Requires improvement

Sussex Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Trust Headquarters
Swandean
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Worthing
West Sussex
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Tel:
Website:

Date of inspection visit: Date of inspection visit: 8th and 9th January 2015
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RX2	Trust Headquarters Swandean Arundel Road Worthing West Sussex BN13 3EP	Hampshire: • Oak Park Children's Services (Havant Community Team - clinical base)	PO9 2AW
RX2	Trust Headquarters Swandean Arundel Road Worthing West Sussex	Hampshire: • Fort Southwick (Havant Community Team - admin base)	PO17 6AR

Summary of findings

	BN13 3EP		
RX2	Trust Headquarters Swandean Arundel Road Worthing West Sussex BN13 3EP	Hampshire: • Friarsgate Medical Centre (Winchester Community Team)	SO23 8EF
RX2	Trust Headquarters Swandean Arundel Road Worthing West Sussex BN13 3EP	Kent: • Knightrider House(Maidstone and Tunbridge Wells Community Team)	ME15 6LU
RX2	Trust Headquarters Swandean Arundel Road Worthing West Sussex BN13 3EP	Kent: • 1 The Courtyard(Medway and Swale ChYP's Service)	ME8 0NZ
RX2	Trust Headquarters Swandean Arundel Road Worthing West Sussex BN13 3EP	Sussex: • The Aldrington Centre(Brighton & Hove Community LD Team)	BN3 4AG
RX2	Trust Headquarters Swandean Arundel Road Worthing West Sussex BN13 3EP	Sussex: • Tier 3 Community CAMHS - West Sussex	RH16 4EX

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

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall we found that these services require improve because we evidence that people were waiting too long for assessments to happen. We also found that there were not always adequate risk assessments and an inconsistent approach to physical health monitoring, particularly for young people on psychotropic medication. In some areas staffing levels did not always ensure that people in need of these services received a timely response.

However, it is positive to see that in the caring domain these services were rated as outstanding. There was good evidence of very positive approaches to involving people and consulting with families and carers. We saw that the user engagement agenda was well developed and embedded across these services and staff were highly committed and passionate about their work.

Outcome measures for children and young people were not routinely used to monitor the effectiveness of care treatment.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- Staffing levels did not ensure that young people in need of CAMHS received a timely service for their needs, which could put young people at risk.
- The risks to young people on the waiting list were not always monitored, which put young people at risk of harm to themselves or others.
- Risk assessments were not always up-to-date. They were not easily accessible to staff due to a transition between paper and electronic records

There were appropriate systems embedded with regards to safeguarding vulnerable adults, children and young people. Safeguarding concerns were reviewed and discussed as part of individual supervision and during team meetings

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- The physical health of young people receiving psychotropic medications was not always monitored.
- Staff did not always receive regular mandatory training updates.
- There was limited recording and monitoring of outcome measures to evidence whether people improved following treatment and care.

Young people, children and families had access to specialist services. Staff worked collaboratively with young people, families and local agencies to meet their needs.

Are services caring?

Outstanding

We rated caring as **outstanding** because:

- The innovative user engagement approaches across the services ensured that young people and their families had a say in how the service was and how to reduce the stigma of mental illness.
- We found staff to be kind, respectful and inclusive of the young person and their families. Feedback from young people and their families was positive. They told us that they found the staff to be passionate, caring and supportive and the therapies and treatments offered involved young people and their families.

Summary of findings

- We observed staff involving young people and their families in making decisions about their care. Staff sought young people's agreement throughout. Family and carers were involved when appropriate and information was shared according to the young person's wishes

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** because:

- The waiting times for assessment and treatment across all the CAMHS services were significantly high which meant that young people did not receive a timely service and could be at risk of harm to themselves or others.

The development of the home treatment team (HTT) has strengthened the emergency response for children and young people and was an effective diversion from hospital admission.

In response to the needs of young people within the Havant CAMHS team, the urgent care service (i2i) was set up to respond to risk and prevent out of area admissions to tier 4 services. The CAMHS services offered a range of groups and specialist clinics to meet people's needs. The Hampshire CAMHS service had implemented a group for parents of transgender young people, which provided support and information to enable parents to understand and support their child.

Are services well-led?

Good

We rated well-led as **good** because:

The aims of the service were clear and focused on the needs of the young people. Despite the lack of resources and staff vacancy rate across the community services, staff demonstrated that they were motivated and dedicated to deliver the best care and treatment they could for children and young people. The trust had identified actions plans and held meetings where the services needed to improve. Staff morale was good and the team supported each other.

Summary of findings

Information about the service

CAMHS community services are delivered in line with a four-tier strategic framework which is nationally accepted as the basis for planning, commissioning and delivering services.

Tier 1 – Consists of practitioners who are not mental health specialists working in universal services; this includes general practitioners (GPs), health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. Practitioners offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development and refer to more specialist services.

Tier 2 – Consists of CAMHS specialists working in both community and primary care settings. Practitioners offer consultations to identify severe or complex needs which require more specialist interventions and assessments.

Tier 3 – Consists usually of a multi-disciplinary team or service working in the community clinic or child psychiatry outpatient service, providing a specialised service for children and young people (ChYP'S) with more severe, complex and persistent disorders.

Tier 4 – Consists of services for ChYP'S with the most serious problems, such as day units, highly specialised outpatient teams and inpatient units.

Sussex Partnership NHS Foundation Trust child and adolescent mental health services (CAMHS) provide specialist mental health services, care and treatment for children and young people up to the age of 18 years across Hampshire, Kent and Sussex.

Our inspection team

The team that inspected child and adolescent mental health services (CAMHS) consisted of nine people; five inspectors, two nurses, a psychologist and a head of paediatric services. Three people on the team visited CAMHS community services in Hampshire. Four people on the team visited CAMHS community services in Kent and Medway. Four people on the team visited CAMHS community services in Sussex.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Visited six of the community teams and looked at the environment and quality of the service.

Summary of findings

- Spoke with young people and relatives/carers of people receiving services.
- Spoke with members of staff from a range of disciplines including consultant psychiatrists, psychologists, art therapist, nurses and administrators.
- Interviewed the service managers with responsibilities for these services.
- Attended and observed handovers, CHOICE appointments and family therapy sessions and case discussion groups.

We also:

- Looked at electronic treatment records of patients.
- Looked at a range of policies, procedures and other documents relating to the running of the services.

What people who use the provider's services say

We spoke with young people who were using the services and their relatives. They were all positive about the service provided by the CAMHS community services. They told us that they found the staff to be passionate, caring and supportive and the therapies and treatments offered involved young people and their families.

Some people told us that waiting times for assessment or treatment were long.

Good practice

- The development of the home treatment team (HTT) had strengthened the emergency response for children and young people and was an effective diversion from hospital admission.
- In response to the needs of young people within the Havant CAMHS team, the urgent care service (i2i) was set up to respond to risk and prevent out of area admissions to Tier 4 services.
- The innovative user engagement approaches across the services ensured that young people and their families had a say in how the service was run and how to reduce the stigma of mental illness.
- We found staff to be kind, respectful and inclusive of the young people and their families. Feedback from young people and their families was positive. They told us that they found the staff to be passionate, caring and supportive and the therapies and treatments offered involved young people and their families.
- CAMHS staff worked with families of young people in their homes to support them with parenting.
- The CAMHS services offered a range of groups and specialist clinics to meet people's needs. For example, they offered learning disabilities, eating disorders and autism awareness. The Hampshire CAMHS service had implemented a group for parents of transgender young people, which provided support and information to enable parents to understand and support their child.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- Staffing levels did not ensure that young people in need of CAMHS received a timely service for their needs, which could put young people at risk.
- The waiting times for assessment and treatment across all the CAMHS services were significantly high which meant that young people did not receive a timely service and could be at risk of harm to themselves or others.

Summary of findings

- The risks to young people on the waiting list were not always monitored, which put young people at risk of harm to themselves or others.
- The assessments of young people did not include a developmental history, which meant that important information was not routinely captured and assessed.
- The physical health of young people receiving psychotropic medications was not always monitored.
- Staff did not always receive regular mandatory training updates.
- Risk assessments were not always up-to-date. They were not easily accessible to staff due to a transition between paper and electronic records.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The Havant CAMHS team was spread across two sites, and the working environment was not always confidential. This did not ensure the best use of resources and that young people's needs were met in a timely manner.
- Young people were not always provided with treatment options in relation to their needs.
- Knowledge and learning from serious untoward incidents was evident within the local teams. However there were no systems in place across the organisation to share any lessons learnt across the wider trust.
- There was limited recording and monitoring of outcome measures to evidence whether people improved following treatment and care.

A range of different sizes of cuff was not always available to support the monitoring of children's and young people's blood pressure.

Sussex Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Oak Park Children's Services	Trust Headquarters
Fort Southwick	Trust Headquarters
Friarsgate Medical Centre	Trust Headquarters
Knightrider House	Trust Headquarters
1 The Courtyard	Trust Headquarters
The Aldrington Centre	Trust Headquarters
Tier 3 Community CAMHS - West Sussex	Trust Headquarters

Mental Health Act responsibilities

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

- At the time of our inspection there was one person who was subject to a Community Treatment Order (CTO).
- Staff told us that training in the Mental Health Act (MHA) and Mental Capacity Act (MCA) was not mandatory within the trust. Records showed that not all staff had undertaken MHA and MCA training.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) does not apply to people under the age of 18 years. Should the need arise to deprive a person under 18 years of age of their liberty, safeguards must be considered. These include the use of the Mental Health Act 1984 (Amended 2007) or section 25 of the Children Act.

The Mental Capacity Act (MCA) does apply to young people aged 16 and 17 years of age. Mental capacity assessments should be carried out to make sure the young person has the capacity to give consent.

For children under 16 years of age, decision making ability is governed by Gillick competence. This competence recognises that some children may have a level of maturity to make some decisions themselves. Staff should assess whether a child has a sufficient level of understanding to make decisions regarding their care and treatment.

- Some of the staff we spoke with had a clear understanding of the Mental Capacity Act 2005 (MCA) and displayed good knowledge about Fraser guidelines. We saw examples where these had been implemented in practice.
- Staff did not always receive regular mandatory training in the use of MCA and DoLS.

Requires improvement

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We rated safe as **requires improvement** because:

- Staffing levels did not ensure that young people in need of CAMHS received a timely service for their needs, which could put young people at risk.
- The risks to young people on the waiting list were not monitored, which put young people at risk of harm to themselves or others.
- Risk assessments were not always up-to-date. They were not easily accessible to staff due to a transition between paper and electronic records

There were appropriate systems embedded with regards to safeguarding vulnerable adults, children and young people. Safeguarding concerns were reviewed and discussed as part of individual supervision and during team meetings.

Our findings

Safe and clean environment

- Access to the community bases was through a staffed reception with comfortable waiting areas that were child friendly.
- We saw that the community bases were equipped with clinic rooms which had the necessary equipment to carry out physical examinations.
- The Havant CAMHS team was spread over two bases, with the clinical site situated approximately six miles from the administrative site. The clinical site did not have a dedicated administrative office and no patient information was stored on site. There was a 'hot-desk' facility which was shared with other services that used the building, including staff from different trusts and providers of services. The records relating to young people were stored on the trust electronic care records system. Also, because the hot desk area was situated some distance from the clinical area, the CAMHS team did not always know which staff were in the building. Staff told us that it took extra time to travel between the clinical and administrative sites. This meant staff spent longer amounts of time on administrative work which took them away from direct work with young people. The booking of rooms was a time-consuming process, which had to balance up the availability of rooms with that of the young person/ parent, which sometimes caused delays in people being seen.
- Staff spoke of the difficulties they encountered in finding desk space to use and the lack of confidentiality and noise disruption in the desk area.
- We saw that assessments had been carried out of ligature risks in the community bases. The trust had a plan of work to reduce the fall hazard at Knightrider House due to the banister rail. Staff we spoke with told us of specific action to be taken to mitigate the risks.
- The services we visited had disabled access. Toilets and doorways were wheelchair accessible and reception desks were lowered.
- Alarm systems were available in each treatment room and staff said that when the alarm was used staff responded quickly.

Safe staffing

- Staff of different disciplines worked across the services. The teams comprised of mental health and learning disability nurses, primary mental health workers, family therapists, drama and art therapy staff, psychologists, psychotherapists and consultant psychiatrists.
- There were a number of vacancies across the teams. We were told that several of the vacancies had already been recruited against and staff were due to commence employment imminently.
- Agency staff were used to cover some clinical vacancies. Staff told us that the trust would no longer agree the use of agency cover for administrative posts and this impacted on their workload further.
- West Kent ChYP's team had a vacancy rate of 18 clinical staff. We were told that the trust was aware of the difficulties to recruit staff to these positions and was increasing the recruitment campaign.

Requires improvement

Are services safe?

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

- At the time of the inspection the Havant CAMHS team was going through a re-tendering process and vacancies were not being recruited against. The service carried out a benchmarking exercise, where they identified that the current staffing levels for Hampshire CAMHS were at 63% of the national average (of NHS guidelines), with just 38% staffing levels when compared with the Royal College of Psychiatrists' best practice guidance. The benchmarking exercise identified that over 3000 young people in Hampshire who should be receiving a CAMHS service were not.
- All the community teams had an on call arrangement to triage urgent referrals outside of normal working hours. The home treatment team (HTT) in Kent provided out of hours support, care and treatment.

Assessing and managing risks to patients and staff

- The CAMHS teams had a duty system. The duty staff triaged the referrals, reviewed the information and prioritised the referrals according to potential risks. Staff signposted young people to other services and made appointments for assessments where necessary.
- The 'i2i' team operated within Hampshire. The 'i2i' team was an urgent care team across the county. In Sussex this was known as the 'urgent help service'. In Kent this was known as the home treatment team (HTT). In Hampshire this operated as an intensive home treatment service, where they carried out urgent assessments and new urgent referrals from GP's. They also carried out seven-to-ten day follow ups for young people discharged from hospital. They carried out the assessment of young people who presented in accident and emergency departments. This meant that young people in crisis received a more timely assessment of their needs.
- A risk assessment of each young person was carried out at their initial assessment/ CHOICE meeting. We saw that young people were involved in identifying their risks and where identified, comments from the young person were included regarding how they would cope with the risks. An example of this was where a young person had spoken about harming themselves, but said it was not something they would carry out.
- Risk assessments were not always complete, reviewed or updated. The trust operated an electronics and paper record system, with the aim of being paper free. Access to records, including risk assessments, was a problem whilst this transition from paper to electronics record systems took place. Records were not easily located and some were stored in paper form several miles away from the community bases at the hub services and so not immediately available for staff to review.
- The waiting lists for treatment across the community CAMHS teams were significantly high. The senior managers we spoke with said the lists were monitored in response to concerns that GPs and schools had about young people. They also said that the waiting list was monitored and kept up-to-date with current information about the young person/family. Staff told us this was not carried out and we saw evidence of this having not taken place. For example at Medway and Swale ChYP's we found that a young person had been on the waiting list from referral in 2012 until our inspection in 2015. There had not been any identified clinical contact for an extended period of time, since 2013. We raised concerns with the manager during our inspection. The manager investigated and fedback to the inspection team that the identified young person should have been discharged in September 2013, however discharge was not actioned on the ecpa system. The manager told us that he was concerned with our findings and plans are in place to undertake an immediate review of the team case load.
- There were appropriate systems embedded with regards to safeguarding vulnerable adults, children and young people. Safeguarding concerns were reviewed and discussed as part of individual supervision and during team meetings. Some of the CAMHS teams were based in the same buildings as local authority children services teams, where staff were able to access face-to-face advice regarding safeguarding concerns.
- Staff we spoke with had an understanding of safeguarding issues and their responsibilities in relation to identifying and reporting allegations of abuse. Staff told us of the steps they would take in reporting this to the safeguarding lead within the team/area and felt confident in contacting them for advice when needed.
- Information provided by the trust demonstrated that not all staff within the CAMHS community teams had completed their safeguarding training.

Requires improvement

Are services safe?

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

- Staff said they followed the trust's lone working policy and when they carried out home visits they kept other staff informed of their whereabouts. Where any risk to others had been identified in a young person, clinicians would 'buddy-up' to carry out a joint meeting. Staff in the i2i team linked with a team member to let them know where they were at all times.
- The CAMHS teams were in the process of transition from written care records to computerised records. Therefore, information about young people was held in different places, which could cause information to go missing.

Track record on safety

- We looked at the record of serious untoward incidents. In the last year there had been seven deaths involving young people using the CAMHS services across Sussex. These deaths had all occurred in the community.
- We looked at the record of serious untoward incidents across the Kent community bases. In the last year there had been six serious untoward incidents. Most of these related to the lack of tier 4 beds. The team managers were able to demonstrate where lessons had been learnt and practices changed. Staff were able to tell us about serious incidents within the county which had initiated changes to improve procedures. For example, the need for 24 hours a day, seven days a week escalation process and access to legal advice should there be a lack of or refusal of tier 4 bed availability.
- Records showed that not all staff were up-to-date with statutory and mandatory training requirements

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to recognise and report incidents on the trust's electronic incident recording system. Staff said they felt well informed of serious incidents via newsletters and bulletins from the trust managers**.** However, when we highlighted serious incidents in CAMHS services in different parts of the trust, some staff were not aware of these. Local senior managers acknowledged that further work was needed on sharing this information at divisional level and cascading it to staff.
- Staff from all the CAMHS services told us that learning from incidents took place through monthly team meetings, group clinical supervision, 'take to team' meetings, and the nurse's forum. Staff spoke of the use of these groups to carry out reflective practice in response to incidents that had happened within CAMHS across the county, and to identify improvements needed to the service.
- In response to local incidents, the staff informed us that they reminded parents via letter to inform them of any concerns about their child. Other learning from incidents was that staff ensured that where previous users of the service had been re-referred, they would be assessed within seven days.
- All incidents were reviewed by the team managers and forwarded to the trust's quality assurance team who maintained oversight. The team managers explained that the increase in the number of incidents was because of the ongoing problem with accessing tier 4 services and lack of bed availability. Whilst not technically a serious incident, the lack of available tier 4 beds nationally is regarded as a serious incident in itself. The trust had therefore decided to report it as such.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

We rated effective as **requires improvement** because:

- Physical health monitoring of young people receiving psychotropic medications was not always monitored.
- Staff did not always receive regular mandatory training updates.
- There was limited recording and monitoring of outcome measures to identify whether people improved following treatment and care.

Young people, children and families had access to specialist services. Staff worked collaboratively with young people, families and local agencies to meet their needs.

Our findings

Assessment of needs and planning of care

- Some young people experienced numerous assessments in accessing treatment from CAMHS. For some, this meant an initial assessment in an accident and emergency department, Choice assessment, then Partnership assessment. There were more assessments if they needed to access inpatient services. Some staff we spoke with acknowledged that it could be stressful for young people to go through so many assessments.
- Work had taken place to enable a more specific assessment and access to service for young people, through the implementation of referral pathways, to assist referrers and enable young people to receive the right support for their needs.
- Staff told us that the community CAMHS teams did not have access to inpatient service computerised records and were not always informed of planned discharge dates of a young person back into the community. Staff told us they were rarely invited to discharge planning meetings by the inpatient services. This meant that effective planning of care and handovers to the community CAMHS teams were not always done.
- The assessments of young people included a history of their mental health, risks to themselves or others and presenting issues. However, there was a lack of information around the assessment of the young person's developmental history.
- The trust's records showed that during the initial assessment young people were told they would be allocated a clinician, though no details of when this would be or the type of therapy they would receive. We observed an assessment where a young person was told about different websites they could access for support whilst they awaited treatment.
- Some of the written notes were not signed or dated by the clinician who had carried out the assessment. Sometimes, where notes had been signed, the name of the clinician had not been recorded.
- Following the assessment a letter was sent to the young person outlining the care plan, this was also sent to the referrer and GP if different.

Best practice in treatment and care

- To improve the experience and outcomes of young people who used the services, the CAMHS teams developed and implemented person centred pathways of care that detailed locally agreed evidenced based clinical standards for a defined care group and adhered to National Institute for Health and Social Care Excellence (NICE). Examples of these pathways were eating disorders, attention deficit hyperactivity disorder (ADHD), deliberate self-harm/self-harm.
- The experience of young people, children and families (outcomes) was reviewed to ensure young people were receiving the right level of care and treatment. Different measures of outcomes were used dependent on the interventions used. Tools used included the strengths and difficulties questionnaire (SDQ) and the revised children's anxiety and depression scale (RCADS). Staff told us, and we saw in the records we reviewed, there was limited recording and monitoring of outcome measures to identify whether people improved following treatment and care.
- Young people had access to psychological therapies as part of their treatment and psychologists were part of the multi-disciplinary team.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- The CAMHS services offered a range of groups and specialist clinics to meet people's needs. For example learning disabilities, eating disorders, autism awareness and transgender.
- The physical health of young people receiving psychotropic medications was not always monitored.
- Across all the CAMHS serives a range of different sizes of cuff was not always available to support the monitoring of children's and young people's blood pressure.

Skilled staff to deliver care

- Most staff told us they received clinical and managerial supervision every month at which they were able to reflect on their practice. Appraisals were carried out annually. The CAMHS services provided a specific preceptorship package for newly qualified nursing staff. New staff we spoke with said they felt well supported and that they were closely supervised by senior staff and a mentor in all aspects of their work to ensure that young people were supported appropriately.
- Some staff outside of Sussex told us they had not attended training for some time because training was provided in Sussex which was a long distance for them to travel. Staff told us that they had raised this issue with the trust and had requested more local training.
- Staff told us they had received training in psychological treatments including cognitive behavioural therapy (CBT).
- The team managers gave us examples where the performance of staff had been managed, and of work they carried out with employees to support them with their work.
- There were regular team meetings and staff told us they felt well supported by their local management structure and colleagues. However, some staff told us that administrative staff were not always invited to team meetings because they needed to provide telephone cover.

Multi-disciplinary and inter-agency team work

- A multi-disciplinary team meeting (MDT) is composed of members of health and social care professionals. The MDT collaborate together to make treatment recommendations that facilitate quality patient care. People we spoke with confirmed they were supported by a number of different professions. Each team held different team meetings to enable staff to discuss work and present cases to the MDT.
- We saw that the MDT had good links with local schools and GPs.
- Within the tier 2 services in Hampshire the teams worked with local authority led 'early help teams', which were co-ordinated by children's services and included joint work with police, health visitors and education to support young people with emerging mental health needs, where work included running an anxiety management group for young people.
- The service provided a 'consultation line' whereby health care professionals had a dedicated time each day to contact a clinician to discuss a young person's presenting needs and seek advice on the appropriateness of a CAMHS referral. A recent survey carried out by CAMHS showed that professionals who accessed the consultation line were satisfied with the service, and would like this to be extended.
- At the time of the inspection the clinical lead for primary mental health in Hampshire CAMHS was delivering training across the county to stakeholders and external agencies on different mental health issues affecting young people, such as anxiety, eating disorders and general mental health. This work aimed to promote understanding of issues and of the services available that professionals could take back to their work with young people.
- The trust did not have its own designated MHA place of safety (a section 136 suite) for young people in Kent. In May 2014 an arrangement with Kent and Medway NHS and Social Care Partnership Trust (KMPT) was put in place so that Kent CAMHS teams could use one of KMPT's section 136 suites. Staff did not have access to each other's clinical record systems when managing young people in the Kent place of safety. At the time of our inspection an information sharing protocol was being developed and was due for completion by the end of January 2015.

Adherence to the MHA and the MCA Code of Practice

- At the time of our inspection there was one person who was subject to a Community Treatment Order (CTO).

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Staff told us that training in MHA and MCA was not mandatory within the trust. Records showed that not all staff had undertaken MHA and MCA training.

Good practice in applying the MCA

The Mental Capacity Act 2005 does apply to young people aged 16 and 17 years of age. Mental capacity assessments should be carried out to make sure the young person has the capacity to give consent. For children under 16 years of age, decision making ability is governed by Gillick competence. This competence recognises that some children may have a level of maturity to make some decisions themselves. Staff should assess whether a child has a sufficient level of understanding to make decisions regarding their care and treatment.

- As part of the assessment young people were informed about confidentiality and who they would/ would not like their information shared with. We were shown evidence of use of the MCA, where the wish of a young person to receive a service without the knowledge of their parent/carers was respected and an alert put onto their care records so that all staff were aware. Staff knew about the Gillick competence and we were given examples of competency assessments for young people under 16 years, such as whether they wanted to be assessed for autistic spectrum conditions.

Outstanding ☆

Are services caring?

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

Summary of findings

We rated caring as **outstanding** because:

- The innovative user engagement approaches across the services ensured that young people and their families had a say in how the service was run and how to reduce the stigma of mental illness.
- We found staff to be kind, respectful and inclusive of the young person and their families. Feedback from young people and their families was positive. They told us that they found the staff to be passionate, caring and supportive and the therapies and treatments offered involved young people and their families.
- We observed staff involving young people and their families in making decisions about their care. Staff sought young people's agreement throughout. Family and carers were involved when appropriate and information was shared according to the young person's wishes

Our findings

Kindness, dignity, respect and support

- Feedback from young people and their families was positive. They told us that they found the staff to be passionate, caring and supportive and the therapies and treatments offered involved young people and their families.
- We observed CHOICE assessments and therapy groups and found the staff to be kind, respectful and inclusive of the young person and their families. They appeared interested and engaged in providing good quality care to people.
- When staff spoke with us about young people, they discussed them in a respectful manner and demonstrated a good understanding of their individual needs.

The involvement of people in the care they receive

- Each service collected feedback from young people, families and carers through tablets and feedback forms in the waiting area of the service. The results of the surveys were feedback to young people through posters that highlighted anonymised comments received from people, and actions taken as a result of feedback received. An example of this was individual discussions with clinicians of comments received about them and improvements made in response to feedback.
- Within Kent CAMHS, service user participation work was taking place across the services to promote mental health in young people. Young people attended focus groups and contributed to the quality of the service. For example, letters were originally sent out addressed to just parents. Young people stated that they felt excluded and not involved. Following discussions in the focus group, the services implemented changes and letters are now addressed to young people and their parents. Newsletters, art days and 'sweep week' questionnaires were available to young people and their families.
- Within the Hampshire CAMHS, there was a lead person for the county and a participation champion in each team who worked with local universities, users of the service, local authorities, user groups and helplines. Training had been provided for young people in areas such as communication skills and interview skills. Healthy lifestyles and fitness were being promoted. Music therapy, competitions and surveys of young people's experience of the service were provided.
- The services also conducted surveys with young people to establish ways of improving the mental health service they received. We were shown the results of a recent self-harm survey and the production of self-help material. As a result of the feedback received from young people, the service was working on a self-help card and phone app that young people could use when they had feelings of self-harm.
- 'You said, we did' boards were displayed in waiting rooms. These contained comments and suggestions from young people and families and the action that the services had taken to implement and make changes to improve the quality of the service.
- We observed staff involving young people and their families in making decisions about their care. Staff sought young people's agreement throughout. Family and carers were involved when appropriate and information was shared according to the young person's wishes

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as **requires improvement** because:

- The waiting times for assessment and treatment across all the CAMHS services were significantly high which meant that young people did not receive a timely service and could be at risk of harm to themselves or others.

The development of the home treatment team (HTT) has strengthened the emergency response for children and young people and was an effective diversion from hospital admission. In response to the needs of young people within the Havant CAMHS team, the urgent care service (i2i) was set up to respond to risk and prevent out of area admissions to tier 4 services. The CAMHS services offered a range of groups and specialist clinics to meet people's needs. The Hampshire CAMHS service had implemented a group for parents of transgender young people, which provided support and information to enable parents to understand and support their child.

Our findings

Access, discharge and bed management

- The waiting times for assessment and treatment across all the CAMHS services was significantly high which meant that young people did not receive a timely service and could be at risk of harm to themselves or others.
- Each team had systems in place which ensured all new referrals were triaged through a single point of access. The teams reviewed each new referral based upon the information they received and assessed what further support was required. Contact details for the services were clearly displayed on the trust website.
- The referrals to the Havant CAMHS service were up to approximately 100 per month. These were triaged by a duty clinician to identify any young people who required an urgent assessment. The aim was for these young people to receive an assessment within a week of referral. Young people who required a less urgent assessment were aimed to be seen within 28 days.
- Monitoring carried out by Hampshire CAMHS showed that from April to September 2014 young people received their first assessment approximately 41 days following referral, with urgent referrals seen within timescale.
- Hampshire CAMHS had a target of treatment taking place within 84 days of assessment, where at 70 days this would be flagged up and acted upon. We were informed that waiting times for routine treatments, in relation to autistic spectrum conditions could take up to a year. However, we found examples where young people had been waiting up to 18 months for routine treatments. Managers told us that the waiting lists resulted initially from when SPFT took over the Hampshire CAMHS, and there was no clarity who was responsible for different assessments, with all teams doing different things.
- The risk register for Hampshire CAMHS identified the waiting times as the highest risk level of severity, which was 'catastrophic'.
- The managers told us about steps they had taken in response to the identified increase in referrals during January and February over previous years, where they limited routine appointments to free up clinicians to carry out urgent assessments.
- Staff told us they received some inappropriate referrals, or incomplete information provided in referrals. Staff told us they closed these referrals and asked the referrer for more information.
- The trust does not have access to its own MHA place of safety (section 136 suite) for young people in Kent. In May 2014 an arrangement with Kent and Medway NHS Trust (KMPT) was put in place so that Kent CAMHS teams could use one of KMPT's section 136 suites. The agreement between both trusts means that SPFT provide a band 6 nurse and KMPT will provide the support workers. Staff told us that this could be complicated and could impact on people's care. For example there had been occasions when the section 136 suite was not available and staff had to make alternative arrangements such as liaising with the police or using Accident and Emergency to maintain the young person's safety.
- We spoke with staff in the Havant CAMHS service about access for young people to a section 136 suite/MHA

Requires improvement

Are services responsive to people's needs?

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

place of safety. Staff were not aware of any places of safety that were specifically for young people, and were not aware of any incidents where a young person had been admitted to an adult place of safety. They told us that in these situations young people would either be held in a police cell or admitted to a general children's ward, with the support of staff from the i2i team.

- The trust runs a tier 4 inpatient facility for young people, which can accommodate up to 16 young people in Sussex. Havant CAMHS is based in Hampshire, and young people were able to access a young person's inpatient unit within Hampshire, which was provided by another trust. The i2i staff attended business meetings to discuss admissions and discharges from the service. Staff spoke of the national issues of lack of tier 4 inpatient beds for young people to access and spoke of occasions when they had to place a young person in another part of the country. They said that contact with the young person would be maintained through visits, teleconferencing and use of online face-to-face meetings.
- The trust does not hold responsibility for Tier 4 bed management in Kent. This is managed by South London and Maudsley NHS Trust (SLAM). Staff told us there were ongoing issues and concerns with regards to each trust's thresholds for admission to a tier 4 bed for young people. This greatly impacted on young people and their families and the CAMHS teams. The trusts were working together to agree thresholds and to put in place a dispute resolution process. At the time of our inspection this remained ongoing and staff were not aware of any updates or completion dates.
- The i2i team worked with young people on an individual basis to prevent admissions and support discharges from hospital. The service was nurse-led, with use of the on-call psychiatrist. The service worked across Hampshire.
- The home treatment team (HTT) worked across Kent and provided intensive support for children and young people with acute mental health needs. HTT provided 2-14 contacts per week over a period of 2-6 weeks to maximise the coping resources of the child or young person and their families. The development of the home treatment team (HTT) has strengthened the emergency response for children and young people and was an effective diversion from hospital admission.
- Staff told us that when people did not attend (DNA) appointments, the duty clinicians would follow up and check the referral for risk. If no risk was identified they would discharge the young person and inform the referrer. Where a risk was identified they would attempt telephone contact with the young person/ parent and inform any other professionals involved with them. The DNA policy identified aspects that could affect attendance at appointments such as transport issues, social isolation and providing advice to other services already involved with the young person. Some work was taking place with local schools to reduce the DNA numbers.

The facilities promote recovery, dignity and confidentiality

- The Havant CAMHS team held consultations with young people and parents at Oak Park Children's Service. The environment was modern, clean and well-maintained.
- Most of the services we visited were clean, comfortable, well-furnished and child friendly. Interview rooms and treatment rooms were adequately sound proofed to ensure confidentiality and privacy. Staff told us that the pressure of room usage was high at all times due to the increased workload and demand for services exceeded capacity. However, in Havant CAMHS a welcoming environment for young people was not promoted, with a lack of pictures/ murals to help young people relax. Comments from a young person was that it was 'sterile' and 'like a prison'
- People who used the service were given information on treatments, associated agencies and how to make a complaint. Information was clearly displayed on noticeboards in the reception/waiting area. This included information for the Patient Advice and Liaison Service (PALS). People we spoke with felt confident that they could make a complaint if they needed to. Staff were aware of the process for managing complaints.

Meeting the needs of all people who use the service

- The cultural and ethnic needs of young people and their families were considered and, where appropriate, their care and treatment was planned and delivered to meet these needs.

Requires improvement

Are services responsive to people's needs?

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

- The services we visited had disabled access. Toilets and doorways were wheelchair accessible and reception desks were lowered. However, there were no baby changing facilities available.
- We found there were different therapies to meet the varying needs of the young people. For example, family therapy, specialist clinics and transgender support groups.
- Within the Hampshire CAMHS work had taken place involved revitalising the waiting areas in the CAMHS community sites to make them more accessible to young people.

Listening to and learning from concerns and complaints

- We looked at some complaints received and the responses to complaints. The responses were completed within timescale, and detailed to the concerned party the steps taken to investigate the complaint and any learning.
- Staff were aware of duty of candour requirements which emphasise transparency and openness. The duty of candour requires NHS and foundation trusts to notify the relevant person of a suspected or actual reportable patient incident.

Are services well-led?

Good

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

Summary of findings

We rated well-led as **good** because:

The aims of the service were clear and focused on the needs of the young people. Despite the lack of resources and staff vacancy rate across the community services, staff demonstrated that they were motivated and dedicated to deliver the best care and treatment they could for children and young people. Governance processes identified where the services needed to improve. Staff morale was good and the team supported each other.

Our findings

Vision and values

- Staff were aware of the trust's vision and values and these were clearly displayed.
- Staff knew the new chief executive of the trust and spoke of 'roadshows' they had attended across the county where they could meet with him. They felt confident in the new chief executive, as they said he was interested in the work they did and gave them autonomy in the running of services to meet local needs.
- Kent CAMHS services have undergone significant change and reconfiguration since being taken over by Sussex Partnership NHS Foundation Trust in September 2012. Staff told us that they were supported and encouraged to contribute to the review of CAMHS services.

Good governance

- Key performance indicators (KPI's) were used to monitor progress and quality of the service provision. The results were displayed in the CAMHS services each month. These demonstrated waiting times for young people, number of referrals and completion of risk assessments and care plans.
- The KPI's set by commissioners for the Hampshire CAMHS team were around improving training for external stakeholders, ensuring groups were part of each care pathway, putting an autistic spectrum disorder care pathway in place and addressing the waiting list of young people awaiting an autistic spectrum condition assessment. The manager told us that this was the only outstanding KPI, and there was a plan in place for this action to be completed by the end of March 2015. However, it was acknowledged that this action would not be met within timescale.
- The risk register for the CAMHS services identified areas that affected the service. There was an action plan for each area of risk identified and progress was monitored. For example, the waiting times of four weeks for assessment and 18 weeks for treatment were being monitored weekly by service directors and monthly feedback was provided to commissioners of the service. A recent 'extraordinary' risk meeting had taken place within the CAMHS, where areas such as the waiting list, staff welfare and staff working extra hours were discussed. At this meeting, managers had acknowledged the hard work of the staff and gave action points for promoting staff welfare, such as encouraging them to discuss their concerns with their manager.
- The learning from complaints and serious incidents was identified and actions were planned to improve the service. These were monitored by the service directors and through regular audits, such as in relation to record keeping and communication with external stakeholders.
- Staff told us, and we saw in the records we reviewed, there was limited recording and monitoring of outcome measures to identify whether people improved following treatment and care.

Leadership, morale and staff engagement

- Despite the lack of resources and staff vacancy rate across the community services, staff demonstrated that they were motivated and dedicated to deliver the best care and treatment they could for children and young people.
- Sickness and absence rates were monitored locally and we were given examples of the use of sickness and absence procedures with staff.
- Managers across all the CAMHS services were accessible to staff. Staff described strong leadership within the

Are services well-led?

Good

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

local teams and said that they felt respected and valued. The senior managers spoke highly of the staff and felt they provided a high quality service, with good outcomes for young people and families.

- Managers within the Hampshire CAMHS services were very aware of the morale within the team, in light of the re-tendering of the service that was taking place at the time. Friarsgate was due to move location in the coming month, and there were some managers in interim rather than permanent positions due to the freeze on recruitment whilst the re-tendering took place. Local 'away days' took place to enable staff to focus on team-building away from the daily work.
- Staff morale remained high across the Kent and Sussex CAMHS services despite the level of vacancies within the local teams. Service managers across all the CAMHS services acknowledged the demand for services exceeded the capacity of staff resources. Staff spoke about the pressure and worry of maintaining high caseloads but continued to work together to provide good quality care. Staff acknowledged that since Sussex Partnership NHS Foundation Trust had taken over the contract for Kent CAMHS, they had begun to see improvements in the service.
- Managers told us they had undertaken training in 'transformational leadership in CAMHS' and had attended an 'improving access to psychological therapies' leadership course. They showed us where this training had been used to implement changes in the services, such as the re-modelling of pathways of care.
- The Hampshire CAMHS was under tender at the time of the inspection. Staff spoke of being involved in the tendering exercise, and of giving their views on what was needed for the service.

Commitment to quality improvement and innovation

- Within the Havant CAMHS team the psychotherapist had implemented a group for parents of transgender young people, which provided support and information to enable parents to understand and support their child. They also supported young people and their parents to link with the national gender identity service for young people.
- The development of the home treatment team (HTT) within Kent and Medway CAMHS team had strengthened the emergency response for children and young people and was an effective diversion from hospital admission.
- In response to the needs of young people within the Havant CAMHS team the urgent care service (i2i) was set up to respond to risk and prevent out of area admissions to tier 4 services.
- Pilot work was taking place with a local school where a number of young people were using CAMHS, particularly around DNA rates and young people and families that took more time to engage with.
- CAMHS staff worked with families of young people in local children's homes to support them with parenting.
- Work was taking place with Hampshire Youth Parliament to increase accessibility to CAMHS and to reduce the stigma of mental health services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18: Staffing Staff did not receive regular mandatory training updates and lacked training in physical health issues to meet the needs of the high number young people with eating disorders nursed at Chalkhill. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The waiting times for assessment and treatment across all the CAMHS services were significantly high which meant that young people did not receive a timely service and could be at risk of harm to themselves or others. This was in breach of regulation 9(1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The risks to young people on the waiting list were not monitored, which put young people at risk of harm to themselves or others. This was in breach of regulation 9(1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The assessments of young people did not include a developmental history, which meant that important information was not routinely captured and assessed. **This was in breach of regulation 9(1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. The physical health of young people receiving psychotropic medications was not always monitored. **This was in breach of regulation 9(1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18: Staffing The trust had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. At Chalkhill the covering of shortfalls of qualified nursing staff with healthcare assistants over long periods of time did not promote the health, safety and welfare of people who use the service, and put young people at risk of inadequate care. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Requirement notices

People were not being protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to people. Risk assessments were not always up-to-date. They were not easily accessible to staff due to a transition between paper and electronic records.

This was in breach of regulation 17(1)(a)(b) (2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014