

Review of children and young people's mental health services

Phase One supporting documentation:
Inspection report analysis

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1 Summary

1.1 Findings

This paper considers the findings of a qualitative analysis of 101 child and adolescent mental health services (CAMHS) inspection reports from CQC. The sample of 101 CAMHS reports was based on the same CAMHS services reported in the End of Programme report published by CQC in July, 2017.¹ The analysis focused on five sections of the inspection reports considered to be most relevant to addressing the aims of the review of mental health services for children and young people being conducted by CQC:

1. good/outstanding practice
2. requirement notices
3. areas for improvement
4. access and discharge
5. multidisciplinary and inter-agency team work.

Some of the key findings from each of these sections are considered in turn.

Good/outstanding practice

- Evidence of patient, parent and/or carer contributions feeding into care and/or service provision, such as in the recruitment of staff.
- Evidence of regular multidisciplinary working across CAMHS services; working with a range of external agencies was highlighted particularly in relation to Specialist Community services.
- Evidence of skills development of staff through education and training courses as well as courses for patients and families on mental health and outstanding Inpatient schooling education for patients.
- Additional evidence of good/outstanding practice in relation to recording and reporting to evaluate and improve services, access and discharge processes, provision of out-of-hours support for young people in crisis, patient assessment and risk management and receipt of awards from the trust or national bodies.

Requirement notices

- Of the 101 services analysed in this report, 48 services were issued at least one breach across 10 different CQC regulations; 27 of these services were Specialist Community, 21 were Inpatient services.
- Regulation 12 (Safe care and treatment) was breached the most followed by Regulation 17 (Good governance) and Regulation 18 (Staffing); Regulation 16 (Receiving and acting on complaints) was breached the least: one Specialist Community service breached this regulation.
- Breaches to Regulation 12 captured issues with the risk assessments not being carried out.

¹ CQC (2017). *The state of care in mental health services 2014 to 2017: Findings from CQC's programme of comprehensive inspections of specialist mental health services.*

- Breaches to Regulation 17 related to issues with recording and reporting and sharing information about consent.
- Breaches to Regulation 18 related to low staffing levels and lack of staff training.

Areas for improvement

- Areas for improvement were divided into *must* and *should*.
- The key areas that *must* be improved on related to the quality of patient assessments, issues around governance and policy, recording of information and service facilities and environment; waiting times were a common theme for Specialist Community services that must be improved on.
- Similar to the areas that must be improved on, the key areas that *should* be improved included recording of information, facilities and environment, governance and policy, patient assessments and training of staff.

Access and discharge

- There was more focus on discussions around access than discharge across the inspection reports.
- Inpatient services usually described having planned admissions; Specialist Community services appeared more involved in dealing with crisis situations including cases that presented in A&E departments.
- Inpatient services usually received referrals through the Specialist Community CAMHS teams.
- Specialist Community teams received referrals from a wider range of sources such as GPs, schools, social service and police and a single point of access was described to be in use in a number of services.
- In a number of Inpatient services, referrals were received from out of the area, this could potentially create issues with collaborative working with services such as community services or schools.
- There were waiting lists in a number of Specialist Community services; some services were proactive in monitoring waiting lists and offering support to those waiting.
- Targets for time taken from referral to assessment and/or treatment were discussed with some services missing targets.
- Inclusion/exclusion criteria were discussed in a number of reports; signposting and referring prospective children and young people elsewhere could happen if the service could not meet their needs or they did not reach the threshold for treatment.
- Did not attend (DNA) policies were described as being in place in some Specialist Community services; appointments were adhered to by services unless there was a real need to cancel appointments.
- Inpatient services ensured children and young people kept their bed on return to the service following overnight stays away to, for example, visit family.
- Inpatient services appeared conscious of planning for discharge early on in the care of children and young people and planned for this with input from other teams closer to the point of discharge.
- Delayed discharges could occur if there was no suitable service or accommodation available for the patient.

Multidisciplinary and inter-agency team work

- Lots of evidence of multidisciplinary meetings with a variety of health professionals taking places within all CAMHS services.
- Close working relationships between Specialist Inpatient and Specialist Community services often cited.
- Close working relationships between Specialist Inpatient services and schools cited.
- Close working relationships between Specialist Community and schools and social services.
- Working relationships between other agencies (for example GPs, voluntary orgs) also cited within both Inpatient and Specialist Community services.
- Possible barriers to close working relationships between agencies due to geographical distances between them.

1.2 Caveats and limitations

While there are a number of strengths to this paper, including the breadth of data considered (101 inspection reports were reviewed), there are some important caveats and limitations to highlight.

Firstly, the inspection reports that were analysed in this report were based on inspections that took place between 2014 and 2017. Therefore, the inspection reports used in the analysis may not reflect the current performance of services as some may have improved or deteriorated in different areas.

Another caveat and limitation of this report relates to the use of only five sections of inspection reports as a data source. These sections were: good/outstanding practice; areas for improvement; multidisciplinary and inter-agency team work; access and discharge; and requirement notices. Given the breadth of information processed and considered during an inspection, not every aspect of a service will be captured and recorded in an inspection report. Inspection reports do not always report on the same nuanced aspects of a service although information does broadly fit into aspects of key questions, such as 'access and discharge' within the responsive key question. Nevertheless, there is some inconsistency in the information presented in inspection reports. Therefore, it is important to note that an absence of information about a certain topic/activity (for example, regular multidisciplinary team meetings) from an inspection report does not equate to a service *not* performing this activity, unless an inspection report stated that this did not take place. It simply means that this was not discussed in an inspection report.

Another limitation to highlight is that the data from inspection reports were often quite descriptive and contained text that report broadly around the topic being discussed without going into some of the depth. In other words, it was difficult to address some of the 'why' or 'how' questions of interest. For example, there may have been discussion around a service working with external agencies, but there would be little explanation about how these working relationships formed, operated and succeeded.

2 Methodology

2.1 Sample

A total of 101 inspection reports were sourced for this analysis. The sample of inspection reports was based on the same set of CAMHS service providers considered in the recent *State of care in mental health services* report published by CQC.² The inspection reports in the sample were published between 2014 and 2017.

Two CAMHS services were considered in the analysis: Child and adolescent mental health wards (that is, Specialist Inpatient) and Specialist Community mental health services for children and young people (that is, Specialist Community). The terms 'Specialist Inpatient' and 'Specialist Community' are used throughout this report to describe these two services.

Figure 1 provides an overview of the sample profile of the inspection reports analysed. The characteristics of the inspection reports have been broken down by CAMHS service type (Specialist Inpatient; Specialist Community), sector (Independent; NHS) and overall rating of the CAMHS service (outstanding, good, requires improvement, inadequate). The overall ratings of the CAMHS services are current up until 31/05/2017.

Figure 1: Overview of sample of inspection reports

CAMHS service type	Overall rating n (%)			
	Outstanding	Good	Requires improvement	Inadequate
Specialist Inpatient (N=54)	3 (3.0%)	41 (40.6%)	10 (9.9%)	0 (0%)
Independent (n=24)	0 (0%)	19 (18.8%)	5 (5.0%)	0 (0%)
NHS (n=30)	3 (3.0%)	22 (21.8%)	5 (5.0%)	0 (0%)
Specialist Community (N=47)	4 (4.0%)	31 (30.7%)	11 (10.9%)	1 (1.0%)
Independent (n=4)	0 (0%)	3 (3.0%)	1 (1.0%)	0 (0%)
NHS (n=43)	4 (4.0%)	28 (27.7%)	10 (9.9%)	1 (1.0%)
Total (N=101)	7 (6.9%)	72 (71.3%)	21 (20.8%)	1 (1.0%)

In the sample of 101 inspection reports, there were 54 services that provide Specialist Inpatient care for children and young people: 30 NHS and 24 independent services. A total of 41 Specialist Inpatient services (76%) were rated as good and three (6%) as outstanding. There were 47 services that provided Specialist Community mental health services for children and young people: 43 NHS and four independent. Overall, 31 (66%) were rated as good and four (9%) as outstanding.

² CQC (2017). *The state of care in mental health services 2014 to 2017: Findings from CQC's programme of comprehensive inspections of specialist mental health services.*

2.2 Analytical approach

The focus of the qualitative analysis of the inspection reports was on five sections, selected based on their relevance to the CAMHS review. These were:

1. good/outstanding practice³
2. requirement notices
3. areas for improvement
4. access and discharge
5. multidisciplinary and inter-agency team work.

The 'good/outstanding practice', 'areas for improvement' and 'requirement notices' sections relate to all aspects of the CAMHS service. These are standalone sections with the inspection reports and they do not fit into one of the five key questions (safe, effective, caring, responsive, well-led). 'Multidisciplinary and inter-agency team' work sits within the effective key question and 'access and discharge' sits within the responsive key question.

The coding framework used to code the sample of data was developed 'ground up' through identifying topics being discussed in the data and creating codes based on these emerging topics. MaxQDA version 11 was used to code the data and assist with the qualitative analysis.

The coding framework was developed through using the topics identified in the first 10 inspection reports and amendments were made to the framework iteratively until a refined coding framework was generated. The two analysts conducting the analysis met to discuss the final coding framework to code the remaining 91 inspection reports. Each analyst carried out coding on the five sections above of the remaining inspection reports using the coding framework. During coding, analysts added some additional codes to ensure all new topics were captured in subsequent inspection reports. Analysts met to discuss any additional codes and merged related codes together. The final set of coded data was agreed and this framework was used to analyse and interpret the data.

Once the analysts had completed the coding process they combined the coded data into one master file within MaxQDA 11.1. Each analytical and report writing stage was reviewed at a number of stages in line with CQC's quality assurance policy.⁴ Analysts reviewed each other's coding, interpretation and presentation of the coding as findings and report writing. Any issues arising from the review were discussed between the analysts and addressed in subsequent iterations of the analysis and report writing.

When analysing Independent inspection reports, often there were multiple services (including the relevant CAMHS service) grouped together in the report. In these cases the analysts aimed to extract only data that was relevant to CAMHS services.

³ Within NHS inspection reports the use of the title 'good practice' was used whereas in Independent inspection reports the use of 'outstanding practice' was used. These were analysed together.

⁴ CQC (2017). Intelligence Unit: Quality Assurance Policy.

3 Findings

3.1 Presentation of the findings

The findings are presented in five different sections that were the focus of the analysis:

1. good/outstanding practice
2. requirement notices
3. areas for improvement
4. access and discharge
5. multidisciplinary and inter-agency team work.

Each section presents the key themes emerging from the written reports of inspectors across the inspection reports. The titles of the key themes, derived through the analysis, are used as section headings from which the detailed findings are hinged. The themes are discussed with a narrative of the findings and examples of text from the inspection reports that illustrate the themes. Identifying information such as ward/provider names have been removed from the examples of text. The inspection report exemplars are referenced with the CAMHS service (Specialist Inpatient; Specialist Community), and the overall rating for the CAMHS core service (outstanding, good, requires improvement, inadequate).

In most sections, findings have been split into the two main types of CAMHS services: Child and adolescent mental health wards (that is, Specialist Inpatient) and Specialist Community mental health services for children and young people (that is, Specialist Community). Where there are disparate findings based on other characteristics of the provider, such as whether it is an NHS or Independent provider or its rating, these are highlighted and discussed. There were minimal differences found across services based on these characteristics.

With the exception of the 'Requirement notices' section (3.3), this report avoids using numbers/percentages to present findings as this can be misleading when considering this 'qualitative' data source. It is important to avoid placing too much emphasis on how many reports discussed a certain topic as this would suggest every report covered the exact same topic, though as noted previously this was not the case. The main aim of this qualitative analysis is to highlight emerging themes from the data to explore key findings contained within inspection reports.

3.2 Good/outstanding practice

Areas of good practice were reported in the NHS services inspection reports and outstanding practice was reported in the independent inspection reports. These were both considered together in this section of 'good/outstanding practice' to explore the areas of practice that inspectors reported were particularly strong elements of care quality.

3.2.1 Patient and parent/carer involvement

The most common area of good or outstanding practice across all of the inspection reports related to the theme of services involving patients and/or their families or carers in their treatment decisions or in aspects of service provision, such as, in the design of the facilities or recruitment of staff.

3.2.1.1 *Specialist Inpatient*

Of the Specialist Inpatient services that discussed good/outstanding practice areas a third of these commented on areas relating to patient and or parent/carer involvement in the service. Some of these inspection reports commented on how patients and families/carers were involved in the recruitment of staff within the service. For example, one inspection report stated that children had contributed to recruiting staff:

*Children had participated in the interview process for a new member of staff and for student placements by developing interview questions for the panel on areas that were important to them.*⁵

Several inspection reports discussed how children and young people and their families contributed to the development of the service through, for example, taking part in ward round activities, meetings and events that aimed to gather their input to feed into the way services operated. The close collaboration between patients and families and care staff was evident in a few cases, such as in the way care plans of patients were shaped.

*Nurses made efforts to involve children in their care as far as their personal capacity would allow and developed care plans in collaboration with the parents of children visiting the wards.*⁶

3.2.1.2 *Specialist Community*

Similar to the Specialist Inpatient services, there was evidence that Specialist Community services reviewed in our sample had input from patients and their families/carers into the development of the services, this was commonly reported to take place through participating involvement groups. Input into services from young people took place particularly in relation to the social media elements of the service.

*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.*⁷

In one service, that was rated as outstanding overall, there were numerous aspects of patient and parent involvement in the service. This included receiving input in a variety of aspects of the CAMHS service, from recruitment of staff, development of self-referral forms, the care pathways model, as well as feeding into social media and web presence.

The level of participation of young people and parents throughout the whole of CAMHS was significant and included fundraising, recruitment of staff, development of self-

⁵ Specialist Inpatient (Good)

⁶ Specialist Inpatient (Good)

⁷ Specialist Community (Good)

*referral forms, contribution to pathway model of care and development of social media presence and website.*⁸

3.2.2 Multidisciplinary and inter-agency collaboration

After patient and parent/carer involvement, multidisciplinary and inter-agency collaboration was the most common area of good/outstanding practice reported across the inspection reports.

The section of inspection reports entitled 'multidisciplinary and inter-agency teamwork' is considered in a different part of this report (please refer to Section 3.6). Some of the findings here overlap with findings of that section, though they are presented in different sections of this report as they were presented in different sections in the inspection reports.

3.2.2.1 Specialist Inpatient

In Inpatient services, there were several mentions of the service being part of a Quality Network such as the Quality Network for Inpatient CAMHS (QNIC), in the case of five services, both NHS and Independent services.

*[Name removed] was accredited as excellent by the quality network for inpatient CAMHS (QNIC). QNIC aims to improve the quality of inpatient child and adolescent psychiatric in-patient care through a system of review against certain standards.*⁹

Other comments about good/outstanding practice in relation to multidisciplinary and inter-agency collaboration were quite general, simply noting, for example, that there was good multidisciplinary team working in place within the service. An example of this general good/outstanding practice in this area was captured in one inspection report that stated:

*There was good multidisciplinary team working within the ward which helped to promote positive outcomes for the young people who used this service.*¹⁰

3.2.2.2 Specialist Community

Within Specialist Community services, in contrast to Inpatient services, the emphasis of good/outstanding practice appeared to relate more to the partner working between the service and other external agencies such as local authorities, schools, and Improving Access to Psychological Therapies (IAPT). An example of working collaboratively with local schools was illustrated in one inspection report that noted the service had established strong links with local schools and that service staff provided training to school link workers. This allowed the school to refer students to CAMHS services:

*The teams had established close links with local schools. Trust staff provided training to school link workers, who could directly refer pupils to child and adolescent mental health services.*¹¹

⁸ Specialist Community (Outstanding)

⁹ Specialist Inpatient (Good)

¹⁰ Specialist Inpatient (Good)

¹¹ Specialist Community (Good)

Other examples of working with other organisations reported by services included working with a local military base¹² and the police.^{13,14}

A CAMHS practitioner was part of the police [name removed] operational team, providing support to victims of sexual exploitation.¹⁵

3.2.3 Education and training

Education and training was discussed as an area of good/outstanding practice in some inspection reports, primarily in relation to education and training for staff. There were also a few instances in which services offered education and training to patients, families and schools.

3.2.3.1 *Specialist Inpatient*

Within the Inpatient services, the training for staff in different areas including eating disorders, substance misuse and learning disabilities¹⁶; urgent care and restrictive practices¹⁷, nurse training¹⁸ and dialectical behavioural therapy¹⁹ was considered good/outstanding by the CQC inspection team.

In relation to education for patients, one report noted that patients could gain work experience in a variety of areas on site²⁰ and in a few reports that the on-site education was considered good/outstanding.

The patients were able to attend regular education at the on-site school which had recently been rated as outstanding by Ofsted.²¹

3.2.3.2 *Specialist Community*

Within Specialist Community services there was discussion around staff receiving training in various areas: female genital mutilation²²; 'Warner' interviewing methods²³; and evidence-based cognitive behaviour therapy, parenting approaches and systemic family therapy.²⁴

Providing education around mental health in schools was highlighted in a few instances. For example, in one service there was a peer education programme that provided mental health education and mentoring by year 12 students, supported by the tier 2 services within the CAMHS service. The programme aimed to raise awareness and reduce stigma about mental illness:

¹² Specialist Community (Good)

¹³ Specialist Community (Good)

¹⁴ Specialist Community (Good)

¹⁵ Specialist Community (Good)

¹⁶ Specialist Inpatient (Good)

¹⁷ Specialist Inpatient (Good)

¹⁸ Specialist Inpatient (Good)

¹⁹ Specialist Inpatient (Good)

²⁰ Specialist Inpatient (Good)

²¹ Specialist Inpatient (Good)

²² Specialist Community (Outstanding)

²³ Specialist Community (Good)

²⁴ Specialist Community (Good)

Peer education programmes are facilitated by [name removed] 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.²⁵

Finally, education and training directed at young people and their families was discussed in several reports. This included a service delivering training for young people to build relationships with their family²⁶, parenting skills for the parents of patients²⁷, and apprenticeships for young people.²⁸

3.2.4 Innovative approaches and patient centredness

Some of the good/outstanding practice appeared to relate to unconventional methods of supporting children and young people and their families. It was clear that these more 'holistic' approaches were in place and had a focus on patient-centredness.

3.2.4.1 Specialist Inpatient

Within the Inpatient inspection reports there were a couple of instances^{29,30} in which there were facilities for family members to stay on site, close to their relatives. In one service, staff had implemented a unique system of having posters with positive affirmations that could be torn off on the walls of the unit for patients to collect:

On the walls all around the wards there were posters with tear off strips that had a positive affirmation written on them. Patients could tear these off as they moved around the ward and use them to help improve their confidence and self-worth.³¹

In another service, a 'therapy dog' was used on the unit. Inspectors reported how young people and staff from the service believed that the dog helped defuse and de-escalate difficult situations:

The service had employed a therapy dog as a member of the team on the unit. We heard about numerous examples from young people and staff of how the dog defused and de-escalated situations. We saw that young people responded positively to the dog and it helped them engage with their care.³²

3.2.4.2 Specialist Community

There were examples of innovative and patient-centred practices within a few Specialist Community services. For example, one service had a practitioner within the team that helped young people attend the local gym and showed them the positive effects of exercise on mental wellbeing:

²⁵ Specialist Community (Good)

²⁶ Specialist Community (Good)

²⁷ Specialist Community (Requires improvement)

²⁸ Specialist Community (Good)

²⁹ Specialist Inpatient (Good)

³⁰ Specialist Inpatient (Good)

³¹ Specialist Inpatient (Outstanding)

³² Specialist Inpatient (Requires improvement)

In [name removed] a practitioner in the team supported young people in sessions in the local gym in line with research which showed physical exercise had positive outcomes on mental health. This was having a positive effect on young people³³

Another example included a service that implemented a 'tele-psychiatry' service that allowed some flexibility to carry out appointments over video calls with young people and other people involved in their care:

A consultant psychiatrist in the CAMHS services had piloted a tele-psychiatry service. Following an initial face to face meeting young people agreed to appointments via Skype which could take place at a time of day to suit the patient, families and other professionals involved in the patients care, such as teachers. The trust had supported the pilot and had agreed funding for the service to continue.

In one NHS trust, one Specialist Community CAMHS team had even employed an innovation worker in order to improve the delivery of services through engaging with schools, families and young people:

[Name removed] Child and Adolescent Mental Health Service (CAMHS) had employed an innovation worker in order to enhance the delivery of services using innovation and creative ideas. There were several examples of innovation to engage with schools, families and young people using initiatives such as [mental wellbeing workshops] and creating an app for phones and tablets. There were future plans to provide information events to communities. There were participation workers in place throughout the trust who were working directly with young people and their families to change the service using their experience.³⁴

3.2.5 Other areas of good/outstanding practice

Other areas of good/outstanding practices that were discussed in relation to a small number of services are considered in this section together. These areas of good/outstanding practice have been grouped together as they were raised by very few services and do not require the same level of discussion in this report. Instead of providing numbered headings to the key topic areas or 'themes', that fit within this section of the report, the themes are presented in **bold** text. Inpatient and Specialist Community services are discussed together.

Recording and reporting

Use of recording/reporting to help evaluate and improve services were discussed by a Specialist Community service³⁵ and an Inpatient service in which area managers used the incident reporting system to help improve the service:

Area managers gave us examples where the incident reporting system had been used effectively to improve the service.³⁶

³³ Specialist Community (Outstanding)

³⁴ Specialist Community (Requires improvement)

³⁵ Specialist Community (Good)

³⁶ Specialist Inpatient (Good)

Access and discharge

The few Inpatient inspection reports that considered good/outstanding practice in relation to Access and Discharge all referred to discharge practices. These services were reported to have good discharge practices through having members of staff (for example discharge liaison nurse, described in the example below) specialising in discharge.

The service had a dedicated discharge liaison nurse, who worked with community services and other agencies from the young person's admission, to ensure packages of care were in place as soon as the young person was ready for discharge.³⁷

Areas of good/outstanding practice in Specialist Community services related more to access than discharge, including an example below that described how a team helped to increase accessibility to CAMHS:

The development of the [name removed] team has increased accessibility to CAMHS and ensured children and young people who are experiencing mental health distress and need to be seen urgently are not waiting for long periods

Out-of-hours

One Inpatient service³⁸ report commented that letters that went to young people (and their families) that used the service had a clear description of how to access help in a crisis/emergency during the week and at evenings and weekends.

One Specialist Community service³⁹ report stated that the service provided out-of-hours support for young people in crisis through the use of an out-of-hours nursing service with management and consultant cover on-call.

Patient assessment and risk management

In a few Inpatient services and a Specialist Community services, there were findings within the good/outstanding section of inspection reports that related to the way patients were assessed and monitored and how risk was reduced. There were a couple of instances in which the assessments undertaken on patients were considered good/outstanding, such as through the CAMHS service undertaking a joint assessment with a school's primary health worker:

Each school had a primary health worker, who carried out joint assessments with the CAMHS team and were the source of all non-urgent referrals to the service.⁴⁰

Areas of risk were reduced through ensuring guidelines were followed (for example, around medicines usage),⁴¹ ligature assessment⁴² and restraint.⁴³ There was also an example of good management of the male and female wards and risk was minimised during admissions of new patients, illustrated below:

³⁷ Specialist Inpatient (Requires improvement)

³⁸ Specialist Inpatient (Good)

³⁹ Specialist Community (Good)

⁴⁰ Specialist Inpatient (Good)

⁴¹ Specialist Inpatient (Good)

⁴² Specialist Inpatient (Good)

⁴³ Specialist Inpatient (Outstanding)

The CAMHS suites, located in the male and female adult inpatient wards, were well managed and risk was minimised when young people needed to be admitted. Examples of risk minimisation included using only permanent staff to provide observation to young people using the suites.⁴⁴

Within the Specialist Community services, there was an example of a service offering an initial assessment clinic on Saturday mornings to help reducing waiting times.

The service opened an initial assessment clinic on Saturday mornings which helped to reduce waiting times.⁴⁵

Awards

A few Inpatient services received awards for good practice. This included an Independent service that received a grant through a '[name removed]' scheme and an NHS service in which a nurse received a best clinician award from the trust the service sat within. This service also won awards for innovation, through having young people take part in gardening activities:

The trust had a range of awards to recognise good practice. [Name removed] had a nurse who had received a best clinician award from the trust for the recovery group work undertaken and was also nominated for a [name removed] award in 2014. The units' garden group in which young people had grown, prepared and cooked with vegetables and herbs were in the top six of the Trust innovation awards.⁴⁶

Similarly, a few Specialist Community services had received awards for good practice including receiving a national grant for developing a peer support group for patients with attention deficit hyperactivity disorder,⁴⁷ a trust award for the eating disorders team for "valuing customers"⁴⁸ and also a 'Health Service Journal Innovation in Mental health' award, as illustrated in the text from the inspection report below:

The [name removed] adolescent outreach team won the Health Service Journal Innovation in Mental Health. Young people's case studies were used to develop a theatre show for school assemblies and a film to address the issue of mental health and emotional wellbeing in schools. The project was run from September 2013 and was delivered in conjunction with a number of CAMHS partner agencies.⁴⁹

3.3 Requirement notices

This section considers the requirement notices section of the inspection reports and the breaches to regulations CAMHS services had. The numbers of breaches to regulation are considered as well as the qualitative findings that described the breaches in the inspection

⁴⁴ Specialist Inpatient (Good)

⁴⁵ Specialist Community (Good)

⁴⁶ Specialist Inpatient (Good)

⁴⁷ Specialist Community (Good)

⁴⁸ Specialist Community (Good)

⁴⁹ Specialist Community (Requires improvement)

reports. This section relates closely to the 'Areas for Improvement' (Section 3.4) as the areas for improvement are typically aligned with the requirement notices given.

3.3.1 Number of services across the sample that had one or more requirement notices

Figure 2 presents the number of services across the sample that had one or more requirement notices listed in their inspection report. of the presentation of these CAMHS services are provided with three accompanying characteristics: CAMHS service type (Specialist Inpatient vs Specialist Community), sector (NHS vs Independent) and overall service rating.

Figure 2: Services that had one or more requirement notices				
	Rating n (%)			
	Outstanding	Good	Requires improvement	Inadequate
Inpatient (N=21)	0 (0%)	12 (11.9%)	9 (8.9%)	0 (0%)
<i>NHS (n=11)</i>	0 (0%)	6 (5.9%)	5 (5.0%)	0 (0%)
<i>Independent (n=10)</i>	0 (0%)	6 (5.9%)	4 (4.0%)	0 (0%)
Specialist Community(N=27)	0 (0%)	15 (14.9%)	11 (10.9%)	1 (1.0%)
<i>NHS (n=25)</i>	0 (0%)	14 (13.9%)	10 (9.9%)	1 (1.0%)
<i>Independent (n=2)</i>	0 (0%)	1 (1.0%)	1 (1.0%)	0 (0%)
Total (N=48)	0 (0%)	27 (26.7%)	20 (19.8%)	1 (1.0%)

Percentage values are calculated by dividing the number of services that had one or more requirement notices by the total number of services reviewed (N=101; see figure 1); the values in figure 2 do not add to 100%.

3.3.2 Number of requirement notices by regulation type

The number of services that had a breach to each regulation type was examined next. The breakdown of these figures is displayed in figure 3.

Overall, the majority of the requirement notices issued were given against regulation 12 (safe care and treatment). In contrast, Regulation 16 (Receiving and acting on complaints) was only issued to one Specialist Community service.

3.3.3 Qualitative findings from the requirement notices

Qualitative data analysis was conducted on all of the requirement notices to consider what the key issues were relating to the breach. This enabled analysts to present some of the themes and the nature of issues pertaining to the breaches, beyond simply considering the number of breaches. Each regulation that had been breached is considered in turn with the key issues discussed for each one presented alongside some illustrative examples of requirement notice text written in the inspection reports.

Figure 3: Breakdown of breaches by regulation type across CAMHS services

Regulation	CAMHS service type	Rating n (%)			
		Outstanding	Good	Requires improvement	Inadequate
Regulation 12 - Safe care and treatment (n=21)	Specialist Inpatient (n=11)	0 (0%)	6 (7.9%)	5 (6.6%)	0 (0%)
	Specialist Community (n=10)	0 (0%)	4 (5.3%)	5 (6.6)	1
Regulation 17 - Good Governance (n=18)	Specialist Inpatient (n=4)	0 (0%)	0 (0%)	4 (5.3%)	0 (0%)
	Specialist Community (n=14)	0 (0%)	7 (9.2%)	7 (9.2%)	0 (0%)
Regulation 18 - Staffing (n=14)	Specialist Inpatient (n=7)	0 (0%)	1 (1.3%)	6 (7.9%)	0 (0%)
	Specialist Community (n=7)	0 (0%)	4 (5.3%)	3 (3.9%)	0 (0%)
Regulation 9 - Care and welfare (n=7)	Specialist Inpatient (n=1)	0 (0%)	0 (0%)	1 (1.3%)	0 (0%)
	Specialist Community (n=6)	0 (0%)	3 (3.9%)	3 (3.9%)	0 (0%)
Regulation 15 - Premises and equipment (n=5)	Specialist Inpatient (n=4)	0 (0%)	2 (2.6%)	2 (2.6%)	0 (0%)
	Specialist Community (n=1)	0 (0%)	0 (0%)	1 (1.3%)	0 (0%)
Regulation 13 - Safeguarding service users from abuse (n=4)	Specialist Inpatient (n=4)	0 (0%)	2 (2.6%)	2 (2.6%)	0 (0%)
	Specialist Community (n=0)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Regulation 10 - Dignity and respect (n=2)	Specialist Inpatient (n=2)	0 (0%)	0 (0%)	2 (2.6%)	0 (0%)
	Specialist Community (n=0)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Regulation 11 - Need for Consent (n=2)	Specialist Inpatient (n=2)	0 (0%)	2 (2.6%)	0 (0%)	0 (0%)
	Specialist Community (n=0)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Regulation 19 - Fit and proper persons employed (n=2)	Specialist Inpatient (n=0)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Specialist Community (n=2)	0 (0%)	1 (1.3%)	1 (1.3%)	0 (0%)
Regulation 16 - Receiving and acting on complaints (n=1)	Specialist Inpatient (n=0)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
	Specialist Community (n=1)	0 (0%)	0 (0%)	1 (1.3%)	0 (0%)
Total (N=76)		0 (0%)	32 (42.1%)	43 (56.6%)	1 (1.3%)

Percentages are based on % of grand total: number of breaches by regulation type across CAMHS services divided by total number of breaches.

3.3.3.1 **Regulation 12 – Safe care and treatment**

Regulation 12 was the most commonly breached regulation across the inspection reports. Both Inpatient and Specialist Community services received breaches in relation to regulation 12. Typically, a notice against this regulation was issued due to concerns with risk assessments as well as the service environment and equipment.

Risk assessments were not being carried out with regard to the young people and their surroundings when appropriate, and therefore prevented the patient from receiving safe care. The majority of services in breach of Regulation 12 for issues around risk to service users were Specialist Community services. For example, an inspection report noted that risk assessments were inadequate for young people on the waiting list:

Risk assessments were found to be missing or not up to date and there were no systems to review risk to young people on the waiting list for first treatment intervention.⁵⁰

Requirement notices were also commonly issued in acknowledgement that the environment and equipment provided were unsafe and could cause harm to a service user. The layout of the premises was described as not meeting the needs of the patients and the equipment was irregularly inspected to ensure that it was functioning. This issue was particularly found within Inpatient services. One inspector illustrated the issues with cleanliness of the environment and how this may cause harm to the service users:

Young people and staff were not being adequately protected against the risk of infection. The kitchen was unhygienic and dirty. Food items were stored unsafely or beyond their use by date.⁵¹

3.3.3.2 **Regulation 17 - Good governance**

Breaches to Regulation 17 were issued to 18 of the services we reviewed, the majority of which were Specialist Community services. The most common reasons for giving these notices were due to the poor recording, reporting and sharing of important information, such as information with regards to consent and requirements, and risk.

Concerns around the lack of recording, reporting and sharing of information when necessary were frequently mentioned in inspection reports (and this was a theme found in the 'Areas for Improvement' section of reports). Incidents were not being reported when they occurred and records with regard to incidents, care plans and waiting numbers were either inaccurate or missing. Inspection reports noted the extent to which at times the documentation of incidents was inadequate and not shared.

The trust had not ensured that all incidents were reported and that learning from incidents and complaints was shared across the CAMHS teams.⁵²

Notices were also issued to a service in reaction to the lack of awareness and action from a service in regard to the assessments and mitigation of risks. Inspectors observed ineffective systems being used and not being recognised:

⁵⁰ Specialist Community (Requires improvement)

⁵¹ Specialist Inpatient (Good)

⁵² Specialist Community (Requires improvement)

Systems were not in place to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Risk assessments did not always reflect changes in people's circumstances, and were not always clearly linked to assessment of needs and identified risks. Capacity, consent and information sharing was not always recorded. This meant the information was not easily available or accessible to staff.⁵³

3.3.3.3 Regulation 18 – Staffing

Requirement notices in relation to Regulation 18 breaches were issued to 14 of the services we reviewed. Usually these were given in reaction to witnessing low staffing levels and inadequate training. Reports referred to insufficient numbers of suitably qualified staff to meet the needs of the young people:

There were not sufficient staff to meet the needs of the population and not safe out of hours cover.⁵⁴

Notices were also given in relation to the lack of training available and undertaken by staff, specifically when they have a specific population group that required further training:

Staff had not received service specific training, including the need to alter the approach when managing violence and aggression with children and adolescents.⁵⁵

3.3.3.4 Regulation 9 - Care and welfare

Requirement notices in relation to Regulation 9 were issued to seven of the services we reviewed. Common concerns which were raised were due to the absence of person centred care, quality of care plans, and waiting times.

Inspectors recorded witnessing the absence of person centred care through services not offering care that was appropriate for a young person or reflected their needs and preferences. One inspector noted that one service did not meet the needs and preferences of the young person:

The trust had not ensured the care and treatment of patients was appropriate and met their needs and reflected their preferences⁵⁶

In a couple instances care plans were missing, or when in place were not accurate or complete.

The trust did not ensure all children and young people had a care and/or treatment plan. In the [name removed] CAMHS community service nine care records had no care plan developed or available.⁵⁷

⁵³ Specialist Community (Good)

⁵⁴ Specialist Community (Requires improvement)

⁵⁵ Specialist Inpatient (Requires improvement)

⁵⁶ Specialist Community (Requires improvement)

⁵⁷ Specialist Community (Good)

Two reports described had listed requirement notices to this regulation in reaction to poor waiting times which would have an effect on the care and welfare of young people:

*Assessment to treatment times were very long for young people needing to access certain interventions and this was not meeting their individual needs.*⁵⁸

3.3.3.5 **Regulation 15 - Premises and equipment**

Five services from the sample we reviewed received a requirement notice in relation to Regulation 15. The majority of regulation 15 notices issued related to the maintenance and suitability of the equipment and facilities used and the appropriateness of the environment.

Infrequent checks on, and maintenance of both medical and non-medical equipment described in many of the notices. One report noted a broken shower for over a year:

*The trust had not ensured that the premises and equipment was properly maintained. A shower had been broken for over a year and the patients had to share one working shower.*⁵⁹

Many of these notices were also given as a result of the premises of services being unsuitable for young people with additional needs:

*Some premises were not suitable. Adaptions for people with a disability were not effective. Sessions were disturbed by ringing alarms and lights going on and off.*⁶⁰

3.3.3.6 **Regulation 13 - Safeguarding service users from abuse**

Requirement notices in relation regulation 13 were issued to four Inpatient services we reviewed. Many were due to practices, such as managing seclusion, not being followed according to the policy of the services and/or in line with Mental Health Act Code of Practice.

*We found that blanket restrictions were in place that were not necessary or proportionate as a response to the risk of harm posed to the service user or another individual this is a breach of regulation 13 (1) (4) (b) (c) and (5) . There was no evidence of any individual risk assessments to justify their application.*⁶¹

3.3.3.7 **Regulation 10 - Dignity and respect**

Requirement notices in relation to Regulation 10 were issued to two of the services we reviewed, both of which were Inpatient services. Both reports noted the lack of privacy from the opposite sex, with one inspector noting the lack of segregation for sleeping accommodation and bathroom facilities:

*People using services should not have to share sleeping accommodation with others of the opposite sex, and should have access to segregated bathroom and toilet facilities without passing through opposite sex areas to reach their own facilities.*⁶²

⁵⁸ Specialist Community (Requires improvement)

⁵⁹ Specialist Inpatient (Requires improvement)

⁶⁰ Specialist Community (Requires improvement)

⁶¹ Specialist Inpatient (Requires improvement)

⁶² Specialist Inpatient (Requires improvement)

3.3.3.8 **Regulation 11 - Need for consent**

Two of the Inpatient services we reviewed received a requirement notice in relation to Regulation 11. A notice was given when there was no evidence of consent being given by patients or family members to perform activities, such as restricting a patient's liberty

*There was no recorded consent for any of the patients on the ward. We found that admission check lists had missed out this area and that doctors were not routinely populating the required area of the notes with consent. We found no written parental consent for any of the patients on the ward or any reference to Gillick competency for those under 16 and able to consent.*⁶³

3.3.3.9 **Regulation 19 - Fit and proper persons employed**

Regulation 19 was issued against two of the Specialist Community services we reviewed who allowed staff to work without obtaining and sustaining the correct disclosure and barring service (DBS) checks that were necessary to work within the CAMHS unit:

*The provider allowed a member of staff to work directly with children and young people without obtaining a Disclosure and Barring Service (DBS) check.*⁶⁴

3.3.3.10 **Regulation 16 - Receiving and acting on complaints**

One Specialist Community service, an independent service, was in breach of regulation 16 in response to the service not possessing an effective complaints system:

*The provider did not operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints.*⁶⁵

3.4 Areas for improvement

This section of the report examines the 'Areas for Improvement' sections within the inspection reports analysed. This section relates closely with the previous section on Requirement Notices (Section 3.3) as areas for improvement often aligned with the nature of the breaches to regulation.

The results of this section are broken down into improvements that 'Must' take place and those that 'Should' take place (that is, CQC recommendations for action by the service), examining the key areas within each. Improvements that *must* be made identify a breach in a regulation which action will be taken against. Improvements that *should* be made detail areas where improvements are recommended but do not represent a breach in regulation and therefore CQC cannot enforce it.

⁶³ Specialist Inpatient (Good)

⁶⁴ Specialist Community (Requires improvement)

⁶⁵ Specialist Community (Requires improvement)

3.4.1 Areas that MUST be improved

3.4.1.1 Patient assessments

Patient assessments were the most common area for improvement across the 'Must improve' sections of the inspection reports. This involved the assessments that patients must undergo when accessing the service and during their treatment.

Specialist Inpatient

The most common area which needed improvement within Inpatient services was the assessing of service users physical health. Particularly, inspectors noted that physical checks were needed after rapid tranquilisation, for example:

The provider must ensure that staff carry out appropriate checks on the physical health of young people after they have been given medicines for rapid tranquilisation.⁶⁶

Specialist Community

The vast majority of Specialist Community services were given an action to improve the service with regard to risk assessments. Risk assessments needed to be completed for all young people using the service. For example, one inspector issued an action as not all patients were being assessed, including those who had been in the service longest:

The trust must ensure risk assessments are completed for all young people utilising the service including young people who had been with the service prior to April 2016.⁶⁷

In some instances, services were issued actions to improve in response to risk assessments not being reviewed. Due to the assessments not being reviewed, they were not kept up to date to reflect the current needs and risks to the patient, which can be seen in the following example:

The trust must ensure that risk assessments are completed fully and regularly reviewed and maintained for all people who use the service.⁶⁸

When services did have risk assessments in place, accessibility to them was difficult. Improved accessibility to these assessments was also a common action given to services to undertake, with one example noting:

The provider must ensure that risk assessments are easily accessible on the electronic records system and that the system enables staff to easily update and maintain the records.⁶⁹

3.4.1.2 Governance and policy

The governance of the service and the policies in place were also a common area that was in need of improvement across services.

Specialist Inpatient

Across Specialist Inpatient services, services were given actions that they must take to improve commonly around the examination and revision of current policies. Inspectors noted

⁶⁶ Specialist Inpatient (Good)

⁶⁷ Specialist Community (Good)

⁶⁸ Specialist Community (Requires improvement)

⁶⁹ Specialist Community (Good)

the importance of reviewing policies to determine whether they are no longer relevant to the service. For example, one inspector gave a service an action to review their policies to understand if they are operational and relevant:

The provider must ensure that their organisations policies and procedures are operational in the service and remove all other policies and procedures from the previous provider.⁷⁰

In addition to reviewing policies, inspectors recommended services ensure that policies are being used correctly by all members of staff at all levels. Particularly, inspectors recommended ensuring that staff were following the Mental Health Act and the Mental Health Act code of practice. For example:

The provider must ensure that the Mental Health Act Code of Practice (2015) is adhered to in respect of caring for patients in long-term segregation.⁷¹

Services were also given actions they must take to improve with regards to services monitoring the quality of the service they provide. Monitoring the quality of the service can be done through internal audits, for example, an inspector gave an action to a provider to carry out an internal audit to monitor its compliance with the Mental Capacity Act:

The provider must introduce an audit of their compliance with the Mental Capacity Act and the application of Gillick competency.⁷²

Specialist Community

Similar to Inpatient services, actions to improve systems to monitor the quality of the service they provide were also given to Specialist Community services. In addition to internal audits being advised, reviewing the complaints and feedback they receive was instructed, for example:

There was no evidence of learning from complaints about the service. The trust must ensure that feedback from people who use the service is evaluated and used to make improvements.⁷³

Ensuring that policies were also being followed correctly was detailed in the inspection reports, because if not done this could put both staff and young persons at risk, for example:

The trust should ensure that staff follow the trust safeguarding policy correctly to maintain the safety of the young people who use the service.⁷⁴

3.4.1.3 Recording of Information

The proper recording of information was found to be given actions to improve the services methods and systems of documenting information.

⁷⁰ Specialist Inpatient (Requires improvement)

⁷¹ Specialist Inpatient (Requires improvement)

⁷² Specialist Inpatient (Requires improvement)

⁷³ Specialist Community (Requires improvement)

⁷⁴ Specialist Community (Good)

Specialist Inpatient

Across Inpatient services, there were issues with the accuracy and completeness of the records kept, leading inspectors to ask providers to improve in this area. One example details how staff must maintain accurate records:

*The trust must ensure that staff maintain accurate, complete and contemporaneous records.*⁷⁵

In addition to records concerning incidents, inaccuracy of records had also been described with regards to patient records. Care plans, medicines, and information on episodes of restraint and seclusion were inaccurate, with one inspector giving a provider an action when observing outdated care plan records:

*The provider must ensure care plans are reviewed and updated based upon changes to assessed risk.*⁷⁶

In addition to information being recorded inaccurately, inspectors observed records that were incomplete, by not fully completing the proper documentation and missing out essential information. For example, one inspector gives a service an action with regards to missing information:

*Staff must ensure that information is stored in the part of the notes that is specified. Essential information was missing from the admission section of the notes and was therefore not easily accessible.*⁷⁷

Inspectors also inferred that there was information that was in need of being recorded that services were not currently recording. These included records on the physical health of patients, medicine management and patient capacity. For example, an inspector gave an action that the provider must take with regards to recording the capacity of service users:

*The provider must ensure that patients' capacity/competency is assessed and documented upon admission and throughout treatment as necessary.*⁷⁸

Specialist Community

As with Inpatient services, Must actions given in the inspection reports from Specialist Community services were given in response to the accuracy and completeness of records within a service. Specifically, Specialist Community services must improve with the accuracy of care plans, as noted in the following report:

*The provider must ensure care records contain up to date care plans to support staff to care and treat young people safely.*⁷⁹

Care and treatment plans were also found to be missing from patient's records in numerous services, and therefore actions ensuring they are in place were given:

⁷⁵ Specialist Inpatient (Requires improvement)

⁷⁶ Specialist Inpatient (Requires improvement)

⁷⁷ Specialist Inpatient (Good)

⁷⁸ Inpatient (Requires improvement)

⁷⁹ Specialist Community (Requires improvement)

The trust must ensure all children and young people have a care and/or treatment plan.⁸⁰

3.4.1.4 Facilities and Environment

For Inpatient services only, actions that must be taken to improve the service were commonly given around improving their facilities and environment. Particularly, inspecting and maintaining their facilities and equipment to ensure that it is safe for use. In one example, facilities had been broken for over a year, causing patients to only have limited access:

The trust must ensure they address ward maintenance issues, including fixing the shower which had been broken for over a year, which meant all the patients had to access one working shower. They must ensure all other repairs take place in a timely manner.⁸¹

Inspectors also typically issued actions that must be taken around ensuring the facilities and equipment are fit for purpose. Specifically for the facilities, many inspectors wanted to ensure that they the privacy of the young people was protected, for example:

The provider must ensure that the patient bedrooms and en suite bathrooms promote and uphold the privacy and dignity of patients' including while using the toilet and bathing facilities.⁸²

3.4.1.5 Waiting times

Reducing waiting times were commonly issued as an action that must be taken to Specialist Community services. Only these services were instructed that they must improve waiting times. The majority of these actions advised services to reduce the times between referral and assessment to treatment. For example:

The trust must review the waiting times from assessment to treatment for patients and put systems in place to reduce the length of wait.⁸³

3.4.2 Areas that SHOULD be improved

3.4.2.1 Recording of information

Similar to section 3.4.1.3, actions that should be carried out were often given to Inpatient and Specialist Community services who did not keep complete and accurate records. Services were advised to ensure that records were filled with up to date information of the service user, and that when filling out documentation, they should ensure all sections are completed for all young persons. As well as accuracy and completeness, services were also advised to record different types of information that they were not currently documenting.

⁸⁰ Specialist Community (Good)

⁸¹ Specialist Inpatient (Requires improvement)

⁸² Specialist Inpatient (Requires improvement)

⁸³ Specialist Community (Good)

Specialist Inpatient

Inpatient services were commonly advised to ensure that the recording systems that were in place were effective. Typically, this would evolve around the processing and storage of information. One inspector advised a service to store its staffing records in a more effective manner:

The trust should ensure that that staff supervision records and any other records about people employed to carry out regulated activity are stored appropriately.⁸⁴

Specialist Community

Specialist Community services were advised to improve how to access the information and documentation they held. Information was not always available in an easily understandable way in order for all stakeholders to understand or information was not easily accessed by those who needed it. One inspector advises consistency in the way records are written so that staff know which documents to locate the information they need:

The trust should work to improve the patient record system to move away from multiple records and ensure information is recorded consistently so it can be located when needed.⁸⁵

3.4.2.2 Facilities and environment

Specialist Inpatient

Services were recommended to maintain their facilities and to start and/or finish refurbishing parts of the services that required reconditioning to improve the facilities and environment. If changes were needed it was suggested to be done in a timely manner in order to keep the facilities functioning, for example:

The provider should ensure that areas used by patients are clean and well maintained, and that repairs to the ward are carried out in a timely manner.⁸⁶

Inspectors also gave actions to services with regards to ensuring that their facilities and/or equipment were fit for purpose. In some instances, the facilities which were available did not offer young people privacy when required, for example when rooms were not soundproofed:

The trust should ensure that all therapy and interview rooms are sufficiently soundproofed to maintain the confidentiality of the patients and staff using them.⁸⁷

Specialist Community

As well as Inpatient services, Specialist Community services were given actions that they should follow with relation to their equipment and facilities being fit for purpose, with many suggesting areas and rooms were not sound-proof in order to protect the confidentiality of patients. In addition to privacy, one inspector recommended improving the service's interior as it was not fit for the different patients that use it:

The trust should improve the [name removed] clinic rooms, which were dull and not appropriately decorated or set up for use by children and young people.⁸⁸

⁸⁴ Specialist Inpatient (Good)

⁸⁵ Specialist Community (Requires improvement)

⁸⁶ Specialist Inpatient (Requires improvement)

⁸⁷ Specialist Inpatient (Good)

Many inspectors suggested that services should take measures to improve the checks that are carried out on their equipment and facilities. The calibrating and safety checking of equipment and cleanliness of child's toys were frequently mentioned throughout the actions that should be taken to improve section. Maintaining the equipment and facilities at a service can mitigate risks towards the service users, for example, one inspector recommended ensuring that toys are kept clean to prevent infection:

*The trust should ensure that all toys within the CAMHS service are cleaned regularly. The toys at several sites we visited appeared to be dirty and there was no cleaning rota. Inspection staff found dirty toys on the floor in therapy rooms and in reception areas. The provider should ensure that toys are cleaned regularly to prevent any infection control issues.*⁸⁹

3.4.2.3 **Governance and Policy**

Similar to section 3.4.1.2, actions that should be carried out were often given to Specialist Inpatient and Specialist Community services that did not review and follow the policies that they had in place. Services were advised again that they should review their policies to make sure that they are still relevant to current guidelines and practices, and ensure that all staff follow the policies that are in place.

Inpatient Services

As well as inspectors recommending that services should review and ensure the following of policies, inspectors also commonly proposed to Inpatient services that they should ensure all staff were receiving proper supervision from their superiors. As we can see from the following example, supervision needs to be continual:

*The provider should ensure staff receive ongoing clinical supervision.*⁹⁰

Specialist Community

Specialist Community services were advised that they should ensure staff are receiving support from their superiors. Support should not only have been extended to care staff but offered to all members of staff across the service, including administrative staff:

*The trust should ensure that the administrative staff receive ongoing support during the period of their roles being reviewed.*⁹¹

3.4.2.4 **Patient assessments**

As noted in Section 3.4.1.1, patient assessments involves recommendations made to improve the assessments that staff and patients must undertake when accessing the service and their time there throughout.

Specialist Inpatient

Across the Inpatient services inspection reports, services were continually advised that they should improve the methods they use for carrying out of patient assessments, particularly risk assessments. It was noted that services were not updating risk assessments regularly, rendering them inaccurate. As well as inaccurate assessments, services were informed that

⁸⁸ Specialist Community (Good)

⁸⁹ Specialist Community (Requires improvement)

⁹⁰ Specialist Inpatient (Good)

⁹¹ Specialist Community (Good)

they needed to improve the way in which they mitigate these risks. One inspector advised a service to improve in both areas:

*The trust should ensure that ligature risk assessments are thorough, updated regularly, and be sure that all staff are aware of risks and how they are mitigating these.*⁹²

Specialist Community

Similar to Inpatient services, Specialist Community services were advised to regularly reassess the risks of the patients and ensure that mitigations against these risks was being carried out. Specialist Community reports also noted the variation of the quality of the risk assessments being carried out, leading many inspectors to advise the improvement of the quality. For example, one inspector advised to improve the consistency of the assessments:

*The trust should ensure that all risk assessments are of a similar high quality.*⁹³

3.4.2.5 Training

Improvements around training staff were advised as an area that 'should' be undertaken by the service.

Specialist Inpatient

Many of the recommendations put forward by inspectors around training were around staff being trained on the Mental Capacity Act, Mental Health Act and Gillick Competence. Although some staff may have had good knowledge of the Acts, many were noted to be unsure of the changes that were made and did not understand their roles in relation to the Acts. One inspector notes the mix in knowledge of the Acts:

*Ensure that Mental Capacity Act and Mental Health Act training is undertaken by all staff. While knowledge on the ward was good in the nursing staff we interviewed there was no guarantee that this correlated across disciplines and skill mixes or that staff would remain up to date with relevant changes to legislation.*⁹⁴

Inspectors also detailed in the reports that services should improve the attendance of mandatory training by staff:

*The trust should ensure that all staff attend mandatory training. Particular focus should be on the management of violence and aggression and the alternative courses for those staff excluded from the training.*⁹⁵

Only suggested for Inpatient services, Inspectors recommended that services review opportunities for staff to have specialist training appropriate to their roles. One inspector suggested reviewing opportunities for specialist training

*The service should review opportunities for professional development, including specialised training appropriate to their role, for all staff.*⁹⁶

⁹² Specialist Inpatient (Good)

⁹³ Specialist Community (Good)

⁹⁴ Specialist Inpatient (Good)

⁹⁵ Specialist Inpatient (Good)

⁹⁶ Specialist Inpatient (Good)

Specialist Community

Services improving staff attendance at mandatory training was also recommended throughout Specialist Community Services. Like Inpatient services, inspector's recommended services encourage staff to attend mandatory training; however there was a particular focus on reaching compliance targets. For example, one service was recommended that particular areas of mandatory training needed improvement in:

*Mandatory training should improve in areas not reaching compliance. The trust should ensure that mandatory training is kept current and ongoing.*⁹⁷

Although not commonly recommended by specific for Specialist Community services, inspectors recommended reviewing the access to and completion of safeguarding training. One inspector recommended that the service should ensure its completion:

*The trust should ensure that staff complete training in safeguarding children levels 2 and 3.*⁹⁸

3.5 Access and discharge

'Access and discharge' was another area of the inspections reports that was analysed. This section focused more on access than discharge and, therefore, most of the discussions in this section relate to access. Key themes emerging from the 'Access and discharge' section of the inspection reports were grouped into the following areas: Referrals and assessment/screening; Response times; Keeping appointments and adapting to needs; Out of hours and crisis intervention; Access to appropriate services; discharge planning and delayed discharges.

3.5.1 Referrals and assessment/screening

3.5.1.1 *Inpatient*

In Inpatient inspection reports, it was apparent that referrals came from a variety of services including Specialist Community services and crisis teams, primary care/GPs. Referrals from Specialist Community CAMHS services were the most common partner described as being the source of referrals to the Inpatient service, such the following example:

*The main source of referrals was from community child and adolescent mental health service tier 3 teams and the crisis team including A&E liaison.*⁹⁹

Some reports discussed how services would receive referrals from outside of the local area. In one inspection report, referrals were received nationwide and this was described as being related to limited nationwide child and adolescent Inpatient beds:

[Name removed] provided an acute child and adolescent ward and a psychiatric intensive care unit. Admission to the hospital was determined by patient need. As a result of limited nationwide child and adolescent inpatient beds the hospital received

⁹⁷ Specialist Community (Requires improvement)

⁹⁸ Specialist Community (Outstanding)

⁹⁹ Specialist Inpatient (Good)

*referrals for admission for eligible children and young people who lived locally and out of the local area.*¹⁰⁰

In many inspection reports, admission to the Inpatient services were described as 'planned', describing how Inpatient services admitted patients via a referral process and planning for the patient's admission.

*Admissions were planned. The service had a clear admission criteria and offered services to people suffering acute mental illness, addiction treatment, child and adolescent mental illness and eating disorders.*¹⁰¹

There were many less mentions of emergency admissions noted in the sections analysed in the inspection reports, though some reports noted that services did have the ability to deal with emergency admissions from the accident and emergency department of a local hospital if a young person arrived in crisis. As an exception to other Inpatient services, one service appeared to deal mainly with emergency admissions, noting that admissions could take place at any time:

*Admissions to the ward were usually emergency transfers from accident and emergency departments. The ward managers said that there were very few planned admissions. As a result, admissions could take place at any time.*¹⁰²

The access inclusion/exclusion criteria to be admitted to services were not discussed in many inspection reports or in great length when it was considered. Some examples of acceptance criteria included that the young person that posed a risk to self and others, had a forensic history or required a secure environment.

*The unit's criteria for accepting a young person was that they were under 18 years of age at the time of admission, presented a risk to self or other and had a forensic profile.*¹⁰³

Another service was described as having exclusion criteria:

*The ward did have exclusion criteria: a forensic history, incidents of arson, incidents of violence or a primary diagnosis of eating disorder.*¹⁰⁴

Inspection reports that described referrals being triaged/reviewed by the service, such as the example below, usually noted that this was carried out by a psychiatrist.

*Referrals were considered on clinical grounds and the overall decision to admit was with the consultant psychiatrist, however, there was a full discussion within the MDT and the needs of the other patients was considered.*¹⁰⁵

¹⁰⁰ Specialist Inpatient (Requires improvement)

¹⁰¹ Specialist Inpatient (Good)

¹⁰² Specialist Inpatient (Good)

¹⁰³ Specialist Inpatient (Requires improvement)

¹⁰⁴ Specialist Community (Requires improvement)

¹⁰⁵ Specialist Inpatient (Good)

There were instances of a service being unable to offer the right level of support to a young person referred. In some cases, signposting and referring to other services was carried out to enable the young person to access adequate support.

They did not admit young people who they could not appropriately treat. These young people were signposted to more appropriate CAMHS Tier 4 services.¹⁰⁶

However, it was not clear whether signposting and support in referring an unsuitable candidate for treatment elsewhere. One inspection report described how some inappropriate referrals were declined access if the service could not provide adequate support to the child/young person – there was no further description of what occurred after the decline of access.

Staff said they sometimes received inappropriate referrals, with patients needing a higher level of care than the service could provide. Staff declined the admission of patients when the provider could not meet their needs.¹⁰⁷

3.5.1.2 **Specialist Community**

Specialist Community referrals came through a wider range of sources than Inpatient services. Referrers included GPs, schools (through school nurses), social services or through self-referral. The diversity of sources of referral are illustrated in the following example:

Referrals into the [name removed] and CAMHS services came from a variety of sources which included; primary care doctors, social care, the non-statutory sector, accident and emergency departments, schools, self-referrals, the police and the criminal justice system.¹⁰⁸

The use of a 'Single Point of Access' (SPA; SPoA) was described specifically in relation to a number of Specialist Community services. The use of the Single Point of Access allowed the Specialist Community team to examine all referrals coming into the service, assess risk levels, and consider the appropriate teams to support children and young people being referred.

Referrals were made through the SPA team (single point of access) where they were triaged and sent to the appropriate team. All referrals were triaged within 24 hours. Once seen, referrals were closed by the SPA.¹⁰⁹

Though not termed a 'Single Point of Access', a number of other inspection reports discussed how the service screened referrals from various sources through the same route, essentially acting in the same manner as a Single Point of Access.

Services had systems in place to screen all incoming referrals daily for immediate risk and appropriateness for the service. Staff wrote back to the referrer with an explanation if the referral was not accepted and signposted to other appropriate services, if possible.¹¹⁰

¹⁰⁶ Specialist Inpatient (Good)

¹⁰⁷ Specialist Inpatient (Requires improvement)

¹⁰⁸ Specialist Community (Good)

¹⁰⁹ Specialist Community (Requires improvement)

¹¹⁰ Specialist Community (Requires improvement)

While not commonly reported across the Specialist Community inspection reports, alternative systems of handling referrals - in contrast to Single Point of Access - were highlighted. There were a couple of instances in which the Single Point of Access was not always being used. For example, some teams within Specialist Community services^{111,112} received referrals directly rather than through the Single Point of Access. As one of these services pointed out, the issues with having this system in place could result in a 'bottle neck' in appointments to be handled by the teams.

The crisis team, eating disorders team and the CAMHS targeted team for looked after children also made internal referrals which did not come through the SPA and this created a 'bottle neck' in appointments.¹¹³

When reported in some inspection reports, access criteria was said to be in place that outlined the types of cases the service was able to accept and support. For example, in one service, the remit for accepting new cases meant that they were no longer accepting certain referrals:

The trust had stopped accepting referrals for young people with attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorders (ASD) unless there was an additional presence of moderate to severe mental health issues.¹¹⁴

While providing treatment to children and young people from out of area was not something that appeared to be an issue for Specialist Community services, there were several references to the issue of having to refer a patient to a different geographical area if they required Inpatient services. For example:

The trust was not commissioned to provide tier 4 CAMHS inpatient beds. The nearest inpatient unit was in [name removed].¹¹⁵

When a service was unable to meet the needs of a young person or if the young person did not reach a threshold for the service, the Specialist Community team could signpost or refer them to other services, as illustrated in this example:

If young people did not meet the threshold for the services, the teams had processes to ensure that these young people were signposted to alternative sources of support. For example, [name removed] CAMHS were part of an improving access to psychological therapies initiative with partners working in the community. [Name removed] CAMHS were part of the [name removed], which included other young people services.¹¹⁶

¹¹¹ Specialist Community (Outstanding)

¹¹² Specialist Community (Good)

¹¹³ Specialist Community (Good)

¹¹⁴ Specialist Community (Requires improvement)

¹¹⁵ Specialist Community (Requires improvement)

¹¹⁶ Specialist Community (Outstanding)

3.5.2 Response times

This section considers the length of time it took services to respond to incoming referrals and urgent cases.

3.5.2.1 *Specialist Inpatient*

Response times in handling referrals were discussed primarily in relation to Specialist Community services. When the response to treatment was discussed in a few instances^{117,118,119} in the Inpatient services inspection reports, it was noted that there was no waiting list for admission to the service.

There was no waiting list for the unit. There was a referral system in place for the network of forensic CAMHS.¹²⁰

Three services^{121,122,123} mentioned a wait from referral to assessment/treatment which may create a bit of a delay in access. Another example of waiting related to waiting for a bed in a patient's local area, but this would have been after accessing one in an out of area location:

*The service was repatriating young people who had had to go to hospitals further away from home, back to the area whenever a bed was available and a waiting list system was in place.*¹²⁴

There were a few examples of CYP waiting for transfer to a psychiatric intensive care unit (PICU) via the Inpatient service, such as the following example, but again this appeared to relate more to patients that had *already had access* to the Inpatient service:

*The ward manager said that it could be difficult to find a bed in a PICU because there were very few services available. One young person had recently been transferred to a PICU in [name removed] as this was the only place available at the time. On the day of our visit, a female patient was being transferred to a PICU after waiting five days for the placement. During the times when patients are waiting for a transfer, their level of observation was increased. The trust had routinely escalated concerns to NHS England and also supported NHS England in offering solutions.*¹²⁵

3.5.2.2 *Specialist Community*

In a number of inspection reports it was noted that there were clear targets in place for dealing with referrals and the length of time it should take for an initial assessment and/or start of treatment. Targets to meet demands were typically partitioned between urgent cases and non-urgent cases. Through appropriate screening and assessment of referral, the length of time to assessment and treatment, as expected, extended with the less severe cases.

¹¹⁷ Specialist Inpatient (Good)

¹¹⁸ Specialist Inpatient (Requires improvement)

¹¹⁹ Specialist Inpatient (Outstanding)

¹²⁰ Specialist Inpatient (Requires improvement)

¹²¹ Specialist Inpatient (Requires improvement)

¹²² Specialist Community (Good)

¹²³ Specialist Community (Outstanding)

¹²⁴ Specialist Inpatient (Requires improvement)

¹²⁵ Specialist Inpatient (Good)

*The trust had set waiting time targets of eight weeks for tier 2 assessments and four weeks for tier 3 assessments. The target wait for both tier 2 and tier 3 treatment was 16 weeks.*¹²⁶

The targets varied across the services though it was evident that urgent or emergency cases were normally dealt with within a day or 48 hours and less urgent cases would take longer, possibly up to 18 weeks before treatment (in line with national guidelines) depending on the assessed needs of the patient. For example, in one service, it was noted that targets were in place for urgent referrals which were dealt with in 48 hours and non-urgent referrals were dealt with in 35 working days. Children in the looked after system were given higher priority, instead of 35 working days before assessment the wait was within 15 working days:

*The service had clear target times from referral to assessment. For non-urgent referrals, this was 35 working days. Non-urgent referrals for children in the looked after system were given an assessment appointment within 15 working days. Urgent referrals were given an assessment appointment within 48 hours. Both teams were meeting these targets.*¹²⁷

Several inspection reports described how crisis teams responded to urgent cases with direct contact, often noted as children and young people showing up at an Accident and Emergency (A&E) department of a hospital following, for example, an incident of self-harm. Target times to responding to these kinds of incidents were four hours.

*The target for young people in [name removed] presenting with crisis at accident and emergency to be seen by specialist staff from the child and adolescent mental health services was four hours*¹²⁸

It was noted in a couple of inspection reports, both of which were for services rated as outstanding overall^{129,130}, that the crisis team had close links with an acute hospital A&E department. For example, at [name removed] there was a [name removed] team based in the children's emergency department at a nearby acute hospital.

*The [team name removed] is based in the children's emergency department at [name removed] hospital and responds to urgent referrals from GPs and children and young people who have presented at accident and emergency requiring an urgent assessment. Its hours are 0800 – 2300 seven days a week.*¹³¹

There were issues with long waiting times noted in a number of reports and they could differ depending on the therapeutic discipline sought after (for example family therapy; cognitive behavioural therapy). Some services appeared to have very long waiting lists for some therapy services, such as the following example in which the longest wait for family systemic therapy was 610 days. Length of waiting times for other therapies or psychiatric assessment also appeared to be very long:

¹²⁶ Specialist Community (Good)

¹²⁷ Specialist Community (Requires improvement)

¹²⁸ Specialist Community (Good)

¹²⁹ Specialist Community (Outstanding)

¹³⁰ Specialist Community (Outstanding)

¹³¹ Specialist Community (Outstanding)

During the inspection we reviewed the waiting lists and found that in [name removed] alone there was a longest wait of 610 days for family systemic therapy, 491 days for creative therapy, 484 days for individual therapy, 588 days for psychotherapy and 493 days for CBT. There was a longest wait of 283 days for psychiatric assessment. [Name removed] had secured funding to employ a worker on a fixed term contract to work on reducing the waiting list. Staff cited the waiting list as the biggest challenge for the service. Families we spoke with during the inspection felt that it was difficult to get into the service and became frustrated with the waiting times.¹³²

While most of the inspection reports that were analysed discussed targets for response times from referral to assessment and/or treatment, there were some instances^{133,134,135,136,137} in which targets were not being met.

The trust had a target of 28 days from referral to assessment. Figures provided by the trust showed that all teams had higher than average waiting times than this. One team, [name removed], had an average waiting time of 75 days. We observed in people's notes that the target was not always met.¹³⁸

However, missed targets were typically not the norm across the Specialist Community service analysed, those inspection reports that presented this information showed that the vast majority of patients were being seen within the target time frame.

In [name removed] from November 2015 (at the start of the contract) through to February 2016, 91% of referrals met the 12 week target between referral and assessment and all children and young people had commenced treatment within 18 weeks. In the [name removed] services from September 2015 through to February 2016 (six months) all referrals met the 12 week target from referral to assessment and 95.5% of children and young people had commenced treatment within 18 weeks from referral. The [name removed] CAMHS service did not have a waiting list at all.¹³⁹

The way in which waiting lists were managed and level of support to those on the waiting list was reported in some inspection reports. Some inspection reports noted that staff would monitor waiting lists to take into account risks of young people waiting to access the service. In several inspection reports, it was clear that some services were taking action to support those that may be waiting to access the service through, for example, updating referrers with the status of the waiting list and signposting to other resources available in the interim. One service¹⁴⁰ was described as being very proactive in monitoring the waiting list and updating referrers on the status of the wait times as well as referring those on the waiting list to another service in the county. This service was also involved in supporting those on the waiting list through arranging counselling through the school nurse for six weeks.

¹³² Specialist Community (Requires improvement)

¹³³ Specialist Community (Good)

¹³⁴ Specialist Community (Requires improvement)

¹³⁵ Specialist Community (Good)

¹³⁶ Specialist Community (Requires improvement)

¹³⁷ Specialist Community (Outstanding)

¹³⁸ Specialist Community (Good)

¹³⁹ Specialist Community (Good)

¹⁴⁰ Specialist Community (Requires improvement)

Counselling was arranged by the school nurse while they waited to help in the interim. This was provided through the local authority and provided a 6 weeks intervention¹⁴¹

3.5.3 Keeping appointments and adapting to needs

This section considers how services were able to keep appointments adapted to the needs of patients through the way appointments were offered. Dealing with 'Did Not Attend' (DNA) cases is considered in this section in relation to handling appointments that were not attended by children and young people.

3.5.3.1 **Inpatient**

Keeping appointments and Did Not Attend (DNA) policy was not something captured by the Inpatient inspection reports. However, within Inpatient CAMHS service inspection reports there was a lot of discussion of how beds were kept for patients when they left the service signifying how the service supported young people that would leave the ward on occasion.

Young people often had home visits (where appropriate) and at the time of inspection, one young person was on a family holiday. Their rooms were kept for their return.¹⁴²

3.5.3.2 **Specialist Community**

In terms of ensuring appointments were kept, some inspection reports described how appointments were rarely cancelled. When appointments were cancelled it was only when it was absolutely necessary, illustrated by text from the following inspection report:

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.¹⁴³

Many inspection reports described how there were Did Not Attend (DNA) policies used by the service. This provided a consistent means in which to handle a situation where a child or young person did not attend a scheduled appointment.

The teams also took a proactive approach to reengaging with people who did not attend (DNA) their planned appointments. There was a policy of two DNAs before a young person was referred back to their GP.¹⁴⁴

Efforts were made to support the child/young person with attending future appointments if they did not attend. However, in a couple instances, it was clear that there was a point in which the patient would be discharged from the service if multiple appointments were missed.

If an appointment was offered, and the patient did not attend, another appointment was offered by letter. If this further appointment was not attended a member of the team would attempt to make telephone contact. If this failed staff told us that they would contact the referrer and discharge.¹⁴⁵

¹⁴¹ Specialist Community (Requires improvement)

¹⁴² Specialist Inpatient (Good)

¹⁴³ Specialist Community (Requires improvement)

¹⁴⁴ Specialist Community (Good)

¹⁴⁵ Specialist Community (Requires improvement)

In the community setting many inspection reports reported the services being flexible with appointment times and venues to support children and young people in attending appointments and mitigate issues with non-attendance. This is highlighted in the following example from an inspection report:

*The service generally operated Monday to Friday 0900 to 1700 but the staff told us they would see young people a bit later if required. The service arranged appointments for young people in a variety of venues in order to support their engagement with CAMHS services and to provide flexibility.*¹⁴⁶

3.5.4 Out-of-hours and crisis intervention

3.5.4.1 **Specialist Inpatient**

Out-of-hours and crisis service provision was discussed in relation to Specialist Community services. In one inspection report, for a service that was rated as outstanding, there was mention of access to emergency admissions to the psychiatric intensive care unit (PICU) in crisis.

*The unit accepted emergency admissions to the PICU and young people in crisis were able to enter the unit via an alternative exterior door... Robust contingency plans for admitting young people in crisis when the unit was full were in place. There was an agreement with an adult mental health ward on site where they would accept an emergency admission at night if the [name removed] centre was full and staff would come from the [name removed] Centre to care for the patient.*¹⁴⁷

3.5.4.2 **Specialist Community**

In a number of inspection reports there were statements about how there were out hours support for children and young people in a crisis or emergency situations. This included patients and families being made aware of how to access services in a crisis and being able to contact staff easily and access services quickly in urgent situations. This could be through having access to a telephone crisis services in emergency situations as noted in some instances, such as the following example:

*Young people and their families would, where appropriate, be given a crisis card saying who to contact in an emergency. The trust also provided a phone line for out of hours advice.*¹⁴⁸

Crisis plans were noted in some cases, such as the following example, that described how the service had crisis plans to turn to, called “keep safe” plans. These plans provided the young person with telephone numbers of adults who the young person could trust (for example family member; friend; teacher) and a number for Childline. Comments from one family suggested that staff could be proactive in ensuring families understood what do in crisis situations as well as how to help manage these situations.

Crisis plans were excellent with clear plans for young people if their mental state deteriorated called “keep safe” plans. These included telephone numbers of trusted

¹⁴⁶ Specialist Community (Requires improvement)

¹⁴⁷ Specialist Inpatient (Outstanding)

¹⁴⁸ Specialist Community (Good)

adults the young person would want to contact such as family, friends or trusted teacher, it also had the Childline number on. Copies were given to families with steps to take and contact numbers. One family said that they understood what to do in an emergency and that staff in the service had explained fully how to access help but also gave advice on how to manage situations.¹⁴⁹

In other cases there appeared to be limitations with the level of access children and young people could have out-of-hours and in crisis. In the case of one service (rated as inadequate) there were concerns about the appropriate help and support in a crisis situation outside of the hours the crisis team worked.

The crisis on-call team worked 9am to 5pm Monday to Friday, which meant that there was limited provision for those young people who required crisis service support out of hours. Between 9pm and 9am, a CAMHS consultant psychiatrist was available for telephone consultation.¹⁵⁰

The issues with availability of out-of-hours care was discussed in one inspection report and noted how staff and families were concerned with the service out-of-hours.

Staff and families all expressed concern at the safety of out of hours arrangements. The service was commissioned to provide 24 hour 7 days a week on call CAMHS practitioner advice line and next day emergency assessment including a specialist community response to those children and young people who have self-harmed and who present to [name removed]. There was no CAMHS psychiatrist for out of hours cover including evenings and weekends. In these circumstances a young person could be seen by the on-call psychiatrist, who would be an adult specialist.¹⁵¹

There appeared to be some reliance on Accident and Emergency (A&E) services for out-of-hours/crisis provision in some cases. It was noted in several inspection reports that children and young people may need to access specialist support outside normal hours via A&E services, such as the following example:

Young people could access specialist help outside of normal opening times by going to accident and emergency departments at the local acute hospital.¹⁵²

3.5.5 Access to appropriate services

There appeared to be issues with children and young people have access to appropriate services to support treatment and recovery effectively in some services. This was an area raised in both Specialist Inpatient and Specialist Community reports, usually in relation to children and young people being supported by adult mental health services teams.

3.5.5.1 Specialist Inpatient

Within some Inpatient services, there was use of adult wards to admit young people when there were no beds available in CAMHS units. The significant challenges some services

¹⁴⁹ Specialist Community (Outstanding)

¹⁵⁰ Specialist Community (Inadequate)

¹⁵¹ Specialist Community (Requires improvement)

¹⁵² Specialist Community (Good)

faced in providing access to appropriate services was highlighted in one inspection report that noted how a service had to place young people in an adult ward before placing them in a CAMHS service, appropriate to the patient's needs.

Tier 4 inpatient beds were sought after and there were times when young people were admitted to adult wards when beds are un-available. If a bed was not available some young people would be placed in an adult ward if urgently required. From November 2015 to February 2016 there were three young people admitted to adult inpatient services.¹⁵³

Another area highlighted in a couple of reports related to potential issues with care continuity in Inpatient settings due to the lack of provision of multiple care pathways. The limitations of not being able to offer multiple elements of the CAMHS care pathway was highlighted in one report that noted that arrangements in an alternative setting would have to be arranged. Issues with not being able to provide a PICU due to lack of availability in psychiatric intensive care unit (PICU) beds noted in three services^{154, 155, 156} including the one below.

The trust did not provide a child and adolescent psychiatric intensive care unit (PICU) and therefore all young people requiring treatment in a PICU had to be treated out of area. These placements were a considerable distance from [names removed].¹⁵⁷

It was noted in one instance, how continuity of care could be delivered through the provision of multiple aspects of the CAMHS care pathway, including a psychiatric intensive care unit (PICU), in the same setting. Staff thought that this facilitated recovery.

The fact that the unit contained a PICU, acute ward and step-down day service meant a significant portion of the CAMHS care pathway was offered by the [name removed] Centre. Staff felt that this continuity of care aided recovery.¹⁵⁸

3.5.5.2 **Specialist Community**

As with Specialist Inpatient services, there were some cases in the Specialist Community inspection reports we reviewed of children and young people being handled by adult mental health services teams. There was also evidence that paediatric wards were being used to admit patients in several instances. For example, one inspector described how within one service 16-18 year olds in crisis were handled by the adult crisis team when they visited local hospitals in an emergency. This report also stated that one person under 16 was admitted to a paediatric ward prior to being seen by the CAMHS team the following day.

Staff reported the adult crisis team staff assessed young people aged between 16-18 years who presented at the local hospitals. Staff admitted one young person under 16 years to the paediatric ward after 11pm at night for assessment by the on-call CAMHS team the next day.¹⁵⁹

¹⁵³ Specialist Inpatient (Good)

¹⁵⁴ Specialist Inpatient (Good)

¹⁵⁵ Specialist Inpatient (Good)

¹⁵⁶ Specialist Inpatient (Good)

¹⁵⁷ Specialist Inpatient (Good)

¹⁵⁸ Specialist Inpatient (Outstanding)

¹⁵⁹ Specialist Community (Inadequate)

3.5.6 Discharge planning

3.5.6.1 *Specialist Inpatient*

Across the NHS and Independent Inpatient services, it appeared that discharge planning was something that services were conscious of from the start of admission. Services appeared to consider discharge planning during the course of stay for patients admitted. For example, in one inspection report, the inspector described how staff considered discharge planning throughout the admission of children and young people and that during regular multidisciplinary meetings patients' progress were considered:

*Staff considered discharge planning throughout the admission and regular care pathway and multidisciplinary meetings were held to discuss individual patient progress.*¹⁶⁰

Closer to the date of an appropriate discharge, meetings would be held to ensure patients could exit the service and transition smoothly out of the inpatient service, at an appropriate time of day, often into the care of the community CAMHS team who would typically be involved in the latter stages of discharge planning.

*Discharge was planned for from admission to the centres, and reviewed as part of the CPA or MDT meetings. On discharge patients, if appropriate, could be offered both increased support from community CAMHS and help to transition back to mainstream school. Discharge plans were shared with the patients, their GP, their parents and other professionals involved in the care of the young person.*¹⁶¹

Discharge plans could be developed prior to discharge, for example:

*Discharge meetings were held prior to discharge. Discharge plans and summaries were produced in advance of a child leaving the service.*¹⁶²

While discharge could happen at a suitable time for children and young people following recovery, there was also planning in place as patients were close to reaching the age of 18, in preparation for patients to be transferred to adult services.

*Six out of seven patients on the unit were 17 years old. Staff had referred patients of this age to adult services. Staff held pathway planning meetings, which planned and looked at discharge arrangements. This ensured patients who were shortly reaching 18 years of age would get continued support from adult services.*¹⁶³

3.5.6.2 *Specialist Community*

While there was not too much detailed information about the discharge process, it was noted in a few reports that patients would be discharged when the patient was deemed to no longer need support, no longer wished to receive support or did not attend multiple appointments (noted in Section 3.5.3).

¹⁶⁰ Specialist Inpatient (Good)

¹⁶¹ Specialist Inpatient (Good)

¹⁶² Specialist Inpatient (Good)

¹⁶³ Specialist Inpatient (Requires improvement)

Patients were discharged from the service when no further support was needed; when the young person did not want further support; did not attend multiple appointments; or if they moved out of area.¹⁶⁴

Within Specialist Community services, the planning the discharge of patients was typically discussed in relation to the transition into adult services when the patient approached the age of 18.

Staff said that should a young person require adult services approaching their 18th birthday, they would begin transitioning them into adult services over a three to four month period before their birthday. Staff would attend young peoples' first appointment with adult services.¹⁶⁵

It was noted in one instance that if a young person did not meet the requirements for adult mental health services than alternative arrangements for care could be made through, for example, referring the individual to NHS therapy services such as IAPT for adults in their area:

For young people who did not meet the threshold for adult mental health services, CAMHS made robust plans for discharge. This included identifying other organisations that could support the young person. For example, in [name removed], young people could be referred to [name removed], which offered self management courses led by the recovery college and psychological therapies.

3.5.7 Delayed discharges

3.5.7.1 Specialist Inpatient

Delayed discharges were discussed with regards to Inpatient services. We found that almost half of services we reviewed discussed issues with delayed or slowed discharges. Service providers kept track of the number of delayed discharges and the number of delayed discharges reported in the inspection reports was quite low during the time windows inspectors reported delayed discharge figures for. For example:

There had been two delayed discharges in the previous six months. One was due to a wait for a further residential placement and the other delayed by one day due to the family's request.¹⁶⁷

Difficulties around finding a suitable placement to transition the patient to as well as the availability of suitable accommodation were the main reasons behind delayed discharges. For example:

There were sometimes delays to discharge because of difficulty linking young people into community services or waiting for suitable accommodation to be identified¹⁶⁸

¹⁶⁴ Specialist Community (Requires improvement)

¹⁶⁵ Specialist Community (Good)

¹⁶⁶ Specialist Community (Good)

¹⁶⁷ Specialist Inpatient (Good)

¹⁶⁸ Specialist Inpatient (Good)

3.6 Multidisciplinary and inter-agency team work

This section of the report focuses on all of the ‘multidisciplinary and inter-agency team work’ sections of the inspection reports. The results of this section are broken down into three areas which capture the key emerging findings from this section of the reports: multidisciplinary meetings, working relationships with other agencies and handovers.

3.6.1 Multidisciplinary meetings

Multidisciplinary meetings were the most common area discussed across the ‘multidisciplinary and inter-agency team work’ sections of the inspection reports. Most inspection reports discussed the regularity of multidisciplinary meetings *within* the service and described that they were taking place. Further information about the health professionals that attended these meetings, the issues discussed during meetings and the involvement of patients/cares/family were also raised when discussing multidisciplinary meetings.

3.6.1.1 *Specialist Inpatient*

Across the Specialist Inpatient services, there were regular multidisciplinary team (MDT) meetings taking place. While in a few instances it was noted that MDT meetings were taking place daily, these were mostly described as occurring ‘weekly’. MDT meetings appeared to be collaborative and it was frequently noted in reports that there was input from a range of health professionals working with the service.

*Wards followed a multidisciplinary team collaborative approach to care and treatment. Nursing staff, occupational therapists, teachers, a consultant psychiatrist, social workers and a psychologist attended weekly meetings to discuss progress and treatment options for each patient.*¹⁶⁹

The multidisciplinary approach to meetings was useful for discussing new referrals, the Care programme approach (CPA), complex cases and risks. For example, in one inspection report it was noted that the input from the full multidisciplinary team provided the opportunity to seek advice and support from colleagues as well as share lessons learned and reflections on incidents that may have occurred.

*The minutes of staff team meetings showed that there was representation of the full multidisciplinary team. We observed that all members of the multidisciplinary team contributed in discussions at meetings. Staff told us that they use meetings as an opportunity to seek help, advice and support from their colleagues. We were also informed that these meetings were used to share experiences and knowledge which included lessons learned and reflection of incidents.*¹⁷⁰

There was evidence of patients and/or their parents/carers input into these meetings within Inpatient services. This was in contrast to Specialist Community services where there was not the same evidence within inspection reports that suggested the same level of involvement of patients/parents/carers in multidisciplinary meetings. Involvement of these individuals in the meetings was highlighted in some reports that described, for example,

¹⁶⁹ Specialist Inpatient (Good)

¹⁷⁰ Specialist Inpatient (Requires improvement)

patients attending MDT meetings or patients, parents and carers sharing feedback via review sheets given to the service.

*We observed patients attending their MDT apart from one patient who had chosen not to. Relatives' views were discussed during the meeting.*¹⁷¹

*Patients were given review sheets to write feedback on treatment over the past week, what has changed and any treatment requests. This meant that the patients were able to give feedback to the team without them being there if that was their choice. There was a form for parents and carers to provide feedback to them team in a similar manner.*¹⁷²

While MDT meetings were held on a regular basis, there was evidence that there was also ongoing multidisciplinary input into caring for children and young people using the service. This was highlighted in a few reports, such as the following example, in which care records included input from various health professionals. This would help to ensure regular updates in care and progress were known to the wider care team supporting a patient.

*Records showed that staff kept in touch with care coordinators and updated them on the progression of their patients. Care coordinators were invited to attend review meetings. As most of the patients at [name removed] lived significant distances from the hospital this was not possible every time. Therefore, the hospital had installed video link and conference call facilities to ensure they were kept involved.*¹⁷³

3.6.1.2 **Specialist Community**

Similar to the Specialist Inpatient CAMHS services, the Specialist Community inspection reports discussed 'regular' multidisciplinary team meetings that took place, in some instances it was noted that the frequency of these meetings took place weekly.

*Staff told us that regular and effective multidisciplinary meetings were held weekly in order to discuss high risk cases, allocation of new referrals and the waiting list*¹⁷⁴

A range of professional staff could take part in these meetings which could include psychiatrists, speech and language therapists, specialist nurses and clinical psychologists. This was illustrated by the following text discussed in one report:

*The group of individual practitioners located at the building consisted of 13 child mental health professionals (two psychiatrists, one speech and language therapist, a paediatric physiotherapist, a family therapist and eight child clinical psychologists). All were independent but collaborated, cross-referred and met regularly to discuss clinical matters and practicalities. During our inspection we spoke with some of the individual practitioners who confirmed they met or corresponded with the consultant psychiatrist on a regular basis.*¹⁷⁵

¹⁷¹ Specialist Inpatient (Requires improvement)

¹⁷² Specialist Inpatient (Good)

¹⁷³ Specialist Inpatient (Good)

¹⁷⁴ Specialist Community (Requires improvement)

¹⁷⁵ Specialist Community (Good)

The multidisciplinary meetings that were held were described in some instances. In those reports that discussed them, they were often described in a similar manner to what was described in the Inpatient services inspection reports: meetings in which new referrals, complex, or high risk, cases were discussed.

*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.*¹⁷⁶

As with Specialist Inpatient services, ongoing multidisciplinary input and care appeared to be taking place in some services, though this was not regularly discussed in the inspection reports. In one example, where this was noted, the inspector described how care records have evidence of input from different professionals and that this multidisciplinary care input was substantiated by young people and their families.

*Care records included advice and input from different professionals. Young people and families we spoke with confirmed they were supported by a number of different professionals in the teams.*¹⁷⁷

3.6.2 Working relationships with other agencies

Another common theme arising from the inspection report analysis related to working relationships between the CAMHS service and other agencies/organisations, including other CAMHS services, schools, GPs, social services, and voluntary organisations.

3.6.2.1 Specialist Inpatient

In many reports inspectors noted that there were links between the service and other agencies. The most commonly cited agencies cited were community CAMHS teams, demonstrating the often close working relationships between Inpatient and Specialist Community CAMHS services.

*The service worked well with child and adolescent mental health teams.*¹⁷⁸

The relationships between the Inpatient and Specialist Community CAMHS services appeared to be particularly strong in some cases, with some inspection reports highlighting the presence of community teams in meetings about patients admitted to Inpatient wards. The example below describes how stronger relationships with the Specialist Community team were developing and that members from the community team would often attend Care Programme Approach (CPA) reviews to discuss referrals and discharge planning:

*The ward staff told us there were improving relationships with the CAMHS community teams. The referring community teams were invited to care programme approach (CPA) reviews and usually attended. Discharge planning was discussed at CPA reviews and included input from the community CAMHS team.*¹⁷⁹

¹⁷⁶ Specialist Community (Good)

¹⁷⁷ Specialist Community (Good)

¹⁷⁸ Specialist Inpatient (Good)

¹⁷⁹ Specialist Inpatient (Good)

Besides community CAMHS teams, it appeared that schools also worked closely with the Inpatient services. Schools were often cited as having a close working relationship with the service. For example, it was noted in one inspection report how the service and the school integrated their work to tailor the care delivered to the child:

*The schools deputy head explained how the school and health team integrated their work. They joined focus meetings, core team meetings, and referral and planning meetings with the aim of tailoring care to the needs of the individual child in a cohesive way.*¹⁸⁰

Services also inked up with other agencies for support which could include participation in group meetings. Organisations that were found to have working relationships with the Inpatient CAMHS services that were cited in some cases included social services, safeguarding boards, GPs and voluntary organisations. The following extract of text from one inspection report illustrates the variety of organisations (for example local authority social work teams, psychologists, hospital managers) that could work in coordination with a service and these organisations had the opportunity to feed into meetings that took place.

*During our inspection we attended care programme approach meetings. We observed that multi-agencies attended meetings regarding patient care, treatment and discharge. We saw that representatives who attended meetings at the hospital included local authority social work teams, education, NHS England, community mental health services for children and adolescents, ward managers, psychologists, social workers, consultant psychiatrists and senior hospital managers.*¹⁸¹

While not common across the inspection reports that were analysed, there were some cases of poor joint working noted in a few inspection reports. For example, one inspection reported that working relationships with healthcare teams and agencies outside the hospital tended to be limited¹⁸² and another inspection report discussed how the links with external organisations were 'varied':

*Links with external organisations were described by staff as 'varied'. In the east, staff told us of good relationships with social care and third sector providers. There were often difficulties in accessing appropriate 'tier two' mental health services for young people. We were told that there was a procurement exercise underway to commission a tier two mental health service. We saw evidence of this through the on-line procurement portal.*¹⁸³

While not discussed within many inspection reports, nor in much detail when it was discussed, there were some instances that suggested how working at a significant geographical distance between other organisations could act as a potential barrier to working closely.

¹⁸⁰ Specialist Inpatient (Good)

¹⁸¹ Specialist Inpatient (Requires improvement)

¹⁸² Specialist Inpatient (Good)

¹⁸³ Specialist Community (Requires improvement)

Staff reported that good communication could be problematic due to geographical distance on occasions. Staff tried to improve communication by sending letters and emails, or making telephone contact.¹⁸⁴

However, working relationships at a distance could be mitigated through, for example, teleconferencing as noted in a few reports, such as the one below:

The community teams involved with the patients prior to admission and other professionals involved in the patient's care were liaised with regularly and invited to attend review meetings, with the option to participate in meetings by teleconferencing when patients were placed at [name removed] from out of area.¹⁸⁵

3.6.2.2 **Specialist Community**

In many inspection reports from Specialist Community services there were reports of close working relationships with Inpatient services. This echoes the findings discussed in the previous section, illustrating how the Inpatient CAMHS services were often described as having close working relationships with the Specialist Community teams.

We looked at care records for young people who had been admitted to out of area inpatient services. There was evidence of effective transfer of care between CAMHS and the provider of the inpatient service. Staff from CAMHS remained involved in the young person's care and attended care planning meetings using the care programme approach.¹⁸⁶

Many reports also discussed how the service had working relationships with other agencies including schools, social services/local authorities, GPs and voluntary organisations. The agencies that were commonly cited among these as having close working relationships were social services and schools.

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.¹⁸⁷

The service had worked with primary care services and local authorities to strengthen communication and relationships.¹⁸⁸

Close working relationships with schools could be advantageous to improve the abilities of staff within schools to support children and young people experiencing mental health concerns. While not an area discussed in most inspection reports, there was discussion in a few reports that services offered training on mental health to schools. This could, as noted in the example below, improve how schools supported young people that may not meet the threshold for a CAMHS service.

¹⁸⁴ Specialist Inpatient (Good)

¹⁸⁵ Specialist Inpatient (Good)

¹⁸⁶ Specialist Community (Requires improvement)

¹⁸⁷ Specialist Community (Requires improvement)

¹⁸⁸ Specialist Community (Outstanding)

School staff told us that CAMHS staff helped them to understand new ways and strategies to support a young person. These made a large difference to how they could support young people and families through school. School staff felt that they could better support those young people that did not meet the threshold for a CAMHS service.¹⁸⁹

The same service was also involved in sharing information with parents during a parents' evening which was described as reducing stigma around mental health.

Staff from [name removed] had attended a parents evening at a local school and gave a presentation to parents about mental health to try to reduce stigma¹⁹⁰

As was highlighted in a few examples in the Inpatient services inspection reports, having a close proximity between services could promote a closer working relationship. This was illustrated in one Specialist Community inspection report in which the CAMHS service was located in the same building as the local authority and educational psychology services. Staff described how this facilitated close working relationships as a result.

[Name removed] CAMHS was co-located in a building with the local authority and the borough's educational psychology services. Staff said this had led to good working relationships between the services.¹⁹¹

The tier 2 and 3 managers were located in the same building and in some cases the same office which contributed to positive communication.¹⁹²

The issues that may arise with fragmenting the location of services was illustrated in one inspection report. In this example, the links between tier 2 and tier 3 services became more fragmented when they stopped working in the same office. Staff suggested that this in turn affected the ability for referrals to be discussed among the teams and categorise them appropriately:

In [name removed], the primary mental health team which included the single point of access service were situated in one office, while tier three services were based in another. Staff told us they felt that the links between the tier two and tier three teams was not as strong as they had lost the flexibility that came with working in the same office. This meant that some referrals were classified as urgent when they would have been discussed with colleagues from the core team and may have been classified as routine.¹⁹³

3.6.3 Handovers

Handovers were another common theme found in the Multidisciplinary and inter-agency team work inspection report analysis. While this theme came from findings related to the Multidisciplinary and inter-agency team work section of the inspection reports, handovers also relate with how CAMHS services work with other agencies (considered in section 3.5)

¹⁸⁹ Specialist Community (Good)

¹⁹⁰ Specialist Community (Good)

¹⁹¹ Specialist Community (Requires improvement)

¹⁹² Specialist Community (Good)

¹⁹³ Specialist Community (Good)

3.6.3.1 **Specialist Inpatient**

While handover meetings were not described in great detail in the multidisciplinary and inter-agency team work section of the reports, some of those that did discuss these noted that there was input from a range of health professionals.

We observed handover between shifts. A wide range of professionals were present and we observed good detailed discussion about patient care, risks and progress. Staff in the meeting demonstrated high levels of care for the patients discussed. This was shown through their behaviour and time they took to explore each case.¹⁹⁴

The frequency of handover meetings were described as taking place at the change of shifts which were often more than once daily.

Handovers took place twice a day, at the start and end of each shift. We attended one handover meeting. At the meeting staff discussed each patient on the ward, covering the level of observation, mental state, attendance at therapy sessions, involvement in education, activities, contact with their family, interaction with other patients and specific incidents.¹⁹⁵

The handover meetings attended were described as a comprehensive discussion around patients including admissions/new referrals, discharges, risks, medications, diet, and safeguarding concerns.

We attended a daily handover which was attended by members of the multidisciplinary team across both wards. The team were very patient focussed and discussed all areas of patient care, including progress, risk, observation levels and leave arrangements.¹⁹⁶

3.6.3.2 **Specialist Community**

In terms of handovers within the Specialist Community services, the discussions pertained more to discharges between CAMHS and adult mental health services which can be considered more of a 'discharge' to another service (discussed more in Section 3.5.6).

We saw examples of effective handover between teams with the organisation. We spoke with a young person who told us that the transition of their care between the child and adolescent mental health team and the adult mental health services had been managed well. Staff explained the process to them in advance and a graded handover of care completed with collaborative working by both teams. Regular review meetings took place as part of the process and psychological input was maintained by the child and adolescent mental health team for a short period after transition to provide continuity of care¹⁹⁷

¹⁹⁴ Specialist Inpatient (Good)

¹⁹⁵ Specialist Inpatient (Good)

¹⁹⁶ Specialist Inpatient (Good)

¹⁹⁷ Specialist Community (Good)

There was not much discussion about the content of handover meetings though it was described as 'effective' in a few instances and in one case the handover meetings that took place appeared to be very patient-centred.

*The patient's welfare was central to discussion. Staff spoke with genuine kindness about patients.*¹⁹⁸

There was also mention of handovers between the crisis team and the community team in a few instances. Staff reported effective handovers between teams within the organisation, for example from the children's crisis response team to the specialist intervention team.¹⁹⁹

3.7 Conclusion

The findings from this report have considered a range of issues relating to good/outstanding practice, requirement notices issued, areas for improvement, multidisciplinary and inter-agency team work and access and discharge. The breadth of issues relating to these areas of service provision from 101 inspection report were discussed and provided evidence about a variety of aspects of service provision within CAMHS services in England.

Areas of good/outstanding practice included how some services:

- involved patients, families and carers in service provision
- worked well and collaborated with other agencies
- provided education and training to staff as well as patients and their families.

Common requirement notices issued due to breaches in regulation included:

- Regulation 12 - Safe care and treatment (commonly issued due to concerns with risk assessments as well as the service environment and equipment)
- Regulation 17 - Good Governance (commonly issued due to the poor recording, reporting and sharing of important information, consent, requirements and risk)
- Regulation 18 - Staffing (commonly issued due to low staffing levels and inadequate training of staff).

Areas for improvement included issues with:

- the way patient risk was assessed
- the way patient information and care plans were recorded/reported
- adhering to governance and policy such as the Mental Health Act Code of Practice (2015)
- the suitability and safety of facilities and environment
- long waiting times.

¹⁹⁸ Specialist Community (Good)

¹⁹⁹ Specialist Community (Good)

With regards to multidisciplinary and inter-agency team work, there was:

- lots of evidence of effective multidisciplinary team working within services
- evidence of services working with other organisations including, for example, other CAMHS services, schools and social services
- possible barriers to close working relationships between agencies due to geographical distances between them.

With regards to access and discharge, we found:

- Specialist Community referrals were often triaged through a single point of access,
- Specialist Inpatient typically had planned admissions
- out-of-hours and crisis plans and provision were in operation in a number of cases
- CAMHS services worked with one another for planning discharge as well as with adult mental health services when children and young people approached the age of 18.

There were no particular differences between NHS and independent services or services, or between that had different overall ratings across the sections of inspections reports analysed for this report.

The exception to this was evidence of some particularly good practice within services rated as outstanding. While the analytical team were observant of the ratings and sector (independent vs NHS) of CAMHS services during data analysis, these did not appear to bring about differences in findings. This may not be surprising as ratings were based on the *overall* rating for the service. Overall ratings of services are derived from multiple areas of service provision that cover five key questions (safe, effective, caring, responsive and well-led). In our analysis, we considered five sections that fed into two key questions (effective and responsive) as well as broad areas of service provision: good/outstanding practice; areas for improvement and requirement notices. Services in the independent and NHS sector did not appear to be dissimilar in the areas examined in this paper. However, there may well be differences that were not found because the analysis focused on only some sections of the inspection reports.

To conclude, as part of Phase I of the review of mental health services for children and young people, this paper helps provide important background information into a range of issues and practices that have been identified in CAMHS services in England. The compilation of findings from 101 inspection reports in this paper helps to contribute to our understanding of CAMHS services and helps to address some of the questions CQC is exploring in the thematic review.