Requires improvement

Cambridgeshire and Peterborough 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)
RT13	Trust headquarters	Community CAMHS Single Point of Access	PE29 2BQ
RT13	Trust headquarters	CAMHS Cambs Core Team (Huntingdon & Cambridge) Brookside Clinic	CB2 8AH
RT13	Trust headquarters	CAMHS Cambs Core Team (Huntingdon & Cambridge) Newton Centre	PE29 3RJ

Summary of findings

RT13	Trust headquarters	CAMHS Cambs Neuro (ADHD/ ASD/LD) Team Brookside Clinic	CB2 8AH
RT13	Trust headquarters	CASUS (Children and Adolescent Substance Use Service) Newton Centre	PE29 3RJ

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

Contents

Summary of findings

Overall summary

We rated Cambridge and Peterborough NHS Foundation Trust specialist community mental health services for children and young people as requires improvement because:

- Interview rooms used by therapy staff were not fitted with alarms or viewing panels on the doors.
- Insufficient levels of staffing affected the referral to assessment and treatment times in community mental health teams. This was up to 62 weeks for some young people, with further delays for some treatments.
- Referrals to the ADHD service had been suspended due to lack of staff.
- Risk assessments were not present on all electronic records and risk assessments were not always reviewed when the young person's situation changed.
- We saw no evidence in the notes that consent and capacity was being discussed with young people or recorded.
- Managers and staff told us that whilst supervision was offered to all staff no records were available to demonstrate this.

However:

- The trust told us that funding has been sourced in order to address the long waiting list and recruit more staff.
- Young people waiting for treatment were prioritised according to their risk.
- Treatment programmes were bespoke and based on the case formulation of the young people and were in accordance NICE guidelines
- We observed staff communicating with young people in a kind and respectful manner. Staff were observed to be sensitive to the needs of the young people and when speaking about them showed good knowledge of their problems and how they could help them.
- Managers had access to trust data to gauge the performance of the team and compare against others. Key performance indicators (KPIs) were used to gauge performance. The KPIs that we saw were in an accessible format.
- Staff were open and transparent with young people and their families.

Summary of findings

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

Are services safe?

We rated specialist community mental health services for children and young People as requires improvement for safe because:

- Interview rooms were available for therapies and staff meetings, but they were not fitted with alarms or viewing panels on the door.
- The service has been placed on the risk register due to the size of the waiting lists, workloads and workplace stress.
- Insufficient levels of staffing affected the referral to assessment and treatment times in community mental health teams. This was up to 62 weeks for some young people, with further delays for some treatments.
- Referrals to the ADHD service had been suspended due to lack of staff.
- Where required rapid access to a psychiatrist was not always possible. We heard that young people would present themselves at accident and emergency in order to expedite access.
- Risk assessments were not present on all electronic records and risk assessments were not always reviewed when the young person's situation changed.

However:

- The buildings were clean and tidy and appeared well maintained.
- The trust told us that funding had been sourced in order to address the long waiting list and staff recruitment.
- The referrals went through a single point of access team who triaged and sent the referrals through as appropriate to the community teams. All referrals were seen with 24 hours.
- The team reviewed people on the waiting list weekly in order to ensure that if there were increased levels of risk they were identified early and the young person was moved to the top of the waiting list and contact was increased.
- Training records showed that 96% of staff were trained in safeguarding.
- Incidents were reported using the DATIX forms which were reviewed and signed off by the manager. Staff told us that they knew what to report and how to report.
- As a response to a serious incident the manager told us that they had tightened up case load management.

Requires improvement

Summary of findings

Are services effective?

Good

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

- Treatment programmes were bespoke and based on the case formulation of the young people. Staff attended meetings to discuss which clinician had the most appropriate skill set to meet the needs of the young person prior to allocation.
- We saw evidence of staff completing the common assessment framework. We saw records that outcome measures were used by the service.
- The services was able to offer NICE recommended treatments in family therapy, cognitive behavioural therapy, interpersonal therapy, eye movement desensitisation and reprocessing, and cognitive analytical therapy. The CASUS service contributed to training professionals in AMBIT (adolescent mentalization-based integrative treatment) methods.
- We saw evidence that staff considered physical health needs of patients.
- Regular and effective multi-disciplinary meetings were held weekly in order to discuss high risk cases, allocation of new referrals and the waiting list.
- The mental health team consisted of consultant psychiatrists and mental health practitioners who were nurses, psychologists, family therapists and social workers.
- The CASUS team consisted of a consultant psychiatrist, nurses and practitioners who had significant experience working in substance misuse.
- Staff had access to appraisal, specialist training and development.
- Consent to share information forms were being signed by the young people.

However:

- We were told that the community teams follow NICE guidelines in the service. However, the community team struggled to keep up with recommendations around frequency of medical reviews due to staffing levels.
- Staff told us that they had been trained in the choice and partnership approach model of working (CAPA). However this had not been fully implemented due to the need to focus on reducing the long waiting times.
- Managers and staff told us that supervision was offered to all staff however no record was kept in order to monitor this process.
- We saw no evidence that consent and capacity were being discussed with young people or recorded in the notes.

Summary of findings

Are services caring?

Good

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

- We observed staff communicating with young people in a kind and respectful manner. Staff were observed to be sensitive to the needs of the young people and when speaking about them showed good knowledge of their problems and how they could help them.
- A young person using the community mental health team told us that they were treated with dignity and felt cared for and listened to by staff.
- A young person accessing the CASUS service told us that they were treated nicely by staff and that staff made an effort to treat people like an individual.
- Parents told us there was a long waiting list to access services for the mental health team after the initial assessment had been completed. However, once their child was receiving treatment the child made good progress.
- Parents told us that they were involved in care planning for their children once the treatment had started.

However:

- A young person said they did not feel listened to by the mental health team.
- Young people told us that there was a lack of continuity of care provided by the doctors as they kept changing in the mental health team.

Are services responsive to people's needs?

Requires improvement

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

- Waiting times for young people to be assessed could be as much as 62 weeks for some young people.
- Following assessment there was an additional waiting list for referral to some treatments.
- The trust had suspended referrals for young people with ADHD and ASD unless they had an additional moderate to severe mental health issue.
- The mental health service was not able to show a DNA (did not attend) appointment policy, but told us that after two DNA appointments the young person would be discharged from the service.

Summary of findings

- Arrangements were in place for the management and investigation of complaints. However, there had been a large number of complaints regarding the lengthy waiting times.

However:

- The CASUS team operated a duty system which allowed all referrals to be triaged once received in to the service and allocated appropriately. This meant that young people were able to access the service quickly when they needed to. There was no waiting time for this service.
- The mental health team had a duty person that was able to respond to phone calls into the service and offer telephone support.
- There were separate access arrangements to facilities for young people and adults.
- We saw evidence that the CASUS team actively tried to engage young people when they failed to attend appointments. Re-engagement strategies were based on the individual.

Are services well-led?

Good

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

- All staff knew who the senior managers were in the organisation. Staff told us that they had felt supported by managers when they had used the 'stop the line' process.
- Staff were able to access both clinical and managerial supervision. Staff had to access continued professional development training and there were forums in place to support training.
- Managers had access to trust data to gauge the performance of the team and compare against others. The key performance indicators that we saw were in an accessible format.
- Staff were offered the opportunity to give feedback on services through the staff survey.
- Staff told us that there were CAMHS champion practitioners within the locality teams. There was a reflective practice group to support morale and staff engagement was good.
- The managers in the community mental health teams told us that they felt the senior managers within the trust were committed to getting extra funding to recruit staff in order to manage the waiting list.

Summary of findings

- The manager of the CASUS service told us that they felt the trust was supportive of their work and also supported them with the relationship with their commissioners.
- The feedback from staff in the CASUS team was entirely positive in relation to staff morale. They felt supported by management and talked about how well the team worked together.

However:

- We received mixed reports from staff in the mental health service around morale. Some staff members reported that team morale was low and there was a high work pressure, others reported they felt well supported by the team and that morale was improving.

Summary of findings

Information about the service

Overall the service comprised:

- The single point of access (SPA) which was the referral management function for CAMH services in the children's directorate. It also provided advice and support for non-mental health practitioners via the telephone.
- Community psychiatric services for children and young people from the age 0-17 years.
- CASUS (children and adolescent substance use service) provided information, support and specialist treatment around drug and alcohol use to young people under 18 years and their families. CASUS provided the service across Cambridgeshire.

Our inspection team

Our inspection team was led by:

Chair: Professor Steve Trenchard, Chief Executive, Derbyshire Healthcare NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Lyn Critchley, mental health hospitals, CQC

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers and support staff and a variety of specialist and experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected the mental health community services for children and young people (CAMHS) was comprised of two inspectors, two specialist advisors, and an expert by experience.

When visiting CASUS the team comprised of one inspector, a specialist advisor and an expert by experience.

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

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 the service, asked a range of other organisations for information and sought feedback from young people and their carers at focus groups.

During the inspection visit the inspection team:

- Interviewed 4 team leaders.
- Looked at the environment of 3 community teams.
- Reviewed 21 care records.

Summary of findings

- Interviewed 13 members of staff including psychologist's, mental health practitioners, support workers and administration staff.
- Reviewed 2 waiting lists.
- Interviewed 10 carers.
- Interviewed 3 young people.
- Received 1 comment card.
- Looked at a range of policies, procedures and other documents.

What people who use the provider's services say

Ahead of the inspection we heard from a number of community groups and individuals about difficulties in accessing the children's community mental health services. Throughout the inspection we heard this from additional carers, service users and other services.

During the inspection:

- Young people told us that they were treated with dignity, and felt cared for and listened to by staff.
- A young person accessing the CASUS service told us that they were supported by the team to engage with the service in a variety of ways including text message reminders, driving them to appointments and attending appointments with them.
- Parents told us that they had involvement in care planning for their child once the treatment had started in the mental health service.
- Parents told there was a long waiting to access mental health services after the initial assessment had been completed. But once their child was receiving treatment their child made good progress.
- A young person in the mental health service said they did not feel listened to. They also said there was a lack of continuity of care provided by the doctors as they kept changing.
- Parents told us that prior to young people accessing treatment they had telephone contact with mental health practitioners, but they were given limited advice. However, once the treatment had started this had improved.

Good practice

The CASUS team had implemented the AMBIT approach within their work. This had included changing the format of their team meeting agendas and case reviews to mirror the same approach that young people use when accessing treatment. This meant that the team had embedded the treatment methodology in all aspects of their work and were role models for the young people they were supporting.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the CAMHS community team have the capacity to ensure that the waiting lists in community mental health teams are reduced and effectively managed.
- The trust must ensure that risk assessments are available, reflect the young person's needs and are updated following any significant change.

Action the provider SHOULD take to improve

- The trust should ensure that actions are taken to address the identified environmental risk areas including call systems in therapy rooms.
- The trust should ensure that clinical supervision records are kept and maintained for individual staff.
- The trust should ensure that consent and capacity is recorded and filed within the young person case records.

Cambridgeshire and Peterborough NHS Foundation 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
Community CAMHS Single Point of Access	Trust headquarters
CAMHS Cambs Core Team (Huntingdon & Cambridge) Brookside Clinic	Trust headquarters
CAMHS Cambs Core Team (Huntingdon & Cambridge) Newton Centre	Trust headquarters
CAMHS Cambs Neuro (ADHD/ASD/LD) Team Brookside Clinic	Trust headquarters
CASUS (Children and Adolescent Substance Use Service) Newton Centre	Trust headquarters

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

CAMHS

- Interview rooms were available for therapies and staff meetings. They were not fitted with alarms and there were no viewing panels on the door. There were no cameras in the rooms other than the family therapy room. Administration staff reported that if there was an issue with violence or aggression then staff would shout for help. However, the area was not staffed so there could be no guarantee that someone would be able to hear a shout from a staff member or young person. Therefore staff could not guarantee the safety of themselves or others around the building. The manager told us that there were plans to have alarms fitted in all rooms.
- There were no clinic rooms at Brookside or at the New Town Centre but we saw a physical health room with weighing scales and blood pressure monitors. We saw records that showed the equipment was calibrated and checked.
- The building was clean and tidy and appeared well maintained.

CASUS

- A variety of rooms were available to see young people for appointments.
- The clinical rooms were clean, tidy and well organised.
- Medication was stored safely in locked cupboards.
- Hand washing information was present in the toilets.

Safe staffing

CAMHS:

- The SPA team had sufficient staff to manage their caseload.
- Staff in the community mental health teams had an average caseload of 25 to 30 patients. There was sufficient staff to manage the actual needs of the patients who were in receipt of treatment however there was insufficient staff to meet the needs of young people on waiting lists for assessment or to begin their treatment.
- Staff told us that they did not use agency or bank clinicians. Fixed term contracts were in place for a psychologist and locum doctor. Administrative support was, at times, covered with agency staff. We saw evidence that showed 163 requests were made for unregistered bank staff from November 2014 to April 2015 and no requests had been made for registered staff. This meant that there had not been effective cover arrangements for sickness or vacant posts during the period.
- Where required rapid access to a psychiatrist was not always possible.
- Staff told us that sometimes young people would present themselves at accident and emergency in order to expedite access. A duty system was in place and the duty person would see the young person at the A&E.

CASUS

- Staffing levels were determined by the treatment contract set by the commissioners.
- There were two vacancies within the team for a full time support worker and a part time practitioner. The service did not use agency or bank staff due to the specialist nature of the service. Staff absence was managed within the team.
- Caseloads were allocated following team discussion in weekly allocation meetings.
- Staff were compliant with mandatory training. The average rate of compliance for the service was 96%.

Assessing and managing risk to young people and staff

CAMHS

- Referrals were made through the SPA team (single point of access) where they were triaged and sent to the appropriate team. All referrals were triaged within 24 hours. Once seen referrals were closed by the SPA.
- Once referrals were received by the community mental health team these were prioritised according to risk via a multidisciplinary team meeting and accordingly placed on the waiting list for formal assessment and treatment. Following this a practitioner was allocated who monitored the young person when on the waiting list. The monitoring provided varied from a phone call to a face to face review.

Requires improvement

Are services safe?

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

- The team reviewed people on the waiting list in order to identify increased levels of risk and where necessary move the young person further up the waiting list. However staff reported there was a limited capacity to respond to risk. Staff gave examples of people's appointments being cancelled in order to respond to risk to others.
- In the previous12 months there had been two incidents involving young people who had been choice assessed and were waiting to start treatment but had not been identified as high risk.
- Out of the eight case records we reviewed the majority of the young people were noted as being suicidal and at risk, however there were no care plans or risk assessments reflecting this. We also found that other risk assessments had not been updated following significant changes. This meant that the young people did not have accurate plans in place to reduce risk to them.
- Training records showed that 96% of staff were trained in safeguarding. Staff were aware of the trust safeguarding policy and were able to explain how to raise a safeguarding alert. We saw management supervision records where safeguarding issues were discussed. All staff had a desk top icon on their computer to access safeguarding children documentation and information. We saw good practice in having a 'what if' conversation to gain support decision making around whether a safeguarding referral needed to be made. There was a safeguarding lead for the trust and the community team had its own safeguarding link worker.
- We heard of good use of the lone working policy from staff who had strategies in place for ensuring safety when care coordinators visited homes.
- There was no medication kept on the premises. However prescription pads were kept in the reception area and locked in a drawer. We saw evidence of recording which prescriptions sheets were used.

CASUS

- Risk assessments were completed at initial assessment. Risk management plans were appropriate for young people and there was evidence that the young person was involved in planning how to reduce risk for themselves.
- However, we saw two examples in care records of risk assessments not being updated when there was a change in a young person's situation. This meant that the risk management plan was not current and meant that staff did not have an up to date plan in place for the young person.
- Referrals in to the service were prioritised by risk. Normal practice would be for referrals to be discussed in a weekly allocation meeting. However, there was capacity in the team to address urgent referrals that could not wait until the meeting.
- Staff were fully compliant with safeguarding training. Staff were able to describe the trust safeguarding policy and also give examples of when referrals should be made. Staff had access to current safeguarding information through the safeguarding satchel on each staff members desktop.
- Staff were aware of the lone working policy.
- There was no-one in receipt of medication from the service at the time of the inspection.

Track record on safety

- In last 12 months there had been three serious incidents in the community mental health teams. Two of the incidents involved young people who had been choice assessed and were waiting to start treatment but had not been identified as high risk.
- The capacity of the community mental health teams has been placed on the trust risk register due to the size of the waiting lists, on call duties and workloads, and errors. We saw the risk registers and noted that there were clear action plans written with a named individual responsible for the actions and dates for when the actions were due. As a result of this additional funding had been sought, which will be used to address staffing difficulties.

Reporting incidents and learning from when things go wrong

CAMHS

- Incidents were reported using the DATIX system and were reviewed and signed off by the manager. Staff told us that they knew what to report and how to report.
- The teams discussed all incidents and outcomes of internal and external investigations in a weekly team meeting.
- We saw evidence that staff were open and transparent and explained the complaints and incidents process to young people.

Requires improvement

Are services safe?

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

- As a response to a serious incident the manager told us that they had tightened up case load management and since held multidisciplinary weekly meetings to discuss treatment proposals and in-depth case specific items. Following this incident all team managers and the chief operating officer had attended a meeting to review the incident.
- Staff told us that, following incidents, they were offered a de-brief from their manager and the team offered extra support if required.

CASUS

- Incidents were reported using the DATIX system and were reviewed and signed off by the manager. Staff told us that they knew what to report and how to report.
- Staff told us that they know what to report and how to report it. Incidents and learning are discussed and the team had time to reflect on this in team meetings.
- There had been no serious incidents involving young people who used the service in the previous12 months.
- We saw evidence of staff being supported following an incident through one to one meetings with the managers.

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

CAMHS

- We saw evidence of staff completing the common assessment framework. Assessments involved an initial choice assessment before being signposted to care coordinators and other relevant assessments such as medical appointments, psychology, school observations and home observations. Once evidence was collected from this further input then a diagnosis could be made.
- When found some issues with record systems. The service was going through a transition from paper documents to an electronic system. As a result there were both paper and electronic copies being used. The paper notes were in the process of being archived.
- We reviewed eight case records and saw that summary care plans and risk assessments were written in a letter format to GP's and families which were then scanned into the electronic system. However we noted that staff were not using the electronic system to enter core assessments and care plans and so these were difficult to locate. This system also did not allow for the plans to be signed by the young people.
- Out of the eight case records reviewed the majority of the young people were noted as being suicidal and at risk, there were no care plans or risk management plans reflecting this. This meant that the young people did not have accurate plans in place to reduce risk to them.
- Staff told us that that all treatment programmes were bespoke and based on the individual case formulation of the young person. Staff attended meetings to discuss what clinician had the most appropriate skill set to meet the needs of the young people prior to allocation.

CASUS

- Comprehensive assessments were completed following referrals being made in to the service. The assessments looked at the young person's current situation as well as taking into account past experience of substance misuse.
- Care plans were completed with the young person and looked at a variety of needs including those contributing to substance misuse behaviour and social needs.
- Information about young people's care was stored on the electronic record system. Not all information was readily available. For example, current risk assessments were not present on two records that were reviewed. When we asked the manager we were told that this could be because they had not been uploaded.

Best practice in treatment and care

CAMHS

- A trust told us that they follow NICE guidelines. However, community mental health teams struggled to keep up with recommendations around the frequency of medical reviews. We were told that it was sometimes not possible to follow up young people on antidepressants within the recommended time frames. The service was also struggling to keep people under medical review for 12 months following successful treatment.
- The service was able to offer National Institute for Care and Health Excellence (NICE) recommended treatments in family therapy, cognitive behavioural therapy, interpersonal therapy, eye movement desensitisation and reprocessing, and cognitive analytical therapy.
- Routinely GPs monitor the young people's physical health. However, staff considered physical health needs and we saw equipment to monitor weight and physical observations.
- Records showed that outcome measures were used at the beginning and end of the treatment programme, these included: children and peoples improving access to psychology therapy (CIP IAPT), revised child anxiety and depression scales (RCADS) and strengths and difficulties questionnaire (SDQ). In addition routine outcome measures (ROMS) were used at the end of each session and commission for health improvement-experience of service questionnaire (CHI-ESQ) was used to measure the experience of the parent and child at the end of service.
- Staff told us that access to the therapies was very difficult. Young people with high risk could be seen within four to six weeks, however for those with lower risk the wait could be over a year. This was not in accordance with NICE guidelines.
- Staff told us that they have been trained in the choice and partnership approach model of working (CAPA). CAPA brings together the active involvement of young

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.

people, demand and capacity ideas, lean thinking and a new approach to clinical skills and job planning. However this had not been fully implemented due to the need to focus on reducing the long waiting times.

CASUS

- The CASUS operational policy refers to all relevant NICE guidance documents that informed the teams practice.
- CASUS also used guidance from the Department of Health, the National Treatment Agency, Public Health England and the Home Office.
- The team delivered therapy under the AMBIT (adolescent mentalization-based integrative treatment) approach.
- The comprehensive assessment include physical healthcare needs and the team had access to equipment to support young people with physical health issues.

Skilled staff to deliver care

CAMHS

- The team consisted of consultant psychiatrists, and mental health practitioners who were made up of nurses, psychologists, family therapists and social workers.
- The manager told us that staff could apply for necessary specialist training where relevant. The training would need to be linked to staff appraisals and would need to be agreed by the service manager.
- The service held a best practice forum twice a month. The forums were well attended by staff and were used to develop areas of learning by providing speakers from local agencies.
- All staff were allocated a learning code based on their professional background in order to maintain their professional registrations.
- Managers and staff told us that supervision was offered to all staff on a four weekly basis. However no record was kept in order to monitor this process and staff attendance. We were told that all staff had to provide evidence that they have attended supervision at their yearly appraisals. The manager did show us some management supervision records and we saw that the staff had open discussion with their line manager about their health and well-being.
- We saw records of appraisals which showed the out of 46 staff, 35 were completed theirs, seven were in progress, and four staff did not have an appraisal.
- The manager told us that current training did not include legal frameworks such as the Children's Act. However within the team there were staff who had experience of different frameworks and the team would seek support and guidance from them if needed.

CASUS

- The staff team consisted of consultant psychiatrists, clinical staff and support workers. The team had a variety of experience, and all staff were experienced in the field of substance misuse.
- We reviewed staff files and saw evidence that staff received regular supervision. The format for these sessions provided staff with a forum to discuss workload and also their health and wellbeing.
- Staff were appraised yearly. Evidence showed that staff were engaged fully in the process and in setting their objectives for the 12 months.
- Staff told us that they have access to specialised training to support their role. This included training in safer injecting and mentalization approaches to treatment.
- We saw where relevant evidence of poor performance being addressed quickly and effectively.

Multi-disciplinary and inter-agency team work

CAMHS

- Staff told us that regular and effective multi-disciplinary meetings were held weekly in order to discuss high risk cases, allocation of new referrals and the waiting list.
- The manager told us that there was also an on-call forum that discussed current issues that had been raised by staff when on-call. The forum was used to look at learning points and lessons learnt. The forum was set up by a senior clinician in order to support staff.
- Staff told us the neuro service was able to refer to the CAMHS team. Staff told us that were good working links with external teams and that they often attended meetings in order to maintain the links.

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.

- Staff told us that after the initial assessment young people were signposted either to locality teams, community paediatrics teams, occupational therapy services or specialist teaching services.

CASUS

- We saw evidence that multidisciplinary meetings took place on a weekly basis to discuss cases and also to allocate new referrals.
- The treatment approach of the service required staff to formulate positive working relationships with other agencies involved in the young person's care. We saw examples of positive liaison with social services, healthcare services and schools.

Good practice in applying the MCA

CAMHS

- Staff were trained in the Mental Capacity Act (MCA) 2005 however two staff said that they were not clear about the five principles of the Mental Capacity Act and did not use these in their day to day work.
- Staff reported that they did not formally assess capacity in all cases but would record it in progress notes if it was an issue. Staff told us that capacity issues were usually addressed by medical staff but if there was an admission to hospital they would do a formal MCA assessment.
- A consent form for information sharing was completed prior to an assessment in order for information to be shared between agencies and schools and was signed by the young people. However, we saw no evidence that capacity and consent to treatment and was being discussed with young people or recorded in the notes.

CASUS

- Staff were able to access training in the MCA.
- Consent to communicate forms were completed regularly with young people accessing the service.

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

- We did not assess the application of the Mental Health Act within this core service.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

CAMHS

- We observed staff communicating with young people in a kind and respectful manner. Staff were observed to be sensitive to the needs of the young people and when speaking about them showed good knowledge of their problems and how they could help them.
- Young people told us that they were treated with dignity and felt cared for by staff. They also said felt listened to and when staff spoke to them they did not use jargon so they could understand what they were being told. One young person said they did not feel listened to.
- Young people told us that there was a lack of continuity of care provided by the doctors as they kept changing. Continuity was provided by the mental health practitioners whom they told us they were pleased about.
- A carer we spoke to said that the care from staff was fantastic.
- We saw a board in reception with positive messages from young people and carers. These include; 'you are helping my child to get better', 'very supportive' and 'helpful and sensitive staff'.

CASUS

- We observed interactions between staff and young people and saw that the staff treated people with respect. The interactions also showed the staff had a good knowledge of the young people's treatment plan and preferences.
- One young person told us that 'my key worker and doctor have saved my life. I don't know what would have happened otherwise'.
- The service collected regular feedback from young people on a monthly basis using an iPad survey. We saw some comments young people had made and they said 'I can understand my worker, she doesn't preach at me' and 'I feel I have improved massively since I have been seeing my counsellor and believe the service would be able to help others too.'

The involvement of people in the care they receive

CAMHS

- Carers told us that they were involved in care planning for their child once the treatment had started. But we did not find this evidence within the electronic system.
- Carers told us that prior to the young people accessing treatment they had telephone contact with mental health practitioners, but they were given limited advice. Once the treatment had started this improved.
- Nine carers interviewed said that there was a long wait to access services after the initial assessment had been completed but once their child was receiving treatment the child made good progress.
- A carer told us that their child was referred and they were contacted by the service and seen within eight days.
- Some carers told us that they were aware of self-help support groups. One carer told us that they had to be 'pushy' in order to get support and information.

CASUS

- We saw evidence of young people signing their care plan after it was completed. This meant they were agreeing to work towards the objectives set out in the plan.
- Care plans were reviewed but this information was not always readily available on the electronic system as the documentation had not been scanned on to the system.
- The manager told us that young people were able to get involved in recruiting new staff by creating questions to be used in the interview process.
- Family members and parents were involved with the young person's care as the treatment methodology saw family relationships as part of the young person's network.
- The service offered an opportunity for people to provide feedback on the service through monthly iPad surveys.
- Advocacy services were available to young people and information to contact advocates was available in the waiting area.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

CAMHS

- In community mental health teams we saw that there were clear criteria for which young people were offered a service.
- The trust had stopped accepting referrals for young people with attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorders (ASD) unless there was an additional presence of moderate to severe mental health issues.
- Referrals were made through the SPA team (single point of access) where they were triaged and sent to the appropriate team. All referrals were triaged within 24 hours. Once seen referrals were closed by the SPA. We saw data that showed from 1 March to 20 May 2015 the SPA team had received 645 referrals. Of these 314 stayed within the service core teams. 331 had been signposted or discharged. The staff told us that when they signpost a young person this was a recommendation not a treatment plan, for example, counselling at an external organisation.
- Once referrals were received by the community mental health team, they were prioritised according to risk via a multidisciplinary team meeting and accordingly placed on the waiting list for formal assessment and treatment. Following this, a practitioner was allocated who monitored the young person when on the waiting list. The monitoring provided varied from a phone call to a face to face review. The team then reviewed people on the waiting list in order to identify increased levels of risk and, where necessary, move the young person further up the waiting list. However, staff reported there was limited capacity to respond to risk. Staff gave examples of appointments being cancelled in order to respond to risk to others.
- The trust had no set target times from referral to triage and from assessment to treatment.
- Information provided by the trust before the inspection showed that there was an average of 13 weeks from referral to formal assessment and an average of 27 weeks from assessment to onset of treatment. At the time of our visit we found that referral to assessment waiting times could be up to 62 weeks for some young people. After assessment there was then a further wait for treatment including medical treatment or psychological therapies.
- The manager showed us key performance indicators for current waiting times. They showed that a total of 254 young people were waiting for an initial assessment. Following assessment, 33 were waiting to be allocated a doctor, 107 young people were waiting to start cognitive behavioural therapy, 64 were waiting for specialised clinical care, and eight young people were waiting for family therapy.
- The manager also told us that that longest waiting time for young people to be seen in the core team was 87 weeks and that 30 young people had been waiting more than a year to access cognitive behavioural therapy.
- We spoke to carers who said that they had been referred in November 2014 and offered an appointment for September 2015. They were only able to be seen quicker in May 2015 due to a cancelled appointment. However, another carer we spoke with said that their child had an emergency so they were given an appointment within two days.
- Another carer said their child had waited six months from referral to assessment but was seen weekly due to a change in medication. The same child had been subsequently been referred to talking therapy but the wait was over a year.
- The team had a duty person who was able to respond to phone calls and offer telephone support.
- The duty person also responded to A&E emergencies and saw relevant service users in A&E. They rang the hospitals each morning to see if there had been any CAMHS issues overnight. This was particularly needed due to the absence of a Section 136 place of safety for young people that meant young people were often kept in a general hospital until a bed could be found. Staff told us that sometimes young people presented themselves at accident and emergency in order to expedite access to the service.
- The service was not able to show a 'did not attend' (DNA) appointment policy. However in practice after two missed appointments the young person would be discharged from the service. There was no evidence that this was done on a risk basis, so higher risk young people could be left when in need.
- The trust told us that funding has been sourced in order to address the long waiting list and staff recruitment. A

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plan had been set and funding secured to recruit six staff on a 12 month fixed term contract, to prioritise the reduction of people on the waiting list. The annual budget for staffing has been increased and this was to be used to recruitment staff to substantive posts. The manager told us they were holding an open day at the Newton Centre for new perspective staff to meet the team and be interviewed on the same day.

CASUS

- The service offered three treatment pathways for people who were assessed as suitable for treatment. They offered advice and information sessions, support for children whose parents misuse substances and a structured treatment pathway for young people with substance misuse issues. The structured pathway included offering substitute prescribing if this was assessed as appropriate by the consultant psychiatrist.
- The team worked in an outreach capacity to offer support to young people in whichever environment the young person chose. This ranged from meeting in cafes to meeting in educational environments.
- The centres were open from 09:00 – 17:00 on Monday to Friday. However, the team gave examples of working flexibly outside those hours to accommodate young people's needs and preferences.
- We saw examples of the team actively engaging young people who were reluctant to access support. This was done in a variety of ways including via text message. The team also offered appointments to people that were more relaxed and informal as a way of building a relationship with young people before starting structured treatment.
- Young people told us that if appointments needed to be changed they were always told in advance.
- If young people failed to attend an appointment, this was discussed in the multidisciplinary meeting and a re-engagement plan was put into place in line with the person's preferences.

The facilities promote recovery, comfort, dignity and confidentiality

CAMHS

- We saw that the reception areas were clean and nicely decorated with enough seating. There were information boards with a variety of posters. Books and toys were provided for a variety of age groups. Wi-Fi was also available.
- We saw a consultation room, family therapy rooms and play rooms including a soft play area. There were physical healthcare rooms.
- In the waiting rooms there were a range of accessible information on treatments, local services, young peoples' rights and how to complain.

CASUS

- There was a full range of rooms to see young people for appointments.
- The reception area was tidy and well-kept and the information displayed was current and in date.
- The reception area contained a variety of age appropriate information including advice lines, events and harm minimisation information.
- Information on how to complain was displayed in the reception area.

Meeting the needs of all people who use the service

CAMHS

- Disabled access was good at Brookside as the service was spread across one floor. There was also a disabled toilet available. Newton Centre staff told us that if disabled access was required then all meetings would be booked in downstairs rooms where there was also access to a disabled toilet.

CASUS

- Disabled access was good at the Newton Centre. Staff said that clients who were unable to be seen upstairs would have rooms booked on the ground floor in advance of their appointment.
- Interpreting services were available for young people, if required.

Listening to and learning from concerns and complaints

CAMHS

- We were provided with data that showed 16 formal complaints had been raised in the previous year. Seven complaints were upheld, two were partially upheld, two were not upheld, one complaint was withdrawn as the complainant was happy that the situation had been resolved, four complaints were still being investigated. The majority of these related to long delays in accessing treatment. We saw evidence that the trust was open and honest with the outcomes of the investigations and that

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Requires improvement

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apologies had been made to the complainants when needed. The information supplied also showed that recommendations were made to prevent further occurrences.

- A manager reported that due to the number of complaints they spent a day per week dealing with complaints.
- Staff told us that complaints came direct to therapists via the young people advisory service or PALS team and via the trust complaint process.

CASUS

- There had been no recent complaints received by the CASUS service.
- One young person told us that they knew how to complain if they wanted to.
- Staff were aware of the complaints procedure and how to support young people regarding how to complain if they needed or wanted to.

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

CAMHS

- Staff were unable to say what the values of the trust were.
- Staff were able to tell us what the main objectives were for the service. All staff knew who the senior manager was in the organisation and told us that they had felt supported by them when they had used the 'stop the line' process.

CASUS

- Staff said that they knew senior members of the trust and some had visited the service.
- Staff were clear on the objectives of the service and the outcomes they were trying to achieve for young people.

Good governance

CAMHS

- Staff were able to access clinical and management supervision, however there was no record kept of these sessions.
- Staff were able to access development training and there were forums in place to support training. One forum was set up by a clinician and was supported by the senior management team in order to provide support to staff to discuss lessons learnt.
- Key performance indicators (KPIs) were used to gauge performance. However not all KPIs were shown to us on the day of the inspection when requested. The KPIs that we saw were in an accessible format.

CASUS

- Staff were able to access supervision on a monthly basis. Staff were also able to access monthly group supervision where cases were discussed.
- Staff told us that they received yearly appraisals and this evidence was seen in staff files.
- Specialist training was available to staff to support their roles in a substance misuse service.

Leadership, morale and staff engagement

CAMHS

- Managers told us there were no bullying and harassment cases.
- Staff told us that they knew how to use the whistleblowing process and they would feel able to raise concerns without fear of victimisation.
- We received mixed reports from staff around morale. Some staff members reported that team morale was low and there was a high work pressure. Some staff said that management were not supportive of the staff and felt they were not being listened to about the risks on the waiting list. Other staff members said that despite the pressure morale was better than it used to be and that there was a supportive team around them.
- We saw evidence that staff were open and transparent. They explained the complaints process to young people.
- Staff were offered the opportunity to give feedback on services through the staff survey. The feedback highlighted that 65% of staff were able to contribute towards improvements at work and 37% of staff agreed that feedback from young people was used to make informed decisions in their directorate/department.
- Staff told us that there were CAMHS champion practitioners within the locality teams.
- There was a reflective practice group to support morale and staff engagement was good. A member of staff in the SPA team had co-written a guidance paper on deliberate self-harm and suicide and presented this at a conference.

CASUS

- There were no issues with staff sickness at the time of inspection. The rate of sickness was zero.
- There were no bullying or harassment cases in progress.
- We spoke to staff about whistleblowing and they were aware of trust policy. Staff said they would feel comfortable raising concerns about the service.
- All staff were positive about the relationships within the team and they said that the team worked well together. They reported morale to be good.
- Some members of the CASUS team were involved in an article about AMBIT treatment that was published in a professional journal.

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.

Commitment to quality improvement and innovation

CAMHS

- The managers told us that they felt the senior managers within the trust were committed to getting extra funding to recruit staff in order to target the waiting list and recruit more staff to meet the required establishment figures.

CASUS

- The manager from CASUS also trains people to deliver AMBIT therapy.
- The team work closely with the Anna Freud Centre to develop and improve the AMBIT therapy offered to young people.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The trust must ensure that the CAMHS community team have the capacity to ensure that the waiting lists in community mental health teams are reduced and effectively managed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • The trust must ensure that risk assessments are available, reflect the young person's needs and are updated following any significant change.