

Requires improvement


South West Yorkshire Partnership NHS Foundation
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)
RXG10	Fieldhead Hospital Ouchthorpe Lane Wakefield West Yorkshire WF1 3SP	Barnsley CAMHS service	S70 1LP
RXG10	Fieldhead Hospital Ouchthorpe Lane Wakefield West Yorkshire WF1 3SP	Wakefield West CAMHS team	WF1 2DQ
RXG10	Fieldhead Hospital Ouchthorpe Lane Wakefield West Yorkshire WF1 3SP	Wakefield East CAMHS team	WF10 5LT

Summary of findings

RXG10

Fieldhead Hospital Ouchthorpe
Lane Wakefield West
Yorkshire WF1 3SP

Calderdale and Kirklees CAMHS
team

HX1 1YR

This report describes our judgement of the quality of care provided within this core service by South West Yorkshire 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 South West Yorkshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of South West Yorkshire Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



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 specialist community mental health services for children and young people as requires improvement overall because:

- the service was using a combination of electronic and paper records and some information was being stored in the clinical records and some on restricted access shared drives
- waiting lists for treatment were long and unless someone contacted the service for assistance it was not possible to monitor any changes in risk. The trust were not able to provide accurate information about how long children and young people were waiting for treatment after they had been assessed
- a procedure was in place for safe visiting, which included staff carrying a personal safety device, but staff were not fully following this which put staff at increased risk of harm from others.
- the trust required clinical staff to have basic life support training but the compliance with this was significantly below trust target, this meant that staff who were not trained were unable to provide basic life support in an emergency situation.
- the trust could not provide accurate up to date information on waiting times and average caseloads of the teams.
- Clinical audits were not being regularly undertaken to ensure quality standards were in place.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- when clinical records were reviewed it was not possible to access the full assessment, care plans and risk management plans in each of the clinical records on the electronic system.
- not all clinical records had a completed Sainsbury risk assessment.
- Staff did not proactively monitor the risks of young people and children who were waiting for treatment.
- staff were not following lone worker arrangements at all times, as they were not using the personal safety device that they had been given by the trust.

However:

- there was a crisis/ assertive outreach function in each team. This meant that people who used the service and families had access to a telephone number and, if required, face to face crisis management, 24 hours a day
- environments where children were being seen were age appropriate, pleasant and accessible
- the services were continuing to refine and enhance assessment, care planning and documentation. On 1 February 2016, the care programme approach model of documentation had started and was being rolled out across the services
- specialist pathways had been developed in eating disorders, looked after children and learning disability to ensure that these children were seen as a priority.
- staff were up to date with the majority of mandatory training, line management supervision and clinical supervision.

Requires improvement



Are services effective?

We rated effective as good because:

- Initial assessments and care plans were seen to be comprehensive and met the needs of the children.
- All clinical interventions were evidence based and reflected best practice such as National Institute for Health and Clinical Excellence guidelines.
- all multi-disciplinary teams included the full range of disciplines required for good quality care in CAMHS.

Good



Summary of findings

- Line management and clinical supervision took place regularly, to support staff in their role. 86% of staff had also received an annual work performance appraisal.
- Staff told us of the positive links with other services such as schools, special schools, and respite units. We received positive feedback from external providers about the hub arrangements in Wakefield. This was specifically around multi-agency working taking place within local neighbourhoods

Are services caring?

We rated caring as good because:

- the young people that we talked to and carers told us the service they received was of high quality and staff were compassionate, respectful and kind. All of the interactions we saw were caring, compassionate and professional
- The young people told us that they were able to give feedback on services, and we saw feedback forms available in the waiting areas of each service.
- There was an active patient participation group within each of the three districts. Young people were involved in interviews for new staff. They had also had input regarding decorations and colour schemes at the team bases.

Good



Are services responsive to people's needs?

We rated responsive as requires improvement because:

- The trust was not meeting their own targets for choice assessment. The waiting times for treatment following assessment were long with the average wait being 147 days and the longest wait 913 days.
- The trust was unable to provide detail of individual staff caseload sizes across of the CAMHS teams due to difficulty extracting the data from their electronic clinical record system. The trust was also unable to provide data detailing how many people were on the waiting lists.

However:

Requires improvement



Summary of findings

- There were clear care pathways and improved responses for children and young people in emergency situations and during crisis. Other revised care pathways such as learning disability and looked after children were improving the ability to manage the waiting times for initial assessment and treatment.

Are services well-led?

We rated well-led as requires improvement because:

- the trust were not able to provide consistent, comprehensive data on how long people had been waiting for therapy and treatment or numbers on care coordinators' caseloads. This made it difficult to compare the service provided across its three directorates.
- Although new systems and processes had been implemented these were not being fully followed. The trust had not undertaken audits to monitor compliance or measure effectiveness of those changes.

However:

- The CAMHS service was at the time of inspection going through a period of change and were reviewing their care pathways and structures. There were some noticeable improvements made from the changes that had already occurred, such as reduced times for access to a choice appointments.
- staff told us that there was clear leadership in the organisation and senior manager posts were at the final stages of recruitment. This had improved morale and team working, staff felt supported and structured governance meetings and supervision across the service had improved.

Requires improvement



Summary of findings

Information about the service

Child and adolescent mental health services (CAMHS) are delivered within a four tier strategic framework. Tier 1 is usually provided by universal service practitioners who are non-mental health specialists, such as GPs, health visitors, school nurses, teachers, and social workers. These interventions are directed toward mental health and wellbeing promotion, identifying problems early and appropriately referring into more specialist services.

Tier 2 practitioners provide targeted services and can include primary mental health workers, psychologists, and counsellors working in GP practices, paediatric clinics, schools and youth justice services. Interventions include family interventions, outreach support and specialist assessment.

Tier 3 Services are multi-disciplinary and provide specialist interventions for children and young people with more severe, complex and persistent problems. These are generally provided in community mental health clinics or outpatient services.

Tier 4 CAMHS services are for children and young people with serious and enduring problems requiring highly specialised outpatient and inpatient provision, the requirement for which cannot be met within tier 3 provision. Most usually, this requires inpatient admission.

The CAMHS teams were well-established tier 3 services. They were provided across three districts: Barnsley, Wakefield, Calderdale, and Kirklees. The trust also provided tier 2 services in Wakefield and Barnsley. They provided specialist input to children and young people up to the age of 18 years. Access to the service was usually determined by registration with a locality GP, although there was flexibility in relation to this.

In addition to providing direct clinical care, each CAMHS team worked closely with tier 1 and tier 2 services in the local area. This was to provide specialist support, advice and supervision to other services to prevent transition to specialist CAMHS where this was appropriate.

The three districts configured their service in a different way but provided the following core CAMHS model within each locality:

- Core CAMHS was available between 9am and 5pm Monday to Friday and each directorate provided evening clinics. This provided individual and family interventions. There was a clear referral pathway and clinical staff undertook new assessments using a standardised assessment process.
- Specialist pathways for people, considered at elevated risk, with complex needs. This included eating disorder, looked after children, and mild to profound learning disability. Each pathway had allocated staff providing the required interventions and treatments.
- Each service provided a crisis response. The duty workers responded to A&E presentations and provided short term follow up. Crisis support included short-term evidence based follow up to support people who used the service whose mental health may be deteriorating and provided intensive support to avoid an inpatient admission. The crisis function could be extended to young people who persistently disengage from services as a means of assertive outreach and engagement.

Our inspection team

The team was led by:

Chair: Peter Jarrett, Retired Medical Director

Head of Hospital Inspection: Jenny Wilkes, CQC

Team leaders: Chris Watson, Inspection Manager, mental health services, CQC

Berry Rose, Inspection Manager, community health services, CQC

The team comprised of a CQC Inspector, a consultant psychiatrist and a senior clinical lead, and an expert by

Summary of findings

experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them, for example, as a carer.

Why we carried out this inspection

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

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the inspection visit, we reviewed information we held about these services, asked a range of other organisations for information, and sought feedback from people who used the service at three focus groups.

During the inspection visit, the inspection team:

- visited each of the four office bases where the CAMHS services were based.
- spoke with five people who were using the service

- spoke with 11 carers, the majority of whom were family members
- spoke with the managers and clinical leaders in the teams
- spoke with 34 other staff members; including psychiatrists, mental health practitioners and therapists
- attended and observed four hand-over meetings and three multi-disciplinary meetings.
- reviewed 24 clinical records of people who used the service
- we sat in on three outpatient appointments
- met two external stakeholders and received feedback about their experience of multiagency working
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

People who used the service and their carers were positive about the care and support they received. They told us there was a delay in receiving a service after being assessed which varied in length between weeks to several months. On first contact they were given an information pack including a contact number if they required more urgent help and this information was helpful. When people who used the service started treatment and interventions they had an allocated care coordinator.

Parents told us staff were understanding, compassionate and they treated themselves and their child with respect and dignity. They described feeling involved in reviews and care planning and they received copies of letters sent to the GP. They were well informed and most had a copy of the agreed care plan.

Summary of findings

The majority of things discussed with staff were kept confidential, but when there have been concerns regarding risk staff had let family know. Individuals and parents or other family members were offered additional parenting support and family interventions.

Parents said they could ring for help and advice when it was needed and this was helpful especially for advice about medication. Parents knew how to access help in a

crisis by either contacting the team, or presenting at A&E. We were given good feedback about the involvement of the crisis team and how this had made a significant difference in a families' ability to manage a crisis.

Seven out of ten parents told us they knew how to raise concerns and make complaints. We were given examples of when people who used the service or carers had raised concerns and the actions the service had taken to quickly rectify the situation. This was not a view shared by all and we were informed of concerns the service did not always respond swiftly to concerns.

Good practice

People who used the service with a serious eating disorder, who ordinarily would have been admitted to inpatient care, were receiving home support during breakfast and evening meal times. This was from the staff providing the crisis response in the service.

Each of the teams provided crisis support at home for children and young people when required.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve:

- The trust must take action to improve the overall waiting time for young people accessing treatment.
- The trust must devise a proactive system for monitoring risks of young people waiting to be seen.
- The trust must ensure audits are undertaken to ensure new systems and ways of working become embedded in practice and quality standards are being followed.
- The trust must devise a system for monitoring total number of open cases, total number of patients on a waiting list, individual staff caseload sizes.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should continue to implement their own identified recovery plans in relation to waiting list management.
- The trust should review and continue to improve access to contemporaneous clinical records.

- The trust should closely monitor the action plan to reduce information governance breaches and undertake regular audit to seek assurances that safeguards are being maintained.
- The trust should ensure staff are up to date with basic life support training.
- The trust should ensure environmental risk assessments have been completed for each of the community bases.
- The trust should ensure team managers undertake an audit of compliance with the lone worker policy and review the policy in line with appropriate staff feedback.
- The trust should ensure regular audits of clinical records are undertaken to monitor compliance with trust policy.
- The trust should ensure regular audits of FP10 prescription use are carried out to ensure safe and appropriate issuing and storage.
- The trust should consider moving the weighing scales in the team bases into more private areas.

South West Yorkshire Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Barnsley CAMHS service	Fieldhead Hospital Ouchthorpe Lane Wakefield West Yorkshire WF1 3SP
Wakefield West CAMHS team	Fieldhead Hospital Ouchthorpe Lane Wakefield West Yorkshire WF1 3SP
Wakefield East CAMHS team	Fieldhead Hospital Ouchthorpe Lane Wakefield West Yorkshire WF1 3SP
Calderdale and Kirklees CAMHS team	Fieldhead Hospital Ouchthorpe Lane Wakefield West Yorkshire WF1 3SP

Mental Health Act responsibilities

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

Staff in the community CAMHS did not receive mandatory Mental Health Act (MHA) training. Staff had reasonable knowledge of the MHA. It was rare for staff to have to refer

to the MHA in their work in the CAMHS tier 2 and 3 care pathways. There were no young people subject to community treatment orders. Staff could describe how they would access any required assistance and guidance in relation to the MHA if it was required.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The Gillick competence framework was used to determine a young person's ability to make decisions. This was because the MCA does not apply to children under the age of 16 years. We saw staff were documenting in individual clinical records that discussions were being held around treatments, options and choice. Staff were recording the child's understanding of those decisions. These were in line with the Gillick competence framework. Staff told us if a person who used the service lacked sufficient capacity to make decisions consent would be sought from the person with parental responsibility.

The MCA does apply to young people over the age of 16. Staff demonstrated an understanding of the core principles underpinning the Act. These included young people should be assumed to have capacity to make decisions, unless an assessment determines otherwise, and assistance should be given to young people to make their own decisions, including those that may be considered unwise. Staff in the service did not receive mandatory Mental Capacity Act (MCA) training.

The deprivation of liberty safeguards within the Mental Capacity Act 2005 (MCA) do not apply to under 18s.

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

During the course of this inspection we visited four bases where the child and adolescent mental health services (CAMHS) were. Each base had interview rooms where people who used the service and their families were seen. Staff were accommodated in those bases in offices with keypad access. There was restricted access in to each of the bases and reception staff oversaw the waiting areas. Staff could activate an alarm in the event of an emergency. We requested copies of recent environmental risk assessments for each of the buildings following the visit. These were not made available but completed security assessments of the four bases were.

Clinical areas and waiting rooms were clean and the furniture and decorations child friendly. The decoration was bright and the furniture was comfortable. All of the bases could accommodate individuals with limited mobility, pushchairs and prams. There were toys and books available for those waiting to be seen.

The bases had specially designed therapy rooms, some with two-way mirrors. These enabled therapeutic interventions for individuals or groups that could include play and family therapy. There was access to height and weight equipment and facilities to undertake a range of physical health assessments including blood pressure. There were appropriate infection prevention measures, including hand washing facilities and posters reminding of the importance of hand hygiene. The operational procedures reminded staff of the need to comply with bare below the elbow policies if they attended the local accident and emergency department to undertake an assessment.

Reception staff managed a signing in and out system for all visitors and staff. Staff saw people who used the service in other venues, including schools, GP surgeries, accident and emergency departments and own homes. Two staff undertake an initial home assessment in order to ensure staff safety until risk assessments are completed. There was a trust lone working policy but not all staff were complying

with it. They were not carrying the trust provided electronic lone working device. The trust had recognised this problem and had arranged additional training in the use of the device in April 2016.

Safe staffing

Staff expressed dissatisfaction with staffing arrangements in the teams. Concerns varied and included concern that posts remained vacant, reduction in the size of the teams, and concerns there were not sufficient numbers of senior clinical staff across the services. Staff said the waiting lists for the service corroborated these views.

The trust provided the following details about staffing levels within the three teams for the twelve months to November 2015:

- CAMHS Barnsley – 39 full time staff with 8% vacancy
- CAMHS C&K– 49.7 full time staff with 7% vacancy
- CAMHS Wakefield– 52.5 full time staff with 6.5% vacancy

At 1 February 2016 total vacancy across the three teams was 21.6 WTE clinical staff. The trust was actively recruiting to vacant posts and additional staff could be employed through the bank system to maintain the service to children and young people.

The trust provided details about sickness levels within the three districts. During the three months to end February 2016 the sickness rate was 3.5% This was lower than the average sickness rate in the NHS in England over a similar period which was 3.9%.

The trust could provide detail of how many cases were open to each team, but not how many people were awaiting a service or individual workers caseload size. This was because of problems with the electronic recording system. It was not possible to verify if the staff capacity was appropriate to meet service demand.

Individual staff reported caseload sizes of 30 – 55 cases each. The 2013 guidance from the Royal College of Psychiatrists identified each WTE clinical staff member would have capacity to manage a caseload of 40. This would be dependent upon the types of cases and other responsibilities.

Are services safe?

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Team managers described caseload management, including the ongoing review of open cases, monitoring of progress, compliance with evidence based guidance for number of sessions to be offered and appropriateness to extended therapy sessions for individuals. In some teams there were new managers in post and this work was being established.

The trust was investing in the children and young person improving access to psychological therapies transformation project. This meant staff were getting additional training in evidence-based interventions including cognitive behavioural therapy, systemic family therapy and interpersonal therapy. However, during the period staff were seconded to undertake the training there was a reduction in clinical work they could undertake in each team. Two staff from each team had reduced from full time clinical work in the service to a reduced two days in order to accommodate the required learning.

Psychiatrists were core members of the teams and there was dedicated psychiatric input into the crisis arrangements within each district. Each psychiatrist provided leadership in one of the clinical care pathways in each district. This ensured those with the most complex need and higher risk had rapid access to a psychiatrist when it was required.

The trust provided information that the average mandatory training rate for staff at the time of this inspection was 86%. This was higher than the trust requirement of 80% compliance. The area where compliance was low however was in basic life support where the districts had the following completion rates for this required training: Barnsley 12%, Calderdale and Kirklees 31% and Wakefield 47%.

Assessing and managing risk to patients and staff

At the choice appointment, an assessment and risk screen was undertaken. A choice appointment is where the first contact with the patient takes place, this offers a choice of interventions, and a choice of how when and where patients are seen by the service. This would determine the most appropriate care pathway. If this was for learning disability, eating disorder or looked after child, the case would be fast tracked to that team. That team would determine the timescale for responding based upon operational procedures. Cases requiring core CAMHS intervention were placed upon the teams' waiting list.

Staff used the Sainsbury risk tool in the community CAMHS. This tool was in two parts. There was an initial level one risk screen. This listed potential risk indicators as a tick list. This enabled clinical staff to consider a range of possible risk domains during an initial assessment with a person who used the service. Staff completed a level one assessment and a copy was sent to others involved in the care and support of the person who used the service, such as their GP. In the event risks were present a level two risk assessment would be completed. This provided detail around the risk identified and identified strategies for reducing those risks.

We reviewed 24 clinical records. In 14 of these, both parts of the Sainsbury risk tool had been fully completed. These cases had a contingency risk management plan. These detailed strategies the worker, the young person and their parents had agreed would be helpful in the event their mental health began to deteriorate or if they felt unable to cope with an impending crisis. These also indicated who would be informed in the event of an increase in risk and who would take specific actions.

The trust told us they had been in the process of rolling out the Sainsbury risk tool across the service from February 2016. In 10 cases the risk tool had not been completed. Risk concerns had been documented in the clinical record but these had not been completed using the appropriate risk screening or comprehensive risk assessment tool in all cases. This meant there was not a clear risk assessment and risk management plan as required in the operational procedures. Staff told us there were significant problems with the electronic clinical record meaning multiple documents failed to be saved in the clinical record. It was not clear if the risk documents in this audit had not been completed at the time of assessment, or if the document had failed to be saved in the appropriate section of the clinical record due to system problems.

Cases allocated to core CAMHS were placed upon the team waiting list. There was no proactive monitoring of people on the waiting list for treatment or system to monitor changes to risk. We saw contact details explaining how to access help through a telephone number if more urgent assistance or advice was required were given. Parents confirmed they had access to this assistance when their child was on the waiting list and when they began treatment with the team it was available to access help and advice in between sessions with their key worker.

Are services safe?

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

Each district provided an emergency response 24 hours a day. This was usually to the local accident and emergency service but also included attendance at other paediatric inpatient wards and urgent new referrals from GPs and other providers. A crisis response was provided to all open cases, new referrals, and people who were on the waiting lists. Each team had allocated workers dealing with referrals each day. This included responding to urgent referrals and providing a same day response if this was required. These workers also provided short term follow up to any young person who had been seen in an emergency at the paediatric service. This enabled an additional assessment outside of a crisis to determine the most appropriate course of action that was required. The workers responded to calls and queries from people who used the service and carers seeking assistance for more urgent support. They provided telephone discussion and advice to potential referrers and feedback regarding referrals made.

Child safeguarding level one training was mandatory for all staff and was completed at induction. Team administrators attended safeguarding level two as mandatory training. All clinical staff had to complete safeguarding level three. At the time of the inspection 87% of clinical staff had complied with mandatory child safeguarding. In addition, staff had access to local authority safeguarding training. Staff could outline the role of the safeguarding lead nurse and knew who it was. They had clear knowledge of the local authority safeguarding teams and referral procedures. Staff could describe how they had accessed support and guidance from the local safeguarding teams when it had been required. Each team described monthly safeguarding supervision being in place. The trust policy required all clinical staff should access safeguarding supervision as a minimum four times per year either individually or in a group. Team managers monitored this compliance.

Risk issues and safeguarding concerns were regularly discussed within the multi-disciplinary team meetings and risk management plans agreed for action. There was good representation by CAMHS and the trust's safeguarding team at the local authority led forums where individual young people were discussed. There was a named doctor and a named nurse responsible for child protection.

Track record on safety

Data provided by the trust indicated no serious incidents since November 2014. Staff were unable to recall any

serious incidents occurring since that time. There had been 54 information governance (IG) issues from September 2015 to February 2016. Of these 31 were confidentiality breaches. Most were due to errors in sending out correspondence from the service.

Information relating to these IG issues was raised at local level in team meetings, incorporated into individual line management supervision and discussed at full service meetings held across the three districts. There was an action plan detailing local actions and progress against those actions in the district with the highest number of IG breaches. Managers were aware of how to use performance management policies in order to address individual capability issues where this was indicated.

Medical staff told us they were not recording the serial number of prescriptions issued, or placing a copy in the clinical records. We observed an unsecured prescription pad had not been placed in a locked cabinet whilst visiting one of the community bases. We sought feedback from the trust regarding the safe storage of FP10 prescriptions and the policy in relation to issuing prescriptions. The trust issued guidance to staff in response to this. This outlined a system for monitoring compliance with guidance.

Reporting incidents and learning from when things go wrong

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.

Senior clinical staff represented the teams in the directorate and trust wide forums. Serious incidents and lessons learned from other trust services were discussed at those forums. Senior staff cascaded information to local teams about issues the teams should be aware of. Staff confirmed incidents and lessons learned were agenda items in the business and team meetings. This was a standing agenda item across all the teams. When a serious incident had occurred in 2014 feedback was given at a full service meeting for the benefit of all the teams. The trust lead for incident investigation had attended these meetings to support the teams.

Managers had a good understanding of duty of candour. They described it as being honest and transparent about what the service does, especially when actions have affected the care of a person who used the service. There

Are services safe?

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

was training available on the intranet and senior staff in the teams had attended additional training. Managers had access to a flow chart detailing clear actions to take. Other staff were not as clear about duty of candour. We were told training was to be cascaded in the teams. Duty of candour

had been discussed in local team meetings and staff reminded to seek guidance from team manager or safeguarding lead if they were unsure if an incident met the criteria.

Are services effective?

Good 

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.

Our findings

Assessment of needs and planning of care

Each of the districts were in the process of defining and streamlining care pathways. Commissioning arrangements had changed in two of the areas and referrals for assessments of children under the age of 14 years with autistic spectrum disorder within Wakefield were now being referred to other community children's services. In Barnsley the new care pathway for children up to the age of 18 years of age autistic spectrum disorder was being provided by paediatric services. In Calderdale and Kirklees the autistic spectrum disorder pathway remained with the trust child and adolescent mental health service.

Health and social services professionals and educational psychologists, education welfare workers, or school nurses could refer directly. The trust child and adolescent mental health service would also respond to the presentation of any young person in an emergency through the accident and emergency departments, regardless of where they usually lived. The criteria for referral to CAMHS were detailed within the directorate's operational procedures.

There was a standardised assessment process across the three districts. There was access to assessment, risk assessment, and care plan templates on a shared computer drive. The trust used an electronic clinical information system (RiOv7). We reviewed 24 clinical records. These were a mixture of cases currently receiving treatment and waiting to start treatment. Not all information was available in the contemporaneous records. Some assessments were in paper records. This meant it was not always possible to have access to all clinical records when working away from the team base.

In 19 of the records reviewed, there were comprehensive assessments and subsequent care plans. These care plans linked to risks that had been identified and they outlined interventions for reducing those risks. There were clear therapeutic aims and desired personal objectives.

Best practice in treatment and care

Each young person had a care coordinator when they began treatment. The care coordinator was responsible for ensuring appropriate ongoing assessment, consultation, diagnosis, formulation, and intervention. The service had adopted the care programme approach framework of assessment, care planning, and review. The care

coordinators utilized a range of standardised assessment tools such as the strengths and difficulties questionnaires and the revised children's anxiety and depression scale. Completed assessments demonstrated recovery and could demonstrate clinical deteriorations as well as improvements.

Care pathways had defined clinical standards that reflected National Institute for Health and Clinical Excellence (NICE) and other best practice guidance. Examples of these included NICE guidelines CG9 for eating disorder and CG28 management of depression, Carl Rogers person-centred approach and Webster-Stratton incredible years parenting. The skill mix of the clinical staff ensured a range of therapeutic and evidence based approaches. These included behavioural, cognitive, and systemic therapies. Specialist workers were able to deliver a range of best practice interventions including therapy, a specialist form of play therapy, dialectical behavioural therapy; eye movement desensitization and reprocessing (EMDR) which is a specialist therapy indicated in trauma focused work, cognitive behavioural therapy and parenting skills and family therapy. Where medication was prescribed, good practice was seen with choice of medication, dosing regime and physical and mental health monitoring. The service provided group therapies including a 10 week cognitive behaviour therapy based group called "cool connections" and a 13 week course in 'mood management' Suitably qualified staff were assigned to work on specific care pathways such as core CAMHS, looked after child, eating disorder or learning disability.

There was good practice in the multidisciplinary team approach to working with young people with eating disorders. Staff reported using the framework of Maudsley model with the family based meal with specialist dietetic support. Staff also reported innovative practice in providing home support during family meals out of normal working hours.

The majority of young people engaged in individual weekly sessions with their care coordinator. There was evidence of regular communication outlining progress sent to the GP and, where appropriate, the young person and their carer. Care coordinators arranged for other workers to co-work where assessed need indicated additional interventions were required, for example a person who used the service might be receiving cognitive behavioural therapy alongside structured family therapy

Are services effective?

Good 

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.

We observed three appointments during the inspection. Young people were encouraged to talk openly and freely, as were the carers/parents. Staff give detailed explanations about the importance of the interventions undertaken. Where appropriate we saw physical health checks were undertaken and the results explained. Staff were following shared care protocols and explaining the type of detail that would be shared with the GP following the appointment.

Skilled staff to deliver care

The teams were multidisciplinary, included consultant psychiatrists, social workers, counsellors, consultant psychotherapist, consultant psychologist, and trained psychological therapists, support workers mental health nurses, learning disability nurses and a team of administrators. Staff were recruited who had experience of working with children and young adults but not specific specialist CAMHS training. Staff were assigned to different care pathways and accessed appropriate specialist training where this was indicated. An example of this was the commitment to the children and young person improving access to psychological therapies training. Staff from each district were seconded to undertake this specialist training.

Staff had access to one to one clinical, peer and group supervision. This was in addition to line management supervision. Senior clinical staff provided supervision to staff both formally and informally. Senior clinical staff held regular consultation meetings where discussions of complex cases and treatment plans were agreed. Staff described how advice and guidance, and if required supervision, would be given to other team members of a different discipline. This allowed staff to consult and work together effectively to meet the needs of the people who used the service.

Line management supervision was happening regularly. Managers used standard agendas and recorded when clinical supervision had last occurred. The majority of staff had line management supervision every six weeks. This was in line with the trust policy. In Barnsley the new manager was in the process of establishing regular line management and clinical supervision and demonstrated all staff had received recent in management supervisions. Staff confirmed they had clinical supervision sessions planned.

Eighty six percent of all staff, including doctors, had an up to date appraisal. Staff confirmed they could undertake additional training to maintain or enhance their skill levels.

Team managers undertook job planning with medical and therapy staff. This was to review and agree how much of their individual working time should be in direct clinical work, providing support and supervision as part of the multi-disciplinary teams and on personal development.

Multi-disciplinary and inter-agency team work

We saw evidence of regular and effective multi-disciplinary team meetings. There were weekly multi-disciplinary team meetings where progress, risk concerns, and other case specific issues were discussed and management plans agreed. There were effective handover arrangements between staff providing crisis support and care coordinators. There were clear and detailed care pathways outlining a consistent approach to care and treatment.

The CAMHS service worked closely with a range of other providers, including statutory and third sector. There were shared care agreements with GPs to effectively and safely treat eating disorders, and these included agreements for weekly weight and height checks, blood pressure monitoring, and blood test monitoring. Specialist advice and guidance was also provided to other local services including promotion of infant mental health, links with health visitors, family nurse practitioners, and involvement with surestart.

Staff described their links with schools, special schools, and respite units. We received positive feedback from external providers about the hub arrangements in Wakefield. This was specifically about multi-agency working taking place within local neighbourhoods. A commissioner informed us the success of this working had resulted in further investment into the model. The teams had close links with the local commissioning groups who supported the access to inpatient beds. None of the directorates had a CAMHS inpatient unit but there were service level agreements with those closest to the services.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff in the community CAMHS service did not receive mandatory Mental Health Act training (MHA). Staff had reasonable knowledge of the MHA. It was rare for staff to have to refer to the MHA in their work within the CAMHS tier two and three care pathways. No young people were subject to a community treatment order. Staff could describe how they would access any required assistance and guidance in relation to the MHA if it were required.

Are services effective?

Good 

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.

Good practice in applying the Mental Capacity Act

The Gillick competence framework was used to determine a young person's ability to make decisions for young people under 16 years old. This was because the MCA does not apply under the age of 16 years.

Staff were documenting in individual clinical records that discussions were held about treatments, options and choice. Staff recorded the child's understanding of those decisions. These were in line with the Gillick competence framework. Staff told us where a person who used the service lacked sufficient capacity to make decisions

consent was sought from the person with parental responsibility. Consent was recorded on RiOv7 and there was a paper record where consent was recorded that could be placed within the paper records.

The MCA does apply to young people over the age of 16. Staff demonstrated an understanding of the core principles underpinning the MCA. These included that young people be assumed to have capacity to make decisions, unless an assessment determined otherwise. In addition, assistance should be given to young people to make their own decisions, including those that may be considered unwise. The trust did not provide data about how many staff in the CAMHS teams had attended Mental Capacity Act (MCA) training. This training was not mandatory.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

People who used the service and their parents told us they were treated with care, compassion and dignity and respect. We saw evidence of this when we observed interactions in four appointments and witnessed behaviours toward people in the reception areas and waiting rooms of the services visited. A parent told us they valued not being judged, despite the difficulties within their family.

In two of the bases, the weighing scales were in a public area not a private clinical room. This did not promote privacy and dignity for the young person

The involvement of people in the care that they receive

Patients and carers were given information, including leaflets, at their first appointment. They confirmed these

helped them understand the choices and interventions available. They described feeling involved in reviews and care planning and they received copies of letters sent to the GP as well as a copy of their care plan.

We saw evidence of an active patient participation group within each of the three districts. Young people had been involved in interviews for new staff. They had also made decisions regarding decorations and colour schemes at the team bases.

Feedback from people who used the service was regularly sought. In waiting areas, we saw eye catching feedback forms had been designed in consultation with the local patient participation group. There were computer terminals with the same questionnaire available for people to complete. These were sent directly to a central point in the trust and outcomes and themes were feedback to the teams. In the February 2016 survey the trust received 100 responses. Of these 25% rated the service they received as poor or very poor. This was mainly due to long waits for treatment. In Barnsley 47% of the 15 respondents had rated the service they received as poor or very poor.

Are services responsive to people's needs?

Requires improvement



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

Our findings

Access and discharge

The three districts had designed their child and adolescent mental health services (CAMHS) to reflect local need and commissioning arrangements. They had standardised the way they work through the team operational procedures. Each district had a single point of access for referrers. In Barnsley and Wakefield this was provided by a daily rota of staff from the different teams acting as a duty team. In Calderdale and Kirklees, a third sector provider who provided tier two interventions provided this. They undertook initial screening and triage and passed over referrals where specialist CAMHS input was indicated.

The service had criteria for responding to routine, urgent and emergency referrals. Crisis teams responded to urgent and emergency referrals and out of hours emergency referrals were managed through the through the local Accident and Emergency service. A worker undertaking the single point of contact / duty function for the team that day screened routine referrals. These were either signposted to other more appropriate services at tier one or two or the referrer offered advice about management of the problem identified. Appropriate referrals were offered a choice assessment. The time scale for this would vary dependent upon risk.

CAMHS had developed four distinct care pathways alongside their core service. Staff were allocated to work within one of those care pathways. Some workers worked across a number of the care pathways dependent upon their specific role within the teams. In effect these teams operated individually holding their own team meetings and referral discussions and allocations. They came together as the district CAMHS service on a regular basis.

The pathways were:

- looked after children
- learning disability
- eating disorder
- crisis team

Referrals that were clearly appropriate for one of these care pathways would not be subject to a wait for a choice assessment. Following triage, the case would be passed directly to the specific team who would respond within their care pathways time scales.

Currently there is no national waiting time target for CAMHS services. There is intention for standards to be in place by 2020. The exception to this are the new eating disorder care pathways and the children and young people improving access to psychological therapies (CYP IAPT).

New referral criteria had been implemented in consultation with commissioners. From September 2015 all new referrals for autistic spectrum disorder (ASD) would be seen by paediatric services when aged under 14 years in Barnsley and in Wakefield when aged under 18 years. Senior managers were confident this initiative alongside additional investment in to the eating disorder care pathway would have a significant impact upon the waiting time for core CAMHS by September 2016.

The trust was not meeting their own targets for choice assessment. The waiting times for treatment following assessment were long with the average wait being 147 days and the longest wait 913 days. This meant in Calderdale and Kirklees young people were waiting on average four and a half months for treatment and in Wakefield six months. The trust could not provide comparable data for the average waiting time in Barnsley as a different recording system had been in use for referrals before April 2015. The data available indicated young people in Barnsley were waiting on average four and a half months to start treatment. Staff told us the majority of young people in Barnsley had previously waited 18 months for treatment and a parent told us their child had waited 18 – 24 months.

The trust reported there had been a reduction in waiting time for a choice assessment appointment in Wakefield, Calderdale and Kirklees and we saw a similar reduction in waiting times in Barnsley was discussed in monthly performance meetings. The trust was confident this data was accurate.

The trust provided the following data regarding the length of time people were waiting for an assessment at January 2016. The detail in days is the average waiting time for each district. The trust target was 35 days:

- CAMHS Barnsley 66 days

Are services responsive to people's needs?

Requires improvement 

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

- CAMHS C&K 24 days
- CAMHS Wakefield 41 days

The trust provided the following data regarding the length of time people were waiting to start treatment following assessment in February 2016. There was no trust target for the waiting time:

- CAMHS Barnsley average wait 146 days longest wait 594 days
- CAMHS C&K average wait 140 days longest wait 896 days
- CAMHS Wakefield average wait 187 days longest wait 913 days

All data provided for Barnsley was from April 2015 and did not include referrals made before that date. Patients waiting for core CAMHS and their parents informed us they had waited from 18 months to 2 years to start treatment post assessment. Patients referred to the care pathways for eating disorder, crisis, looked after children and learning disability were seen quicker than the figures above.

The trust was unable to provide detail of individual staff caseload sizes across of the CAMHS teams due to difficulty extracting the data from RiOv7. The trust was also unable to provide data detailing how many people were on the waiting lists. As part of the ongoing work being undertaken within the trust there had been a change in the recording of cases on the waiting lists. The trust were confident the data for cases referred to the service post April 2015 would be accurate but had concerns the inconsistent recording of data before that date meant much of the information was flawed.

In addition the service in Barnsley were piloting an amended waiting list. Rather than all cases awaiting core CAMHS being placed on one continuous waiting list cases were being assigned to a waiting list for the specific intervention type they were awaiting, such as psychotherapy, play therapy and EMDR.

Each district had a crisis team. In January 2016 these teams were achieving targets for responding to emergency presentations within 4 hours 64% of the time. The crisis provision in Barnsley was by the outreach team. Two full time staff were being recruited in Barnsley to help them manage high levels of demand.

People who used the service and parents confirmed the crisis support was effective. Parents told us if there were

increased concerns or need to speak to someone for advice and guidance they were able to access this through a provided telephone number. Staff were flexible and tried to provide appointments at convenient times. This was in order to make access to the service required as easy as possible.

The facilities promote recovery, comfort, dignity and confidentiality

The clinical rooms at the team bases were appropriate for seeing people who used the service and the accommodation was bright, clean, and well maintained. There were a range of information leaflets and posters within the waiting areas. Information included details of local participation groups, explanations about how to raise concerns or safeguarding alerts, and information about local support groups and information services. There was a range of medication information leaflets. There were trust leaflets explaining about confidentiality.

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.

CAMHS worked closely with other organisations, which included Barnardo's, family information services, youth offending services, and a range of adult services. Where transition arrangements to adult services were required, these began formally when the patient was 17.5 years old. Transitions for looked after children involved multi-agencies working together.

There was a range of information leaflets available. The trust confirmed these were available in a variety of languages in order to meet the needs of the people who used the service. Interpreters and or signers could attend individual appointments. The clinical areas visited were accessible for people with mobility difficulties. There was access to hearing loops and adapted bathrooms. Where CAMHS services were in multipurpose buildings, there was clear segregation from adults who were attending services

Are services responsive to people's needs?

Requires improvement 

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

in the same building. Staff had access to translation services and told us they would book longer appointment times or home visits if this facilitated easier access to the service.

Listening to and learning from concerns and complaints

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. Attempts were made to attempt to resolve the complaint informally in the first instance. Learning from complaints was shared in the team meetings and in full service meetings.

In 32 cases the complaints were in relation to waiting times for treatment. The trust provided the following detail about compliments and complaints November 2014 – February 2016.

- CAMHS Barnsley 19 complaints of which 15 upheld
4 compliments
- CAMHS C&K 41 complaints of which 31 upheld
16 compliments
- CAMHS Wakefield 2 complaints of which 1 upheld
0 compliments

Are services well-led?

Requires improvement 

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.

Our findings

Vision and values

Staff were aware of the trust values. These values were:

- honest, open and transparent
- respectful
- person first and in the centre
- improve and be outstanding
- relevant today, ready for tomorrow
- families and carers matter

Staff were aware of the senior management team and the chief executives' blog. The trust scored better than national average in the 2015 NHS staff survey for staff satisfaction. Despite staff concerns about waiting times and changes in working practice they were highly motivated, dedicated and proud of the evidence based care provided to individuals

Good governance

Although staff were allocated to specific care pathways they stayed within the same management structure. A deputy director for CAMHS oversaw the service and each district had a general manager and practice governance coach. Team managers line managed multi-disciplinary team members and administration managers line managed the admin staff. There was a trust wide clinical lead for CAMHS.

The service had a range of meetings that took place including governance groups, service line meeting, and an extended directorate management meeting. These meetings reviewed clinical effectiveness, monitored safeguarding, identified risk themes, and agreed actions following audits. Senior managers told us performance indicators were monitored regularly within these meetings. These were jointly held with the trust lead for performance and information. The senior management team worked closely with the local authority and clinical commissioning groups within their areas. Performance and service developments were reviewed, and actions agreed in regular monthly forums.

Team managers had access to an electronic dashboard called the work performance wall. These provided team managers with up to date and accurate data and supported

managers to monitor compliance with supervision, sickness management, and training needs of the staff team. The system provided a red, amber, and green rating system to enable managers to quickly identify staff who required sickness absence meetings, return to work reviews, or were becoming out of date for mandatory training. Managers followed staff performance policies and took action when concerned about practice.

Changes to where, and how, information was recorded meant the trust could not provide accurate data relating waiting times. The trust had been working to improve data quality, and was confident recent data was accurate and consistently recorded. The trust was not confident data input in to the system before April 2015 was accurate. This affected the data available for Barnsley in particular.

The trust were not able to provide combined data for how many cases individual clinical staff were working with or how many patients were waiting for therapy. It was therefore not possible to determine how effectively and efficiently the trust were managing capacity and demand within the service. It was not possible to identify potential bottlenecks within the workflow.

It was noted that the lack of detail noted in a number of clinical records mirrored issues raised in the trust clinical record keeping audit in December 2015. At that time an action plan was to be developed to address these issues however there was no evidence these same standards were being routinely monitored or additional audits undertaken to ensure change or measure improvements within the teams.

Leadership, morale and staff engagement

Staff described improving morale. In February 2015, the trust brought a new senior management team together to oversee the developments across the three districts. This included a deputy director of operations and a director with CAMHS responsibility within the trust. Each of the directorates had a relatively new management team. The final team manager vacancy had been filled and the staff member was on induction. Staff were well supported by their direct line managers.

The service had a practice governance coach employed full time in each district. Their role was to lead with quality improvement, safety, staff support, and clinical excellence coaching. This role carried no operational management responsibilities. Clinical leads, from within each of the

Are services well-led?

Requires improvement 

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.

services, contributed to local strategic development of children's services including children's disability services and special educational needs boards. Senior clinical staff from each of the care pathways attended strategic trust wide groups relating to their professional group.

Commitment to quality improvement and innovation

The teams had a range of key performance indicators. These were monitored within local teams and the management team. CAMHS senior management team worked closely with the local authority and clinical commissioning groups within their areas. Performance and service developments were reviewed and agreed in regular monthly forums.

There was evidence clinical audits were being undertaken. An example was auditing CAMHS mental health and learning disability needs within GP caseloads. We were informed 30 GPs had engaged with the invitation.

There had been improvements in the service provided by the trust, most notably in the waiting times for a choice assessment appointment. Senior managers were satisfied new systems had been introduced meant each of the districts were recording referrals consistently. Managers were working with individual staff reviewing clinical work, monitoring interventions and prompting appropriate and timely discharge from the service. The management team were satisfied these measures along with recruitment into all manager posts, the investments into CYP IAPT, redesign of ADS assessment pathways and the eating disorder care pathway would all have a positive impact and significantly improve timely access to CAMHS.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met

- Risk concerns had been documented within the clinical record but not been completed using the appropriate risk screening or comprehensive risk assessment tool in all cases. This was the case at each of the community bases.
- Following assessment and placement upon a waiting list for treatment there was no system to proactively monitor changes in these assessed levels of risk. This was the case at each of the community bases.

This was a breach of regulation 12(2)(b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met

Waiting times for treatment were high with an average wait in excess of five months for the Wakefield CAMHS service.

The trust could not provide comparable data relating to the Barnsley CAMHS waiting lists. This was because there were problems extracting accurate information.

This section is primarily information for the provider

Requirement notices

The trust was not regularly undertaking audits to determine new systems and processes were being embedded into practice. This was the case at each of the community bases

Examples of this were the lack of improvement in clinical record standards. Also an admission by a number of staff they were not following the trust lone worker policy and inconsistent understanding of the requirements of the completion and storage of FP10 prescription pads.

This was a breach of regulation 17(2)(a)(b)(C)