Good

Cheshire and Wirral Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Trust Board Offices
Upton Lea
The Countess Of Chester Health Park
Chester
Cheshire
CH2 1BQ
Tel: 01244 364186
Website:www.cwp.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)
RXAX2	Trust Headquarters, Redesmere	Wirral LD CAMHS	CH43 6TX
RXAX2	Trust Headquarters, Redesmere	Wirral Parent Infant Mental Health Service	CH43 6TX
RXAX2	Trust Headquarters, Redesmere	Wirral Tier 2 CAMHS	CH43 6TX
RXAX2	Trust Headquarters, Redesmere	Wirral Tier 3 CAMHS	CH43 6TX
RXAX2	Trust Headquarters, Redesmere	Wirral Adcote Health Education Unit	CH43 6TX

Summary of findings

RXAX2	Trust Headquarters, Redesmere	Wirral 16 to 19 Team	CH44 5UF
RXAX2	Trust Headquarters, Redesmere	West Cheshire Tier 2 CAMHS	CH1 3DY
RXAX2	Trust Headquarters, Redesmere	West Cheshire Tier 3 CAMHS	CH1 3DY
RXAX2	Trust Headquarters, Redesmere	Vale Royal Tier 2 CAMHS	CW7 1AS
RXAX2	Trust Headquarters, Redesmere	Vale Royal Tier 3 CAMHS	CW7 1AS

This report describes our judgement of the quality of care provided within this core service by Cheshire and Wirral Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Cheshire and Wirral Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cheshire and Wirral Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- Staff had a thorough understanding of the safeguarding procedures and were confident in making safeguarding referrals. Lessons were learnt from the serious incidents within the service.
- Progress that young people were making was measured and recorded. This was also gathered in an innovative way of an iPad remotely, and in real time, to avoid delays and ensure information was current.
- Goal based care plans were in place for young people with individual aims. The care plans were co-produced by the young person and their practitioner from the CAMHS team.
- Staff received supervision every four to six weeks.
- Job mapping was completed with their managers to ensure equity of allocations of new referrals for the choice and partnership allocations.
- We observed good multi-disciplinary working within the teams that were young person focussed.
- Staff treated young people using the service, and their family, with dignity and respect. We observed several sessions with practitioners and young people, all of them showed supportive, nurturing and encouraging approaches from staff. Young people we spoke to said they felt supported, listened to and were pleased that someone showed an interest in them.
- The young people who used the specialist community mental health services created the Mymind website and twitter account. The resources provided information for young people and professionals including self-help resources on addressing their mental health needs, the services that were provided by the trust and what to expect from the service in an accessible format.
- Young people who used the service help to run training for professionals on topics including self-harm. Evaluation of the training was extremely positive and the most helpful part of the feedback was young people's involvement.
- There was a clear statement of vision and values. Staff were aware of this and embedded it into their daily practice. Staff felt valued and had job satisfaction and appreciated the innovative approaches and projects they had been involved in.
- Senior managers had highlighted the risk of an increase in demand for the service. They introduced an innovative way of limiting the intervention in tier two services and submitted a business case to commissioners for increased funding for four new posts, which was successful.

However:

- Individual risk assessments for young people using the service were not comprehensive or completed in a timely manner after the needs of a young person changed.
- There was limited understanding of the lone worker policy within the service. Staff did not follow the trusts' lone worker policy consistently.
- Team mangers did not have the information they needed available to them in a centralised system. This meant they could not monitor the waiting list for the service or take into account risks to young people waiting for the service.

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:

- Individual risk assessments for young people using the service were not comprehensive or completed in a timely manner after the needs of a young person changed.
- There was limited understanding of the lone worker policy within the service. Staff did not follow the trusts lone worker policy consistently.
- Team mangers did not have information they needed available to them in a centralised system. This meant they could not monitor the waiting list for the service or take into account risks to young people waiting for the service.

However;

- Staff had a thorough understanding of the safeguarding procedures and were confident in making safeguarding referrals.
- Lessons were learnt from the serious incidents within the service which were shared with the team to improve future practice.

Are services effective?

Good

We rated effective as good because:

- There were a variety of therapies and treatments available to young people using the service. Young people were encouraged to share knowledge, in relation to mental health needs, by the peer project based in schools and by helping to run training for professionals.
- Outcome measures were used to measure the progress that young people were making. This was also gathered in innovative ways of iPads remotely and in real time to avoid delays and ensure information is current.
- Goal-based care plans were in place for young people which had been co-produced.
- Staff told us and records confirmed that they received supervision every four to six weeks. Job mapping was completed with their managers to ensure equity of allocations of new referrals for the choice and participation allocations.
- We observed good multi-disciplinary working within the teams that were young person focussed.

Are services caring?

Good

We rated caring as good because:

Summary of findings

- Young people using the service and their family were treated with dignity and respect. We observed several sessions with practitioners and young people, all of them showed supportive, nurturing and encouraging approaches from staff. Young people we spoke to said they felt supported, listened to and were pleased that someone showed an interest in them.
- Young people had been involved via the involvement and participation group to create a hospital passport that was appropriate to their needs. Young people were involved in the planning of their care and support by creating goal based plans.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The young people who use the specialist community mental health services created the Mymind website and twitter account which provides information for young people and professionals including self-help resources on addressing your mental health needs, the services that are provided by the trust and what to expect from the service in an accessible format.
- Young people who used the services co facilitated training for professionals on topics including self-harm. Evaluation of the training was extremely positive and the most helpful part of the training feedback was young people's involvement in the training.
- "Sloth" was the young person's participation and involvement group. The group had developed a hospital passport and had been involved in recruiting and selecting staff.
- Kidstime which was an out of hours activity, jointly run with the adult mental health services and the youth theatre for young people whose parents have a mental health need. Mental health conditions were explained to young people in a meaningful way.
- A peer education programme provided mental health education in schools and mentoring by year 12 students, supported by school staff. Fifteen students have been trained in seven schools.

However;

Tthere was a wait for an assessment and choice appointment for up to six months.

Are services well-led?

Good

We rated well-led as good because:

Summary of findings

- There was a statement of vision and values which staff were aware of and embedded it into their daily practice. Staff felt valued and had job satisfaction and valued the innovative approaches and projects they had been involved in.
- Senior managers had highlighted the risk of increase in demand for the service and had introduced an innovative way of limiting the intervention in tier two services and had submitted a business case to commissioners for increased funding which was successful for four new posts.
- Young people were involved in the running and design of the service in a meaningful way, via the involvement and participation group and the mymind website.
- Outcome measures were being gathered within the service to evaluate provision. The service was investing in the IAPT training for the workforce.

Summary of findings

Information about the service

Within child and adolescent mental health services (CAMHS) there was a four tier strategic framework. This is nationally accepted as the basis for planning, commissioning, and delivering of services to children and young people with mental health needs.

Tier one was provided by practitioners who are not mental health specialists working in universal services. These included GPs, health visitors, school nurses and teachers. Cheshire and Wirral Partnership NHS Foundation Trust provided services from tier two to four. Tier two was targeted services that offered brief intervention at a lower level that could include psychological therapy. Tier three provided specialist services including a team for young people who had a learning disability. Their support for young people may be longer term and would include therapies and possibly medication. Tier four services were highly specialised services including inpatient services.

The CAMHS community teams at Cheshire and Wirral Partnership NHS Foundation Trust were multi-disciplinary and included: nurses, psychiatrists, psychologists, psychotherapists, social workers, support workers and therapists including speech and language therapists. Their aim was to support children and young people to improve their mental health by addressing what makes them worried, upset or angry. Focus would be on thoughts, feelings, and behaviour. The teams supported children and young people aged five to 19. There was an additional team for parents with mental health needs who had babies, this service was based in Wirral.

Teams we visited included tier 2 targeted services which offered brief interventions at a lower level and tier 3 specialist services including a team for young people who had a learning disability. We visited:

- Wirral learning disability CAMHS
- Wirral parent infant mental health service: for parents with mental health needs.
- Wirral tier 2 CAMHS
- Wirral tier 3 CAMHS
- Wirral Adcote health education unit
- Wirral 6 to19 Team
- West Cheshire tier 2 CAMHS
- West Cheshire tier 3 CAMHS
- Vale Royal tier 2 CAMHS
- Vale Royal tier 3 CAMHS

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, Director Mental Health, Department of Health (retired)

Head of Inspection: Nick Smith, Care Quality Commission

Team Leaders: Sharon Marston, Inspection Manager (mental health), Care Quality Commission

Simon Regan, Inspection Manager (community health services), Care Quality Commission.

The team that inspected this core service comprised: a CQC inspector, a consultant psychiatrist specialising in child and adolescent mental health services (CAMHS), a consultant psychologist, two mental health nurses specialising in CAMHS, an expert by experience with lived mental health experience and an expert by experience whose child accesses services.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

We visited Adcote House where the Wirral teams were based on 24 June 2015 and Marsden House and Hawthorn Centre where Vale Royal and West Cheshire teams were based on 25 June 2015.

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups. We also left comments boxes at both venues.

During the inspection visit, the inspection team:

- toured all environments
- met with six young people who use services and received 13 completed comment cards
- spoke with 13 parents and carers
- spoke with 33 staff
- observed three education sessions at Adcote House
- observed two home visits and three sessions within the bases
- observed seven multi-disciplinary meetings including team meetings and a kidstime planning meeting
- observed a consultation meeting where professionals attend to discuss specific cases and receive guidance and strategies from the CAMHS workers to assist young people
- reviewed 23 care records

We also 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

The two young people that we spoke to at the education service reported that education was tailored to meet their needs and they felt staff were approachable. Young people using the service reported feeling confident about making complaints verbally to staff. Young people using the service highlighted staff communication skills in their comments. Rather than dictating, staff make suggestions and encourage them to think differently.

Young people using the service felt safe and trusted the staff. They also reported that staff were supportive, helpful, and showed an interest. Children using the service valued the toys available when waiting for appointments. One young person highlighted how staff clearly explained their rights in relation to confidentiality at the beginning.

Areas for improvement suggested by the young people using the service included reducing the waiting list by having stricter criteria of who the teams supported and also offering support at evenings and weekends if you were in crisis.

Parents said that the services offered hope and had been extremely supportive to the whole family unit, not just the young person using the service. The service provided information relating to their child's condition and translated into other languages where needed. Staff were respectful, caring and tailored the support to the individual needs. Parents felt that consultants and therapists communicated openly. Improvements and progress were evident with their children.

Parents felt areas for improvement were the delays in response to phone calls and the length of wait for the service. One parent reported waiting six months for their initial appointment following referral. Parents would also value support groups for certain conditions that their child may be diagnosed with and training sessions of how best to support their child in relation to their mental health needs. One parent reported her child not being able to access the service as the wait for her child's specific needs, an eating disorder, would mean she would be 16 when she reached the top of the waiting list.

Summary of findings

Good practice

- Mymind website and twitter account were created by young people. These provided information including self-help resources on addressing your mental health needs, the services that are provided by the trust and what to expect from the service in an accessible format.
- Young people who used the service helped to run training for professionals on topics including self-harm.
- "Sloth" was the young person's participation and involvement group. The group had developed a hospital passport and had been involved in recruiting and selecting staff.
- Kidstime was an out of hours activity jointly run with the adult mental health services and the youth theatre for young people whose parents have a mental health need. Mental health conditions were explained to young people in a meaningful way.
- An education programme provided mental health education in schools and mentoring by year 12 students, supported by school staff.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all young people using the service have a completed comprehensive individual risk assessment.

Action the provider SHOULD take to improve

- The trust should ensure that there is an effective system in place to keep staff safe when visiting people in the community including increased understanding and compliance with the lone worker policy.
- The trust should complete an environmental risk assessment of Hawthorn centre to identify risks and how they will be mitigated.
- The trust should review the collation of the waiting list to ensure effective measures are in place to monitor the risk of people waiting to be seen. Including enabling team managers to access the waiting list to ascertain the number of young people waiting and how long they have been waiting.

Cheshire and Wirral Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
• Wirral LD CAMHS	
• Wirral parent Infant Mental Health Service	
• Wirral Tier 2 CAMHS • Wirral Tier 3 CAMHS • Adcote Health Education Unit • Wirral 16 to 19 Team • West Cheshire Tier 2 CAMHS • West Cheshire Tier 3 CAMHS • Vale Royal Tier 2 CAMHS • Vale Royal Tier 3 CAMHS	Trust Headquarters, Redesmere

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.

Mental Health Act (MHA) training is offered by the trust as a mandatory classroom based course. Across all of the Specialist community mental health services for children and young people 62% of staff had attended.

Detailed findings

Staff were aware of their role in relation to the MHA, considering the possible use of the act if a child deteriorates mentally and there is a concern for their own safety or the safety of others.

The consultants we spoke to were section 12 approved. A doctor who is 'approved' under section 12 of the Act is approved on behalf of the Secretary of State as having special expertise in the diagnosis and treatment of 'mental disorders'. Section 12 approved doctors have a role in deciding whether someone should be detained in hospital under section 2 and section 3 of the Mental Health Act.

Information on accessing advocacy services was displayed in all venues.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) does not apply to young people aged under 16. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. When working with children, staff should, assess whether or not a child has a sufficient level of understanding to make decisions. The Mental Capacity Act does apply to young people aged 16 and 17.

Training in the MCA was offered by the trust as a mandatory eLearning course across all of the Specialist community mental health services for children and young people 79% of staff had attended.

Staff were aware of exploring capacity of the young people who use the service in relation to the Gillick principles. Within the mymind website for young people and their families to access it clearly states that if a child is over the age of 16 the trust do not have a duty to discuss their child's treatment if the child wishes for the information to not be disclosed and has the capacity to make this decision.

We found evidence that young people were provided with information about treatment options and consented to their treatment in 14 of the 23 care records we reviewed. Capacity and the young person's ability to understand their treatment was explored at the choice appointment.

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

Summary of findings

Our findings

Safe and clean environment

The community venues were clean and welcoming.

Adcote house had alarms in the therapy and education rooms but did not have a formalised staff response process. Staff were not aware of what they should do to respond if the alarms went off. The manager agreed to resolve this immediately.

Marsden house had alarms in all of the meeting rooms, accessible on ground level. There were no alarms at Hawthorn centre which had recently been redecorated. There were blinds on the back of all doors which could pose a risk due to the cord attached to open and close the blind. The environmental risk assessment was not available when requested.

Safe staffing

The figures below were provided by the trust and relate to the time period 01/01/2015 – 31/03/2015

Establishment levels: qualified staff (WTE)

Partnership team specialist CAMHS: 15

West - 16 - 19 service specialist CAMHS: 10

West - Chester and Ellesmere Port specialist CAMHS: 18

West - learning disabilities specialist CAMHS: 4

Winsford specialist CAMHS: 10

Wirral - child and family services specialist CAMHS: 64

Wirral - learning disabilities specialist CAMHS: 9

There were no assistants roles.

Number of vacancies: qualified (WTE)

Partnership team specialist CAMHS 2%

West - 16 - 19 service specialist CAMHS 2%

West - Chester and Ellesmere Port specialist CAMHS 4%

West - learning disabilities specialist CAMHS 3%

Winsford specialist CAMHS 3%

Wirral - child and family services specialist CAMHS 8%

Wirral - learning disabilities specialist CAMHS 9%

Staff sickness rate (%) in 12 month period

Partnership team specialist CAMHS 5%

West - 16 - 19 service specialist CAMHS 2%

West - Chester and Ellesmere Port specialist CAMHS 3%

West - LD CAMHS specialist CAMHS 6%

Winsford specialist CAMHS 14%

Wirral - child and family services specialist CAMHS 5%

Wirral - learning disabilities specialist CAMHS 1%

Staff turnover rate (%)in 12 month period

Partnership team 7%

West - Chester and Ellesmere Port team 11%

Winsford specialist CAMHS 40%

Wirral - child and family services 11%

Staffing was on the risk register for the west CAMHS service. Both 0-16 and 16-19 teams experienced significant increases in demand for the service and received more complex referrals, which put pressure on the capacity of the available services. The clinical services manager presented commissioners with a business case for increased staffing. They successfully received funding for an additional four band six posts; two for each team.

The average staff caseload was 30.

The trust had a number of mandatory training courses including; equality and diversity, health and safety, moving and handling, and management of violence and aggression. Information provided by the trust prior to the inspection showed that overall the staff in specialist community mental health services for children and young people had achieved 84% of their mandatory training. The trust target is 85%. Basic life support (BLS) training had achieved 68% but more recent updated figures from the trust show 80% attendance of BLS.

Requires improvement

Are services safe?

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

Assessing and managing risk to patients and staff

We reviewed 23 care records across the community CAMHS teams. Eight of the records had a detailed clinical assessment of risks to self and others individual risk assessment, which was current and had been reviewed. Ten records had a risk assessment but they hadn't been reviewed recently. We did not find a risk assessment in five of the files. This was across tier two and three services and the different teams.

We found both electronic and paper files in place for young people who use the services. However, they did not synchronise and the teams were in the process of moving to full electronic records with the aim of being a paperless service.

Team managers did not have access to a centralised system where they could locate the number of people waiting for the service and their length of time on the waiting list. There was no current method of reviewing the risks of the young people waiting to access the service.

A carer reported how the young people had developed a positive relationship with their CAMHS practitioner. When their mental state deteriorated the practitioner would accommodate an urgent appointment.

Senior members of staff provided cover for the risk rota, which provided urgent assessments for young people presenting at hospital with self-harming behaviour or suicidal ideation. There was on call CAMHS psychiatry provision out of hours too.

Mandatory training was offered to staff in safeguarding children and safeguarding family. The specialist community mental health services for children and young people had achieved 90% attendance of the safeguarding children level three. Eighty percent attendance at safeguarding family level one and 84% attendance at safeguarding family level two. Staff we spoke to had a clear understanding of their role in the safeguarding process and how to make a safeguarding referral. Safeguarding flowcharts were displayed in the bases and there was a safeguarding file in the Wirral team for ease of access to all necessary documentation.

The trust had a lone worker policy in place dated November 2012. Staff we spoke to talked about the buddy system which was within the policy. Others referred to a safe name to use if calling for assistance. This was not referenced in the policy. There were localised lone working arrangements in place where staff may be buddied with an admin team member or another practitioner. Lone working practice was inconsistent between teams and deviated from the trust policy.

Track record on safety and reporting incidents and learning from when things go wrong

There have been two serious incidents in specialist community mental health services for children and young people in the last year. One young person took their own life. Another young person attempted to take their own life and was seriously injured. Staff learned three key things from the incidents; communication between the trusts' staff, young people were being transferred between teams and staff did not receive a thorough handover. Staff not reading about the history of a young person when they had been allocated to their caseload. Staff not updating the electronic record system, carenotes in a timely manner following a session. It also identified that additional training in relation to risk assessment and suicide prevention was required. Data provided by the trust showed that 93% of the staff completed training in the principles of clinical risk assessment. Team meeting minutes showed the learning being shared amongst the team and case discussions for young people assessed as high level risk occurred at their weekly meetings to ensure they shared information.

Senior managers attended the business and governance meetings where learning from experience was an agenda item. Minutes showed the actions for senior managers to share the learning from serious incidents with their teams.

Staff we spoke to were confident about reporting incidents via the datix system and said how supportive their colleagues and managers were.

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.

Summary of findings

Our findings

Assessment of needs and planning of care

We reviewed 23 care records. Seventeen of the records had care plans in place that were goal based. These were communicated to the young person by letter which was also copied to the GP too. We could not find completed care plans in six of the records we reviewed. The PIMHS care record we reviewed did not have a care plan in place and we could not find any care plans in five of the care records reviewed at the winsford team, the care plan and outcomes tab in the electronic recording system were empty.

The team were in the process of moving to full electronic care records. Currently they have some paper records too which could pose a risk for locating information promptly.

Best practice in treatment and care

When a young person was sent a letter to opt into the service they and their family were sent some questionnaires to complete before their appointment. These were strengths and difficulties questionnaire which is a brief measure of psychological well-being in 2-17 year olds and revised child anxiety and depression scale questionnaire which is completed at the point of entry to the service then reviewed during the sessions and at the discharge from service. The scores are captured on the electronic carenotes system and some practitioners were trialling electronic tablets to upload information remotely and in real time to avoid delays in updating the system.

The trust joined the wave three programme with NHS England for IAPT (Improving access to psychological therapies) where monitoring data was submitted to NHS England. The next step of children and young peoples (CYP) IAPT is to use Skype and other technological advances of communication.

The team had just introduced QB testing for assessing if a child has attention deficit hyperactivity disorder (ADHD). The QB test uses a device which the person wears on their head, the device assesses the core symptoms of ADHD; hyperactivity, inattention and impulsivity. Staff have been trained to facilitate this testing, and we were shown how the system works. The trust have supported three team members to be trained in eye movement desensitization and reprocessing (EMDR) which is a new psychotherapy technique which research has shown has been very effective in helping people who suffer from trauma, anxiety, panic, disturbing memories and post-traumatic stress. Other therapies that are offered are cognitive behavioural therapy, dialectical behaviour therapy and several staff were completing their IAPT training. Two team members were currently completing the children and young people's IAPT in Wirral.

Consultants reported positive links with paediatricians for physical health needs of the young people using the service.

Skilled staff to deliver care

Specialist community mental health services for children and young people included a variety of disciplines such as consultant psychiatrists, consultant psychologists, family therapists, psychotherapists, nurse consultant, nurses and learning disability nurses, social workers, speech and language therapists and counsellors. The service worked closely with the teachers and youth workers for the joint provision of education and kidstime project.

Staff reported that the trust was supportive of additional role specific training.

Staff received supervision every four to six weeks. Job mapping was completed with their managers to ensure equity of allocations of new referrals for the choice and participation allocations.

Appraisals were undertaken annually to review staff members' performance and set objectives for the following year. The percentage of non-medical staff that had an appraisal in the last year from the data that the trust sent were:

- CAMHS partnership team specialist CAMHS 90%
- CAMHS West - 16 - 19 service specialist CAMHS 56%
- CAMHS West - LD CAMHS specialist CAMHS 75%
- CAMHS Wirral - Child and family services specialist CAMHS 81%
- CAMHS Wirral - learning disabilities specialist CAMHS 88%
- Primary Care CAMHS West specialist CAMHS 50%
- West Cheshire 0-16 tier 3 specialist CAMHS 67%

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.

- Winsford 0-16 tier 3 specialist CAMHS 50%

This was an average of 69% over the specialist community mental health services for children and young people. This was lower than the trusts' average score for staff appraised in the last 12 months of 86% and lower than the national average of 88%.

Multi-disciplinary and inter-agency team work

We observed seven MDT meetings which included mindfulness exercises. All team members participated and there was a clear agenda which covered new referrals, risks of young people, progress with young people, training, engaging with marginalised groups including travellers and consultation events with professionals.

The tier 2 and 3 managers were located in the same building and in some cases the same office which contributed to positive communication. All referrals were triaged on a daily basis by workers from tier 2 and 3 services to ensure consistency of allocation and criteria for the service. Within the MDT meetings at west Cheshire, they had joint tier 2 and 3 meetings then separated into individual tiers for more detailed case discussions. We observed the discussion of young people being transferred from one tier to another due to level of need. There were positive interactions amongst teams. Within the team meeting for both tier two and three they updated on the consultation work they had been providing for professionals in relation to black and minority ethnic and traveller communities. There was joint work underway with the police and children's services to target and increase engagement with traveller communities and young people at risk of child sexual exploitation.

The tier two team at west Cheshire offered consultation events for professionals to book a time slot to talk about a particular young person they have concerns about. The aim of this service was to share strategies with other professionals to equip them with the skills to support young people to try and avoid the need of young people accessing services. We observed a consultation event which was attended by health visitors, nursery nurses, school head of year, special educational needs coordinator (SENCO) and a family case worker. The team evaluated the session by asking at the beginning of the session their level of confidence supporting the child on a scale of one to 10. They then repeat the question at the end of the consultation. All of the scores had increased after each consultation, ranging from an increase of two points to an increase in five points, the professionals talked positively about the consultation service. At the tier 2 MDT meeting we observed the updated leaflet being finalised to promote the "West Cheshire Tier 2 0-16 CAMHS consultations service for professionals" for the next quarter.

Adherence to the MHA and the MHA Code of Practice

Mental Health Act (MHA) training was offered by the trust as a mandatory course, across all of the specialist community mental health services for children and young people. 62% of staff had attended which was below the trusts' target of 85%.

Staff were aware of their role in relation to the MHA, considering the possible use of the act if a child deteriorated mentally and there was a concern for their own safety or the safety of others.

The consultants we spoke to were section 12 approved. A doctor who is 'approved' under section 12 of the Act is approved on behalf of the Secretary of State as having special expertise in the diagnosis and treatment of 'mental disorders'. Section 12 approved doctors have a role in deciding whether someone should be detained in hospital under section 2 and section 3 of the Mental Health Act.

Good practice in applying the MCA

The Mental Capacity Act (MCA) does not apply to young people aged under 16. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. When working with children, staff should assess whether or not a child has a sufficient level of understanding to make decisions. The Mental Capacity Act does apply to young people aged 16 and 17.

Training in the MCA is offered by the trust as a mandatory eLearning course. Across all of the specialist community mental health services for children and young people 79% of staff had attended which was below the trusts' target of 85%.

Staff were aware of exploring initial capacity of the young people who use the service in relation to the Gillick principles. Within the mymind website for young people and their families to access it clearly states that if a child is

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.

over the age of 16 the trust do not have a duty to discuss their child's treatment if the child wishes for the information to not be disclosed and has the capacity to make this decision.

We found evidence that young people were provided with information about treatment options and consented to their treatment in 14 of the 23 care records we reviewed. Capacity and the young person's ability to understand their treatment was explored at the choice appointment.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

We observed two home visits and three therapy sessions within the bases. All staff interactions with young people who use the service and their family were extremely respectful and supportive. Staff were passionate about their roles. We observed support being offered to a parent whose child had learning disabilities and mental health needs. Due to their child's complex needs the parent was anxious about their child's transition to a new school. The practitioner supported the parent at a transition meeting with the new education provider to explain the needs of the young person and how best to support them. The aim was for the transition to be as smooth as possible. The practitioner provided reassurance and positive affirmation to the parent. When we talked to the parent alone they said how respectful, caring and supportive the practitioner was. They had arranged for their other children to attend a sibling support group, acknowledging the impact on the whole family. The practitioner also provided information in a different language as one parent's first language was not English.

Another visit we observed was a home visit as part of the parents in mental health services. This is an innovative service for parents with a mental health need who have a baby and are finding it difficult to form attachments with the child. Interactions we observed were friendly, with open communication, allowing the parent to share progress made and challenges faced. The parent acknowledged that with the support received from the service, they were able to enjoy looking after their child. The practitioner shared the assessment document with the parent for their views and to ascertain if there were any inaccuracies. The support observed was holistic, including the wellbeing of the parent, employment and education. Active listening was used and positive feedback provided to the parent. When talking to the parent alone they reported feeling listened to by the team and happy because of the service provided and would definitely recommend the service to others.

We observed a therapy session with a young person using the service, the practitioner and young person made use of their mood and feeling and memories of good times book. The interactions observed were nurturing, encouraging and used several cognitive behavioural therapy approaches. The practitioner set the agenda jointly with the young person. Due to challenges and worries of the young person's school the practitioner offered to facilitate a meeting with school to discuss a way forward and how best to support the young person. The young person was visibly pleased with the suggestion. Both the young person and practitioner were well engaged and a positive rapport was evident due to how open the young person was with sharing information.

One young person told us of the leaflet they received at their first appointment and they received an explanation in relation to their confidentiality.

We also observed a choice appointment which is the initial assessment into the specialist community mental health services for children and young people. The practitioner was welcoming, warm, and used child friendly language that enabled the young person to visibly relax. Active listening was observed with regular summaries reflected back to the young person to ensure they had heard correctly. There were clear co-production with the young person regarding the future sessions.

The involvement of people in the care they receive

Young person friendly documentation was in use including the mood and feeling and memories of good times book. Seventeen of the 23 records we reviewed had goal based care plans. The goals were sent to the young person and their GP in letter format. Seven parents told us they were involved in the development of their child's care plan.

We met with members of the patient participation and involvement group which young people had called the "sloth" group. Young people reported being able to shape the sessions and being listened to. They were offered training to be involved in the recruitment and selection of staff. This allowed them to be involved in sitting on panel interviews. The group met monthly and had been involved in the plans for the new building. Information was also displayed in communal areas for young people to make suggestions for a name for the new building and also communicated via twitter.

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The young people had created a hospital passport for them to take to accident and emergency which included a bit about me, my treatment option, who is important to me and anything else I want to say. We were shown copies of the documents which included a section of things you need to know about me which I do not want to discuss and questions not to ask. The observation of the joint MDT team meeting of tier two and three services discussed the hospital passport with the aim of introducing it for more young people.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

The trust target was for urgent referrals to be allocated an appointment within two weeks of referral. Parents told us that their child had accessed services within two weeks of referral.

Tier 2 services at Wirral used the choice and partnership approach for allocating new referrals. Practitioners provided availability for choice assessments and partnerships which are interventions with young people. Families and young people who have been referred can ring up and book into an available slot. Staff told us this has reduced the number of missed appointments. Availability for choice and partnerships appointments were agreed at work planning meetings with managers to ensure fairness and equity.

Team meetings for tier two and tier three CAMHS services in West Cheshire occurred weekly. There they discussed caseloads, new referrals and cases that were being closed.

Routine referrals had an average wait of three months before having their choice assessment. From choice assessment to partnership, direct intervention with a practitioner the average wait was eight weeks in Winsford and Wirral and 12 weeks in Chester.

The senior staff were involved in updating the risk rota, which was a duty rota for staff to cover at the general hospital for young people presenting with self-harm behaviour or suicidal ideation. Young people were assessed within the day. If needed they would then be triaged into services.

We spoke with 13 parents and carers. Four parents told us their child was assessed within two weeks of referral. One parent said their child was offered an appointment within three weeks of referral. Four parents said their child was offered an appointment within three months. One parent reported waiting six months for an assessment. The NHS benchmarking network completed a CAMHS benchmarking report for these services in December 2013 and their indicative target from referral to treatment was 18 weeks.

A parent of a child with an eating disorder complained of their child not being able to access services. Due to the length of wait their child would be 16 before a service could be offered. Staff confirmed there had been an increase in demand for support with eating disorders and demand outweighed capacity currently.

Appointments were being offered from eight in the morning to six in the evening to reduce the impact of appointments on young people's attendance at school.

Due to the demand for provision at Tier two in West Cheshire, they had introduced a choice plus three session to reduce the waiting list. After the choice assessment if a young person requires intervention and is willing to engage, they will offer three sessions to provide strategies including to the family. This service also identifies additional resources which they could access with the aim of moving people through the service more effectively. If there was a young person with more significant needs there was the opportunity for additional sessions or a transfer to tier three services, this was observed within the case discussions of the tier two team as a couple of young people required more than three sessions.

The facilities promote recovery, comfort, dignity and confidentiality

The waiting area at all community venues were welcoming with a variety of leaflets and posters on display including how to complain, PALS, the mymind website and treatments. There were a variety of toys and activities to occupy children while they waited. There was also a translation phone number for people to receive information about the service in different languages. At the Hawthorne centre there was a lift to access the facilities as they were on the first floor. The waiting room was calming and had music being played in the background.

The west Cheshire welcome pack had bright colours, symbols and photos of the venue within it for directions, where to press the buzzer, what the waiting room is like and what to expect at your first session. The pack included information on confidentiality, talking therapies and a word search at the rear of the pack to make it as accessible and interesting as possible for young people.

The mymind website was developed by young people in Wirral who were part of the dialectical behaviour therapy group. The website was very young person friendly with age appropriate symbols and graphics. The website was

Are services responsive to people's needs?

Good

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

split into two age sections; five to 12 and 13 to 19. Each section talked about what is CAMHS, what to expect, confidentiality and people you may see. The website clearly stated they are not an emergency service and if a young person is struggling out of office hours, they need to contact their doctors surgery or go to hospital. The website also had a section called the box which has a variety of mindfulness resources that can be downloaded for free including exercise, trying new things, talking to others and how to relax. Young people still oversee the website via the involvement and participation group. Information for professionals and parents and carers was also on the website with links to other service. The website links to the twitter account where the staff member who oversees the twitter account advised there are over 1500 followers. The twitter account shared positive news stories and articles for people to read.

Meeting the needs of all people who use the service

Hawthorne centre was based on the first floor of a building and has lift access. Marsden house meetings rooms were on the ground floor and were accessible for people with mobility difficulties. Adcote house had the majority of meeting rooms on the ground floor but some were on the first floor. There were specialist workers in both of the regional area services that we visited including workers that focused on young people who were looked after, have had involvement with the criminal justice system or were having difficulties with drugs and alcohol, have a severe learning disability and presented with behaviour that challenges.

Parents told us of information that had been translated into Greek for their partner to understand within the LD CAMHS service.

Consultants have attended a meeting at a child's school to explain the condition to the school and how best to support the young person.

Kidstime, which is an out of hours activity jointly run with the adult mental health services and the youth theatre for young people whose parents have a mental health needs. Mental health conditions were explained to young people in a meaningful way and feelings and experiences of young people were explored. We observed the planning meeting for kidstime. Activities were planned involving games for young people and how to support their parents who have mental health needs. The group aimed to reduce barriers to attendance by assisting and arranging transport if needed. They met out of office hours to ensure the group did not affect education.

Peer education programmes are facilitated by Wirral tier 2 services, the programme provided mental health education in schools and mentoring by year 12 students, supported by school staff. Fifteen students had been trained in seven schools in mental health first aid. The aim was to raise awareness and understanding and reduce stigma. The project started in 2013 and the young people with support from educational staff facilitated a lesson for year 9 students as part of their personal social health education curriculum. The project was evaluated by questionnaires completed at the beginning and end of the session. Results have shown an increase in mental health knowledge and a reduction in stigma.

Listening to and learning from concerns and complaints

Across the whole of the specialist community mental health services for children and young people data from the trust showed there were 12 complaints. Six were upheld and none were referred to the ombudsman. We saw evidence of the complaints being processed, investigated and resolved. The patient advice and liaison service were the lead department for overseeing this process. Reasons for complaints included access to the service, reports written, a misinterpretation of communication between parents and practitioners.

Young people were advised of their use of the mymind website and that they would access this resource to find out how to complain. How to complain is also within the welcome packs and displayed on the notice boards in all of the communal areas.

One parent of the 13 we spoke to said they didn't know how to make a complaint.

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.

Summary of findings

Our findings

Vision and values

Staff were aware of the trusts' six c's: care, compassion, competence, communication, courage and commitment. We saw the values embedded within the teams. Staff were caring and showed compassion to the young people using the service and their family. Open communication was taking place amongst colleagues and senior colleagues for advice and guidance too.

Good governance

Both of the clinical service managers were fairly new in their role, one had been in post for eight months and the other for nine weeks. When meeting with the clinical services managers they had a clear understanding of the pressures on the service. Increase in demand was common in both teams, in west Cheshire there had been an increase in young people being referred who had an eating disorder. Managers had the ability to add items to the risk register and staffing has been added to the risk register for west CAMHS. The clinical services manager had presented commissioners with a business case for increased staffing capacity, they had successfully received funding for an additional four band six posts, two for each team. Choice plus three appointments had been introduced for Tier two in West Cheshire to reduce the waiting list.

The choice and partnership approach to accessing the service had been introduced to reduce the number of failed appointments.

The staff in specialist community mental health services for children and young people had achieved 84% of their mandatory training which is very close to their target of 85%. Of the teams we visited 69% of the non-medical staff had had an appraisal within the last 12 months.

Both teams had access to administrative support that processed referrals and supported the wider team with other tasks.

Leadership, morale and staff engagement

Average staff sickness rates were 5% in the last 12 months. Staff turnover rate in the teams that we visited in the 12 month period was 13%

Staff were very positive about working in the service, they were passionate about their role, and team managers had been in their role for over 10 years.

Staff felt supported by their managers and the multi-disciplinary team meetings that we observed showed positive communication between colleagues. Staff valued the introduction of the choice plus three appointments in west Cheshire to reduce the waiting list. Positive feedback was received regarding the additional staffing resources to their teams.

Staff valued the opportunity to attend training relevant to their role including EMDR and CYP-IAPT and felt the trust supported learning and development.

Team meeting minutes showed learning being shared amongst the teams and case discussions for young people assessed as high level risk occurred at their weekly meetings to ensure information is shared. Senior managers attended the business and governance meetings, where learning from experience is an agenda item and minutes showed the actions for senior managers to share the learning from serious incidents with their teams.

Commitment to quality improvement and innovation

Monitoring of young people using the service progress from referral is via the outcome measures of strengths and difficulties questionnaire and the routine outcome measures. Innovation is being trialled with the use of iPads to capture the ratings in real time with young people and this could occur remotely.

The mymind website were rated as 'highly commended' in the innovation in mental health category at the Health Service Journal (HSJ) Awards 2014.

Adcote House was visited by the Office for Standards in Education, Children's Services and Skills (Ofsted) who inspect and regulate education providers. Ofsted awarded the school provision at Adcote House a judgement of 'outstanding' for the first time, deemed to be highly effective in delivering outcomes exceptionally well for all its pupils' needs.

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Wirral CAMHS ran an interactive workshop called 'CAMHS apprentice' at the children's commissioner's take over day 2014, allowing young people to be creative in designing their own CAMHS worker, journey and budget. The ideas were being raised at the trust board by the 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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12.2 (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The provider has not consistently assessed the risks to the health and safety of service users receiving care or treatment. Some care records did not have comprehensive risk assessments in place for the young people using the service.