Requires improvement

Sheffield Children's NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Becton Centre for Children and Young People,
Sevenairs Road, Beighton, Sheffield, S20 1NZ
Tel: 0114 271 7000
Website: www. sheffieldchildrens.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RCUX1	Becton Centre for Children and Young People	Beighton community child and adolescent mental health services	S20 1NZ
RCUX1	Becton Centre for Children and Young People	Centenary community child and adolescent mental health services	S6 3BR

This report describes our judgement of the quality of care provided within this core service by Sheffield Children's 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 Sheffield Children's NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Children's 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?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- Environmental risks within the service had not been assessed and therefore there were no plans as to how such risks were to be mitigated. No risk assessments were completed in relation to lone working practices.
- We found out of date items in clinic rooms and equipment that had not been calibrated to ensure it was accurate to use. There were no regular checks of clinical areas and infection control practice which meant these issues had gone unnoticed.
- Some young people in the generic services had to wait significant amounts of time for treatment. These timescales exceeded the trust's own target and NHS referral to treatment time scales.
- There was no oversight of staff training and supervisions at service level in order to ensure staff received necessary training and support. There was a lack of audits that took place in order to monitor the effectiveness of the service.
- There was no evidence of how staff had assessed young people as being competent to make their own decisions. Staff were not required to have training in the Mental Capacity Act 2005 as this was not mandatory training.
- The system for reporting incidents did not allow for detailed incident analysis to be undertaken. Some staff felt they did not always receive meaningful feedback from incidents.
- Although the service was able to offer some flexibility of appointments, including out of hours, some carers said that a lack of flexibility in their cases impacted upon their routine and that of their child.
- The service did not use agency staff and tried to maintain continuity of care for young people. However, there were instances where staff absences had not been effectively covered or communicated to carers and young people.

However:

- Staff used recognised clinical outcome rating scales to assess and monitor young people's progress. There were a variety of professionals at the service who were able to offer different treatments to suit young people's need.
- Staff regularly reviewed waiting lists and there was a consultation line for carers and young people to contact if their circumstances deteriorated. The service could offer rapid response appointments where these were deemed as being required.
- The service had introduced initiatives to try to combat high demand and reduce waiting times. The service was participating in a schools project to address early intervention for mental health problems in children.
- Young people and carers spoke positively about staff who they described as caring, supportive and professional. Our observations of how staff engaged with young people and carers supported this.
- Staff felt confident about their safeguarding responsibilities and had resources to support them with this.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- No risk assessments had been completed in order to identify and mitigate potential risks within the environment and to maintain the safety of young people.
- The clinic rooms contained out of date items and medical equipment that had not been calibrated therefore could not be relied upon to give accurate recordings.
- Although staff were aware of the lone working policy and individually took actions to mitigate potential risk, no risk assessments in relation to lone working practices were regularly undertaken as required by trust policy.
- Some carers reported lack of continuity in young people's care due to staff absences.
- Staff did not always feel that learning from incidents was fed back effectively and in a way that was meaningful.
- There were shortfalls in some key areas of mandatory training.

However:

- Staff felt confident about their safeguarding responsibilities and reported good support from within the trust and local authorities.
- Young people had risk assessments and management plans in place which were updated in response to any changes to risk level.
- Staff monitored risks to young people on a frequent basis within meetings and supervision. There was a consultation line for young people and carers to contact should their circumstances deteriorate.

Are services effective?

Requires improvement

We rated effective as requires improvement because

- All staff had not completed Mental Capacity Act 2005 training and this was not mandatory training.
- There was no evidence of how staff had assessed young people as being competent to make their own decisions and give consent in relation to their care and treatment.
- Although staff had access to supervisions and support within their roles some said these sessions were not always well attended.
- There was a lack of audits at location level in order to monitor the effectiveness of the service.

However:

Summary of findings

- Young people were assessed upon admission to the service. Staff completed regular physical health observations and checks of young people.
- Staff used recognised clinical outcome rating scales to assess and monitor young people's progress.
- There was a wide ranging multidisciplinary team made up of a variety of professional disciplines who were able to offer different treatments as recommended in National Institute for Health and Care Excellence guidance.
- Carers reported good joined up working and said the service worked positively and proactively with other organisations such as schools and GPs

Are services caring?

Good

We rated caring as good because

- Observations showed that staff were caring and respectful in their interactions with carers and young people.
- Carers and young people spoke positively about staff and said staff they were caring, supportive and professional.
- Observations showed, and carers and young people confirmed, that they were involved in their care and able to give their own views and input.
- There were opportunities for carers and young people to give feedback and help influence the service.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Waiting times for treatment exceeded the service's own aims and NHS referral to treatment time scales.
- Although there was some flexibility of appointment times, some carers said they would like more flexibility in relation to when and where appointments took place.

However:

- Staff signposted referrals on to other more appropriate agencies where they did not meet the criteria of the service.
- The service had introduced some initiatives such as specialist clinics to try to combat high demand for the service and reduce waiting times.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

Summary of findings

- There were regular meetings to review incidents however the system for reporting incidents did not allow for detailed analysis to be undertaken to identify themes and trends.
- There was no effective oversight of staff training and supervisions at service level.
- There was no set plan about what training all staff required in order to be suitably equipped for their roles.
- There was a vacancy for the role of service manager which had been vacant for some time. One team leader had responsibility for both sites.
- Interaction between both generic services was not routine and dependent on individual staff relationships. Staff reported they did not feel part of the acute trust.

However:

- Staff said they felt supported within their teams and got support from senior staff.
- The trust staff survey showed that the division had more positive responses about management than the rest of the trust.
- The service was participating in a schools project to address early intervention for mental health problems in children. This was as a result of a successful bid whereby the service had been awarded NHS England funding to carry out this project.

Summary of findings

Information about the service

Sheffield Children's Hospital Foundation Trust has two community child and adolescent mental health services which cover the whole of Sheffield. These consist of two generic services which provide both tier two and tier three provision. Tier two services consist of child and adolescent mental health specialists working in community and primary care, such as mental health workers and counsellors working in clinics, schools and youth services. Tier three services consist of a multi-disciplinary team working in the community which provides a specialised service for more severe disorders. Our inspection focussed on the two generic services

The community services also incorporate a citywide team for learning disability and mental health, a vulnerable children's team which includes the forensic team and the multi-agency psychological support team for looked after children.

Beighton community child and adolescent mental health service is based at The Beighton Centre for Children and Young People. The service sees around 1000 children a year at outpatient appointments. Centenary community child and adolescent mental health service is based at Centenary House. The service sees around 1200 children a year at outpatient appointments. Both teams see young people up to the age of 18.

Referrals to the service are accepted from GPs, social workers, educational psychologists, paediatricians and the clinical psychology department at Sheffield Children's Hospital.

Sheffield Children's NHS Foundation Trust has been inspected by the Care Quality Commission three times since it was registered in April 2010. The community child and adolescent mental health services have never been inspected as part of these inspections.

Our inspection team

The team was comprised of two CQC inspectors, a child and adolescent mental health consultant psychiatrist, a nurse consultant who specialised in community child and adolescent mental health, a child and adolescent mental health clinical psychologist, a clinical services director and an expert by experience. The expert by experience had experience of the type of service we inspected.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the Becton Centre and Centenary House where community child and adolescent mental health services operated from

Summary of findings

- spent some time with the learning disability and mental health children's community team based at Centenary House but did not fully inspect this service
- sought feedback from three young people and two carers at two focus groups
- spoke in person with five young people, and ten carers of young people, who were using the service
- collected feedback from three young people and three family members using feedback forms
- spoke with the team leader for the generic community child and adolescent mental health services
- held a focus group attended by six staff members who were a mixture of disciplines working at the service, including clinical psychologist, therapists and a psychiatrist
- spoke with a range of other staff members; including consultant psychiatrists, qualified professionals, administration and reception staff
- interviewed the clinical and associate director with responsibility for the service
- attended and observed one team meeting and one allocations meeting
- with consent of the young people and carers, we attended one treatment clinic and one home assessment visit
- looked at 12 care records for children and young people
- 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

We spoke in person with five young people, and ten carers of young people, who were using the service. We received feedback from three young people and three family members using feedback forms

The majority of carers and young people with were positive about the service. They described staff as caring, supportive, professional and helpful. They spoke highly about how the service had helped them and their child. Most described communication as good and said they received consistency of care and young people saw the same therapists. Young people said that staff sought their views and explained things to them. Young people and carers felt able to make any complaints and give feedback about the service. Some were part of a parent participation group that worked with the service. Some young people were involved with a charity that worked closely with the service.

However, some carers expressed concerns about high demand for the service which led to lengthy waiting times. Most carers said appointments suited their needs but some said a lack of flexibility had a negative impact on their routine and that of their child. Some carers felt the service should be able to provide more support for young people in crisis. One young person said long waiting times increased anxiety as they did not know what to expect. They felt advocacy support could be improved.

Good practice

The service had been successful in securing NHS England and local clinical commissioning group funding for a child and adolescent mental health service schools link pilot scheme. The aim of this was to improve joint working between child and adolescent mental health service and schools. The project arose from the 'Future in Mind' Department of Health document and the transformation plan to improve early access to mental health support for young people. The scheme consisted of a number of tier three child and adolescent mental health professionals working within 10 schools. The project had been positively received by the funders and organisations involved.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that environments are assessed in order to identify and mitigate risks that may be present to people using the service.
- The provider must ensure that lone working procedures are risk assessed as necessary and lone working processes are suitably robust to maintain safety.
- The provider must ensure there are appropriate systems in place at service level in order to effectively assess and monitor the service and how it operates. This should include the ability to identify and monitor staff training requirements and that staff supervisions are undertaken in accordance with policy.
- The provider must ensure that clinic room equipment is safe and suitable for use. There must be effective systems and processes to monitor infection control practices. These should be able to identify and highlight shortfalls in practice.
- The provider must ensure staffing levels are sufficient to enable young people to access treatment within timescales set out in trust and NHS national targets.

Action the provider SHOULD take to improve

- The provider should review how it demonstrates that young people deemed to be Gillick competent have been assessed as such.
- The provider should ensure that relevant staff receive necessary training where required in relation to the Mental Capacity Act 2005 and the Mental Health Act 1983.
- The provider should offer flexibility of appointments to meet the needs of young people and carers where possible and appropriate.
- The provider should ensure waiting areas provide necessary information for young people and carers.

Sheffield Children's NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Beighton Community CAMHS	Becton Centre for Children and Young People
Centenary Community CAMHS	Becton Centre for Children and Young People
Learning disability and Mental Health team	Becton Centre for Children and Young People

Mental Health Act responsibilities

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

Some qualified staff had recently completed Mental Health Act training however the Trust did not provide details of how many staff had completed this. The training was not mandatory.

The service did not support any young people who were the subject of a community treatment order at the time of our inspection.

A Mental Health Act administrator employed by Sheffield Health and Social Care Trust provided Mental Health Act administration duties to the service. Staff said the administrator was a point of contact they could go to for information about the Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was not mandatory for staff and not all staff had completed this training. The Trust did not provide details of how many staff had completed this

The consent policy incorporated the Mental Capacity Act and provided guidance about the key principles of the Act and assessments of capacity. Deprivation of Liberty

Detailed findings

Safeguards do not apply to people under the age of 18 years. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. These include the existing powers of the court, particularly those under s25 of the Children Act, or use of the Mental Health Act.

We saw evidence of signed consent in care records. Staff said if the young people who were Gillick competent and had capacity to make their own decisions could give their own consent. For children under the age of 16, a young person's decision making ability is governed by Gillick competence. This recognises that some children may have sufficient maturity to make some decisions for themselves. However, We saw no evidence of assessments to demonstrate how this had been considered.

Carers confirmed that staff contacted them to give consent on behalf of their child where necessary.

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

At Beighton Centre, the environment was clean and free from clutter. Young people and carers said they found the premises clean and tidy. Centenary House was a leased building and much older than the Beighton Centre. The rooms looked tired and some were cluttered however, young people and carers said it was clean. We observed the main rooms and waiting areas were clean.

Procedures for dealing with emergencies were not robust. At the Beighton Centre, staff had pagers available to use to request help in an emergency. However, this was not routine practice and some staff were unsure how these worked. At Centenary House, there was no alarm system or pagers. There was a telephone in each therapy room. The process for emergencies was that the staff member requiring assistance would call the receptionist to alert them that they needed help, or the emergency services depending on the severity. The receptionist would then seek someone suitably trained to assist. The therapy rooms were located on the lower ground floor which was isolated and access up to reception level was via a staircase. This system for assistance and the layout of the premises meant responding to immediate risk could be delayed.

No environmental risk assessments had been completed, including identification of any potential ligature points, at either site. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. We saw obvious ligature risks such as grab bars and alarm cords in accessible toilets at both locations. Staff we spoke with did not recognise these as a risk but told us if a young person was known to be at risk of self-harm they would monitor them. However, this method was subjective and reliant on individual staff practice. As no risk assessments had been completed, we could not be assured that staff were aware of what mitigation was required. It also meant the service had not fully considered ways of lessening the risks that were present in order to keep people safe.

The clinic rooms at both sites, and equipment within these, were not safe. At the Beighton Centre, the room was secured with a key pad however, we observed this to be open and insecure on three occasions during our inspection. All equipment within the resuscitation kit had expired between 2013 and 2015 which meant it could be unsafe to use. This had been replaced during our second visit to the service. The blood pressure monitor and weighing scales had not been calibrated since 2011 so could not be guaranteed to give accurate readings. There was no clear system for ensuring equipment was checked regularly and staff were unclear about whose responsibility this was.

At Centenary House, the clinic room was not kept locked however it was in an area only accessible by staff. The room was cluttered and areas for storage were limited. We found out of date items such as blood kits, needles and syringes. Sharps equipment was stored in an unlocked cupboard and the sharps bin was incorrectly assembled. Staff told us blood samples were taken in this room on occasion. The room was carpeted, the examination table was old and no protective covering was available. Single use hospital gowns were stored in a cardboard box but a used one had been put back in the box. This demonstrated that the service did not adhere to good infection control practice. There were three resuscitation grab bags stored in the staff kitchen which were very dusty and one had out of date equipment within it. Staff were not clear why there were three separate bags which could cause confusion.

Safe staffing

Each team comprised of a core group of medical staff, nursing staff, allied health professionals and support staff. The teams were supported by administration staff. There were some vacancies but recruitment into vacant posts was ongoing. There was an existing vacancy for a service manager and the current team leader was overseeing both sites. The team leader said the main pressure regarding staffing was filling child and adolescent mental health psychiatrist posts. The shortage of staff to fill these posts had been a challenge and was recognised as a risk at trust level. The team was trying to manage this by reviewing how psychiatry time was used in the service. The clinical director and team leader told us they were looking at the possibility of increasing the number of nurse prescribers to fulfil tasks that psychiatrists currently had responsibility for.

Requires improvement

Are services safe?

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

The service did not use agency staff as it was deemed as not suitable to the type of service. The associate director said there was minimal sickness and absences were managed by re-arranging staff members' appointments on their return. Staff said if they were off, their cases did not get normally get handed over. Some carers reported disruption caused by staff absences. Two carers told us that when the professionals treating their children had been off work, the fact that the cases were not reallocated had affected the young peoples' routines. One young person's records showed that a clinician had taken sick leave but the family had not been informed. They had contacted the service about their dissatisfaction of lack of contact and that no interim arrangements had been made to cover the case. Other carers and young people gave positive examples of consistency of care and reported no or minimal disruption with being able to see staff.

There were two on call rotas for out of hours medical provision which consisted of junior doctors and consultants. Staff told us they were able to access emergency provision which was provided in a timely manner.

Staff did not each have an average number of cases they were responsible for. Caseloads were managed through line manager arrangements and supervision to ensure that workload was manageable. The amount of cases for each staff member was often dependent on their role as opposed to a set number of cases. As a result of this, caseloads were variable. Some staff thought there was an average number of cases they were meant to hold but others were not aware of this, which suggested a lack of clarity. Some staff said that within their disciplines, when staff had left and moved on, their posts were not always filled which led to increased workload. Several carers we spoke with said the service needed more staff to meet the high demand of the service. Staff and carers felt lack of provision in child and adolescent mental health services was also a national issue and not exclusive to the service.

At the time of our inspection there were 274 cases at Centenary House awaiting allocation. Two hundred and eleven of these were awaiting initial assessment with the remainder awaiting treatment. The learning disability and mental health team had 26 cases awaiting allocation.

Sixteen were waiting initial assessment and 10 waiting for treatment. Beighton Centre had 206 cases awaiting allocation, 143 were awaiting initial assessment and the remainder waiting for treatment.

The trust target for mandatory training compliance was 85%. This target had not been reached for all required mandatory training. For example, only 73% of staff had completed fire safety training, 40% of required staff had completed medicines management training and 79% had completed safeguarding level three training.

Some mandatory training was provided online and some staff described this as a 'tick box' exercise. They said completion of training could be impacted by demand for clinical work which would often take precedence. Some felt that mandatory training seemed general acute care focussed and therefore not as meaningful to the staff and the client group they supported.

Assessing and managing risk to patients and staff

Staff completed a risk assessment and management plan for each child and young person upon their initial referral to the service. We saw these present in care records and evidence that they were updated and reviewed in response to changes.

The service provided a telephone consultation line which carers and young people could call if their mental health needs or circumstances changed. A clinician assessed the information to determine whether earlier or alternative interventions were required. Carers and young people also received information and advice in correspondence letters about what steps they could take if their situation deteriorated. One carer said they had found the consultation line really useful.

Staff monitored waiting lists in order to detect increase in levels of risk. This was done in weekly clinical assessment team meetings. Staff said they often sought further information from relevant parties to inform risk planning and prioritisation of cases.

All staff were required to complete mandatory level three safeguarding children training however not all staff were current with this. Staff were clear about how to raise concerns and make referrals. Staff told us that refresher training was kept current and up to date. For example, recent training had focussed on radicalisation of young people. Safeguarding was an ongoing agenda within team

Requires improvement

Are services safe?

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

meetings. There was a safeguarding lead nurse at the service and staff knew who this was. There were resources available to staff and an out of hours number for safeguarding advice.

The trust had a safeguarding adults and a safeguarding children policy that had regard to the statutory guidance Working Together to Safeguard Children (2013). However, this statutory guidance was updated in 2015; there was therefore a risk that current guidance was not reflected in the policy.

The trust had a lone working policy but staff did not follow this consistently. The policy stated that risk assessments for lone working should be carried out and reviewed regularly. However, no lone working risk assessments had been completed in accordance with this. Staff were aware of the policy and told us about steps they took to maintain their safety. These included ensuring diaries were accessible and up to date, undertaking out of hours appointments at the service when other staff were present and using their own clinical judgement about risk levels. Staff felt they were able to suitably manage the risks present.

The service did not store or manage any medicines on site.

Track record on safety

No serious incidents had been reported in the 12 months prior to our inspection.

Reporting incidents and learning from when things go wrong

There were procedures for reporting incidents and staff said they were clear about what to report. Feedback from staff was variable about reporting frequency. Some staff had never reported incidents before as they said there had been any. Where others had reported incidents they did not always get direct feedback. For example, one said feedback from incidents was often vague such as informing the staff member the incident was being looked at with no other information. Systems were in place to cascade incident information in other ways such as at staff meetings. However, staff felt information about learning from incidents often felt 'diluted' and did not necessarily correspond with incidents they had experienced. This meant there were limitations on what learning could be derived from these.

The trust did not have an electronic system for reporting incidents. Staff completed incident forms via a paper record, or on a word document. The current system meant it was not easy to effectively identify trends and themes and this was acknowledged by senior staff. As a result, there were limitations about how much meaningful analysis could be derived from incidents in order to improve the service.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients, or other relevant persons, of certain 'notifiable safety incidents' and provide reasonable support to that person. The duty of candour was incorporated into the trust's incident reporting policy. Training in the duty of candour was being rolled out to staff.

Are services effective?

Requires improvement

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

Staff completed a comprehensive assessment for each child and young person upon their admission to the service. Parents and young people we spoke with confirmed they were involved in assessments and we saw these in the twelve care records we reviewed.

There was no single standard care plan document that was used for all young people. Some plans of care were outlined within the initial assessment or correspondence letters. We saw evidence of goal based care plans in some records. There was information present that demonstrated what outcomes young people were working towards. We were able to see that progress towards goals was demonstrated in most care records that we looked at. Carers we spoke with said that they knew what the plan of care was for the young person. They told us these were reviewed at each session.

Positive behaviour support is an evidence-based approach used to support people with behaviour that challenges. Positive behaviour support plans were not fully embedded into the learning disabilities team however the team were knowledgeable about, and working within the principles, of this approach. They were undertaking further work to develop and evidence this.

Records were paper based and stored in locked filing cabinets in staff areas. The trust was in the process of implementing electronic patient records across all sites but staff said this was a slow process. The vulnerable children's team had recently become fully electronic as they were part of the pilot scheme. There was variance in practice used for undertaking and recording outcome assessments. Some staff used paper format and others used IPads. This information was input onto systems by administration staff in a way so that data could be used clinically with carers and young people. Some staff had reported systems for accessing records electronically as being a frustration.

Best practice in treatment and care

There was evidence in care records that staff completed routine checks and monitoring of young people's physical health and we observed these were completed during assessments. Carers confirmed their children received support with their physical health and said the service linked in with the young person's GP. One young person told us they had their height, weight and blood pressure checked at each appointment. They said the doctor had told them about their medication, how it may affect them and what to do. The service promoted good health for young people such as lifestyle and nutritional advice.

From discussions with staff, and review of records, we found that the service worked in accordance with recognised guidance and good practice. For example, we saw that staff used clinical outcome rating scales which included; strengths and difficulties questionnaire, the revised child anxiety and depression scale, outcome rating scales and goal based outcomes. Staff were able to offer psychological therapies as recommended by the National Institute of Health and Care Excellence.

Apart from trust led interventions and projects, we saw no evidence of recurring clinical audits that staff routinely completed at service level in order to identify and make improvements. For example, no audits were undertaken in relation to infection control practices, the environment and clinical equipment where we had found shortfalls. The clinical director said as a service they also wanted to do more work around monitoring and identifying the outcomes of interventions as this was a weak area.

Skilled staff to deliver care

There was a wide range of professional disciplines available at the service. These included doctors, qualified nurses, family therapists, art therapists, cognitive behavioural therapists and psychologists.

New staff completed an induction which consisted of a corporate induction and then a further local induction on site. A two day introduction to child and adolescent mental health course was available for all staff. Completion of the course allowed staff access to further specialised training in areas such as eating disorders and self-harm in children and young people.

Staff said they had recently been allocated four extra days training provision time per year. However, it was not apparent from information provided what training each staff member had undertaken and what they were expected to complete to ensure they had suitable skills. The training department was undertaking a learning analysis to establish exactly what training each staff group were required to have.

Are services effective?

Requires improvement

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 team leader said clinical staff had monthly clinical supervision and caseload management supervision. Extended supervision was available for complex case reviews. Various types of supervision were given to staff which included team supervision, initial assessment supervision and line management supervision. Staff also had individual supervision, the rates of which were determined by the requirements of their professional body and therefore varied between different roles. Staff said supervision did not always happen and was sometimes poorly attended due to workload demands. They acknowledged the importance of supervision, especially at times when the service was stretched but highlighted difficulties in maintaining this, especially with the different types of supervisions they were expected to attend.

The service was involved in some development work to look at improvements within supervision and having a more streamlined effective model. We saw examples of supervision records which had clear information about cases discussed issues identified and agreed plans. The service used the Leeds alliance in supervision scale which is a tool used to review that supervision meets the staff member's needs.

Staff received annual appraisals. The trust target for appraisal rates was 80%. The only staff groups which had exceeded this rate was allied health professionals. Only 46% of nursing staff and 74% of other professional groups were recorded to have received an appraisal which was below the trust target.

There were processes to address staff performance issues. These included informal discussion in managerial supervisions through to disciplinary procedures where appropriate.

Multi-disciplinary and inter-agency team work

There was comprehensive multidisciplinary input available at both sites. The service could offer a variety of different treatment options such as cognitive behavioural therapy, family therapy, art therapy, psychotherapy and parenting skills. Both teams employed primary care mental health workers who were the links into the multi-agency support teams. Their role provided gatekeeping into child and adolescent mental health services, diversion to alternative mental health services or accelerated referrals into the service. Staff from the generic child and adolescent mental health service and as well as the primary mental health workers reported positive and effective working relationships with each other and within the team in general.

Staff described variable working relationships with the tier four service inpatient child and adolescent service provided at the Becton Centre. Some felt communication could be improved as they often got short notice about key meetings such as young people's discharge and were not always able to attend. One felt it would be helpful if young people had a single care co-ordinator throughout the service to improve continuity between teams and individuals. Staff said where they had existing or previous working relationships with specific individuals within the tier four services then this was beneficial with knowing who to link in with.

Carers told us of good joint working and spoke positively about how the child and adolescent service interacted with other services. They told us that correspondence was always copied into relevant parties such as the young person's school and GP and these agencies would be consulted with directly where required. We saw evidence and correspondence in care records to support this. One parent told us their child had involvement with another service within the trust and that the communication between both services had been great and 'really impressive'.

Adherence to the MHA and the MHA Code of Practice

Mental Health Act training was not included in the list of mandatory training provided by the trust but the team leader said staff had started to receive training in this. However, it was not clear what amount of staff had completed this as the trust did not provide this information.

As the service provided community support, it did not detain people under the provisions of the Mental Health Act. The service did not support any young people who were the subject of a community treatment order. A community treatment order is part 17A of the Mental Health Act. The order allows a person leave hospital and be treated safely in the community rather than hospital.

A Mental Health Act administrator employed by Sheffield Health and Social Care Trust provided Mental Health Act

Are services effective?

Requires improvement

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.

administration duties to the service. This was by way of a service level agreement between both trusts. Staff said the administrator was a point of contact they could go to for information about the Act.

There was no requirement for staff to report any breaches of the Mental Health Act. Mental Health Act activity was not reported to board level, which meant there was no oversight by the trust about use of the Act, including whereby young people may be on community treatment orders.

Good practice in applying the MCA

The Mental Capacity Act 2005 does not apply to young people aged 16 or under. For children under the age of 16, a young person's decision making ability is governed by Gillick competence. This recognises that some children may have sufficient maturity to make some decisions for themselves.

It was not possible to establish from information the trust provided, how many, and which staff, had completed Mental Capacity Act training. The training was not mandatory for staff and not all staff we spoke with had completed this training. They said that capacity was discussed during interactions with carers and young people.

We saw evidence of signed consent in care records. For example, young people and their parents had signed consent to treatment and consent to share information. Staff we spoke with were aware of the principles of Gillick competence and said this would determine if young people could make their own decisions regarding their care. However, there was no evidence of how staff had assessed young people as being Gillick competent and able to consent to decisions where they were under 16 years of age. Parents signed consent on behalf of children where this did not apply. Parents confirmed that staff contacted them to give consent on behalf of their child where necessary. One parent said her child was over 16 and had been assessed as not having capacity. Staff consulted with the parent to make decisions in the young person's best interests.

The consent policy incorporated the Mental Capacity Act and provided guidance about the key principles of the Act and assessments of capacity. There was also a policy for the Deprivation of Liberty safeguards which are part to the Mental Capacity Act. Deprivation of Liberty Safeguards do not apply to people under the age of 18 years. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. These include the existing powers of the court, particularly those under s25 of the Children Act, or use of the Mental Health Act.

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

The majority of carers and all of the young people we spoke with were positive about the staff and the support they received. They said staff were professional, caring, friendly and helpful. Many commented specifically that staff were supportive and did their best to help. One young person said staff are 'nice and friendly and I trust them'. Positive views of staff were shared in the feedback forms that we received. One carer said they felt staff did not always take them seriously at times when they contacted the service.

We attended a home visit with a member of staff that was undertaken to assess a possible referral to the service. We also observed an attention deficit hyperactivity disorder clinic session. At both of these, the staff members involved with the carers and young people were polite and professional throughout. Staff showed empathy where appropriate, for example by acknowledging the carer's feelings of frustration during the home visit. Staff were open and honest about timescales and the options and next steps available to support the young person in each case. Staff adopted a supportive and listening approach throughout.

Carers and young people said they were treated with respect by staff. One young person using the service was experiencing difficulties in the development of their gender identity. The clinicians corresponded with the young person using their chosen name as part of their gender identity process which showed respect for their individual choices.

One young person said the success of treatment could be dependent on the relationship they had with their therapist and that if the therapist changed then this could impact upon the outcome. Therefore, consistent relationships between young people and staff were important. The majority of carers we spoke with commented positively about consistency of staff who understood and engaged well with their child. Young people had named therapists and staff they routinely saw.

Our other observations of staff contact with carers and young people showed they were respectful, professional and friendly. We did not hear any staff compromise people's confidentiality such as disclosing personal information. Carers and young people told us that staff maintained their confidentiality.

The involvement of people in the care they receive

There was evidence in care records of carers and young people's involvement within their own care. Young people's views were captured and recorded during sessions with staff. Carers told us they were involved within the young person's care and received correspondence and feedback following therapy sessions which detailed the plans of care.

Young people felt involved in their care. One young person told us the doctor always asked them for their views. During our observations of the home visit and assessment clinic, we saw that staff members sought the views of carers and the young people they were engaging with. They involved them at all stages of the process. Staff clearly articulated the reason for the visits and confirmed this was the carers' understanding also. They listened to the carer and young person where present, and asked appropriate questions in order to clarify certain points. Throughout the assessments, staff members ensured the carer and young person where applicable, had full understanding about what was happening and knew who to contact in the interim with any further queries of concerns.

There was information about advocacy services on display. One young person said they felt these services should be explained better to young people.

Young people and carers said they felt engaged with the service directly. A parent participation group met monthly. The group had been involved with, and given input into, transition, transformation and crisis care developments at the service. Staff worked closely with a local young people's empowerment project who had recently undertaken a review of the community service. The learning disability and mental health team offered support and training to parents and carers every half term. This had been requested by parents and facilitated by the team. Staff also undertook an annual experience of service questionnaire. We also saw that feedback was displayed in the waiting areas on both sites.

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

Referrals were made into the service via a central access point within the administration team. The team leader said most referrals came via young people's GPs. A child and adolescent mental health clinician completed a daily screen of all referrals so that any identified as urgent could be booked in for a rapid response appointment. These normally took place within one to two days.

The provider's website said the vast majority of children and young people aimed to be seen within 13 weeks of referral. NHS England guidance states the time from referral to treatment for psychological therapy should not exceed 18 weeks. The trust had agreed with commissioners to try to meet this 18 week target. However, this was not currently being achieved. At the time of our inspection, the waiting time from referral to initial assessment at the Beighton centre was 20 weeks. At Centenary House this was 22 weeks. Following initial assessment, the internal waiting lists for treatment were lengthy in many cases. The waiting times varied dependent on the therapy a young person had been assessed as needing. The longest wait for therapy at both services was for art therapy which at the Beighton centre was 28 weeks and 30 weeks at Centenary House. This meant that young people being referred had to wait excessive lengths of time for treatment. Some therapies had significantly shorter waiting lists, for example two weeks for psychotherapy at Centenary House and one week for interpersonal therapy at the Beighton centre.

The learning disability and mental health team reported that the maximum wait for their service was 17.5 weeks. There was one case as an outlier which had a waiting time of 35 weeks. Staff said this was due to engagement issues.

The service had previously received investment to implement waiting list initiatives in order to reduce waiting times. These included Saturday morning clinics, teenager anxiety groups, mindfulness and cognitive behaviour therapy groups for under 12s. As a result, waiting lists had reduced to below 18 weeks in the past but the targets had not been achieved since March 2016.

In 2016, a children and young people's involvement project had completed an evaluation of people's experiences of the community services. One of the main concerns for people that had been identified was the length of waiting times. Several carers we spoke with were also concerned about long waiting lists. One parent said they had found it difficult to get support from the service for their child due to high demand. Another said their child had waited at least six months for an appointment following a GP referral. Two parents told us the wait for their child's appointment had taken too long. One young person told us they felt internal wait times were too long which added to their anxiety about what to expect.

The referral criteria for the generic services were young people who had significant mental health difficulties that did not respond to first line treatments or help. The service held records of referrals and reasons for rejections were documented. The main reason was that the referral did not meet the threshold for the service. The majority of referrals that were not accepted were signposted on to more appropriate services and organisations.

If young people were in crisis and needed immediate support for their mental health, they were signposted to the emergency department at the Trust where there was access to out of hour child and adolescent psychiatrists. A deliberate self harm rota was in operation which staff were part of. The purpose was to assess young people who had attended the emergency department with deliberate self harm. Some staff from the generic and learning disability teams felt more resources were required to provide intensive support to children which could help prevent out of area placements. Two carers felt there was a lack of suitable acute and crisis out of hours provision for children and young people in mental health crisis.

The service monitored rates of appointments where people did not attend. There was a policy for staff to follow in relation to appointments that people did not attend. This included efforts and attempts to encourage contacts and make further appointments through to the process for eventual discharge after a certain amount of non attendance. Appointment letters informed families that they could be discharged due to non attendance. We saw evidence in care records of where young people and families had not attended appointments and a clinician had contacted the family to follow this up.

Staff said they could offer later clinic slots if required and could work flexibly to some degree. The team leader said 15% of appointments offered were outside the core hours of 9am to 5pm. Staff were able to undertake home visits

Are services responsive to people's needs?

Requires improvement

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

where young people may have anxiety issues and social phobia. The learning disability team spoke about a high risk case where they were able to work with the young person in school in order to suit their needs.

Most carers felt the appointments suited theirs and the young person's needs. They said they were offered a choice of times and days. Pre booked appointments were rarely cancelled and were rescheduled in cases where they were. Most appointments took place on site at the service. However, three parents said that as appointments were on site, with their own commitments it was difficult to manage these in core hours which also caused disruption to their child's schedule. They said staff had not been able to facilitate out of hours appointments or visits elsewhere such as school. Lack of flexibility of appointments had also been identified as a concern during the 'patient's experience' project that had been undertaken.

One parent whose child received support from the learning disability community team spoke highly about the transition process. They knew which clinicians their child would be seeing when they moved into adult services. They had also been given practical advice to help ensure a smooth transition and said they felt well prepared.

The facilities promote recovery, comfort, dignity and confidentiality

There was good availability of rooms at both locations. Centenary House was situated over three floors. There was a mixture of therapy rooms, group rooms, one to one rooms, office space and reception areas on two of the floors. The clinic room was located on the first floor. Some of the therapy rooms had décor that looked old and dated. The main waiting room was small. Two carers said the environment was suitable. One said the reception area could get crowded at times due to the small size. Another had concerns about confidentiality during calls to the service as the receptionist would have to discuss personal information that could be easily overheard due to close proximity of the waiting area. They said they would feel more reassured if there was a text message service to pass on personal information. One young person also said they would find a text message service beneficial.

Beighton Centre facilities were based on two corridors. One corridor included the waiting room, clinic room and toilets and the second had nine therapy rooms located on it. The therapy rooms were individual in décor and some were specific to age and purpose, for example rooms providing recordable sessions via camera and two way window. Relatives attending the Beighton centre said the premises were comfortable, bright and the waiting room was large enough and suitable. One young person said it was often too busy for them. Young people at the focus group felt the waiting room should be more age appropriate. Parents also said the environment was not age appropriate as it was too small child focussed. One parent sometimes felt uncomfortable in the rooms with cameras as they said staff did not always say if these were recording or not.

There was information about other community services and support services available and accessible at both sites. There were various help leaflets about different mental health and medical conditions and advocacy information. At Centenary House, there was an A4 notice in each waiting area displaying complaints information with a website address people could make complaints to. The information was not very detailed and did not include all avenues open to patients about how to complain. There was no information on display at the BeightonBeighton centre about how to make complaints.

Meeting the needs of all people who use the service

The Beighton centre was fully accessible for disabled access. Centenary House had steps up to the main building with a disabled lift fitted externally to the building. This contained a button to call for assistance which went through to reception staff. The lift looked unappealing and was rusty in areas. There were accessible bathrooms at both locations.

Staff told us they had access to interpreter services if required. Information about interpreter services was on display at the Beighton centre but not at Centenary House. There were leaflets in different languages at Centenary House. We saw use of interpreters had been considered within care records we looked at where applicable.

Listening to and learning from concerns and complaints

There were nine complaints made in relation community child and adolescent mental health services between April 2015 and May 2016. One of the complaints was a multi-agency complaint and it was deemed that there was no input required from the service. Of the remaining eight complaints three were not upheld, two were upheld and three were partially upheld. There were no particularly

Are services responsive to people's needs?

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recurring themes within the complaints. Two complaints relating to documentation were concerns around the discharge documentation in place for patients. The average time taken to respond and close complaints was 29 days. The Trust target to respond to complainants was 25 working days which meant the service had exceeded this timescale.

As there was no complaint information on display at the Beighton centre, staff said people could attend the reception desk to make a complaint. During our inspection, we saw some complaints leaflets were later made available in the reception area of the Beighton Centre. Families and young people using both services were not familiar with the formal procedure for making complaints. They told us they would speak with staff or phone up if they wished to complain. No one we spoke with had made any formal complaints and had not felt the need to.

Staff told us that complaints and any learning from these were discussed at team meetings where appropriate

Are services well-led?

Requires improvement

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

Our findings

Vision and values

The trust values were based around commitment to excellence, teamwork, accountability, compassion and integrity. Consistent visions that all staff spoke about were team work and pulling together to provide quality care for the patients. However, there was an absence of leadership at the services which was impacted by the fact the one team leader covered both sites and there was no service manager. However, work was ongoing to fill these roles and recruit staff into deputy posts.

Staff said they did feel supported within their team but there was little evidence of cohesion between the two community teams. There were some links between individual staff groups at both sites but not as whole teams. Within the teams themselves, primary mental health workers and staff from specialist joint services reported they felt part of the service and had positive working relationships.

Staff did not always feel they were part of the whole trust. Staff on the out of hours and self harm rota had links via provision of emergency mental health care but said there was no 'real relationship' outside of this.

Good governance

The systems to monitor and assess performance at site level were not effective. There was no central system to establish what training each staff member had completed outside of mandatory training, and what they were required to have. This included specialist training. Both the clinical director and team leader advised that work was underway to identify staff training needs. There was no system to provide oversight of complaints and safeguarding for all the teams at service level. However, this information was shared at clinical governance meetings from individual team leaders.

There was no effective system to ensure staff received both clinical and managerial supervision and at the required frequencies. Information was recorded in generic hours only and not split down to individual level. The service did not record amounts of supervisions for each staff member. One professional we spoke with kept their own record of staff members they supervised in order to establish supervision was taking place as required. However, these were relevant only to the specific staff group and not accessible to anyone else, for example, if the person went on leave. There were no wider service monitoring of supervisions which meant it was not possible to establish whether there had been shortfalls in frequency and non attendance. Supervision figures were not reported to senior managers. This meant there was a lack of oversight to ensure the supervision took place as required and staff received necessary support.

The division as a whole reported performance against key performance indicators on a monthly basis. This included corporate objectives and indicators required by NHS England and clinical commissioning groups to whom the service had to report specific information to. This included information such as treatment timescales and number of young people waiting. There were various forums and meetings which took place to discuss service performance. Various audits and projects had taken place at divisional level, however, there was a lack of audits completed in some key areas to monitor the service provision at location level.

There was a risk register in place for the child and adolescent mental health division and management staff were able to add to this. This was reviewed by staff at divisional level. The associate director said they were going to include the lengths of waiting times as a risk. One item on the risk register for the division was 'self harm opportunities provided by building design and fittings'. This did not include any such risks within the community services despite these being present. This demonstrated that staff had not effectively identified all service level risks.

Leadership, morale and staff engagement

A staff survey had been undertaken for 2015 for the whole of the community, well-being and mental health division. It was not split down into separate locations so we could not establish the results relevant specifically to the community child and adolescent mental health services. The response rate for the division was 45.9% compared to overall trust response rate of 44.9%. Overall the division scored better than the trust average in relation to feedback about how they were managed and support they received from managers in their roles.

Are services well-led?

Requires improvement

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

The service's annual staff turnover rate from information provided by the trust equated to 3.9%, which was significantly lower than the turnover rate at trust level of 13.9%. The sickness rate for the service was 3.1% which was lower than the trust level sickness rate of 4.3%.

Staff at all levels said they would feel confident in speaking out if they had any concerns to raise. One staff member gave us an example of a historical incident relating to a staff member's behaviour which been dealt with effectively. They said senior staff had been very supportive to all involved and appropriate actions had been taken. There was a policy for raising concerns at work which provided guidance for staff about different ways they were able to do this.

Commitment to quality improvement and innovation

The service had been successful in securing NHS England and local clinical commissioning group funding for a child and adolescent mental health service schools link pilot scheme. The aim of this was to improve joint working between child and adolescent mental health services and schools arising from the 'Future in Mind' Department of Health document and the transformation plan to improve early access to mental health support for young people. Six tier three child and adolescent workers worked in ten pilot schools as part of the project to support staff and children's understanding children around young people's mental health. The team leader said the project had been very successful and well received and commissioners had expressed a desire to continue with it.

The service was working on a project for tier 3.5 child and adolescent mental health services. The intention for this was to be a high intensity team to fulfil the needs of young people between tier 3 and tier 4 services with a view to try to reduce need for admissions.

The service did not currently participate in any formal accreditation schemes. The clinical director said that at trust level, they were keen for the service to partake in the quality network for community child and adolescent mental health services in future.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way. The environment at both services had not been suitably assessed to identify and mitigate any risks that may be present to young people. Lone working risk assessments were not carried out in accordance with trust policy. Some equipment, such as items in the clinic rooms, was not fit for purpose due to being of date or not having a current service. This was a breach of regulation 12 (1) (a) (b) (e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There was no set structure for the service as to what specialist training each staff group was required to have in order to perform their roles. There was no effective system to identify and monitor staff training and supervisions and ensure that these took place as required. There were no robust systems to monitor adherence to effective infection control practices.

This section is primarily information for the provider

Requirement notices

The system to monitor and assess the service was not robust. Information from incident reports was not sufficiently detailed or being used to analyse themes and trends.

This was a breach of regulation 17 (2) (a) (b)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

Sufficient amounts of staff were not deployed in order to meet the requirements of the service.

The waiting times from initial referral to actual treatment meant some young people had significant waits to access treatment.

This was a breach of regulation 18 (1)