WM QRS West Midlands Quality Review Service

NHS

Towards Children and Young People's Emotional Health and Well-being

Worcestershire Health and Social Care Economy

Visit Date: 23rd and 24th February 2015 Report Date: June 2015

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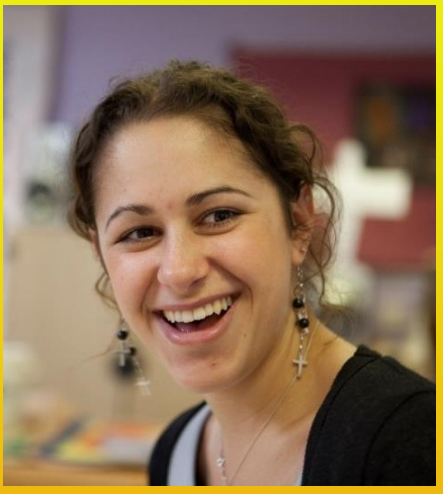

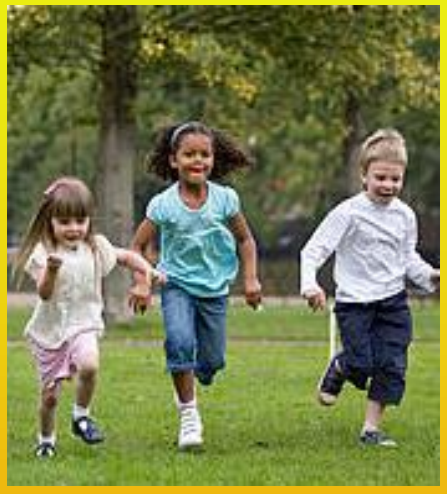

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INTRODUCTION

This report presents the findings of the review of Worcestershire services for children and young people's emotional health and well-being that took place on 23rd and 24th February 2015. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Towards Children and Young People's Emotional Health and Well-Being: Quality Standards for Local Services, Version 1, October 2014

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care, which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team that reviewed the services in Worcestershire health and social care economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- Worcestershire Health and Care NHS Trust
- Worcestershire County Council
- NHS South Worcestershire Clinical Commissioning Group
- NHS Redditch & Bromsgrove Clinical Commissioning Group
- NHS Wyre Forest Clinical Commissioning Group

The contribution of Worcestershire Acute Hospitals NHS Trust to the care of some children and young people with mental health problems is also described, although services provided by this Trust were not reviewed in detail.

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation, liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is Worcestershire County Council.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews – often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Worcestershire health and social care economy for their hard work in preparing for the review and for their kindness and

helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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Towards Children and Young People's Emotional Health and Well-Being

Health and Social Care Economy

The following table shows the 'towards emotional health and well-being' services within Worcestershire and the approach taken to their review:

Service	Provided by:	Commissioned by:	Review approach
Early Help Provider Services (Tier 1/2)	A range of voluntary and statutory sector providers in each district	Worcestershire County Council Children's Services	Summary of issues included, but not compliance with Quality Standards (QSs).
School Nurses (emotional well-being / self-harm pathways) (Tier 1/2)	Worcestershire Health and Care NHS Trust	Worcestershire County Council Public Health / Children's Services (section 75)	Included in report as part of Universal Services (issues and compliance with QSs)
Specialist CAMHS / Integrated Service for Looked After Children Team	Worcestershire Health and Care NHS Trust and Worcestershire County Council	Worcestershire County Council Children's Services (section 75)	Reviewed as targeted (Tier 2) service (issues and compliance with QSs)
CAMHS Tier 2	Worcestershire Health and Care NHS Trust	Worcestershire County Council Children's Services (section 75)	Reviewed as targeted (Tier 2) service (issues and compliance with QSs)
Specialist CAMHS (Tiers 3 and 3+)	Worcestershire Health and Care NHS Trust	Worcestershire County Council Children's Services (section 75)	Reviewed as specialist (Tiers 3 and 3+) service (issues and compliance with QSs)
Specialist CAMHS Learning Disabilities (Tier 3)	Worcestershire Health and Care NHS Trust	Worcestershire County Council Children's Services (section 75)	Reviewed as specialist (Tier 3) service (issues and compliance with QSs)
Commissioning	Worcestershire County Council Children's Services (section 75)	-	Reviewed against commissioning QSs (issues and compliance with QSs)

General Comments and Achievements

Worcestershire's pathways of care for children and young people's emotional health and well-being had undergone significant change since 2012/13. A needs assessment had been undertaken in 2011, and several changes had been made as a result. A Single Point of Access service had been introduced that provided advice and accepted referrals from all health, social care and education professionals. Targeted and specialist child and adolescent mental health services were provided by a team in each of the three localities (South Worcestershire, Wyre Forest, and Bromsgrove and Redditch). An enhanced specialist (Tier 3) service had been introduced in all three localities.

A pathway of care for children and young people with neurodevelopmental disorders had been developed and was in the process of being implemented. An urgent care pathway had been developed in 2014, including joint

protocols between social care, specialist CAMH services, adult mental health services, Worcestershire Health and Care NHS Trust, Worcestershire Acute Hospitals NHS Trust, and police, ambulance and GP services (in and out of hours). An enhanced (Tier 3+) service had been introduced. Child Outcome Research Consortium (CORC) measures of the effectiveness of interventions had started to be used. Improving Access to Psychological Therapies (IAPT) for children and young people was starting to be developed, including the use of all IAPT activity and outcome measures.

These changes had resulted in a more accessible and equitable service across Worcestershire. Feedback from GPs about the Single Point of Access service was particularly good.

Immediate Risks[1]

1 **Follow up**

The process and arrangements for the follow up of young people who had self-harmed and then attended an Emergency Department or been admitted to a paediatric ward were not robust. Some young people who had been assessed by the Mental Health Liaison Team or by the CAMH service were then discharged from acute hospital care without a named contact or an appointment for follow up by specialist child and adolescent mental health services. Young people were given an appointment at a later stage (within 24 hours if urgent and otherwise within four weeks).

Concerns

1 **Overview**

Reviewers were seriously concerned about some aspects of the care available for children and young people with mental health problems in Worcestershire for a combination of reasons, in particular:

a. Very little targeted (Tier 2) services was commissioned. This issue is described in more detail in the commissioning section of this report. Reviewers considered that the limited availability of preventive interventions could lead to greater pressure on specialist (Tier 3) services.

b. In specialist (Tier 3) CAMH services, waiting times for some non-urgent therapeutic interventions were long, and arrangements for care planning and risk assessments were not robust. This issue is described in more detail in the 'Specialist (Tier 3) CAMH Services' section of this report.

c. Several aspects of the response to young people in crisis were of concern to reviewers (see below)

2 **Crisis response**

Several aspects of the response to young people in crisis were of concern to reviewers:

a. The agreed urgent care pathway involved the 'all ages' Mental Health Liaison Team the enhanced Tier 3 service and the all-ages Psychiatric Assessment Team. The Mental Health Liaison

[1] **Trust response:** Urgent Care flow charts to be laminated and distributed to places where trust staff can become more familiar with the pathway. In line with urgent care protocol those who have been admitted may be followed up by CAMHS Tier 3+ team with arrangement agreed before discharge or referred to CAMHS Tier 3 team. For some who are not admitted and do not have suicidal ideation, an appointment with one of the Tier 3 locality teams will be given to them at a later date and will take place within the urgent timescale defined in our service specification of 4 weeks, or 24 hours if an emergency appointment is indicated. As an immediate action to mitigate this risk information will be provided to advise all young people at point of discharge from A&E, and those admitted to the ward of contact numbers both in and out of hours if they need additional support.
WMQRS response: The immediate risk response addresses the issue of ensuring that children and young people will receive an appointment with one of the Tier 3 locality teams at a later date and this will take place within the urgent timescale defined in your service specification of 4 weeks, or 24 hours if an emergency appointment was indicated. Of note is that although the timeframe for follow up does not appear to be defined in national guidance, other organisations across the West Midlands have implemented policies for seeing those who have self-harmed within 5-7 days, in line with the management of other urgent referrals.

service took referrals from 8am to 9pm, including at weekends. The team undertook mental health assessments in the Emergency Department up to 10pm each day. At weekends, but not on weekday evenings, the team would go to paediatric wards and undertake mental health assessments. How the team would respond also varied depending on the type of self-harm. The enhanced Tier 3 service would attend paediatric wards between 9am and 5pm, Monday to Friday, and supported ward staff in managing the care of young people with mental health problems. The social services Emergency Duty Team and the all-age Psychiatric Assessment Team were available from 10pm to 8am and offered telephone advice as well as Mental Health Act assessments. Reviewers found this pathway quite complex and confusing. At the time of the review some Emergency Department staff were not aware that children and young people could be referred to the Mental Health Liaison Service. Reviewers recognised, however, that considerable work had been put into developing the pathway and getting agreement from all the agencies involved, and that the pathway was not yet fully implemented.

b. It was not clear that staff in the Mental Health Liaison Service had competences in the care of children and young people with mental health problems, although one nurse was undertaking a CAMHS pathway course and others had spent some time with CAMHS teams.

c. Children on paediatric wards awaiting a Tier 4 bed were 'specialed' by agency nurses. A nurse with CAMHS competences was requested but was not always available.

3 **Data collection and monitoring**

Some 'key performance indicators' were set by commissioners but all the expected data were not yet being collected, and so service quality could not be fully monitored by commissioners. Issues relating to waiting times data are discussed below.

Further Consideration

1 A local Planning and Coordination Group that included all stakeholders with responsibility for improving children and young people's emotional health and well-being in Worcestershire was not yet in place. A number of other groups were working on aspects of the needs assessment, strategy and urgent care pathways. For example, a 'Children and Young People Integrated Commissioning Group' with senior representation from public health, commissioning (CCGs and County Council), education, social care, the Early Help Service, the police and NHS England met bi-monthly. An urgent care mental health pathway group was also meeting. There was, however, no ongoing group for coordinating pathways other than urgent care. Some staff working in different services did not appear to know each other, and effective arrangements for liaison between services were not apparent.

2 Mechanisms to involve children and young people and their families in improving services were generally not well developed, although a Youth Board was being implemented. Reviewers suggested that this could be taken forward through a local Planning and Coordination Group.

3 Arrangements for educational input for children with mental health needs, including those waiting on paediatric wards for a Tier 4 bed, did not appear to be robust. Reviewers were told that these children did not receive the educational input available to children with physical health needs.

4 Different definitions of a 'place of safety' appeared to be in use across the health and social care economy. In particular, reviewers were told that paediatric staff at Worcestershire Acute Hospitals NHS Trust considered any child waiting for a Tier 4 bed on a general paediatric ward to be a serious incident. This approach appeared to reviewers to differ from that adopted in some other parts of the West Midlands, and a more positive attitude to the best interests of the children and young people involved may be more helpful.

5 The urgent care pathway used agency nurses to 'special' young people waiting for a Tier 4 bed. Reviewers suggested that collaborative work with the specialist CAMH service to develop health care assistants with appropriate mental health competences may be a more cost-effective approach. Additional support and

training for paediatric staff in caring for children with mental health problems may also help to improve the care provided.

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UNIVERSAL SERVICES

General Comments and Achievements

The Single Point of Access service provided advice and guidance to staff working in universal services. School nurses were commissioned to provide emotional support and guidance, including some 1:1 work with children and young people, as part of the emotional well-being and self-harm pathways. Youth Mental Health First Aid training had been commissioned by Worcestershire County Council Public Health Department, and both STORM and suicide prevention training were available, although reviewers did not see details of these training programmes.

WORCESTERSHIRE COUNTY COUNCIL: EARLY HELP SERVICE

General Comments and Achievements

Worcestershire County Council provided an integrated family-based support service for families with children aged up to 19 years. An Early Help Service was available in each locality, coordinated through an Early Help Hub. These services were commissioned for outcomes and so the model of service provision varied in each locality. The services were not specifically commissioned to provide targeted (Tier 2) child and adolescent mental health services, but 1:1 and family-based interventions were offered, including cognitive behaviour therapy-based counselling.

An easy-to-use Early Help website was available and provided video life stories of some of the people who had found support through the Early Help Hub. Self-referral to family support workers was available. The Early Help Hub was co-located with the CAMHS Single Point of Access service and referrals that did not meet the criteria for CAMHS could be re-directed to the Hub.

The Early Help Hub usually offered support for a period of four weeks from a Family Support Worker for families and young people needing additional support. Staff in the Early Help Hub also contributed to the training of staff in universal services on request.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Referrals**

The criteria for acceptance of referrals by the Early Help Service were not clear. Reviewers were told that there had been a substantial increase in the volume of referrals, although they did not see activity or outcome monitoring data about the service. Very few of the Quality Standards for targeted child and adolescent mental health services were met by the service. Because of the lack of data, reviewers were not able to comment on whether the service had sufficient staff for the work being undertaken.

2 **Staffing competences**

Reviewers saw no evidence that the staff providing therapeutic interventions with individual clients and families had appropriate competences for the work they were undertaking. Reviewers were particularly concerned that:

a. It was not clear whether staff had undertaken appropriate training in using cognitive behavioural therapy in therapeutic settings.

b. Some staff did not appear to understand issues of capacity to consent and confidentiality, especially in relation to young people aged 13 to 19.

c. Some staff were not clear about the criteria for referral to more specialist services, including the Sexual Abuse Response Service. Reviewers were told of some young people being cared for by the Early Help Service who did not appear appropriate for a Tier 2 service.

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TARGETED AND SPECIALIST CHILD & ADOLESCENT MENTAL HEALTH SERVICES

INTEGRATED SERVICE FOR LOOKED AFTER CHILDREN: TARGETED (TIER 2) CAMHS

General Comments and Achievements

The staff on this team were employed by Worcestershire Health and Care NHS Trust or Worcestershire County Council, but the team was based within the Integrated Service for Looked After Children (ISL), which also included a carer support team. The ISL was a multi-agency service, jointly provided and managed by Health and Children's Services in Worcestershire. Line management for Trust employees was provided by the Worcestershire Health and Care NHS Trust. At the time of the review visit, discussions were taking place about the future location and management of the team. The needs assessment for the ISL-CAMH service was in the process of being updated.

A single point of referral to ISL was in place, and the multi-agency nature of the team meant that there could be a holistic response to the needs of Looked After Children. At the time of the review visit the team comprised 10 staff, including two clinical psychologists (1.6 wte), three social workers (1.4 wte), one community and leisure worker, one 16+ practitioner, a named nurse for Looked After Children and administrative support. The team had recruited to a mental health practitioner vacancy shortly before the review.

Immediate Risks: No immediate risks were identified.

Concerns

1 Reviewers were seriously concerned about the ISL-CAMHS team for a combination of reasons:

a. At the time of the review, the team did not have an identified lead manager.

b. The team was clear about the criteria for acceptance by the service but not about the criteria defined in the service specification. It was not clear whether the team's criteria were the same as those defined in the service specification.

c. It was not clear whether the staffing of the service was sufficient. The ISL-CAMHS team considered staffing levels to be insufficient for the 680 children and young people known to the service. Accurate data on numbers of referrals and ongoing caseload were not available, however, and so the demand and capacity of the team could not be assessed. At the time of the review there was a six-week wait for an initial routine appointment, and the team appeared to be overwhelmed by responding to crises. Urgent referrals were seen in less than one week if required. Reviewers considered that the team may not be performing the preventive work needed to avoid future problems. Data on outcomes of the interventions provided were also not available.

d. Processes for management of the team's caseload and clinical guidelines for the therapeutic interventions offered were not seen by reviewers.

e. The therapeutic interventions being delivered by the team were not clearly defined and it was not clear to reviewers that children and young people accessing the service would receive the same therapeutic support as those accessing other child and adolescent mental health services. Service managers considered that close links with specialist CAMH services were in place, with referral of clients or joint work as appropriate.

f. The team appeared to be working in isolation from other CAMHS services in Worcestershire, and the strategy for the development of the service was not clear at the time of the review. Reviewers recognised, however, that the team was under review and that changes would follow from this review.

WORCESTERSHIRE HEALTH AND CARE NHS TRUST: ALL SERVICES

General Comments and Achievements

Considerable work had been undertaken to improve child and adolescent mental health services. The feedback from the young people who met the visiting team was that they felt listened to, valued and understood by the services.

CAMHS teams had been re-structured and combined into locality-based Tier 3 teams. Tier 2 and enhanced Tier 3+ services were provided by county-wide teams who worked closely with the Tier 3 services in each locality. Quarterly 'away days' were held when the services met together. Staff also said that they were supported to attend training.

The Single Point of Access service had been established and appeared to be working well, with particularly good feedback from GPs. The service was staffed by one person each day, with additional support in the morning. The service undertook telephone liaison as well as providing a direct source of advice to staff in universal services.

A good website had been developed and a conference on self-help and self-harm had been organised shortly before the review visit.

Reviewers commented on the particularly friendly and positive attitude of the Worcestershire South team, including a very pleasant reception given to clients, staff and visitors.

Many aspects of the services were still in development at the time of the review. In particular, the urgent care pathway and the pathway of care for children and young people with neurodevelopmental disorders had been developed and implemented.

Good Practice

1 Transition 'champions' had been identified in each of the Tier 3 services and in one of the adult mental health teams. These 'champions' acted as leads for the transition of young people to adult services. Plans for county-wide transition champions in adult mental health services were being developed.

Immediate Risks: See the 'Specialist (Tier 3) and Enhanced (Tier 3+) Child and Adolescent Mental Health Services' section of this report.

Concerns

1 **Facilities**

At Wyre Forest the clinical rooms had no means of summoning help and were a long way from the office. The office space was cluttered and crowded. In the Bromsgrove and Redditch clinical rooms there was also no means of summoning help in an emergency. Corridors at the South Worcestershire team facility were cluttered and in need of decorating, and were not 'child-friendly'.

Further Consideration

1 Referrals to the Single Point of Access were transferred to clinical teams on paper and via the internal post rather than electronically. The Trust was planning to move to electronic patient records.

2 A Trust Transition Policy was not implemented for young people with learning disabilities, as adult services would not accept clients until their 18th birthday. No adult service was available for young people with autistic spectrum disorder and so there was no service to which to transition. Reviewers were told that the arrangements for the transition of young people with ADHD were variable and depended on the decisions of individual Trust clinicians and individual GPs. Formal shared care arrangements for the care of these clients were not yet in place. A Worcestershire all-age autism strategy had, however, been published in March 2015 and there were plans to implement an all-age autism pathway.

3 Reviewers also suggested that the referral process between the Youth Offending Team (YOT) and CAMHS may benefit from review. Reviewers were told that some referrals (having already been assessed by a CAMHS worker) went back to 'Choice' rather than going straight to 'Partnership'. Also, activity by the

CAMHS YOT worker was recorded by the YOT but not by CAMHS and it may be helpful for these data to be available to CAMHS in order to give an overview of CAMHS needs and activity.

4 The pathway of care for children and young people with neurodevelopmental disorders had been developed and was starting to be implemented. Some staff were concerned that they did not have enough time allocated in their job plans for work on this pathway. Review of job plans may be helpful to ensure the care of this group of clients does not get 'squeezed' by other pressures on the teams.

5 In view of changes in legislation relating to Deprivation of Liberty Safeguards (DOLS), reviewers suggested that, at a minimum, the CAMHS management team should undertake DOLS training.

6 Reviewers commented that many of the issues identified in this report could be resolved by active engagement of staff, and by teams working together. Reviewers observed some tendency for services and teams to wait for their management to take action. Further work on staff empowerment, encouraging staff to resolve issues rather than escalate them, and developing good communication between services may be helpful.

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TARGETED (TIER 2) CAMHS

General Comments and Achievements

Targeted (Tier 2) child and adolescent mental health services were provided by a small team comprising 4.4 wte mental health practitioners, spread across the three localities. At the time of the review, one post was taken up with developing the Improving Access to Psychological Therapies service for children and young people, although 'backfill' was available, and there was a 0.5 wte vacancy within the team. The service was expected to provide:

- A training programme for staff working in universal services
- Advice, guidance and supervision for staff working in universal services
- Short therapeutic interventions (four weeks) for individuals meeting specific criteria

The expected ratio of work with universal services to direct work with clients was 60:40.

Concerns

1 See the commissioning section of this report in relation to the commissioning of targeted services.

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SPECIALIST (TIER 3) AND ENHANCED (TIER 3+) CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

General Comments and Achievements

See the Worcestershire Health and Care NHS Trust, All services, section of this report.

Immediate Risks

1 **Risk assessments**[2]

Robust arrangements for risk assessments were not evident to reviewers. The expected risk assessment process was not clearly documented and most of the case notes seen by reviewers did not contain risk assessments.

[2] **Trust response:** The Trust had recently agreed to rollout the use of the electronic e-GRIST as the standard risk assessment tool in all CAMHS, adult mental health and learning disability services. In the meantime, CAMHS will introduce the paper based version of GRIST with immediate effect and audit its use to ensure that it is embedded in practice.
WMQRS response: The actions addresses the issue so long as they and the planned audit arrangements are implemented

Concerns

1 **Waiting times**

Reviewers were seriously concerned about waiting times for some non-urgent therapeutic interventions, especially because of the potential for a child's condition to deteriorate while on the waiting list or for children and young people to be lost to follow up. Waiting times were long and data showing the true picture of waits were not available. The position found by reviewers was as follows:

a. Waiting times for 'Choice' appointments were up to 18 weeks, although most clients were seen sooner, and more urgent appointments were available if required. At the 'Choice' appointment clients were not given a 'Partnership' appointment (i.e. the full CAPA model was not used). After their 'Choice' appointment clients were either prioritised for an urgent 'Partnership' appointment or went onto a non-urgent waiting list. At Redditch one member of staff had specific responsibility for monitoring and reviewing clients on the waiting list. The process for monitoring and reviewing clients on the waiting list in other teams was not clear. Reviewers were also concerned that, because of the number and turnover of locum staff, the clinical responsibility for clients on the waiting list whose 'Choice' appointment was with a locum who had subsequently left the service was not clear. Clients were told to ring their 'Choice' clinician if further help was needed before their 'Partnership' appointment but, in practice, many of these clinicians were no longer in the Trust and clinical staff were 'holding' caseloads of children and young people who they had never met.

b. At the time of the review, waiting times for non-urgent 'Partnership' appointments were four to five months in Wyre Forest, six months in South Worcestershire and seven months in Redditch. Waiting times for specialist interventions, if required, were even longer. At the time of the review the reported waiting time for family therapy was up to 12 months, and for psychotherapy was up to 20 months. The neurodevelopmental disorders 'umbrella' pathway could be delayed for up to nine months if the client was waiting for clinical psychology input. In particular, the autism pathway in some areas was delayed by at least nine months for young people needing assessment by a clinical psychologist.

c. The 'dashboard' used by commissioners did not fully reflect waiting times. An 'average wait' from 'Choice' to 'Partnership' was measured, and this was 10 weeks at the time of the review. Given that the lowest reported wait from 'Choice' to 'Partnership' was four months (Wyre Forest), it appeared that urgent referrals were being included in the data on average waiting times.

2 **Care planning**

Care plans were not routinely completed for clients, and staff had varying views about whether all clients required a care plan. Most clinical notes seen by reviewers of young people cared for by specialist CAMHS did not contain care plans with clear goals. Arrangements for reviews of care plans were also not robust. (Some clients seen by the enhanced Tier 3 team did have a care plan). The only care planning documentation seen by reviewers did not have a header, footer or any evidence of approval for use, or document control.

3 **Clinical leadership**

The service had been through a significant re-structuring, and full implementation of the new arrangements had been delayed by staff sickness. Reviewers were concerned, however, about the following issues:

a. The interface between teams and the CAMHS senior management team may not be working effectively. Roles were defined but it was not clear that this was how the service functioned in practice. For example, staff appeared to expect the Service Lead for Psychological Interventions to take operational responsibility, but this was no longer part of his role. The mechanisms for two-way communication with staff and for two-way communication with other agencies were

not clear. This situation was not helped by the long-term absence of one of the CAMHS Managers (to whom Team Leaders were accountable).

b. The acting Team Leader of the Wyre Forest team and the interim management at the Redditch and Bromsgrove team were under particular pressure. They had clinical caseloads as well as their acting management responsibilities and some had not had clinical or managerial supervision for six months.

c. Medical staff were structured into three different locality teams, each of which had a small number of staff. It was not clear that medical staff were effectively involved in multi-disciplinary teams in each locality, including

    i. Whether medical staff were contributing fully to multi-disciplinary audits, including audits of outcomes

    ii. Whether data collection on activity and waiting times included activity of medical staff

    iii. Whether the three medical teams provided effective cross-cover for absences.

4 **Staffing levels**

It was not clear to reviewers whether staffing levels in any of the teams were sufficient for the number of clients and therapeutic interventions offered by the service. The number of referrals had increased and the skill mix within the teams had changed. The service appeared to have a high proportion of locum staff (psychiatrists and nursing staff). Some staff were undertaking IAPT training, and there were some delays in appointing to 'backfill' posts. Managers of the team were not clear about the staffing capacity needed to deliver the service. Managers did not appear to be planning staffing levels proactively using data on the number of referrals, caseloads and therapeutic interventions delivered.

5 **Dietician staffing**

Dietician staffing was insufficient to support appropriate input for the care of young people with eating disorders. No dietician had time allocated for work with the CAMH service. A new community dietician service was, however, being commissioned with the intention that this would provide support to the CAMH service.

6 **Guidelines**

Guidelines covering the work of the Single Point of Access (SPA) service were not available to reviewers. Some pathways had been developed but these were not specific about:

a. The type and expected duration of therapeutic interventions offered

b. Arrangements for multi-agency input to therapeutic interventions

c. Shared care arrangements with other services

d. Prescribing, including initial prescribing and monitoring arrangements

e. Monitoring and follow up

Reviewers were told that the SPA Operational Policy covered these issues, but this was not easily available at the time of the review.

Further Consideration

1 The enhanced (Tier 3+) service was available from 9am to 5pm, Monday to Fridays, and reviewers were given different information about the role and the extent of home treatment provided by the service. Reviewers suggested that it may be helpful to compare the service model being provided in practice with that operating in other areas.

2 Given the number of medical staff working in the service, reviewers were surprised that a 24 hour on call rota was not run for Worcestershire. Further consideration of the benefits this could bring to the urgent care pathway for children and young people may be helpful in improving the quality of this pathway.

3 The data collected may not be sufficient to support effective management of the service. Data on referrals, the number of clients accepted and transition to adult services were collected. Data on waiting times and therapeutic interventions offered were not clear. It was also not clear whether available data were being used actively by Team Leaders to manage and plan service provision.

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SPECIALIST MENTAL HEALTH SERVICE FOR CHILDREN AND YOUNG PEOPLE WITH LEARNING DISABILITIES

General Comments and Achievements

The service for children and young people with learning disabilities and mental health problems was functioning well. The team had made considerable progress over the previous 18 months and had plans to continue its development. A holistic, flexible approach to the needs of children and young people was provided by a team of highly committed and motivated staff. Waiting times for the service were short. In the South team, the waiting time for a 'Choice' appointment was three to four weeks and then one to two weeks for a 'Partnership' appointment. Waiting times in the North team were six weeks and then two to four weeks (except for psychology appointments) respectively.

Reviewers did not see the care plans for children and young people cared for by the service and so were not able to comment on several aspects of the Quality Standards.

Good Practice

1 A visual 'social story' was used with clients coming to the service for the first time. The 'social story' had been designed specifically for those with learning disabilities. It had photographs of the building and staff and a brief explanation of what would happen at the appointment.

2 Occupational therapists were involved in providing therapeutic interventions for individual clients.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Crisis response**

The arrangements for a crisis response, if required, were not clear. The Learning Disabilities CAMHS team was available during normal working hours, but it was not clear that referrals of young people with learning disabilities would be accepted by the crisis team.

2 **Care planning**

Robust arrangements for care planning were not evident to reviewers. Reviewers were told that care plans were completed, but staff could not describe in detail the expected content or the process of review of care plans. It was not clear that young people were always given a copy of their care plan in an appropriate format, and reviewers were told of some instances when young people were given information that was not in an appropriate format.

3 **Transition**

Transition to adult services did not follow the Trust policy, and the transition process for users of the service did not begin until they were nearly 18.

Further Consideration

1 Development of information for clients in accessible formats may be helpful.

2 Several different risk assessment forms were in use and a smaller number of simpler forms may reduce time spent on paperwork.

3 Reviewers suggested that more active engagement of service users and carers in care planning and in improving service delivery should be considered.

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COMMISSIONING

General Comments and Achievements

Joint commissioning arrangements for child and adolescent mental health services were in place, with the lead being taken by Worcestershire County Council. Commissioners had developed a dashboard of indicators for the services and were in the process of updating the needs assessment.

Immediate Risks: No commissioning immediate risks were identified.

Concerns

1 The level of targeted (Tier 2) services commissioned was extremely limited. The Early Help Service provided some 1:1 and family-based therapeutic interventions, although these were not specifically commissioned. School nursing services were commissioned to provide some targeted (Tier 2) interventions. In the integrated CAMHS teams, if staff were following the commissioner-defined ratio of indirect to direct client contact then, at the time of the review, less than 1.0 wte mental health practitioner for the whole of Worcestershire was providing individual or group therapeutic interventions with clients needing a targeted service (other than Looked After Children). Reviewers considered that this level of targeted (Tier 2) service provision must have been impacting on specialist (Tier 3) services.

2 A Monday to Friday enhanced CAMHS Tier 3 service was commissioned, but not a seven day intensive home support service.

3 The 'dashboard' used by commissioners did not fully reflect waiting times. The 'average wait' from 'Choice' to 'Partnership' was measured at 10 weeks at the time of the review. Given that the lowest reported wait from 'Choice' to 'Partnership' was four months (Wyre Forest), it appeared that urgent referrals were being included in the data on average waiting times.

4 Other sections of this report identify issues that require commissioner attention:

   a. Follow up: See Health and Social Care Economy, Immediate Risks
   b. Facilities: See Health and Social Care Economy, Concern 1.
   c. Crisis response: See Health and Social Care Economy, Concern 2.
   d. Referrals: See Early Help Service, Concerns 1 and 2.
   e. Staffing competences: See Early Help Service, Concern 2.
   f. Integrated Service for Looked After Children: See Targeted (Tier 2) CAMHS, Concern 1.
   g. Facilities: See Worcestershire Health and Care NHS Trust, All services, Concern 1.
   h. Risk assessments: See Specialist (Tier 3) and Enhanced (Tier 3+) Child and Adolescent Mental Health Services, Immediate Risks.
   i. Waiting times: See Specialist (Tier 3) and Enhanced (Tier 3+) Child and Adolescent Mental Health Services, Concern 1.

j. Care planning: See Specialist (Tier 3) and Enhanced (Tier 3+) Child and Adolescent Mental Health Services, Concern 2.

k. Clinical leadership: See Specialist (Tier 3) and Enhanced (Tier 3+) Child and Adolescent Mental Health Services, Concern 3.

l. Staffing levels: See Specialist (Tier 3) and Enhanced (Tier 3+) Child and Adolescent Mental Health Services, Concern 4.

m. Dietician staffing: See Specialist (Tier 3) and Enhanced (Tier 3+) Child and Adolescent Mental Health Services, Concern 5.

n. Guidelines: See Specialist (Tier 3) and Enhanced (Tier 3+) Child and Adolescent Mental Health Services, Concern 6.

o. Crisis response: See Specialist Mental Health Service for Children and Young People with Learning Disabilities, Concern 1.

p. Care planning: See Specialist Mental Health Service for Children and Young People with Learning Disabilities, Concern 2.

q. Transition: See Specialist Mental Health Service for Children and Young People with Learning Disabilities, Concern 3.

Further Consideration

1 The service specification for child and adolescent mental health services was not clear about the therapeutic interventions to be offered by each service. Being clearer about this may help providers to establish whether staffing levels are sufficient.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Kaye Berry	Chief Executive	The CLD Trust
Elaine Cook-Tippins	Acting Team Manager / Neurodevelopmental Team Co-ordinator, CAMHS	2gether NHS Foundation Trust
Elaine Day	Patient Representative	
Kal Johal	Therapeutic Service Programme Manager	Murray Hall Community Trust
Dr Simon Lalonde	Consultant Clinical Psychologist (CAMHS)	Birmingham Children's Hospital NHS Foundation Trust
Katie Lawrance	CAMHS Manager	Shropshire Community Health NHS Trust
Dr Tanveer Sandhu	Lead Consultant: Child and Adolescent Psychiatry	Birmingham Children's Hospital NHS Foundation Trust
Jonathan Stringer	Nurse Consultant	Dudley & Walsall Mental Health Partnership NHS Trust
Tonita Whittier	Acting CAMHS Case Manager	NHS England, Birmingham, Solihull and Black Country Area Team
Alicia Wood	Senior Commissioning Officer – Children's Mental Health Joint Commissioning Unit	NHS Walsall CCG

Observers

Jamie Scott	Deputy General Manager	Hunters Moor Neuro-rehabilitation Centre

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service
Sue McIldowie	Quality Manager	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of Applicable QS	Number of QS Met	% met
Towards Children and Young People's Emotional Health and Well-Being			
Universal Services	4	4	100
Targeted and Specialist Child & Adolescent Mental Health Services	184	73	40
Integrated Service for Looked After Children Team (ISL)	(43)	(18)	(42)
Worcestershire Health and Care NHS Trust: Targeted (Tier 2) CAMHS	(42)	(16)	(38)
Worcestershire Health and Care NHS Trust: Specialist CAMHS, including enhanced provision (Tier 3 & 3.5)	(51)	(16)	(31)
Worcestershire Health and Care NHS Trust: CAMHS Learning Disabilities Team	(48)	(23)	(48)
Commissioning	6	2	33
Health and Social Care Economy	**194**	**79**	**41**

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