Good

Leeds Community Healthcare NHS Trust

Specialist community mental health services for children and young people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RY6X6	Leeds Community Healthcare NHS Trust Headquarters	East CAMHS Reginald Centre	LS7 3EX

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services responsive?	Good

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the service as good because,

The service had good provisions and clinic facilities for children, young people and families.

The trust were using an electronic system to store patient records. Staff had completed patients risk assessments in a timely manner and they contained all the relevant information. This had been an improvement from the last inspection.

The teams had a sufficient number of staff to meet the needs of the patients. They did not have to rely on bank or agency staff to fill clinical roles. There were a high number of experienced band seven and eight staff within the teams.

Staff were aware of their responsibilities in adult and child safeguarding, this was reflected in the high training figures throughout the teams.

Children and young people experienced shorter waiting times for assessment and treatment than at the last inspection. The teams had mechanisms in place to monitor wait times and were continuously aiming to improve them. Staff were able to offer immediate short term interventions which meant children and young people discharged from the service sooner. The trust were meeting their target for emergency assessments within four hours and urgent assessments within a week.

However :

The service was not assessing children and young people for autism and attention deficit hyperactivity disorder (ADHD) within the trust's 12-week target. The trust had a recovery plan to reduce wait times to 12 weeks for assessment by the end of March 2017. The average waiting time for an autism assessment had reduced from 40 weeks to 20 weeks since the last inspection.

Some specialist treatments had wait times of above 18 weeks; these were cognitive behavioural therapy and play therapy. The average wait time over the year for both treatments was around 20 weeks.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Children and young people had access to clean, well maintained and comfortable clinical environments.
- There was highly experienced staff working across all the teams, this included senior clinical staff that.
- Risk assessments were completed in a timely manner and were regularly audited for quality assurance.
- Staff were up to date with their child safeguarding and adult safeguarding training.
- Staff understood their responsibilities under the duty of candour and were able to tell us about how they operated in an open, honest and transparent service.

However:

- The high use of agency administration staff meant the teams had regular turn over and retraining of new administration staff.

Are services responsive to people's needs?

Good

We rated responsive as good because :

- There were clear care pathways and improved responses for children and young people in emergency situations and during crisis.
- The trust were meeting their target for emergency assessments within four hours and urgent assessments within a week.
- The service had improved wait times for general assessments and treatment from our last inspection. Staff had oversight on wait times through the trusts electronic dashboard which enabled timely responsive if access to assessment and treatment was too long.
- Staff were flexible in their approach to meet the needs of children and young people. They facilitated appointments which were best suited for young people, for example in schools.
- We saw the trust were responding to complaints appropriately, they were detailed, clearly written were sincere.

However:

Summary of findings

- Children and young people waiting for assessments in autism and attention deficit hyperactivity disorder (ADHD) had to wait longer than the trust's 12 weeks assessment target.
- Wait times for cognitive behavioural therapy and play therapy were above the 18 weeks' target.

Summary of findings

Information about the service

Child and adolescent mental health services deliver services in line with a four-tier strategic framework. This is nationally accepted as the basis for planning, commissioning and delivering services.

Tier one: Consists of practitioners who are not mental health specialists, for example GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. Practitioners offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist

services.

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

Tier three: Consists of community mental health team or clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders.

Tier four: Consists of services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units.

This child and adolescent mental health service in Leeds Community Trust falls under tier three. We were told the trust were moving away from the recognised tier model to the 'thrive model'. The 'thrive model' focuses on the needs and requirements of level of intervention required, and it uses risk to prioritise individuals where appropriate.

This service covered three regional areas and comprised three teams, South, East and West. The teams operated from bases within their region but had access to micro sites across the district to carry out clinics for children, young people and families. This enabled better accessibility.

All three teams configured their service in the same way, offering assessments and treatment for routine and specialist care. They operated between 9am and 5pm Monday to Friday, with crisis services available out of hours.

We last inspected this service in November 2014 where we found the service was in breach of

regulation 20 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the trust not recording patient risk appropriately and not having sufficient mechanisms in place to manage and monitor risk assessments. In addition, we found that patients had to wait a long time for assessment and treatment.

Our inspection team

The lead inspector was Hamza Aslam. The team that inspected this core service comprised two CQC Inspectors.

Why we carried out this inspection

We inspected this core service as part of a responsive inspection to review the compliance actions issued following our last inspection in November 2014.

Summary of findings

How we carried out this inspection

This was an unannounced inspection.

During the inspection we looked at the following key questions :

- Is it safe?
- Is it responsive?

Before the inspection visit, we reviewed information that we held about this service.

During the inspection visit, the inspection team:

- reviewed six patient care notes
- we interviewed the service manager and a team leader
- interviewed four staff from different bandings
- reviewed policies and procedures
- reviewed data provided to us by the trust in relation to performance targets
- reviewed patient experience and feedback
- spoke to two carers
- toured the premises, and clinical rooms.

What people who use the provider's services say

We reviewed feedback from the people who use the service. Friends and family tests results between March 2016 to May 2016 indicated that 86 % of people who use the service would be 'extremely likely' to recommend this service. Fourteen per cent said they would be 'likely' to recommend this service.

Some of the other feedback we sought included what people who use the service had to say about what service they received. We found emerging themes about how people felt listened to, how staff were understanding and the positive rapport staff had built with children young people and families.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should continue to work towards improving wait times for assessments and treatments that fall out of the trusts 12 week and 18 week target respectively.

Leeds Community Healthcare NHS Trust

Specialist community mental health services for children and young people

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
East CAMHS , Reginald Centre	Leeds Community Healthcare NHS Trust Headquarters

Good

Are services safe?

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

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

Our findings

Safe and clean environment

We visited the East child and adolescent mental health services as part of our responsive inspection. Staff facilitated appointments at the team base, other locations within the community and at the young person's home. They had moved in to new premises since our last visit. The team now operated in a new office where facilities were available to see patients and carers. We were told they had moved into this base 12 months ago.

Children and young people were greeted in a spacious reception area with comfortable seating available. The team had access to several appointment rooms, some of which were dedicated to the child and adolescent mental health team, and some for general usage. Staff had access to clinic rooms to undertake physical health checks.

All the rooms varied in size depending on usage. They were comfortable, had natural light and provided a suitable therapeutic environment for the children, young people, carers and families. The visitors' area and therapeutic rooms were clean and well maintained. All the rooms were fitted with call points which alerted the reception area for support.

Staff told us they were happy with the facilities and they were appropriate for use. They did not feel as though there were limitations in accessing rooms because many appointments were facilitated from other locations around the Leeds district.

Safe staffing

Since our last visit we found the staffing levels had improved. The trust had recruited new staff to fill gaps within the teams and to provide safer care. Staff told us the staffing situation was better now and they felt as though they could function more effectively as a team.

Establishment levels for the child and adolescent mental health teams were as follows :

- The East team had 22 clinical and seven administration staff. This included three consultant psychiatrists, 12 band seven staff and four band six staff.
- The West team had 35 clinical and eight administration staff. This included two consultant psychiatrists, seven band eight staff and eight band seven staff.
- The South team had 21 clinical and three administration staff. This included a consultant psychiatrist, eight band seven staff and three band six staff. The South team had four vacancies at the time of the inspection.

The teams had a good range of skilled staff with different professional backgrounds. They included clinical psychologists, nurses and social workers. We found the majority of clinical staff were above band six. This meant the trust had employed skilled senior workers with a view to deliver a high quality service.

Staff held caseloads averaging 40 patients. The 2013 guidance from the Royal College of Psychiatrists identified each clinical staff member would have capacity to manage a caseload of 40. This would be dependent upon the types of cases and other responsibilities.

The teams managed caseloads based upon risk and frequency of contact. Staff with higher caseloads had young people that were less active or not being seen currently. We found staff did not identify caseloads as an issue during the inspection. Caseloads were managed through supervision, this give staff the opportunity to discuss levels of work and how they were coping.

Sickness levels were 4%, which is just below the national average at 5%. The teams had provisions in place for staff to cover sickness and leave. For example, two members of staff facilitated initial assessments. This meant if the primary named worker could not attend any appointments due to sickness or leave, another member of staff that the young person was familiar with could intervene. In sensitive cases, where rapport had been built between a staff member and a patient, staff told us they would re-arrange the appointment as they felt it was the most appropriate thing to do.

The teams had recently undertaken a skills audit of the staff. This looked to identify what skills the staff had that were being underutilised. For example, if a clinician was trained in cognitive behavioural therapy and not utilising it,

Good

Are services safe?

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their skills would be used within another team where there was a need. This looked to optimise the abilities within the team, reduce risk and give management better oversight of their staffing.

There was no use of agency or bank staff to replace clinical positions. However, the provider used agency staff for admin when required. We were informed about the difficulties this brought. The use of agency administration staff meant the teams did not always have consistency, regular turn over meant the trust had to retrain the staff.

All the teams had psychiatrists working within them that were specialised to work with young people. Children and young people had access to a psychiatrist when needed. They could be seen within the day if there was an urgent need. The psychiatrists held regular clinics as well as facilitating community visits.

Training figures across the three teams demonstrated that all the teams achieved over 80% completion in Mental Capacity Act training and safeguarding adults training. Safeguarding children training averaged 91% across all the teams. We found the East child and adolescent mental health team achieved a lowest training average in 'infection control' training at 64% and the South team in 'health and safety' at 62%. Over all training figures were high across all the teams.

Assessing and managing risk to patients and staff

All children and young people had risk assessments completed within their first two appointments. We reviewed six records, all of which had up to date risk assessments, reviewed appropriately We were informed staff had to provide a narrative for risk assessments not completed within this timeframe. The primary reason for risk assessments not meeting the deadline was missed appointments by patients.

The trust were regularly auditing risk assessments to ensure quality standards were being met. We reviewed the trust dashboard which demonstrated monthly performance figures. Over the previous 12 months all three teams were consistently achieving above 95%. This provided management with oversight and enabled them to establish trends.

The teams had developed a bespoke risk assessment tool based on the existing 'functional analysis of care environment' risk assessment. This bespoke risk assessment tool had three elements to it, the first was the risk screening assessment tool, which provided an overview of the risk. We saw the risk screening tool was modified through learning from a serious case review. It was modified to contain a section to explore domestic violence.

The second element was the risk formulation which was done alongside the 'Five P's' model. Staff formulated risk by identifying and exploring five areas, 'presenting problem ', 'predisposing factors', 'precipitating factors', 'perpetuating factors' and 'protective factors'. This holistic approach uses a cognitive behavioural therapy framework in identifying risk and issues surrounding risk.

The final element of risk assessments was the 'my plan', which is completed by the young person. This is equivalent to a crisis plan, and contains information such as key telephone numbers, relapse signs and what to do in a crisis. The teams were in the process of developing an 'open outreach programme' alongside other trusts and universities. This was a smart phone application where young people would have their own profiles. Within the profile it contained important information such as the 'my plan'. It was designed to enable the patient to have it on their persons at all times. To protect confidentiality the patient chooses who can access their profile, for example their G.P and teachers. The prototype application looked innovative and user friendly. It was evident the team were trying to understand their patient group and what works best with them.

At our last inspection, we found risk assessments were not always completed and had relevant information included. However, during this inspection we found risk assessments had been completed appropriately for the six patients we reviewed. The risk formulations were very detailed and comprehensive. Staff clearly understood the 'five P's' model and reflected it within the records. Not all patients had a 'my plan' as it was not always appropriate, but the ones we reviewed had been completed and signed by the patients then a copy uploaded onto the electronic system.

The team had a systematic approach to managing risk. Provisions were put in place for patients who were deemed as high risk, for example, having increased contact. Children and young people that attended accident and emergency, or were referred because of self-harming, had to be seen within four hours. Cases requiring core child and adolescent mental health intervention were put on a

Good

Are services safe?

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waiting list. Waiting time could be different depending on the young person's risk profile. Children and young people could still be seen whilst waiting for specialist intervention. They could arrange appointments with staff if they felt they needed support. Out of hours crisis services were available 24 hours a day seven days a week.

Risk issues and safeguarding concerns were regularly discussed within the multidisciplinary team meetings and risk management plans agreed for action. There was a named doctor and a named nurse responsible for child protection.

Safeguarding children and adults was a part of the mandatory training. All the clinical staff were required to have up to level three training. We saw the teams were all concordant with this. Staff were clear in the local safeguarding protocols and key issues that faced young people , such as child sexual exploitation. Managers monitored the safeguarding training and were notified if staff needed to refresh their training. This meant managers could inform staff to complete any outstanding training when required and keep up to date.

There was a lone working policy in place, and staff understood their responsibilities in practicing safely. This included signing in and out, keeping their diaries up dated and administration staff making telephone calls to colleagues if they have not returned on schedule. It was clear that most appointments happened in clinics around the community therefore staff seldom would visit patients in their homes out of hours.

Track record on safety

The data provided by the trust indicated there were no serious incidents in between 1st June 2015 to 31st May 2016. Improvements were being made to the service when gaps or areas of risk were identified through the reporting system.

Since the last inspection, the trust had taken steps in recruiting and retaining their staff. We saw an example of how staff were prioritising safety over expanding their services. As part of the child and adolescent mental health service the teams were developing an eating disorders service. Many of the staff already employed by the child and adolescent mental health team expressed interest in moving to the new eating disorders service. We were told these staff would only move into those positions once their current position was filled.

Reporting incidents and learning from when things go wrong

The trust used the DATIX system to report incidents. Staff understood the DATIX reporting system and knew how to report incidents and which type of incidents needed to be reported. Managers were aware of all incidents in their teams. The evidence provided by the trust demonstrates staff were appropriately reporting incidents and putting measures in place in order to reduce future events.

Between 1st June 2015 and 31st May 2016 there had been 22 incidents in the West team, 11 in the South team and 17 in the East team. The data provided by the trust indicated one of key areas of reporting were around 'abusive, violent, disruptive or self-harming behaviour', there were 12 incidents in the last year. Staff at the trust investigated incidents and learning was cascaded into the monthly team meetings. The trust clearly recorded incidents and used a 'red, amber, green' system to identify the severity of the incident. This determined the level of response.

Staff had a good understanding of the duty of candour. The DATIX reporting system prompted staff to consider if incidents required consideration to the duty of candour. Management had oversight of this and had to action where appropriate. The management were clear of their responsibilities in managing a service that is transparent, honest and accountable.

Although no serious incidents had occurred, staff informed us they were debriefed after any incidents which had an impact on them. There was a team ethic, which endorsed supporting staff and putting interventions in place to aid learning.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

There was a single point of access where referrals were received. Each team had a duty worker on call who received the referral and made a decision on what to do next. Their role meant they had to screen and triage the referrals. If a referral was not appropriate the referrer would be signposted to the services which could support them.

The 'clinical assessment and intervention model' used by the provider provided a clear access pathway into the service. Once a referral has been made into the service there were three assessment pathways available for children and young people :

- self-harm urgent assessment
- consultation clinic assessment and intervention
- general assessment (cases not requiring consultation clinics).

Access to treatment was in two stages. The first line of interventions provided children and young people with basic interventions and specialist assessments. We saw a wide array of interventions offered to children and young people This included low-level psychological support, for example cognitive behavioural therapy levels one and two. It also included learning disability interventions, trauma therapies and general intervention, which could last up to four sessions.

If children and young people met the threshold for the second line of interventions, they received more specialist and focused support. This included medication, child psychotherapy, creative therapies and specialist work around autism.

Emergency referrals from the accident and emergency paediatric service had to be assessed within the trust target of four hours. In May 2016 two out of 33 emergency referrals had not been not met. The trust provided information to explain why the target was not achieved on the two occasions. Over the last 12 months 97% emergency referrals were being met within four hours. Out of hours emergency referrals were managed through the local paediatric service accident and emergency service.

Urgent referrals were seen within half a week, against a target time of one week. An urgent referral was one where there was high concern around a child or young person but there was not any immediate risk.

The trust target for all other referrals to assessment was 12 weeks. We found 84 children and young people had to wait four weeks to have a general assessment in May 2016. Over the last 12 months average wait times for general assessments were 11 weeks.

Assessment wait times were higher for more specialised services such as autism and attention deficit hyperactivity disorder (ADHD). Forty six children and young people waited 21 weeks to be assessed for attention deficit hyperactivity disorder in May 2016. In the last 12 months the average time children and young people waited to be assessed for this service was 20 weeks. In the same period the average wait time for children and young people to be assessed for autism was 24 weeks. In May 2016 184 children had been waiting for 21 weeks. The wait times for these specialist services had decreased since our last inspection. In November 2014 autism assessments had a waiting of up 40 weeks and attention deficit hyperactivity disorder 26 weeks.

Assessment to treatment times varied depending on the level of intervention children and young people required. We saw the teams were able to put immediate support in place if required for a short duration of time. This could be up to six sessions. These types of interventions included low level psychological intervention such as basic cognitive behavioural therapy, work around coping mechanisms and general support around mental health. It also enabled staff to refer into partner services in the voluntary sector. The service could discharge children and young people after this period if they did not require further intervention.

The wait times for specialist treatments had improved since our last inspection. There was a 'red, amber, green' (RAG) system in place on the trusts electronic dashboard to show when wait times were becoming too long. Treatments flagged as red had a wait time of over 18 weeks, amber was between 12-18 weeks and green was below 12 weeks. This enabled staff to have better oversight on wait times and make improvements where necessary.

Child psychotherapy had an average wait time of 17 weeks in the last 12 months. In May 2016, 10 children and young

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Good

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people had to wait11 weeks for treatment. Family therapy had an average wait time 14 weeks in the last 12 months, and creative therapies such as 'drama therapy' was 13 weeks in the same period.

There was immediate access to a psychiatrist if the child or young person was in a crisis. However, the wait time for routine consultations was an average of nine weeks in the last six months. In May 2016 87 children and young people waited four weeks for a consultation clinic.

There were longer wait times to be treated in cognitive behavioural therapy, with an average of 20 weeks between the period of September 2015 till May 2016. In May 2016 there were 81 children and young people waiting 19 weeks. The average waiting time for play therapy in the last 12 months was also 20 weeks. These treatments were flagged as 'red' on the trusts electronic dashboard.

Children and young people could be prioritised for their treatment if their risk profile changed. This meant if a young person was at high risk of suicide or self-harm they would be prioritised to receive the specialist services sooner than a young person who was more stable.

There was evidence the teams were continuously working towards improving wait times for assessment and treatment. For example, weekly taskforce meetings with managers and clinicians were being undertaken to address the waiting time for autism assessments. The focus was to understand the demand and calculate resources so they are able to improve wait times but not significantly impact on other services. Wait times were discussed in team meetings and how the service could work to improve areas that were flagged as 'red or amber'. They looked at how they could improve patient experience by offering therapeutic interventions in a timely manner after the assessment.

The service manager was undertaking a skills audit of all the staff. This enabled management to see if staff skills that were being underused could be used more effectively.

The child and adolescent community mental health teams had an inclusive approach which aimed to work around the children and young peoples needs. For example many of the group activities were done after school, it enabled better engagement. Children and young people who did not actively engage with services were supported in alternative ways, through schooling, family support and a pro-active team ethos.

Appointments were only rearranged under special circumstances. If the practitioner was unavailable and they had a sensitive relationship with the young person, then the appointments would be rearranged. This was due to the nature of the relationship, it may not be appropriate for another practitioner to see the young person.
Appointments times were being met, staff had to provide a clear narrative if an appointment couldn't happen. We saw the primary reason for appointments not going ahead were because the young person could not make the session.

The facilities promote recovery, comfort, dignity and confidentiality

The clinical rooms were appropriate for seeing people who used the service and the accommodation was bright, clean, and well maintained. There was a large, open plan, comfortable waiting area. There were a range of information leaflets and posters within the waiting areas. Information included details of local groups, explanations about how to raise concerns or safeguarding alerts, and information about local support groups and information services. There were trust leaflets explaining about confidentiality, and facilities for people who use the service to provide feedback.

Meeting the needs of all people who use the service

A number of clinics and appointments were arranged within the local and special schools. In addition people were seen in their own homes, GP clinics or other community based venues. This was to improve ease of access in to the service and enhance partnership working with other key support services for the person using the service.

There was a range of information leaflets available. All leaflets were in English, however, the people who use the service could access the website which could be changed into different languages. Interpreters and or signers could attend individual appointments. The clinical areas visited were accessible for people with mobility difficulties. The service we visited was in a multipurpose building, there was clear segregation from adults who were attending services in the same building.

Listening to and learning from concerns and complaints

Are services responsive to people's needs?

Good

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

Parents confirmed they knew how to raise concerns or complaints. There were posters and leaflets within the clinical waiting areas visited. Staff understood how to respond to complaints in line with the trust policy. Learning from complaints was shared in the team meetings.

In the last 12 months there were 34 complaints made across all three child and adolescent mental health teams.

12 complaints were partially upheld, 11 fully upheld, five not upheld and six on going. There were 25 complaints in relation to access and availability, 18 of which related to wait times in receiving an appointment.

The trust provided us with examples of how they responded to complaints. Clear explanations were provided to people who use the service outlining the complaint, and what the trust are doing to resolve it. Apologies were provided within some of the response letters, they were appropriate and sincere.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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