based in one building and in the absence of clinical records made notes of the assessment that was later transferred to patient records. The clinical records of some young people would be transferred between services, sometimes regularly. If a young person received care at CONNECT and First Steps and saw a psychiatrist regularly, this would happen. The CONNECT and First Steps clinical records could remain in the psychiatrists' office for some weeks. There was a high risk that some young peoples' clinical records would not always be available for staff that needed them. There was also a high risk that not all clinical records would contain all information. We saw an example of this. This was because some young people had more than one clinical record.

Best practice in treatment and care

- A small number of young people were prescribed medicine for attention deficit hyperactivity disorder. The medicines were prescribed in accordance with NICE guidance.
- The CAMHS ASD service used appropriate assessment tools to diagnose young people with autistic spectrum disorders. These were in accordance with NICE guidance.
- A range of psychological therapies were provided by the services to meet the needs of young people. These included cognitive behavioural therapy and dialectical behaviour therapy. The positive parenting programme (Triple P) was available to support carers. This was in accordance with NICE guidance. The paediatric psychology service provided a range of different psychological interventions. These reflected the different needs of young people and carers using the service.
- Young people prescribed medicine for attention deficit hyperactivity disorder had their physical health checked at each appointment. There was a shared care protocol with general practitioners regarding the young persons' physical health. This was in accordance with NICE guidance. Young people with eating disorders had their height and weight checked. However there was no protocol describing shared care with general practitioners. This was not in accordance with NICE guidance.
- The paediatric psychology service used a number of outcome measures. These measured how effective treatment was. CAMHS ASD service used the HONOSCO and Sheffield Learning disability questionnaire as an outcome measure. The other community services also used outcome measures, but not consistently. Some staff members used different outcome measures. This meant the effectiveness of some services could not be assessed.
- Clinical audit took place in all of the services. A small number of clinical records were regularly audited. This audit was undertaken by staff members' colleagues. Once a year all of the clinical records in services were sent to another service to audit. Other clinical audits took place. These were time-limited and dependent upon individual staff members' initiative and motivation.

Skilled staff to deliver care

Are services effective?

Inadequate

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.

- The psychiatrists for the services were not based within services. There was no psychiatrist in, or attached to, CAMHS ASD service. This was not in accordance with NICE guidelines. There was a lack of psychiatric input into CONNECT and First Steps services. We observed a case discussion of a young person being prescribed medicine. No psychiatrist was involved in the case discussion. The exception was the CAMHS Disability service. A consultant psychiatrist spent one and a half days within the service.
- The paediatric psychology service consisted almost entirely of senior, experienced psychologists. Due to the complex needs of the young people seen by the service, this was appropriate. CAMHS Disability was staffed with learning disability nurses and a senior psychologist. There was also a behavioural psychotherapist and a speech and language therapist. CAMHS ASD was staffed with nurses and a senior psychologist. There were a number of different professionals in CONNECT and First Steps services. These included play and parenting specialists, a drama therapist and an art therapist.
- Overall, staff received regular supervision. These were known as 'case management reviews'. Staff members' caseloads were discussed. Areas, such as training, were also discussed at these times. However, in CAMHS ASD there was no record of staff attending supervision. Staff in all services had an annual appraisal, and were positive about these. However, most of the appraisals we reviewed lacked detail. The staff members' progress, development and performance was not always recorded. There were many areas on the appraisal forms left blank. Personal objectives for the coming year were often limited to attending certain training.
- All services had regular team meetings, and staff attended these.
- Staff were able to undertake specialist training. Specialist training included autism, theraplay, eating disorders and systemic family therapy.

Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary meetings held in all of the services. Young people with more complex needs were discussed to identify the most appropriate care and treatment. Psychiatrists did not regularly attend these meetings. This included when young people were being prescribed medicines. However a psychiatrist regularly attended such meetings in CAMHS Disability. The CAMHS ASD service did not include, or have regular access to, a psychiatrist. This was not in accordance with NICE guidance. Staff in the paediatric psychology service had regular meetings with professionals in the acute hospital.
- Psychiatrists and staff in CAMHS Disability maintained regular communication with young people's general practitioners. For young people prescribed medicine for attention deficit hyperactivity disorder there was joint working with general practitioners. CAMHS Disability and CAMHS ASD had strong links with the community paediatricians. In CONNECT CAMHS and First Steps services there was not regular communication with general practitioners. This was also the case concerning young people with eating disorders. This was not in accordance with NICE guidelines. Social workers in CONNECT and First services provided a link with social services.

Good practice in applying the MCA

- Staff in the services undertook MCA training. The MCA would apply only to 16 and 17 year olds. There was no record that any young person had, or had required, a best interest's assessment.
- There had been no specific recent training for staff regarding Gillick competence. Overall, staff understood the test for Gillick competency, for young people under 16 years of age. They knew the age range of young people where such an assessment may be appropriate. However some staff did not have an understanding of Gillick competence.
- There was little evidence concerning capacity in young people's clinical records.

Good

Are services caring?

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

Our findings

We rated caring as good because:

- The way staff communicated with children and young people was thoughtful and respectful.
- The majority of young people and carers were very positive regarding staff. Young people could trust staff and felt listened to. Carers felt that staff had a real interest in their child or young person.
- Staff demonstrated a thorough understanding of young people and their families' needs.
- Staff had undertaken evening and weekend work to reduce waiting lists. They were not required to do this.
- Young people were always included on interview panels during staff recruitment.
- The IAPT service, based within CONNECT and First Steps, had a children and young peoples' youth council. The youth council had a significant input into a new website. The website provided help and advice to young people and carers preparing to access CAMHS services.
- Young people and carers had been involved in developing the new care pathways for the services. They were also being recruited to join the CYP directorate management meetings.

However, a small number of young people and carers had a negative view of staff. Young people and carers were not consistently asked to provide feedback on services. It was not clear if changes were always made as a result of young peoples' and carers feedback.

Kindness, dignity, respect and support

- Staff were sensitive, compassionate and showed understanding for young people and their carers. The way staff communicated with children and young people was thoughtful and respectful. Staff members' approach encouraged young people to feel comfortable and open. When speaking with families, difficult issues were dealt with sensitively and with empathy.
- The majority of young people said they were able to trust staff. They felt they were listened to. Carers said that they felt staff showed real interest in the child or young person. Carers said the service, and staff, were 'brilliant', 'excellent' and 'great'. However, a small number of young people and carers had negative views of some staff. They reported that they were not listened to.
- Staff demonstrated a thorough understanding of children and young people and their needs. They understood how they could assist individual families and worked hard to meet their needs.
- Staff were careful regarding maintaining confidentiality. This was particularly the case with young people. A carer specifically praised staff for their approach regarding confidentiality.
- Staff had undertaken evening and weekend work to reduce waiting lists. They were not required to do this.

The involvement of people in the care they receive

- Young people and carers took an active role in planning their care. We observed this during appointments. Young people's care plans did not, however, reflect this.
- Young people were always included on interview panels during staff recruitment.
- The IAPT service, based within CONNECT and First Steps, had a children and young peoples' youth council. The youth council had a significant input into a new website. The website provided help and advice to young people and carers preparing to access CAMHS services.
- Young people and carers were not consistently asked to provide feedback on services. Some services operated a carers' group. One service had a 'suggestion box' in the reception area. Attempts were being made to obtain feedback, but this was not co-ordinated. It was difficult to establish if changes were made as a result of feedback.
- Young people and carers had been involved in developing the new care pathways for the service. They were also being recruited to join the CYP directorate management meetings.

Are services responsive to people's needs?

Inadequate

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

Our findings

We rated responsive as inadequate because:

- Young people waited three to four months to receive a non-urgent initial assessment.
- Following assessment, young people waited a year for partnership appointments.
- The waiting lists for school observations and the CAMHS ASD service were a year or more.
- Many young people first received treatment well over a year after the initial referral.
- The buildings in which services were based were not suitable.
- The majority of carers said that they did not know the complaints procedure. Staff did not consistently tell young people or carers how to complain.
- There was no system for monitoring concerns of young people or carers. Possible themes or trends were not always identified.

However, the findings from complaints investigations were discussed in team meetings. Staff also received individual feedback from complaints and learnt from this.

Access and discharge

- Access to almost all of the CAMHS community services was via a central referral hub. Anyone was able to refer to the services, including parents, carers and young people themselves. Once a referral was received, staff reviewed the referral. If the referral was urgent, the young person would be seen the same day. When young people attended the emergency department of the acute hospital they could be seen the same day. A 'priority worker' was available to assess them during weekdays.
- CAMHS ASD accepted referrals via the hub and from paediatricians. The paediatric psychology service accepted direct referrals from acute hospital colleagues.
- The services, except paediatric psychology, had a referral to assessment target time of four weeks. This meant young people would be assessed within four weeks after they were referred to services. The assessment to treatment target time was 14 weeks. This meant young people should be receiving treatment within 18 weeks of being referred. This is a national standard. When the referral was non-urgent, young people were assessed in 12 to 16 weeks. When referrals were urgent, young people were being assessed within two weeks. Staff had worked evenings and weekends to reduce the waiting time for assessments. Two locum staff had also been funded for a fixed period to reduce this waiting list. Although some action had been taken, young people were still unable to have a non-urgent appointment in a timely manner.
- Following the assessment, almost all young people and carers had a further wait. For young people requiring psychological treatment or a therapist, they would wait for a partnership appointment. The wait for a partnership appointment was up to one year. For young people identified as a 'high priority' the wait was up to eight months. This was unacceptable. Some young people had been assessed as requiring school observation by a staff member. The waiting list for school observation was up to one year. Following school observation, most young people then had an appointment with a psychiatrist. The wait for a non-urgent appointment with the psychiatrist was two or three months. Many young people first received treatment well over a year after the initial referral. This was unacceptable.
- Some young people were referred by other agencies directly to the CAMHS ASD service. The waiting list for an appointment in the CAMHS ASD service was up to one year four months. There were 55 young people on the waiting list for CAMHS Disability. The waiting time was from 13 to 20 weeks.
- The waiting list for the specialist paediatric psychology services was short. Young people were seen within two weeks. Sometimes young people were seen the same day. For the general paediatric psychology service the average wait was ten weeks. However, one young person had been waiting nine months.
- When carers had been offered the Triple P programme they were sent an invitation letter. This included the times and dates of groups. In some case text reminders were also sent to carers before the sessions.
- Some carers reported that they were able to change their appointment times easily.
- A small number of young people moved on to adult mental health services when they reached 18 years of age. Some adult services staff would attend joint appointments before the young person was 18 years of age. Other adult services staff would not work with a young person until their 18th birthday.

Are services responsive to people's needs?

Inadequate

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

The facilities promote recovery, comfort, dignity and confidentiality

- The reception and waiting rooms in all of the services were very small. They could accommodate only a small number of people.
- CAMHs ASD and Disability services shared the same building. There were five rooms, including a family room and play room. There were not enough rooms for both services. CONNECT and First Steps (Stoke) also had a shortage of suitable rooms for children and young people. Recent renovation work had slightly increased the number of rooms available. CONNECT and First Steps (Newcastle) had only one room on the ground floor. There was no lift. The building was unsuitable for its current use. Plans were in place to move some of the services to a different building.
- None of the interview, family or therapy rooms in the services had sound proofing. This meant that privacy could not always be maintained for young people or their carers.
- At CONNECT and First Steps (Newcastle) a wide range of information leaflets were available for young people and carers. These included leaflets about some interventions, deafness, discrimination, healthwatch, and how to make a complaint. At the CAMHS ASD and Disability services there was information on safeguarding and parent support. There was also information on complaints, healthwatch and support for parents of disabled children. At CONNECT and First Steps (Stoke) there was information on being a carer, drug and alcohol services, confidentiality and complaints. None of the services had freely available information about specific mental health problems.

Meeting the needs of all people who use the service

- All of the services were accessible, and could be used by, people with disabilities.
- Waiting rooms, and most interview rooms, had toys suitable for small children. CONNECT and First Steps (Stoke) was the only service to have age appropriate interview rooms, suitable for adolescents. There was also a garden with interactive toys and games.
- There was no information available for people who did not speak English. This largely reflected the local population. Staff were aware of how they could obtain an interpreter. We observed a team discussion regarding a young person and their family. None of the family spoke English. The team discussed, in detail, how they could effectively support the family.

Listening to and learning from concerns and complaints

- The majority of carers said that they did not know the complaints procedure. They said that they felt able to approach staff with any concerns if they had them. Staff did not consistently tell young people or carers how to complain.
- Most concerns were from carers. Many of these concerns involved waiting times for assessment or treatment. Concerns were dealt with informally by the service manager or deputy service manager. There was no system for monitoring concerns of young people or carers. This meant possible themes or trends were not always identified. The CYP directorate wasplanning to monitor concerns from young people and carers.
- When complaints were made, the findings of investigations were shared with managers in all CAMHS services. The findings from complaints investigations were discussed in team meetings. Staff also received individual feedback from complaints and learnt from this.

Are services well-led?

Inadequate

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

- Some staff were aware of some of the providers' values. Most staff were not fully engaged with the providers' values. They had their own values to which they worked.
- Staff knew the most senior managers in the CYP directorate. The chief executive had recently visited some of the services. However some staff did not know who the most senior managers were.

Good governance

- There was a lack of robust governance systems in CAMHS community services to underpin safe and high quality care. There was under-reporting of incidents. The duty worker system in CONNECT and First Steps services was not robust. There was no effective system for obtaining access to a psychiatrist quickly.
- In most services there was minimal clinical audit. A clinical audit of care plans at CONNECT and First Steps (Newcastle) identified poor care plans. However, this had not led to improvement.
- The standard of care plans across services was generally poor. Risk assessments were not completed in accordance with the providers' policy. A number of young people were at significant risk and did not have a risk assessment or safety plan.
- There was no system for monitoring young people on the waiting lists.
- There was no overall system for monitoring that NICE guidance was followed. The Choice and Partnership Approach (CAPA) had been the model for almost all services for some time. Not all elements of CAPA were in place and it wasn't fully effective.
- Services did not have an operational policy to underpin the quality and safety of the services.
- Environmental risks in each service were not assessed. Infection control audits did not take place.
- Outcome measures were not used consistently, so service effectiveness could not be assessed.
- Some young people had more than one clinical record, which introduced additional risk.
- Feedback from young people and carers was not co-ordinated. Concerns from young people and carers were not effectively monitored.
- The providers' key performance indicators concerned waiting times until assessment and treatment. There were no key performance indicators for other waiting lists. The lack of service information limited the number of performance measures.
- Mandatory training was monitored. However the monitoring system did not identify the level of safeguarding training which was undertaken.
- The service managers and deputy service managers did not control their own budgets. They could not authorise additional staff when needed. They also lacked administrative support.
- The recent service transformation had reduced the number of managers in services. There had been eight team leaders. This had been reduced to two service managers, and two deputy service managers. The service managers, and their deputies, managed all of the CAMHS community services. As services were located on different sites, the managers and their deputies did not usually work at the same base. The service managers, and their deputies, had limited capacity to drive quality improvement and service development. The impact of the recent service transformation on the quality of care was not well understood.
- Four additional staff had been employed to reduce waiting times. However this was recent, for a fixed period, and only related to some waiting times. They had minimal, if any, impact on waiting times for partnership appointments, school observations, or the CAMHS ASD waiting list. The plan to reduce the waiting lists was not comprehensive. It only addressed some of the difficulties, and was time limited. The plan did not have the level of impact required.
- Staff did not know what issues were on the CYP directorate risk register.

Leadership, morale and staff engagement

- There were low levels of staff sickness in the services. Sickness levels were below 3%. This figure also includes CAMHS in-patient wards.
- There were no bullying or harassment cases in the CAMHS community services.
- Staff knew how and felt able to raise concerns. There was some indication that this had not been the case until recently.
- We observed staff morale to be low in all of the services, except paediatric psychology. Staff morale had been

Are services well-led?

Inadequate

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affected by several factors. The recent service transformation had affected some staff members' job roles and conditions. A further change to services was planned, and staff were uncertain how this would affect their role. Staff described high levels of stress.

- Over 50% of staff were very concerned about the waiting lists for services and interventions.
- In the six months before the inspection, six staff had left the services. At the time of the inspection, four other staff were working their notice period.
- Managers in the CYP directorate had attended the Aston leadership programme. Staff were positive regarding the new management in the CYP directorate.
- In all of the services, there was a strong sense of team cohesion. Staff provided mutual support to each other.
- When mistakes were made, the matter was referred to a service manager or deputy service manager. These managers were aware of their responsibilities, and the actions they needed to take.
- Staff were able to provide feedback during regular team meetings. The new service managers, and their deputies, were open to receiving staff feedback. During the recent transformation of services, the proposed plan for services was subject to staff consultation. Some staff reported that during the consultation they learnt that the proposed plan was being signed off. Staff considered there was a lack of transparency at a senior level. New care pathways were being developed for the CAMHS community services. Staff had been involved in 'task and finish' groups contributing to this work.

Commitment to quality improvement and innovation

- The new planned care pathways were going to be aligned to NICE guidelines. Monitoring of young people and carers' concerns was being planned. Service risk assessments were also planned. The new management team in the CYP directorate were clearly committed to improving the quality and safety of services.
- Some CAMHS community services were planning to relocate to different premises. As part of this plan, consultant psychiatrists would become part of the multi-disciplinary team in services.
- CAMHS community services participated in national audit of prescribing observatory for mental health (POMH-UK). The services did not belong to any national accreditation schemes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment, and systems and processes were not operated effectively to prevent abuse of service users. This was because all staff providing care and treatment were not trained to level three safeguarding children. Reception and administration staff received no safeguarding children training. This did not follow national guidance. This was a breach of Regulation 13(1)(2)

Regulated activity	Regulation
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Premises The premises used by the provider were not suitable for the purpose for which they were being used.

This section is primarily information for the provider

Requirement notices

The reception areas and waiting rooms in all of the services were too small. There were not enough interview, therapy or group rooms in any of the services. None of the interview, therapy or group rooms in services were sound proofed.

This was a breach of Regulation 15(c)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred care The care and treatment of service users was not appropriate, did not meet their needs, or reflect their preferences. Care and treatment was not designed with a view to achieving service users' preferences and ensuring their needs are met. Not all young people using the services had a care plan. When they did have a care plan, this was not always appropriate. Care plans described interventions, were not specific, detailed or personalised. Not all of the young persons' needs were recorded. Young people, or their carers', views and preferences were not recorded. This was a breach of Regulation 9(1)(a)(b)(c)(3)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users.

This section is primarily information for the provider

Enforcement actions

1. Risks to the health and safety of service users of receiving the care and treatment were not always assessed. Services did not do all that was reasonably practical to mitigate such risks.

2. Some people providing care or treatment to service users did not have the skills and experience to do so safely.

3. The equipment used for providing care or treatment to a service user was not safe for such use.

4. Services were not assessing the risk of, and preventing, detecting and controlling the spread of, infections.

1. Young people did not always have a risk assessment. This included young people with multiple or serious risks. When young people did have a risk assessment, with risks identified, they did not always have a risk management or safety plan.

2. Weighing scales in the services had not been calibrated regularly. This was particularly important for young people with eating disorders.

3. Infection control audits were not undertaken. Plastic toys in waiting areas and interview rooms were not disinfected regularly.

This was a breach of Regulation 12(1)(2)(a)(b)(c)(e)(h)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014

Good governance

Systems or processes were not established or operated effectively.

1. Systems or processes did not effectively assess, monitor and improve the quality and safety of the services provided (including the quality of the experience of service users in receiving those services). They did not effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

2. There was not an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

3. Concerns from, and the experience of, people using the service, or their carers, were not effectively monitored to identify themes and trends.

4. The duty worker system was not operated effectively.

5. There was no reliable system for accessing a psychiatrist.

6. In most services, there was an absence of an operational policy to ensure the quality and safety of the services.

7. Environmental risks, in the locations carrying on the regulated activity, were not assessed.

8. Outcome measures were not used consistently so that the quality of services could be monitored and improved.

9. People using the service may have more than one clinical record regarding their care and treatment, and decisions taken in relation to their care and treatment. Clinical records for people using the service were not always complete.

This section is primarily information for the provider

Enforcement actions

This was a breach of Regulation 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the CAMHS community services. There was a lack of staff deployed in services to meet the demands on services. This was a breach of Regulation 18(1)