

**Requires improvement**

Isle of Wight NHS Trust

# Specialist community mental health services for children and young people

## Quality Report

St. Mary's Hospital

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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)
R1FAV	St Mary's Hospital (Mental Health Management)	Community CAMHS	PO30 1JW

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

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

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

# Summary of findings

## Ratings

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

### Overall rating for the service

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 requires improvement because:

- Care plans, risk assessments and crisis plans were not comprehensive and did not assist staff to deliver safe care and treatment to young people. Staff members recorded information and stored records inconsistently.
- The service did not deliver all the psychological therapies recommended by NICE. There was no provision for young people with attention deficit hyperactivity disorder or autism spectrum disorder who were excluded from the service.
- The contract with clinical commissioning group stated that they expected out of hours crisis support to be in place by June 2016. However, there was no out of hours provision for young people. Young people admitted to hospital at the weekend had to wait until the following Monday before being assessed by CAMHS staff.

- There was limited evidence of learning from incidents.

However:

- Staff were passionate and caring about the young people had high morale. Young people and carers were positive about the staff team. We observed interactions between staff and young people and their families that were warm, good humoured, and professional. Young people we spoke with said the staff they worked with were respectful, supportive and caring.
- Treatment that was offered was effective and in line with guidance. High risk young people were managed well.
- The service had a pleasant environment suitable for young people with a range of toys and story books in the waiting areas that were engaging and described how to manage mental disorders in an age appropriate way.

# Summary of findings

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

### Are services safe?

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

- Crisis plans were not comprehensive and risks assessments were not consistently completed. There was not an effective system in place to assess the risks to all young people and crisis plans were not completed in all records to manage risk.
- Discussions with the staff team about incidents that took place at the service confirmed that staff reported too few incidents. There were no improvements or learning made following the incident involving a young person having access to a stairwell in 2015.
- Information about a young person being under the care of the local authority or subject to safeguarding procedures was not clearly highlighted or readily accessible.

However:

- All areas of the clinics and therapy rooms we saw were clean and appeared well maintained.
- There was a low staff vacancy rate.
- Staff members were involved in decisions about the allocation of patients and how many cases they should have on their caseloads.
- Young people assessed as being at high risk were discussed at the daily risk meetings and managed well.

**Requires improvement**



### Are services effective?

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

- Care plans did not assist staff to deliver safe care and treatment to young people.
- Staff members were inconsistent about the storage of the plans on the electronic notes system so they were not easy to find.
- The service did not deliver all the psychological therapies recommended by NICE. Young people did not have access to timely treatment for autism spectrum disorder and attention deficit hyperactivity disorder after diagnosis.
- Staff members did not all receive sufficient regular supervision.
- Capacity and consent was not always recorded.

However:

**Requires improvement**



# Summary of findings

- Comprehensive assessments were documented in each of the 12 care records we reviewed and had been carried out at the young person's first appointment.
- There were daily team meetings and regular multi-disciplinary meetings.
- The staff team had built very good working relationships with the local schools.

## Are services caring?

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

- We observed interactions between staff and young people and their families that were warm, good humoured, and professional. Young people we spoke with said the staff they worked with were respectful, supportive and caring.
- Staff showed good knowledge of individual needs of the young people who used the service.
- Young people were involved in the production of the newsletter.

However:

- Although young people were involved in some decisions about the service they were not currently able to be involved in staff recruitment.
- Young people were not consistently involved in their care and treatment plans.

Good



## Are services responsive to people's needs?

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

- The contract with clinical commissioning group stated that they expected out of hours crisis support to be in place by June 2016. However, there was no out of hours provision for young people. Young people admitted to hospital at the weekend had to wait until the following Monday before being assessed by CAMHS staff.
- The service did not deliver all the psychological therapies recommended by NICE. There was no provision for young people with attention deficit hyperactivity disorder or autism spectrum disorder who were excluded from the service. This service was not commissioned.

However:

Requires improvement



# Summary of findings

- There was no waiting list for the service and young people were seen quickly.
- The trust produced age appropriate and accessible information leaflets. There was also a wide variety of toys and age appropriate self-help books available in the waiting rooms which young people said they enjoyed.

## Are services well-led?

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

- There was not an effective governance system in place to ensure consistency in standards and work processes across the teams.
- There were not effective systems in place to ensure learning from incidents.

However :

- Staff morale was high.
- Staff described good team working between their immediate team members and wider professional groups and supportive management.

**Requires improvement**



# Summary of findings

## Information about the service

The Isle of Wight NHS trust community child and adolescent mental health service provided children's mental health services, including primary and secondary

care, for young people with emotional mental distress. The service worked with children from 0-18. There was one team on the Isle of Wight, based at Pyle Street in Newport.

## Our inspection team

Inspection was led by:

Joyce Frederick, head of hospital inspection, CQC.

The team that inspected specialist community mental health services for children and young people comprised: one CQC inspection manager, one CQC inspector and one specialist advisor who was experienced in working in children's mental health services.

## Why we carried out this inspection

We inspected this core service as part of a responsive follow up focussing on areas for improvements arising from last inspections and concerns from ongoing monitoring.

## 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 and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited the community mental health services for children and young people in Newport. We looked at the quality of the clinic environment and observed how staff interacted with young people who use services and carers

- read information from 18 young people and carers on our comment cards
- spoke with six young people who were using the service
- spoke with eight carers of young people who were using the service
- attended one school visit with a staff member
- spoke with the manager for the service
- spoke with nine other staff members
- attended and observed the team meeting and risk meeting/MDT
- observed one family therapy session
- held a focus group with young people.
- looked at twelve treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.



# Summary of findings

## What people who use the provider's services say

Two of the parents of young people who used the community CAMHS services told us that they were not satisfied with the lack of provision for young people with autism spectrum disorder or attention deficit hyperactivity disorder (ADHD) provision. Six said they were overall happy with the service and two said We spoke with four young people who were using the service

who said they were overall happy with the service and said they found it useful. Although concerns were raised about the wait for assessment by CAMHS staff whilst on the paediatric ward over the weekend.

At the end of the inspection, we collected comment boxes from the community services. We received 18 comment cards 16 of which were positive about the service. Two carers complained about the provision for young people with ADHD.

## Good practice

The service provided storybooks in the waiting areas that were engaging and described how to manage mental disorders in an age appropriate way.

## Areas for improvement

### Action the provider **MUST** take to improve

- The trust must ensure that the care records system contains accurate and contemporaneous information, including care plans and copies of letters, to ensure that staff have sufficient information to care and treat young people.
- The trust must ensure that young people's records include a risk assessment to ensure their safe care and treatment.
- The trust must ensure that young people in crisis over the weekend period are assessed quickly.
- The trust must ensure crisis plans are completed for all young people who are assessed as requiring them to keep them safe.
- The trust must review with commissioner's access to treatment for young people with autistic spectrum disorders and attention deficit hyperactivity disorder.

### Action the provider **SHOULD** take to improve

- The trust should ensure monitoring of incidents within the service and there is evidence of lessons that can be learnt from them.
- The trust should consider how to increase participation of young people in influencing the direction of service. They should also ensure all young people are involved in their care planning.
- The trust should ensure information about a young person being under the care of the local authority or subject to safeguarding procedures is readily accessible to staff members.

The trust should ensure that Gillick competency was recorded in young people's records.

Isle of Wight NHS 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
Community CAMHS	Trust HQ

### 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.

The Mental Health Act was rarely used by the specialist community mental health services for children and young people. All clinical staff we spoke with said they had received training in the Mental Health Act 1983.

### Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act only applies to young people aged 16 years and over. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.

Records showed that Gillick competency was not always recorded. There was only evidence of consideration of capacity and consent in two of 12 cases reviewed.

The deprivation of liberty safeguards apply only to people aged 18 and over.

# 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

- All of the interview rooms we saw were fitted with alarms, so staff members could alert other staff if they needed assistance.
- The therapy rooms were clean and appeared well maintained. We reviewed the most recent cleaning records and they were up to date, completed and filled in correctly. The team had won a trust award in 2016 for the cleanliness of the building.
- There were no environmental risk assessments on site to assess the potential risks to young people. For example, young people had easy access to the ground floor of the service as there was not key pad access in place. They could easily enter the offices in these areas. The team had not considered this as a potential risk even though there had been an incident in 2015 where a young person had become agitated and left the room and got access to the stairwell and the manager's office. At the time of the inspection the open stairwell still posed a risk as there had been no changes made since the event or been identified in an environmental risk assessment. The top of the stairwell had been blocked off and was key coded to the offices upstairs.
- Staff adhered to infection control principles including hand-washing. There was signage explaining hand-washing techniques on the premises instructing how to wash hands correctly.

### Safe staffing

- The CAMHS team was well staffed with a low vacancy rate. There was currently a vacancy of one band 8a Psychologist with another on maternity leave but interviews were scheduled at the time of our inspection.
- The current staff complement was 23 staff members. These included mental health nurses, nurse practitioners, in-reach/outreach mental health nurses, family therapists, primary mental health practitioners, a child psychotherapist consultant psychiatrists and the manager.

- The average cases loads were between 28 to 50 young people for each staff member with the average being 41. All caseloads in the community CAMHS teams were reviewed by the manager and the team to ensure equity across the team.
- Staff members were involved in decisions about the allocation of patients and how many cases they should have on their caseloads. They said they were always busy but their caseloads felt manageable. However they did feel the caseloads were high. The case work was managed by the manager who decided in conjunction with clinicians how many young people could be worked with at any one time. The staff team had monthly clinical supervision where they looked at caseloads. Decisions were taken based on clinician's specialities and the acuity of their current caseloads.
- There were clear arrangements for cover arrangements for sickness, leave and vacant posts to ensure patient safety.
- There was no use of bank or agency staff.
- At the time of inspection, young people experienced timely access to a psychiatrist during working hours. In the middle of 2016 locum cover was in place to assist the workload of the current psychiatrist. This reduced their caseload from 160 to the current position of 87 patients. However, there was no access to psychiatry out of hours including at weekends. The duty on call rota of adult psychiatrists did not cover young people who had to wait until Mondays for assessments. There was a policy which stated that a clinician from the crisis resolution team covered young people out of hours. However, staff and young people spoken to at the inspection told us this was not their experience.
- The overall score for staff completion on mandatory training across both services was high at 98%. Training included breakaway technique training, paediatric resuscitation information governance and safeguarding adults.

### Assessing and managing risk to patients and staff

- Staff did not undertake a risk assessment of every young person at initial triage/ assessment and update them regularly. Risk assessments were only evident in three of 12 case notes we reviewed. Information about risk in the daily records evidenced good consideration of risk and

# Are services safe?

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

patients involvement in their care. However staff members who assisted us in our review of records could not find this recorded in notes easily. For patients who were not assessed as high risk there was little in the way of risk assessments. For example, in one young person's file a referral letter stated a young person had tried to strangle themselves following a diagnosis of autistic spectrum disorder and had aggressive violent outbursts, but there was nothing in their records to say how high the current risk was, how it was to be managed or how family should manage risk.

- High risk patients did have clear risk assessments in place and had risk discussed daily in a clinical meeting where the discussion was recorded in the individual clinical record. The meeting considered the risks holistically and the involvement of parents, other agencies and schools. Protective factors were also discussed and how to build on those to keep the young person safe.
- Collaborative crisis plans that could be accessed by young people, families and teams were in place for only two of the 12 files. These were for young people who were assessed as high risk. There was none in place for other young people with lower risk.
- There was no waiting list so the service didn't need management of risk for young people on their waiting lists.
- All staff spoken with in both CAMHS teams knew about the trust's safeguarding policy and could tell us how to make a safeguarding alert and when it would be appropriate to do so. 100% of staff had completed level three child protection training. The team had good links with the local safeguarding board. However, the electronic care records system did not highlight young people who were subject to a child protection plan to alert staff and safeguarding referrals were not clearly recorded.

- The trust had a lone working protocol which was available in all of the specialist community mental health services for children and young people. The staff we spoke with were aware of the protocol and could explain how they followed it.

## Track record on safety

- In the trust's analysis of reportable incidents for CAMHS for the year to September 2016, we found that there was only one incident coded to CAMHS in the data for that period. The incident involved an agitated young person who had unsupervised access to the open stairwell. Staff told us of other incidents where young people had got unsupervised access to the service but these had not been reported.

## Reporting incidents and learning from when things go wrong

- There was no evidence of improvements in safety as a result of the incident where the young person had unsupervised access to the stairwell.
- Incident reporting was low as there was little evidence of any incident reporting apart from the one incident above. Staff members stated that they knew how to report incidents but rarely did as there was lack of clarity about what incidents were reportable.
- The minutes of multi-disciplinary team meetings recorded that the teams had not discussed learning from incidents within CAMHS services but in the focus group staff told us about incidents in other services within the trust. For example, they were aware of a recent incident where the learning for clinicians was to work closely together to avoid information being lost.
- We were told by staff that following any serious incidents they were offered support and debrief sessions. Staff members told us they found this valuable.

# 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

- Comprehensive assessments were documented in each of the 12 care records we reviewed and had been carried out at the young person's first appointment.
- There was inconsistent standard of record keeping across CAMHS team. We reviewed 12 care records on the electronic patient record system and found inconsistent practice across team members. There were only care plans evident in five of 12 case files reviewed. These were in letters mainly and failed to evidence discussion with either patients or carers, or to reflect the patients' views, discussions of best practice, treatment options or national institute for health and care excellence (NICE) guidance. They did not contain sufficient information to assist safe care for young people and children.
- The service was already aware of these shortfalls but had not addressed them. A 2015 audit completed by the service stated "that a care plan was included in 100% of the letters sent out from CCAMHS for the one hundred and sixteen cases included in the analysis above. In completing the audit it was identified that some care plans were not as clear as others and it required reading the whole letter to establish the plan". However following this audit there was no evidence this recommendation had been acted on.
- Staff members were inconsistent about the storage of the plans on the electronic record system so they were not easy to find. Staff using the service could also not find records of consent, care plans or risk assessments when we asked. Five staff members including the manager looked through the files with the inspectors and they were unable to find them on the system. However, towards the end of the inspection day we discovered that letters including assessments by clinicians were being stored a separate computer storage system by the administrative staff which had not then been added to the electronic clinical record. Clinical staff did not know how to access this system and therefore did not have access to the information.
- The CAMHS team told us that they were able to offer psychological therapies recommended by NICE. For example, they had a family therapy room and we observed a family therapy session taking place which was well managed and well documented in line with the guidance. Young people did not have access to timely treatment for autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) after diagnosis.
- The CAMHS teams followed NICE guidance when prescribing medication. Staff followed NICE guidelines in relation to psychosis and schizophrenia in children and young people. These included: recognition and management NICE (2013); depression in children and young people; identification and management in primary community and secondary care NICE (2015).
- The service ensured analysis of outcome measures across CAMHS to inform service development. Staff used outcome rating scales like children's global assessment scale. This is a numeric scale used by mental health clinicians to rate the general functioning of youths under the age of 18. Scores range from 1 to 90 or 1 to 100, with high scores indicating better functioning. They also used the strengths and difficulties questionnaire which is a self-reporting inventory behavioural screening questionnaire for children and adolescents ages from the ages of two through to 17 years old.
- Clinical staff in participated in a variety of clinical audits. For example, they completed audits in, care plans, 'did not attend' (DNA) and eating disorders. The improvements made as a result of findings of the audits was mixed. For example they did not act on the finding of the care plan audit but used the information from the (DNA) audits to improve their practice and improve service delivery.
- We received mixed feedback from young people and their families about the care they received from the service. Some felt they had made good progress and were being heard and others felt that their children's needs were not being met as the service did not provide autism spectrum disorder or attention deficit hyperactivity disorder treatment.

### Best practice in treatment and care

- Staff did not routinely monitor young people's physical health care unless, for example, the patient had an eating disorder. Any other physical health monitoring was met through the patient's GP.

### Skilled staff to deliver care

# 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 clinical team included mental health nurses, nurse practitioners, in-reach/outreach mental health nurses, family therapists, primary mental health practitioners, child psychotherapist and consultant psychiatrists and the business support administration staff.
- The team had a variety of experience with some working for several years and others were new to the team.
- When staff started working at the service they completed an induction, which consisted of completion of all the mandatory training. New staff were required to complete a range of competencies during the probationary period. Staff also received an orientation period that included familiarisation with policy and procedures.
- Staff received regular monthly clinical supervision. The service also held peer group supervision every two weeks in three distinct closed groups held with the consultant. These were used to discuss complex cases and share insight and knowledge. One-to-one managerial supervision was irregular with some staff not having supervision for several months. Only 60% of clinical staff had received supervision every four to six weeks.
- Staff received yearly appraisals with 98% of staff had received appraisals in the year 2015 to 2016. All members of staff had a personal development plan that was monitored, assessed and modified during the annual appraisal process. All appraisals were recorded well and had objectives and training needs identified and were individualised.
- The provider was able to offer non vocational qualifications in a wide range of clinical and management areas. Staff told us they could attend external training programmes through which they could achieve nationally-recognised qualifications.
- There were monthly team meetings but attendance at these meeting was limited to clinical staff. However, administrative staff felt well supported by colleagues in the service.

## Multi-disciplinary and inter-agency team work

- The service had regular multi-disciplinary meetings (MDT) where a range of clinicians and the manager discussed the needs of young people. They discussed

new referrals, alternative strategies and treatments for the young people and high risk cases. We observed them discuss young people in a kind, professional and informed manner.

- Staff told us the multidisciplinary team worked well as a team.
- The service had made strong links with local schools. We observed a visit to a local school where the relationship between the clinician and school staff was well established and there were detailed discussions about management of risk and interventions to aid young people in the school environment.
- The community CAMHS teams had good working relationships with social services and the nearest inpatient ward a neighbouring trust on the mainland.

## Adherence to the MHA and the MHA Code of Practice

- The Mental Health Act was rarely used by the specialist community mental health services for children and young people.
- The community CAMHS service had had training guidance on the Mental Health Act and Code of Practice relevant to CAMHS.
- All clinical staff we spoke with confirmed they had received in house training in the Mental Health Act.

## Good practice in applying the MCA

- The Mental Capacity Act only applies to young people aged 16 years and over. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and stated they used this to include the patients where possible in the decision making regarding their care.
- Records showed that Gillick competency was not always recorded. There was only evidence of consideration of capacity and consent in two of 12 cases reviewed.
- Mental Capacity Act (MCA) training took place at induction and was ongoing throughout the year.
- There was a MCA policy and staff knew who to approach in the trust if they need support or advice.
- There were no MCA audits to monitor adherence to the MCA.



# Are services caring?

Good 

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

## Our findings

### Kindness, dignity, respect and support

- All of the interactions we saw between young people and carers and the staff members were respectful and supportive.
- All young people or carers we spoke with said the staff they worked with were supportive and caring. The six parents of young people who used the service gave us positive feedback regarding the staff team.
- The staff we met spoke respectfully of the young people and their carers and were able to give us many examples to demonstrate their understanding of the individual needs of the young people who used the service.

### The involvement of people in the care they receive

- Young people told us they were not always involved in decisions about their care. They said that they were encouraged to attend their review meetings. Four young people said they had not seen a copy of their plan.

- Young people were encouraged to give feedback on CAMHS service. There was an informative and useful newsletter produced by the service and young people were invited to contribute. Staff gathered the views of the patients through the use of yearly surveys after discharge. Staff discussed responses to surveys at team meetings and used this information to develop practice and make changes where needed. For example, some young people stated they didn't like the amount of time they had to wait to see some clinical staff particularly the psychiatrist. The team addressed this with the introduction of a Locum Psychiatrist.
- Young people had access to advocacy services. However the manager told us few young people had advocates. There was no evidence in the 12 files reviewed of discussion between staff and young people about the potential advantages of having an advocate. The manager told us this was an area for development.
- Patients were not currently involved with the recruitment of staff. The manager said they had formed part of the recruitment panel eighteen months ago but not in the last year. They stated this was an area for development.

# 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

- There was no provision of CAMHS clinicians out of hours or at weekends. Young people in crisis would be admitted to the paediatric ward in the acute general hospital. If a young person was admitted to the paediatric ward on a Friday then they were not seen by the team until the following Monday. Two young people said they found this wait difficult when they were admitted over the weekend. The contract with clinical commissioning group stated that they expected out of hours crisis support to be in place by June 2016. However, this was not in place at the time of the inspection.
- The team ensured urgent referrals were seen quickly within their target of three days and non-urgent referrals within three weeks. They had an open referral system that could be accessed by a variety of sources including the young people themselves, their GP or school. The referral was then checked by either the manager of the duty clinician. If the case was assessed as being urgent then there was an immediate response otherwise the case was taken to the team at either the daily risk review meeting or the weekly referral meeting. The paediatric ward rang the service if they had any young people that required an assessment, these referrals would be reviewed at a daily risk meeting and then visited by a clinician.
- The service measured their waiting times from the point of referral to the service to time it took the clinician to make contact with the young person. At this meeting the assessment took place and treatment began. Young people or children who used the CAMHS service had an average wait of three weeks for a service. The waiting time reduced to three days if the referral was assessed as being urgent.
- In the second quarter of the year for the months of June, July and August 2016, 85% of patients were seen in less than six weeks. 197 patient were seen between April and the end of September 2016. Five percent of patients waited the longest wait at 12 weeks. No patients at all waited 18 weeks for treatment which was the team's key performance indicator.
- There was no waiting list for young people to meet with clinicians. Staff members at the focus group told us their strengths lay in their signposting to other services and timely discharge. They also ran a lot of workshops for young people that could be easily accessed. These included workshops in coping with anxiety, self harm and resilience. Young people spoken with told us they valued these workshops and found them useful. Three carers and four young people told us that they found access to the service was good.
- The team responded promptly and adequately when young people phoned into the service. The call was directed to either to the daily clinician on duty or to their own clinician if the case was open to the service.
- There were clear criteria for which young people would be offered a service that did not exclude young people who needed treatment and would benefit. These included all young people with emotional and mental distress. For example, those with a psychosis, eating disorder, anxiety and depression.
- The team took active steps to engage with young people who found it difficult or were reluctant to engage with mental health services. They phoned, texted or visited young people who had been identified. They also visited schools to encourage young people into the service. The CAMHS team contacted their schools and/or their GP to ensure their wellbeing.
- The team took a proactive approach to monitoring and re-engaging with young people who did not attend (DNA). The service monitored the rates of DNA and found in July and August 2016 the rate of young people who did not attend their appointments increased from 10% to 25%. This meant that 17 young people did not attend appointments each month instead of three or four that would normally not attend each month. In order to address this, the service introduced in October 2016 a system where staff in the administration team rang each young person to remind them of their forthcoming appointment. Staff at the time of inspection were monitoring the effectiveness of this system.
- Where possible, young people had flexibility in the times of appointments. These included after school appointments but not weekends.
- The team ensured that appointments were only cancelled when absolutely necessary and when they were then young people received an explanation and were given help to access treatment as soon as possible.



# Are services responsive to people's needs?

Requires improvement 

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

- Staff in CAMHS told us when appointments had to be cancelled staff members contacted the young person and/or carer to explain and to re-arrange the appointment. Young people and carers spoken with said they valued this approach.

## **The facilities promote recovery, comfort, dignity and confidentiality**

- The reception was welcoming with comfortable furniture. The waiting room contained information leaflets regarding local services, medication and how to make complaints. Information leaflets about CAMHS were provided by the trust in age appropriate formats. Information included how to access counselling and substance misuse services, contact advocacy and how to make a complaint.
- The waiting room had a wide toys and books appropriate to the needs of young people and children. This included storybooks which addressed issues like anxiety and self-image in age appropriate language. Young people were seen reading these books whilst waiting to see clinicians and spoke positively about them.
- The CAMHS teams used a range of different therapy rooms. One room had a mobile swing chair where young people could alter their sitting position when talking to a clinician. The therapy rooms were comfortable with a range of equipment to assist clinicians in engaging young people.
- The service had a sensory room with a range of interactive equipment. Staff said young people liked the sensory room.
- All of the therapy rooms were sound proofed so conversations could not be overheard.

## **Meeting the needs of all people who use the service**

- The CAMHS service had disabled access with a ramp for wheelchair access, an adapted toilet with grab rails. There was no lift but wheelchair users could be accommodated on the ground floor.

- The service provided accessible and age appropriate information booklets regarding health issues and conditions and produced accessible care planning information for young people with a learning disability.
- Interpreters and signers were available to staff from the trust

## **Listening to and learning from concerns and complaints**

- The service had received three formal complaints in the 12 months prior to inspection. None were upheld. The manager provided a written response to complainants. One was referred to the ombudsman and was not upheld by them.
- Clients could make a complaint verbally to staff and there was a short paragraph about this in the welcome pack. Staff told us they didn't send out a complaints form with the welcome pack but often spoke about how to make a complaint at their first meeting with a client.
- Information on how to make a complaint was also displayed in the corridor and office. This included information about the role of independent advocacy services in complaints. Young people in the focus group and young people and carers we either spoke with or those who commented on the comment cards were mixed about staff response to their complaints. Some said they complained about the attitude of one staff member and nothing was done about it. Another said they complained about having to wait in hospital over the weekend before being seen by the CAMHS staff and that this was still the case.
- The complaints policy and procedure were part of staff induction process, and staff understanding was reviewed through training, supervision and appraisals. Staff were aware of what to do if the young people made a complaint and how to support them.

# 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

- Managers and staff spoken with knew the organisation's vision and values.
- The manager said communication from a senior manager was effective. There were regular emails and staff forums where senior staff shared communications and invited comments from staff teams on the running of the service.
- The staff team had contact with senior managers who visited the service. These included the clinical director and the chief executive of the trust. Staff members spoken with knew who senior managers were.

### Good governance

- There was not an effective governance system in place to ensure consistency in standards and work processes across the team. We found shortfalls in record keeping and across the team with little consistency. For example, they did not make any changes following the 2015 care plan audit which identified shortfalls in care plans.
- Risks assessments were not consistently completed for all young people and there was not an effective system in place to assess the risks to all young people. Letters including assessments by clinicians were being stored on a drive by the administrative staff which was not added to the electronic clinical record. As clinical staff did not know how to access this system they did not have access to the information. There was no monitoring of these shortfalls or plan in place for their resolution.
- There was no effective governance to ensure staff implemented recommendations and learning from the incidents. There had been no improvements made to access to the stairwell following an incident where a young person could have fallen. Information on incidents was stored inconsistently and was not monitored by the manager.
- The service did not use KPIs or other indicators to gauge the performance of the team. However, the team's performance against trust targets in relation to mandatory training, targets around waiting times were on the trust's computer system and were accessible in the local services.

- The manager felt they had sufficient authority and administration support. The manager stated that they could submit items to the trust risk register. There was not a separate risk register for the service.
- The managers across both CAMHS teams ensured the overall score for staff completion on mandatory training across both services was high at 98%. All staff members received appraisal and clinical supervision but only 60% had received managerial supervision to enable them care and treat young people and children safely. There was no plan in place to resolve this.
- The team undertook clinical audits to ensure they were following NICE guidance when prescribing medication to the children and audits young people.

### Leadership, morale and staff engagement

- Staff members had tried to address the difficulties they encountered with the IT system. However, the overall governance of the situation was not well managed as staff were inventing individual 'work arounds' and storing information inconsistently.
- The service had a yearly staff survey where they could express their views about the service.
- Sickness and absence rates were low. Staff also had access to health and wellbeing support via occupational health at the trust.
- Staff told us there was not a bullying or harassment culture in the team. They knew how to raise concerns and felt they could do so without fear of victimisation. Staff told us that they knew how to use the whistle-blowing process and that they would use it if they had concerns.
- Staff told us they enjoyed working in their team and were well supported by peers and their manager. Staff morale was high and they described themselves as an innovative team with a can do attitude to their work. Staff at our focus group prior to the inspection told us that they worked well together and took pride in their work and the care and treatment that they delivered. Staff described good team working between their immediate team members and wider professional groups.
- Staff members had opportunities for secondment and leadership development.
- Staff we spoke with understood the term duty of candour. The manager gave us examples of being open and transparent with patients and explained when things have gone wrong.

# Are services well-led?

Requires improvement 

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## **Commitment to quality improvement and innovation**

- The service participated in the national CORC programme for monitoring the quality of the service to compare their performance against other services nationally.
- The service had achieved the 'you're welcome' accreditation. This showed that the staff, environment, information leaflets and correspondence had been evaluated against national standards by young people to be young people friendly.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <b>Regulation 12 Safe Care and Treatment</b></p> <p>Regulation 12 (2) (a) assessing the risks to the health and safety of service users receiving the care or treatment: the trust did not ensure risk assessments were completed and reviewed regularly. Risk assessments should include plans for managing risks.</p> <p>The trust did not ensure crisis plans were completed for all young people who were assessed as requiring them to keep them safe.</p> <p>The trust did not ensure young people in crisis over the weekend period were risk assessed and treated quickly.</p> <p>This was a breach of regulation 12 (1) (a) (b) (d) 12 (2) (b) (c).</p>
Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance <b>Regulation 17 (2)(c )</b></p> <p>The trust did not maintain securely an accurate and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.</p>

This section is primarily information for the provider

## Requirement notices

The trust did not ensure there is an effective system in place to ensure consistency in standards and work processes to ensure learning from incidents is implemented.

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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