Surrey and Borders Partnership NHS Foundation Trust

Child and Adolescent Mental Health Services

Quality Report

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Date of inspection visit: 7-11 July 2014
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust Headquarters	RXXHQ	Children and Young People Learning Disability Team - South	GU7 1QU
Trust Headquarters	RXXHQ	Children and Young People Learning Disability Team - East	GU2 7LX
Trust Headquarters	RXXHQ	CAMHS Community Team - South	KT19 8PB
Trust Headquarters	RXXHQ	CAMHS Community Team - East	KT19 8QJ
Trust Headquarters	RXXHQ	CAMHS Community Team - North	TW15 3AA
Trust Headquarters	RXXHQ	CAMHS Community Team - North	KT16 0PZ
Trust Headquarters	RXXHQ	Primary Mental Health Team - East	KT19 8QJ
Trust Headquarters	RXXHQ	Primary Mental Health Team - South	GU2 7LX

Summary of findings

Trust Headquarters	RXXHQ	Primary Mental Health Team - North	TW15 3AA
Trust Headquarters	RXXHQ	Primary Mental Health Team - North	KT16 0PZ

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

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Surrey and Borders Partnership NHS Foundation Trust child and adolescent mental health services (CAMHS) assess and support children and young people coming into contact with mental health services for the first time and those who require longer term support with complex mental health needs.

The trust provided a safe service, though needed to ensure that all staff knew how to report incidents and were familiar with the lessons that are learned from incidents.

The services provided by the trust were effective, though improvements were needed. We saw staff using best practice and clinical guidance well. We found that staff were not always able to explain how they would obtain consent for young people under 16 appropriately.

The trust provided a caring service. The staff were committed to their work and the support of young people and their families. Young people felt the staff had a good understanding of their needs and worked in collaboration with them.

The services provided by the trust were responsive. There was good planning for young people making the transition into adult services. Young people felt that the service they received was designed to meet their individual needs.

The services provided by the trust were well-led, though more support needed to be provided to staff during periods of change.

Summary of findings

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

Are services safe?
There were systems for reporting incidents; however, not all staff knew about these. The majority of staff we spoke with were not aware of serious incidents or of the learning from these. Staff had been trained in adult and child safeguarding. Staff identified risks to young people's safety through assessment and on-going monitoring, and by reviewing their risk management plans.

Are services effective?
Staff knew how to use the Mental Capacity Act 2005. However, they did not demonstrate to us that they clearly understood their responsibilities in relation to 'Gillick Competencies', which meant that consent for young people under 16 might not be appropriately applied. We saw evidence that staff were using national guidance and best practice tools in the services we visited. Staff had received some mandatory training, but there were gaps. Continuing professional development of staff was not routinely recorded to show that staff were appropriately trained to support young people. Good multi-disciplinary and multi-agency work was taking place.

Are services caring?
The staff in all the teams we visited were committed to their work and spoke passionately about their work with people and ensuring they received a good service. The people who use the service told us they felt respected by the staff and that they listened to them. People spoke of being fully involved in their support and worked with staff to ensure that their treatment was what they wanted and needed. The care plans were 'person centred' and individualised to the needs of each person, including their mental health needs, emotional support and problem solving techniques.

Are services responsive to people's needs?
Young people were able to access services across a number of different community sites in Surrey. This helped them receive treatment near to their home. While there were variations between teams, young people were being assessed and received treatment in a timely manner. We saw that young people needing an inpatient service have to access services outside the trust. Also, some young people needing acute care had to be temporarily accommodated on an adult ward while a bed was found, but this was carefully managed. The transition of young people into adult services was planned jointly with adult services and the young person to ensure that all needs were accommodated and planned for. The service took complaints seriously and responded to them promptly.

Summary of findings

Are services well-led?

Staff knew about the reconfiguration of the CAMHS service. However, a number of staff did not feel listened to about changes that affected them. Staff knew the senior managers of the trust and who to contact within the trust to seek support with specific issues. Some services had experienced a lot of change in their management arrangements and this resulted in staff from those teams not being well-led. There were concerns about future management arrangements and whether this would provide sufficient staff support. The service had systems to seek feedback from young people and their parents, although the results of these were not available to see if improvements had taken place.

Summary of findings

Background to the service

Surrey and Borders Partnership NHS Foundation Trust provides health and social care services for people with mental health problems, drug and alcohol problems and learning disabilities in Surrey and North East Hampshire.

Services are provided to children and young people, adults of working age, adults with learning disabilities, and to older people.

The trust has 24 locations registered with CQC. Thirteen locations are registered to provide social care for children and adults with learning disabilities. The remaining locations are registered to provide a range of healthcare services. Acute and older people's inpatient beds are provided at a number of locations: Farnham Road Hospital, West Park Epsom, Mid Surrey Assessment & Treatment Service, Ridgewood Centre, St Peters Site, and Willows, Woking Community Hospital. Services for people with learning disabilities are provided at Bramdean and April Cottage.

Margaret Laurie House Inpatient Rehabilitation Unit provides rehabilitation services. Community based services are registered to trust headquarters in Leatherhead.

The trust was formed in 2005 and became a foundation trust in May 2008. It employs 2,300 staff across 56 sites, including nursing, medical, psychology, occupational therapy, social care, administrative and management staff.

It serves a population of 1.3 million people. Deprivation is lower than the national average, although some areas of deprivation do exist. Life expectancy is 6.3 years lower for men and 4.0 years lower for women in the most deprived areas of Surrey than in the least deprived areas. In Surrey, 9.7% of the population is non-White.

The trust works with partner agencies and the voluntary sector to provide a range of services. The services are delivered through four divisions:

- Mental Health Services for Adults of Working Age
- Mental Health Services for Older People and Specialist Services
- Services for People with Learning Disabilities
- Services for Children and Young People

Surrey and Borders Partnership Foundation NHS Trust's locations have been inspected on 51 occasions since registration across 29 of its locations. Reports of these inspections were published between April 2011 and March 2014. At the time the comprehensive inspection was undertaken the trust was non-compliant for at least one regulation at 20 of its locations. Of these locations 12 were non-compliant for the safety and suitability of their premises and 10 for the care and welfare of people who use services. Two locations were compliant for all regulations. Seven locations were no longer registered to provide services. This non-compliance was followed up as part of this comprehensive inspection.

Surrey and Borders Partnership NHS Foundation Trust child and adolescent mental health services (CAMHS) assess and support children and young people coming into contact with mental health services for the first time and those requiring longer term input with complex mental health needs. The services provided by the trust include the primary mental health services (PMHS) and CAMHS Tier 3 community based services for children and young people with a mental health difficulty including a learning disability service. There are no Tier 4 inpatient beds within the child and adolescent mental health services (CAMHS).

CAMHS support is provided by a number of community teams throughout Surrey. These are divided into the sectors of North, East and South. Each sector is led by a CAMHS and a PMHS manager. We inspected the mental health, primary mental health and learning disability services in a number of locations across the county. There are a number of other services which we did not cover as part of our inspection.

At the time of the inspection the trust was reconfiguring CAMHS, with changes to the services and staff required for these.

Changes were taking place to move from four sector teams to three. The plan is for all staff to work within sectors on pathways with some of them working across countywide pathways such as neurodevelopmental and urgent pathways.

As part of the reconfiguration the staff were involved in a consultation process. Some had to take part in a

Summary of findings

competitive interview process and some were able to be slotted in and some had an amendment to their hours of work or base. This meant that at the time of the inspection some staff had to be re-deployed, and some staff did not know their future job position. As part of this process 1 out of 4 sector manager posts were removed.

Before this inspection, neither we nor the Mental Health Act Commissioners had inspected the community CAMHS.

Our inspection team

Our inspection team was led by:

Chair: Sheena Cumiskey Chief Executive Officer at Cheshire & Wirral Partnership NHS Foundation Trust

Team Leader: Jane Ray, Care Quality Commission

The team of 50 people included CQC Inspectors, Mental Health Act Reviewers, and an analyst. We also had a variety of specialist advisors which included a consultant psychiatrist, nurses, junior doctors and social workers.

We were additionally supported by five Experts by Experience who have personal experience of using or caring for someone who uses the type of services we were inspecting.

The team that inspected child and adolescent mental health services consisted of a CQC inspector and a variety of specialists: a CAMHS consultant psychiatrist, social worker and a hospital director.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme. This trust was selected to enable the Care Quality Commission to test and evaluate its methodology across a range of different trusts.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, 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?

The inspection team inspected the following core services, which are inspected at each trust:

- Acute admission wards
- Health-based places of safety
- Psychiatric Intensive Care Unit
- Services for older people
- Adult community-based services
- Community-based crisis services
- Child and adolescent mental health services
- Services for people with learning disabilities or autism
- Long stay/rehabilitation services

We also inspected the Specialist eating disorder services provided by the trust.

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

Summary of findings

Before the inspection visit took place, we met with five different groups of people who use the services provided by the trust. We also met with the trust's council of governors. They shared their views and experiences of receiving services from the provider.

Before and during the week of the inspection we undertook separate inspections at 10 social care services provided by the trust: Ashmount, Beeches Bungalow, Court Hill House, Derby House, Ethel Bailey & Oak Glade, Hillcroft, Larkfield, Redstone House, Rosewood and The Shieling. These inspections are reported on separately, although their findings are included in the 'well-led' section of this report.

We inspected all the acute inpatient services and crisis teams for adults of working age. We visited the psychiatric intensive care unit on Langley wing at Epsom hospital. We went to the three places of safety located in Langley Wing, Epsom General Hospital, Wingfield ward, Ridgewood Centre, Frimley and the St Peter's site.

We also inspected the inpatient and some community services for older people. We visited a sample of community teams across a range of services, including services for adults, services for people with learning disabilities, and services for people with eating disorders,

During our visit the team:

- Held focus groups with different staff members such as nurses, student nurses and healthcare assistants, senior and junior doctors, allied health professionals and governance staff.
- Talked with patients, carers, family members and staff.
- Looked at the personal care or treatment records of a sample of patients.
- Observed how staff were caring for people.
- Interviewed staff members.
- Reviewed information we had asked the trust to provide.
- Attended multi-disciplinary team meetings.
- Collected feedback using comment cards.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

What people who use the provider's services say

We spoke with young people who use the service and their parents/carers during the inspections and during consultation events prior to the inspection. The majority of young people were positive about their experience of using the services, and said that the staff provided a high level of service to them.

People said that the staff were kind, supportive and listened to them. People spoke of being fully involved in their support and working with staff to ensure that the treatment they received was what they wanted and needed. People felt they received a service that was specifically designed to meet their needs. The staff in all the teams we visited were committed to their work with young people and ensuring they received a good service.

Good practice

- The CAMHS youth advisors (CYA) are an innovative user-led service run by young people who use/ have recently used the service. The CYA are a support network for young people experiencing emotional distress and mental health issues for the first time. They actively encourage young people to get involved in their work through workshops, trips out and groups.
- The CAMHS service ran the targeted mental health in schools (TaMHS) approach that worked to support school staff to recognise young people with emerging mental health and emotional needs, and provide access to early advice and consultation from a mental health professional.

Summary of findings

- The CAMHS social work service worked jointly with the Surrey youth support service under the 'No Labels' approach. This was to try and connect with young people using a youth work model rather than traditional CAMHS interventions, to reduce the stigma relating to mental health and involve young people who were known to services, but not actively engaged in treatment.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that all staff know how to report incidents and are made aware of the findings.

Action the provider SHOULD take to improve

- The trust must ensure that there is a clear record of the training completed by staff so that refresher training can take place and training needs can be identified and addressed.
- The trust should ensure that staff have a clear working knowledge of their responsibilities in relation to consent and Gillick Competencies, so this can be used in their work with young people.
- The trust should ensure that staff are appropriately supported about changes that affect them during the ongoing reconfiguration of the community services.
- The trust should ensure that the results of feedback received from young people and their parents are readily available and clear improvements made as a result.

Detailed findings

Surrey and Borders Partnership NHS Foundation Trust

Child and Adolescent Mental Health Services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Children and Young People Learning Disability Team - South	Trust Headquarters
Children and Young People Learning Disability Team - East	Trust Headquarters
CAMHS Community Team - South	Trust Headquarters
CAMHS Community Team - East	Trust Headquarters
CAMHS Community Team - North	Trust Headquarters
CAMHS Community Team - North	Trust Headquarters
Primary Mental Health Team - East	Trust Headquarters
Primary Mental Health Team - South	Trust Headquarters
Primary Mental Health Team - North	Trust Headquarters
Primary Mental Health Team - North	Trust Headquarters

Mental Health Act responsibilities

<Summary here>

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The majority of staff we spoke with demonstrated a working knowledge of the Mental Capacity Act 2005 and their responsibilities within this for young people over the age of 16 years. Where the teams consisted of a social worker, this person was also the best interest assessor to provide advice on capacity issues.

We found that staff awareness of Gillick Competencies, in deciding whether a young person under 16 years was able to consent to treatment without the need for parental permission or knowledge, was not consistent across the teams. In most teams we found that there was a general assumption that the parents would give consent where the young person was under 16 years.

The guidance to staff on consent for young people was found in a number of trust documents. The consent forms in use were for all services, but a separate sharing information form for children and young people ensures consent is sought taking into account Gillick competency guidance.

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

There were systems for reporting incidents; however, not all staff knew about these. The majority of staff we spoke with were not aware of serious incidents or of the learning from these.

Staff had been trained in adult and child safeguarding.

Staff identified risks to young people's safety through assessment and on-going monitoring, and by reviewing their risk management plans.

Our findings

Track record on safety

We were shown the electronic system used for the recording and reporting of incidents. The system ensured senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these. Senior staff we spoke with gave us examples of incidents they had reported; however the majority of staff we spoke to during our visit working in the community teams did not know how to report an incident.

Learning from incidents and improving safety standards

We saw that incidents had been investigated and discussed in a range of forums. The majority of staff we spoke with were not aware of recent serious incidents that had occurred within CAMHS, or of the learning from these. Those that did know about incidents said that they found out through a colleague who worked in the team in which the incident occurred, or they had heard about it in the media.

We also found that some recommendations made as a result of an investigation following an incident, took a long time to be implemented. An example of this was that substance misuse training had been recommended for staff in July 2013, but had not yet taken place due to changes in the service that would deliver this that was not within the scope of the trust.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

The community teams we visited consisted of trust staff and social workers who were seconded from Surrey County Council. This meant that the teams could respond promptly to any safeguarding issues using a multidisciplinary approach. The staff we spoke with had a clear understanding of safeguarding and their responsibilities in relation to identifying and reporting safeguarding issues. All the staff we spoke with knew who was the safeguarding lead for the trust and felt able to contact them for advice when needed. We observed a team meeting where staff discussed an allegation made by a young person and of the steps they had taken in response to this, which was in accordance with appropriate guidelines

The training records confirmed that staff had received training in adult and child safeguarding and that this was kept up-to-date.

Assessing and monitoring safety and risk

Care records demonstrated that the risks young people presented to themselves, and others, had been assessed and reviewed regularly to ensure they received appropriate support. Risk management plans detailed the actions that were required to minimise the risk to the individual and any triggers/risk behaviours that the person needed to be aware of, as well as different strategies for managing these risks. Staff told us that risks were reviewed each time they had contact with a person, and in care programme approach (CPA) meetings. This ensured that the level of support and treatment young people received was monitored and adapted to any changes in the person's mental health or social circumstances.

Each team had a duty system, which was staffed by any member of the CAMHS or PMHS. The duty staff triaged calls and signposted or made appointments for assessments where necessary. Similarly, when a young person presented at the A&E department of a local acute hospital the duty staff would attend to carry out an assessment of their needs.

The staffing of the teams varied. At the time of the inspection there were vacancies across all the CAMHS teams. Staff across all services spoke of a shortage of

nurses within the tier 3 CAMHS teams. The general manager told us that part of the reconfiguration was for staff to work across all teams within the sector, which meant that not all team bases would be fully staffed, but that there would be access to staff across the sector in which they worked. Across the two sites in the north sector there are between 8-15 staff working each day. There is an established minimum of 2 staff at Ashford from Monday to Fridays. At the time of the inspection there were no nursing vacancies and as a result of the redesign additional band 5 and 6 posts were available and recruitment was underway.

We asked staff about training they had received in physical/ non-physical interventions to support people in challenging situations. Some staff told us they had received training in restraint and de-escalation techniques, and we saw evidence to confirm this. We were also told that this training is provided as part of the staff induction and further training is available if needed.

Understanding and management of foreseeable risks

Across the teams the staff described the procedures for following up where young people did not attend for appointments. These ranged from telephone contact, to home visits and sending of letters. They showed us how they recorded this, and of the information sent to the person's GP to keep them informed.

Are services effective?

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

Staff knew how to use the Mental Capacity Act 2005. However, they did not demonstrate to us that they clearly understood their responsibilities in relation to 'Gillick Competencies', which meant that consent for young people under 16 might not be appropriately applied.

We saw evidence that staff were using national guidance and best practice tools in the services we visited.

Staff had received some mandatory training, but there were gaps. Continuing professional development of staff was not routinely recorded to show that staff were appropriately trained to support young people.

Good multi-disciplinary and multi-agency work was taking place.

Our findings

Assessment and delivery of care and treatment

The assessments of young people were carried out by any member of the teams, which consisted of psychologists, social workers, psychiatrists, mental health nurses and other professionals. All new referrals were reviewed on the day they were received, and allocated to one of the team, according to the needs of the person and the specialism of the staff member. There were a number of sites within each sector in which the teams operated. Young people could be assessed at a site accessible to them, and this was arranged when booking the appointment. The assessments included comments from the young person and their parent/carer to ensure these were recorded and used for future planning.

Any physical health or medical needs of the young person was recorded as part of the assessment process, and staff demonstrated a clear knowledge of these needs and how they could impact on people's mood and behaviour. There was evidence of good liaison with the person's GP to ensure that all relevant physical health issues of people were captured. The care records also showed that young people were supported to access services to meet their physical healthcare needs.

Some staff within the learning disabilities services spoke of the length of time it could take to assess a child with learning disabilities, sometimes due to their being unable to verbally communicate, and limited communication through other methods. Similarly, they also spoke about the longer treatment times needed for children with complex needs, which they did not feel the trust always acknowledged.

The majority of staff we spoke with demonstrated a working knowledge of the Mental Capacity Act 2005 and their responsibilities within this for young people over the age of 16 years. Where the teams consisted of a social worker, this person was also the Best Interest Assessor to provide advice on capacity issues. However, we found that staff awareness of Gillick Competencies, in deciding whether a young person under 16 years is able to consent to treatment without the need for parental permission or knowledge, was not consistent across the teams. In most teams we found that there was a general assumption that the parents could give consent where the young person was under 16 years.

The guidance to staff on consent for young people was found in a number of trust documents. The consent forms in use were for all services, but a separate sharing information form for children and young people ensures consent is sought taking into account Gillick competency guidance.

Outcomes for people using services

The young people and parents, who use the service, said that the staff understood their needs and were able to support them in the way they needed. The feedback we received was that they felt the service was tailored to their needs and appropriate for their support. The staff we spoke with conveyed a good knowledge of the needs of the people who used the service and ensured that people were supported safely.

We saw examples of the use of national guidance and best practice tools throughout the services we visited. This included brief solution-focused therapy and cognitive behavioural therapy to support young people. The CAMHS team had recently introduced the Social Care Institute for Excellence 'think child, think parent, think family' initiative to ensure the mental health needs of all immediate family members/carers were assessed, to find out if parents were also in receipt of services, and carry out joint assessments with the adult team where necessary. We received positive

Are services effective?

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.

feedback from people about this. The parents we spoke with said that whilst the young person was the focus of the assessment and treatment, they felt included and were encouraged to participate in the treatment for their child.

All of the CAMHS teams used the children's global assessment scale (CGAS) to rate the young person as part of the assessment.

We saw information to evidence that the CAMHS teams were members of the Quality Network for Community CAMHS, which meant they were subject to peer review checks by the Royal College of Psychiatrists, as well as self-audits of specific areas. The most recent audits were carried out in September 2013, where a number of areas for improvement had been identified and an action plan had been developed to make these changes.

Staff, equipment and facilities

In all the teams we visited the staff said they felt well supported by their peers and direct line managers, and that there was good team work taking place. Staff were committed and proud of the work they did and the services in which they worked. There was good teamwork and respect for each other's skills and professional backgrounds. We saw evidence of individual and group supervision for staff and team meetings. However, this was not consistent for all staff, with some teams not receiving these levels of support for a number of months.

Across the CAMHS teams there had been a number of manager vacancies, and these had been filled by interim managers for up to 18 months. At the time of inspection there was one permanent general manager, one interim sector manager, one recently appointed sector manager and one permanent sector manager who had been in post for over 12 months. We found that the induction for new managers consisted of the corporate induction, though little structured induction when they joined the community teams.

Mandatory training, such as health and safety, equality, diversity and human rights, and information governance was provided by the trust. However the training records showed that a number of staff had not undertaken all their mandatory training. The staff and managers told us that whilst electronic training records were not always up-to-date some of this training still needed to take place.

Staff within the community services told us they could access some other relevant training and keep up-to-date with their continuing professional development (CPD). Some staff spoke about having recently undertaken training in family therapy, epilepsy, nurse prescribing, autism and trauma. However, some staff also said that training was hard to access, or there were long waiting times for these. We found that CPD was not routinely recorded, so it was unclear how the trust assured itself that staff were appropriately skilled to meet people's needs.

The teams were based in different buildings throughout Surrey, with a number of the teams sharing each location which the staff said led to more effective working across the teams.

Multi-disciplinary working

Most of the community teams were multi-disciplinary and they also worked well with professionals from other teams and providers.

During the inspection we observed a meeting between the PMHS and behaviour support teachers who work with local schools, to identify ways of improving referrals to address the specific needs of young people. This included agreements around more joined up working for young people with complex needs. There were also CAMHS community nurses who worked with schools to provide support to teachers and young people. Similarly, the service ran the targeted mental health in schools (TaMHS) approach that aimed to skill up school staff. This would help them to identify pupils with emerging mental health and emotional needs helping to provide access to early advice and consultation from a mental health professional.

For young people who were referred to the CAMHS service but were hard to engage the social workers from the CAMHS service worked jointly with the Surrey youth support service under the 'No Labels' approach. This was to try and engage with young people using a youth work model rather than traditional CAMHS interventions.

Are services caring?

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

Summary of findings

The staff in all the teams we visited were committed to their work and spoke passionately about their work with people and ensuring they received a good service.

The people who use the service told us they felt respected by the staff and that they listened to them. People spoke of being fully involved in their support and worked with staff to ensure that their treatment was what they wanted and needed.

The care plans were 'person centred' and individualised to the needs of each person, including their mental health needs, emotional support and problem solving techniques.

Our findings

Kindness, dignity and respect

The feedback we received from children, young people and parents who use the service was that the staff treated them with respect, were very caring and listened to them. People said that staff worked in collaboration with them to ensure they received a service that suited their needs. However, some people told us that whilst the reconfiguration had been taking place they had at times felt ignored and where appointments had been cancelled at short notice. However, they were positive about the services they received since that time and that they now received appropriate support.

During our inspection we saw that staff communicated with people in a calm, friendly and professional way. We observed a home visit with a family. We saw that there was a good process of engagement, assessment, explanation of what would happen, and people were treated with kindness and dignity

Some parents fed back that some questions asked during their assessment were not appropriate to be asked in front of their children. Similarly, some young people said they would like to be asked questions without their parent present. We observed a session where a parent and child were being interviewed. Where questions were directed at the parent, these were 'mouthed' to the parent, which did not demonstrate respect for the parent or young person present. The parent told us this situation did not make them feel comfortable, and felt there should be follow-up contact arranged by the professional to ensure all information was captured.

People using services involvement

The feedback we received from people was that they felt involved in their treatment, and worked in collaboration with the staff in deciding what support they wanted. The care plans we reviewed showed evidence of young people's, and their parents', views and how they decided what was important for them and how they wanted to be supported. People spoke about the service working with them and giving them the information to make decisions about their life and support needs. They said that the treatment was specific to their needs and was the right support for them.

The staff across all teams spoke of working with people to ensure they were committed and engaged in their support.

Emotional support for care and treatment

People who used the service told us they received emotional support through the individually planned treatment they received. Where people needed support, care plans were developed around emotional distress.

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

Young people were able to access services across a number of different community sites in Surrey. This helped them receive treatment near to their home.

While there were variations between teams, young people were being assessed and received treatment in a timely manner.

We saw that young people needing an inpatient service have to access services outside the trust. Also, some young people needing acute care had to be temporarily accommodated on an adult ward while a bed was found, but this was carefully managed.

The transition of young people into adult services was planned jointly with adult services and the young person to ensure that all needs were accommodated and planned for.

The service took complaints seriously and responded to them promptly.

Our findings

Planning and delivering services

The CAMHS teams were spread throughout Surrey so that young people could receive support close to where they lived. Whilst each team operated slightly differently, the shared management structures ensured they worked to meet the needs of the young people.

Right care at the right time

The responsiveness of the community teams was monitored. This included the monitoring of referral to assessment to treatment times. The average findings ranged within the trust targets, which showed that people generally received a timely service. In each team the staff were aware of the targets they needed to meet.

Young people and parents that we spoke with said they did not have to wait long from referral by their GP, to assessment and receiving treatment. As a result they said the service was timely and appropriate to their needs. The services offered treatments such as art therapy, family therapy, play music and music therapy.

Where young people needed support out of hours they could contact the crisis line for support. There was no out of hour's crisis line specifically for young people.

The teams collected the 'protective characteristics' of young people who used the service, which captured information such as their ethnicity and religion. Along with this, staff within all the services told us about the diversity of people living within Surrey and its borders. They identified there were growing Eastern European communities, areas of high Indian-Asian populations, as well as travellers who had needed to access the service. In accommodating the diverse needs the staff told us they had access to interpreters who could be present for a meeting, and were able to translate written communication sent out to people. If a young person wanted an assessment by a certain gender of staff, then this would be accommodated.

Care Pathway

Within the learning disability services we found care pathways in relation to specific needs, such as emotional wellbeing pathway, prescribing pathways and those for taking blood from children with learning disabilities, which meant that the processes for these were clear and young people received a seamless service.

The staff of the PMHS and CAMHS teams told us that all referrals are screened primary mental health and tier 3 clinicians and are then signposted for assessment to the appropriate tier, either PMH or tier 3. If the young person required more support this would move to tier 3 services. There are no tier 4 (inpatient) services with the trust.

Due to commissioning arrangements there were no inpatient NHS CAMHS beds within Surrey. Where an inpatient stay was required the use of private hospitals was sought, though often this could mean the young person needed to move to a CAMHS inpatient service in another part of the country. The staff spoke about the difficulties with this as families were having to travel to see the young person, and the issues of arranging weekend leave and maintaining a professional relationship with the young person.

On occasions young people had been admitted to adult inpatient acute wards within the trust.

During the past year there were 23 admissions to adult inpatient wards, and these were reported as an incident to senior managers within the trust. The breakdown of data

Are services responsive to people's needs?

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

for this showed that young people were admitted for a maximum of three days before being moved to a CAMHS facility or being discharged. The young people were also aged 17 years. The general manager told us that where young people were admitted to an adult ward they provided support to staff and visited the young person during their stay.

Where young people were six months away from their 18th birthday the process of transition into adult services was initiated. The general manager said there was some flexibility within this, where young people were not always transitioned as soon as they turned 18. This included factors such as the young person taking exams or encountering particular stress in their life which meant transition was delayed for some months. Within the learning disability services we found that some people had not fully transitioned into adult services after a year or so, due to their specific needs or ongoing safeguarding investigations. There were records of joint meetings with adult services to ensure that the transition was well planned, and we saw examples of joint care planning around areas such as managing anxiety of the young person, family and peer relationships.

Learning from concerns and complaints

We saw information on display in the waiting areas of how people could make a complaint. The young people and parents we spoke with told us that they would feel able to raise complaints about their care and they felt confident these would be listened to and acted upon. The staff we spoke with told us they would listen to people if they raised a concern and if they could not address it themselves they would refer the person to the sector manager or the patient advice and liaison service (PALS).

We looked at the records of some complaints received and the correspondence relating to them. We found that complaints were taken seriously and responded to promptly. The complainant was provided with an individualised response to their complaint and given contact details of other bodies they could raise the complaint with if they were dissatisfied with the outcome of the complaint.

The team meeting minutes showed that complaint issues were discussed and actions taken to ensure that issues were highlighted and areas of improvement identified and acted upon. An example of this included the tracking of referrals made to ensure young people received a timely assessment of their needs.

Are services well-led?

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

Staff knew about the reconfiguration of the CAMHS service. However, a number of staff did not feel listened to about changes that affected them.

Staff knew the senior managers of the trust and who to contact within the trust to seek support with specific issues.

Some services had experienced a lot of change in their management arrangements and this resulted in staff from those teams not being well-led. There were concerns about future management arrangements and whether this would provide sufficient staff support.

The service had systems to seek feedback from young people and their parents, although the results of these were not available to see if improvements had taken place.

Our findings

Vision and strategy

The staff were aware of the values and vision of the trust.

A number of staff spoke about the changes that had, and were continuing to take place within CAMHS. Some staff mentioned the recent pilot to introduce a single point of access which they felt was rushed without heeding concerns they raised. The pilot was led by senior clinicians and managers and considered if changes were required. As a result of the pilot the plan was revised. The general manager told us that there were plans to re-introduce the pilot, taking into account the lessons learned.

There had been a number of recent changes within CAMHS, through a reconfiguration of the services provided. The recent changes have reflected changes in commissioning arrangements and included a review of the support provided to each young person/parent. These changes had meant that some people had a different care coordinators. Some of the staff we spoke with told us they felt unable to give people the service they felt they needed. The managers of the service said that these changes were necessary to focus on the service they were commissioned to provide and ensure people received the service they needed.

Responsible governance

There was a clear management structure and staff knew who to contact within the trust to seek support with specific issues. Staff knew who the senior management of the trust were and their scope of responsibility.

There was a quality action group (QAG) for the CAMHS division. The minutes of these meetings showed that areas such as performance, incidents, and plans for improvement were discussed. However, what was clear in the minutes and of the staff we spoke with was that information and discussion from the QAG were not always cascaded to front line staff. An example of this was in the May 2014 where QAG meeting minutes stated that more conversations needed to take place in terms of learning from serious incidents, and serious incidents need to be addressed in team meetings. However, there were no actions planned to ensure this was carried out.

During 2013 a 'deep dive' review of the CAMHS service took place which identified improvements needed for the service. An action plan had been developed as a result and was still being implemented at the time of our inspection. There were also periodic service reviews that took place by staff from another part of the trust, with the most recent of these being in June 2014.

Leadership and culture

Within the community teams we found effective leadership, where there had been a consistent CAMHS sector manager. The staff felt supported in their work and part of a team. However, across the majority of teams the staff spoke of there being low morale and of a reactive approach to work and managing issues. This was particularly where there were interim managers. One North East team manager had had three different line managers over the past 18 months. Due to the interim management arrangements across a number of the community teams, staff did not always feel that the services had been well-led at a local level. As a result staff in some teams spoke about becoming more cohesive and reliant on each other, where they worked as a team to ensure they continued to deliver a service.

The changes in management structures meant that sector managers were managing more staff across a number of teams. Some staff and managers spoke about their concerns with these management arrangements and lack of local managerial support. As a result they felt they missed out on communications and information relevant to them. Some spoke of not having a senior person within

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the team base to seek guidance from, and felt that the day-to-day management of staff did not take place, due to a lack of managerial presence in the teams. New managers spoke of being anxious about the management arrangements and the lack of deputy/team leader support in each team.

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Performance improvement

Within the community services, dashboards were completed by the sector managers, which fed back to the trust. They included monthly key performance feedback about areas such as care planning, number of referrals and where people did not attend for appointments.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated activities)** **Regulations 2010** **Assessing and Monitoring the Quality of Service** **How the regulation was not being met:** The registered provider had not protected people at risk of inappropriate or unsafe care. There was not an effective system to ensure that changes were made to treatment or care provided, by the analysis of incidents. Not all staff knew how to report incidents and were not made aware of the findings. This was a breach of Regulation 10(2)(c)(I)