Good

Humber 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)
RV936	Willerby Hill	Primary Mental Health Team	HU17 9 PL
RV936	Willerby Hill	Intensive Intervention Team	YO25 6AT
RV936	Willerby Hill	Single Point of Access Team Hull	HU13 9NW
RV936	Willerby Hill	Core CAMHS Team	YO25 6AT
RV936	Willerby Hill	Core CAMHS Team	HU13 9NW
RV936	Willerby Hill	Intensive Intervention Team	HU13 9NW
RV936	Willerby Hill	Paediatric CAMHS	HU13 9NW

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Humber 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 Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber 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	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Requires improvement 
Are services well-led?	Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Humber NHS Foundation trust specialist community mental health services for children and young people good because:

- Patients and their parents/carers told us that staff provided positive support. Patients were visited at home as well as the local children and adolescence mental health services office. Parents/carers told us that staff had always treated them and their child with dignity and respect.
- Patients felt safe within the service. Staff had a thorough understanding of the safeguarding procedures and were confident in making safeguarding referrals. Information was available for patients and their parents/carers on how to complain. The trust responded promptly when someone made a complaint.
- Patients told us that staff included them in their care plan and kept their parent/carers informed. Patients were encouraged to become involved in a patient participation group and for those interested, patients were involved in the recruitment of staff.
- To ensure patients had the best support possible, staff worked with other agencies to ensure they understood the condition the patient had been diagnosed as having. Staff assessed patients to determine whether they had a sufficient level of understanding to make decisions.
- Staff had started a group for parents/carers of patients who had attention deficit hyperactivity disorder; feedback from the group was positive and they found it supportive. Hull children and adolescence mental health services were able to refer patients with a low mood or anxiety to a service with MIND. Patients found this to be a valuable service to them.
- Staff had recognised and highlighted with their managers that the waiting time for assessments was unmanageable. In response to these concerns, extra funding was provided to ensure the backlog of referrals could be cleared and they were able to meet their 18 weeks target for assessment. A crisis team had been established to ensure children and adolescence mental health services were available 24/7.
- Staff were committed to providing a good service even when they were struggling to meet deadlines for work. They understood the values of the trust and patient care was at the centre of their work.
- Staff told us their managers were supportive and understood the pressures they were under.
- Learning was shared throughout the organisation.
- A member of staff had set up a peer support group for patients with attention deficit hyperactivity disorder and had received national recognition for the group.

However:

- Patients were waiting up to 37 weeks for treatment from the date of their referral.
- Not all the care plans were saw contained evidence that the patient had received a copy of their care plan.
- Not all care plans had information about a patients capacity to make decisions.
- Staff were not receiving supervision in line with the trusts policy.
- Staff did not have access to personal alarms when having a one-to-one session with patients.
- Letters sent to patients from the East Riding team informing them about a wait for services, did not contain any information about other services they might be able to access whilst they were waiting for an assessment or treatment.

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:

- Staff had a thorough understanding of the safeguarding procedures and were confident in making safeguarding referrals.
- Lessons were learnt from the serious incidents within the service, which were shared with the team to improve future practice.
- Staffing levels had been increased in the short term to manage the backlog of referrals.
- Care plans and assessment documentation had been completed.
- A crisis team had been established to ensure the children and adolescence mental health services were available twenty four hours a day seven days a week.

However:

- The trust should ensure that there is an effective system in place to keep staff safe when working with patients in the therapy rooms.

Are services effective?

Good

We rated effective as good because:

- Staff used a variety of measuring tools to measure the outcomes of interventions. These included the 'strengths and difficulties questionnaire' and the revised child anxiety and depression scale questionnaire.
- Specialist community mental health services for children and young people included a variety of disciplines such as consultant psychiatrists, consultant psychologists, family therapists, psychotherapists, nurse consultant, nurses and learning disability nurses and support workers.
- Allocation and group supervision was provided so that staff had the opportunity to discuss any issues on their caseload with their peers.
- To ensure patients had the best support possible, staff worked with other agencies to ensure their staff understood the condition a patient had been diagnosed with.
- Staff assessed patients to determine whether they had a sufficient level of understanding to make decisions.

However:

Summary of findings

- The trust should ensure that patients' records clearly showed the patient had received a copy of their care plan.
- The trust should ensure supervision is carried out in line with the trust policy.
- The trust should ensure that a patient's capacity is clearly recorded in their file

Are services caring?

Good

We rated caring as good because:

- Patients and their parents/carers told us that staff provided positive support. They were empathetic and listened to their concerns, issues and included the whole family in the work carried out.
- Staff worked with other professionals to ensure they knew the positive responses that would help the patient to have a good experience.
- Patients told us that staff included them in their care plan and kept their parent/carers informed.
- Patients were encouraged to become involved in a patient participation group and for those interested, patients were involved in the recruitment of staff.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Some patients had been waiting up to 37 weeks for treatment following their assessment

However:

- Staff had recognised and highlighted with their managers that the waiting time for assessments was unmanageable. In response to these concerns, extra funding was provided to ensure the backlog of referrals could be cleared and they were able to meet their 18 weeks target for assessment. A crisis team had been established to ensure children and adolescence mental health services were available 24/7.
- Patients were able to access other support through applications on their phone and through the trust website.
- The trust responded to informal and formal complaints in a timely manner.

Are services well-led?

Good

we rated well-led as good because:

Summary of findings

- The trust values were embedded within teams and staff had patient care at the centre of the work they carried out. There was clear communication between service managers and the board about the issues caused by the increased demands on the service.
- Whilst staff were working to achieve the 18 week deadlines they remained positive about their role. They felt that they were supported by their peers and managers.
- Regular meetings were held where managers shared 'lessons learned 'information.
- Learning was shared throughout the organisation.
- A member of staff had set up a peer support group for patients with attention deficit hyperactivity disorder and had received national recognition for the group.

Summary of findings

Information about the service

Humber NHS Foundation Trust provide specialist community mental health services for children and young people for both East Riding of Yorkshire and Hull. The services are commissioned by two clinical commissioning care groups and this is reflected in the model of service they provide. The services include :

Intensive intervention teams (IIT) in both Hull and East Riding

Core child and adolescence mental health services teams in both Hull and East Riding

A single point of contact (SPOC) in East Riding and a single point of access (SPA) in Hull.

Hull and East Riding has a paediatric service within their child and adolescence mental health services team.

East Riding has a learning disabilities team within the child and adolescence mental health services team.

We visited:

The intensive intervention teams and core child and adolescence mental health services for East Riding and Hull.

The primary mental health service in East riding – this service included the single point of contact.

The paediatric child and adolescence mental health services in Hull.

The single point of access in Hull.

Each core team has the following pathways of care:

Attention deficit hyperactivity disorder

Conduct

Mood – i) anxiety, ii) depression, iii) trauma

Self harm

Psychosis

Gender identity pathway

Under 19 substance misuse pathway

Eating disorder

Humber NHS Foundation Trust has been inspected nine times since registration. The comprehensive inspection, that took place on 20-23 May 2014 and 5 June 2014, did not result in a rating.

There were four actions identified from the previous inspection for the child and adolescence mental health services that required action to improve:

- The trust must address the leadership and staff engagement issues within the children's services.
- The trust must have an effective system in place to identify, assess and manage the risks of young people on its waiting lists.
- The trust must take action to ensure that all incidents that result in harm for a child or young person are reported internally, recorded and investigated and all external report recommendations fully implemented.
- The trust must take action to ensure that all its staff working within child and adolescence mental health services adhere to safeguarding children's procedures and that all incidents that result in harm are referred onto the appropriate local authority safeguarding team.

We found the trust had taken actions to address all of these points.

Our inspection team

This inspection was lead by:

Chair: Dr Paul Gilluley, Head of Forensic services at East London Foundation Trust and CQC National Professional Adviser

Head of Inspection: Jenny Wilkes, Care Quality Commission.

Team Leader: Patti Boden, Inspection Manager (Mental Health) Care Quality Commission.

Summary of findings

Cathy Winn, Inspection Manager (Acute) Care Quality Commission

The team that inspected specialist community mental health services for children and young people comprised a CQC inspector, a nurse, a social worker and a psychologist all of whom had experience of specialist community mental health services for children and young people.

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 that we held about these services, asked a range of other organisations for information and sought feedback from staff at three focus groups.

During the inspection visit, the inspection team:

- visited one location in East Riding and one location in Hull and looked at the quality of the environment
- spoke with 10 patients who were using the service
- spoke with 11 parents and/or carers
- attended a group for relatives of patients with attention deficit hyperactivity disorder (ADHD).spoke with the service managers and team leaders for each team
- spoke with 28 other staff members; including consultant psychologists, registered mental health nurses, a paediatric nurse, a drama therapist, a special educational officer, and a nurse whose speciality was learning disabilities
- attended and observed a cognitive behavioural therapy supervision, a training forum and an allocation and group supervision meeting
- observed a meeting to assess the patient
- looked at 20 treatment records of patients

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

Patients told us either directly or through feedback that staff gave them time to express their concerns, fears and anxieties and treated them with respect and dignity. All of the feedback indicated that patients were involved in their care plans although several patients told us they did not think staff listened to them.

Parents told us that once they had been referred to the service it was 'outstanding'. They explained that work done with staff helped their children to cope and understand their issues. This understanding brought about a change in behaviour. Several parents/carers told us they thought the communication between staff and the patient and parent/carer was not always as good as it could be. Where errors had been made people had received apologies from the trust.

Summary of findings

Good practice

A member of staff had been recognised nationally for a peer support group for patients with attention deficit hyperactivity disorder. The group was called #.H.A.S.H.T.A.G. They won a £1000 grant to help with the group.

Areas for improvement

Action the provider MUST take to improve

The trust must review the waiting list for treatment times to ensure that they meet the national guidance.

Action the provider SHOULD take to improve

- The trust should ensure that patients records clearly showed the patient had received a copy of their care plan.
- The trust should ensure supervision is carried out in line with the trust policy.
- The trust should review the systems in place to keep staff safe when working with patients in the therapy rooms.
- The trust should ensure that a patients capacity is clearly recorded in their file.
- The trust should ensure that when patients are put on a waiting list letters are sent out from East Riding that contain information about other services that could be beneficial to patients whilst they wait for a service.

Humber 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
Primary Mental Health and single point of contact team East Riding	Willerby Hill
Intensive Intervention Team East Riding and Hull	Willerby Hill
Core child and adolescence mental health services Hull and East Riding	Willerby Hill
Paediatrics child and adolescence mental health services Hull	Willerby Hill

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.

Mental Health Act training was not a mandatory training course for staff, however staff had received a days training on the Code of Practice. The trust had guidance on safe and appropriate care for young people on an adult mental health ward. It contained information from chapter 19 of the Mental Health Act Code of Practice, which provides guidance on the particular issues that arise in relation to children under 16 and those aged 16 and 17.

The consultants we spoke to were section 12 approved. A doctor who is 'approved' under section 12 of the Act is approved on behalf of the Secretary of State as having special expertise in the diagnosis and treatment of 'mental disorders' . It was a condition of their revalidation that they continued to be approved.

Detailed findings

There were no patients in the child and adolescence mental health community services on a community treatment order. There were seven patients in a child and adolescence mental health service inpatient unit outside the Humber region.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act does not apply to young people aged under 16. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have a sufficient level of maturity to make some decisions themselves.

We saw evidence in care plans that capacity was considered and assessed during times where treatment was provided or discussed.

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

The community venues were clean and welcoming. Information about good hand hygiene was available throughout the buildings.

Rivendell House and Coltman Avenue had several therapy rooms. They contained appropriate equipment to help staff engage with the patient. The rooms did not contain an alarm system nor did staff have a personal alarm to have with them when they were working with patients on a one-to-one basis. An assessment had been carried out on the environment to ensure it was safe for young people who used the service to access it.

Safe staffing

Staffing figures provided by the trust for the period 01December 2014 – 30 November 2015 showed the following information:

Establishment levels: qualified staff (WTE)

The Community Core child and adolescence mental health services team at Rivendell House - 14.3

East Riding Contact Point & Primary Mental Health Work - 7.1

East Riding Intensive Intervention Team - 8.4

Hull Intensive Intervention Team - 20.6

child and adolescence mental health service Core Team – Hull - 25.5

child and adolescence mental health service Crisis - 9.8

Hull child and adolescence mental health service Contact Point - 3

Number of vacancies: qualified (WTE)

The community core child and adolescence mental health service team at Rivendell House – 15.4%

East Riding Contact Point & Primary Mental Health Work -10.3%

East Riding intensive intervention team - 0

Hull Intensive Intervention Team - 1.9%

Child and adolescence mental health service core team – Hull - 0

Child and adolescence mental health service crisis - 0

Hull child and adolescence mental health service contact point - 0

Staff sickness rate (%) in 12 month period

The Community Core child and adolescence mental health service team at Rivendell House – 4.5%

East Riding Contact Point & Primary Mental Health Work – 8.7%

East Riding Intensive Intervention Team 3.4%

Hull Intensive Intervention Team – 4.7%

Child and adolescence mental health service Core Team – Hull – 2.2%

Child and adolescence mental health services Crisis - 0

Hull child and adolescence mental health service contact point – 2.9%

During the inspection, both service managers provided evidence that the vacancies had been filled in each team after the trust had submitted their information.

The trust had a number of mandatory training courses including; equality and diversity, display screen equipment, health and safety and the Mental Capacity Act 2005. Information provided by the trust prior to the inspection indicated that 71% of staff had completed the display screen equipment whilst only 23% had completed equality and diversity. During the inspection, managers and staff provided evidence that staff either had completed their mandatory training, or were booked on to course to ensure compliance.

Assessing and managing risk to patients and staff

We looked at 20 patient records across the community child and adolescence mental health service teams. We found they all contained an assessment, a risk assessment and a care plan. These documents were nine pages long and there was no designated space for staff to sign or initial each page. Not all of the pages had the name of the patient on them although the information was

Good

Are services safe?

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

requested. This meant if the pages became detached there was no way to determine where they had come from. People who used the services and/or their carers told us they had been given a copy of their care plan. This was not always clear from the records.

Patients were sent a holding letter explaining there would be a long waiting times for an appointment.

The commissioners for the Hull service had provided extra resources so that staff could achieve the 18-week assessment deadline. The service manager provided us with evidence that by the end of March 2016 people who used the service were being seen within the 18-week deadline.

Each area had a single point of contact or single point of access for the child and adolescence mental health service. In the last 12 months, staff in East Riding single point of contact had seen an increase from 100 to 200 calls made each month and in the Hull single point of access, the figure had risen to 500 calls a month. We observed staff on several of these calls and they were calm and reassuring. They were able to obtain relevant information on the triage assessment. In East Riding, staff had developed an appointment system to respond to calls. This meant they could ensure all the relevant people were available to discuss the referral. In Hull, they continued to try to contact people as and when the referral was made. The referral was passed to the Core child and adolescence mental health service teams.

Crisis services also operated across the East Riding of Yorkshire and Hull seven days a week and 24 hours a day. The crisis team had to respond to urgent referrals within four hours of receipt of the referral. This had only been available since January 2016 and they were still developing their protocols including protocols for when they needed support from a doctor.

Staff were trained in safeguarding and knew how to make an appropriate safeguarding alert. Safeguarding was considered mandatory training for staff. The specialist child and adolescence mental health service had achieved 79% attendance of the safeguarding children level three. Staff we spoke to had a clear understanding of their role in the safeguarding process. Safeguarding flowcharts were displayed in the bases. Information was available to trust staff on safeguarding issues of female genitalia mutilation, domestic abuse and forced marriages. Staff could seek advice on safeguarding matters from the safeguarding lead within the trust. Whilst attending a team meeting, a call was received from a patient who was threatening to self harm. Contact with the patient was maintained whilst the police were contacted and the worker managed to stay on the phone until the police arrived. Following this incident a de-brief took place. Actions were determined that ensured the patient was followed up to ensure they received support. Staff also raised an alert with the safeguarding team.

The trust had a lone worker policy in place dated January 2016. Staff we spoke to talked about the buddy system, which was within the policy. Others referred to a safe name to use if calling for assistance. One of the managers told us they were going to discuss what safe word should be used in an emergency as they currently had to ask for a 'red file' and in the assessment process urgent referrals were being put in a red file. To avoid any confusion the teams were going to look at the safe word. Staff had not been issued with personal alarms for use when they were in one-to-one sessions where the persons behaviour could become challenging.

Track record on safety

There had been no major incidents in the period 01 April 2015 – 31 March 2015.

The trust had introduced a crisis team to ensure patients had a service twenty four hours a day seven days a week. This was in response to the last inspection report where gaps in the service were identified.

Reporting incidents and learning from when things go wrong

Staff we spoke with were confident on how to report incidents on the Datix system. We saw that incidents reported now included safeguarding alerts. The managers responsible for reviewing the alerts told us they ensured any safeguarding alerts were dealt with promptly.

The trust sent out blue light alerts to ensure all staff were made aware of any information they needed following any major incidents. We saw minutes of team meetings where incidents were discussed and any lessons learned were shared with the team. Incidents were also discussed at an allocation and group supervision meeting and a cognitive behaviour therapy (CBT) supervision forum. Staff took part

Good

Are services safe?

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

in role play during the cognitive behaviour therapy supervision. This was so they could look at an incident from start to finish and determine how staff might have handled it more positively.

Staff understood their responsibility in relation to the duty of candour.

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

We looked at 20 records and saw that comprehensive assessments were completed in a timely manner. The care plans were appropriate to the person who used the service and clearly stated the treatment plan.

We found both electronic and paper files in place for young people who used the services. They were synchronised, however the IT system Lorenzo did not carry out all the functions required by staff when they needed to create a graph to illustrate how someone had improved. Staff collated the information on paper, transferred it to Lorenzo on the computer and then had to access another programme to create a graph, then save this to the records on the computer and print it of for the paper file. Staff told us this meant there were times that they spent more time on administration than on working with people who used the service.

Best practice in treatment and care

Staff used a variety of outcome measure to determine how effective the treatment was. This included a strengths and difficulties questionnaire which is a brief measure of psychological well-being in 2-17 year olds. They also used a revised child anxiety and depression scale questionnaire which is completed at the point of entry to the service then reviewed during the sessions and at the discharge from service. The scores were captured on the electronic system Lorenzo. This meant staff were able to show patients how their thinking had changed during treatment based on the results of these measures.

Other therapies that were offered included cognitive behavioural therapy and several staff were completing their Improving Access to Psychological Therapies training. This training gives staff the skills to provide talking therapies to patients and means people get treatment in a more timely way. Seven team members were currently completing the children and young people's improving access to psychological therapies in Newcastle.

Other support available was the Timid Tiger project for working with parents and Pesky Gnats a cognitive behaviour therapy sessions for children.

Skilled staff to deliver care

Specialist community mental health services for children and young people included a variety of disciplines such as consultant psychiatrists, consultant psychologists, family therapists, psychotherapists, nurse consultant, nurses and learning disability nurses and support workers.

Neither East Riding nor the Hull CAMHS teams had a social worker based in the teams due to funding restrictions. The service managers were in discussion with their commissioners to develop the skill mix to include social workers.

Information received from the trust before the inspection indicated that staff were not receiving regular supervision and/or appraisal. Out of a 135 non-medical staff, only 37 had received an appraisal in the period 01December 2014 – 30 November 2015. On inspection, we saw evidence that all staff had been appraised by 31 March 2016. Staff and managers told us that clinical and management supervision was provided but this had not been happening in line with the trust policy which states 'managerial and clinical supervision should take place every four -six weeks. The policy also stated that 'live supervisions', this is where observations of the way a member of staff works followed by a discussion of any practice issues, should take place; we found no evidence that this was happening.

Multi-disciplinary and inter-agency team work

We attended an allocation meeting and group supervision session in East Riding and a conative behaviour therapy supervision forum in Hull. These were led by either a team leader or a psychologist and were an opportunity to look as caseloads and practice issues. We also spent time with staff on visits and they worked with teaching assistants, educational specialists and housing officers during the course of their visits.

In the East Riding district, the primary mental health team, which included the single point of access service were situated in one office, whilst tier three services were based in a another. Staff told us they felt that the links between the tier two and tier three teams was not as strong as they had lost the flexibility that came with working in the same office. This meant that some referrals were classified as urgent when they would have been discussed with colleagues from the core team and may have been classified as routine.

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.

Staff had been to a multi-agency conference around sexual exploitation (MASE) and this highlighted the need for greater collaborative work between CAMHS , the police authority and the local authority. Work was also going on with a local group in Hull known as Haven. This was a one stop shop for refugees coming in to the city and it had been agreed that when necessary, they referred people to the CAMHS team.

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

Mental Health Act (MHA) training was not a mandatory training course. Staff were aware of their role in relation to the Mental Health Act and had attended a day's update training on the Code of Practice. They considered the possibility of using the act if a childs mental health deteriorated and there was a concern for their own safety or the safety of others. They told us that when they have had to admit a young person to hospital they followed the trust guidance 'Safe and Appropriate Care for Young People on Adult Mental Health Ward'. It contained information from chapter 19 of the Mental Health Act Code of Practice (CoP), which provides guidance on the particular issues that arise in relation to children under 16 and those aged 16 and 17. The chapter includes information on issues such as informal admission and capacity to consent to admission and treatment. The trust does not have an inpatient provision for CAMHS and we established that there were seven patients in hospital outside of the Humber region.

The consultants we spoke to were section 12 approved. A doctor who is 'approved' under section 12 of the Act is approved on behalf of the Secretary of State as having special expertise in the diagnosis and treatment of 'mental disorders'. Section 12 approved doctors have a role in deciding whether someone should be detained in hospital under section 2 and section 3 of the Mental Health Act

Good practice in applying the Mental Capacity Act

The Mental Capacity Act (MCA) does not apply to young people aged under 16. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. When working with children, staff considered whether or not a child had a sufficient level of understanding to make decisions.

Training in the Mental Capacity Act is offered by the trust as a mandatory course. Across all of the specialist community mental health services for children and young people 79% of staff had attended which was below the trusts' target of 85%. Managers showed us evidence that all staff had been booked on to appropriate training courses.

Staff were aware of exploring initial capacity of the young people who use the service in relation to the Gillick principles. There was information on the trusts CAMHS web page that clearly states that if a child is over the age of 16 the trust do not have a duty to discuss their child's treatment if the child wishes for the information to not be disclosed and has the capacity to make this decision.

Young people who used the service and/or their carers told us that staff always considered the capacity of the young person who used the service to consent to their treatment. We saw that consent was always considered as part of the assessment but when we spoke with staff who could complete the assessment but they told us that they expected the psychiatrist to complete an assessment to determine whether the young person met the criteria of the Gillick competency.

We found evidence that young people were provided with information about treatment options and consented to their treatment in the records we reviewed.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed two home visits and spoke to seven parents by phone. All staff interactions with patients and their family were extremely respectful and supportive. Staff emphasised the progress that had been made and could be measured by the outcome measures used. In addition, information was given about applications for the patient's phone; one for mood, another for crisis and anxiety. Patients found these helpful. Parents/carers mentioned that the crisis team was now available on weekends if they needed extra support. Information received from feedback obtained by the service during treatment and from speaking to parents/carers indicated that patients and their families were treated with dignity and respect.

We also attended a professionals meeting where seven patients were discussed. The patient's circumstances were fully considered from mental health issues, social, housing and educational issues.

Staff were passionate about their roles. We observed support being offered to parents whose child had learning disabilities and mental health needs. Due to their child's complex needs, the parents were anxious about their child's experience in school. The practitioner supported the parent and gave them time to explain and explore their concerns. The special needs care officer was also present and learnt about the needs of the patient and how best to support them. The practitioner provided reassurance and positive affirmation to the parents. When we talked to the parents, alone they said how respectful, caring and supportive the practitioner was.

We also attended a relatives group run by staff for carers/ relatives of patients who had attention deficit hyperactivity disorder. People who attended the group said that they found it supportive being able to discuss issues with other people who were in a similar position. The staff helped guide them to think about how they may do things differently to change how the patient reacts to them.

The involvement of people in the care that they receive

Of the 20 records we reviewed, 15 had goal based care plans. Whilst patients and their parents/carers told us, they had received a copy of the plan there was no evidence in the case records that this had been the case. Patients told us they were involved in the development of their care plan and considered the family's needs as well.

There was a newly developed patient participation and involvement group. In the short time, they had been established they had started to develop a new web site for the trust's web page with information in a child friendly format. They were offered training to be involved in the recruitment and selection of staff. This allowed them to be involved in sitting on panel interviews.

Information was available in communal areas for young people so they could access other services if they wished, such as local MIND groups or an art therapy group.

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 trust target for urgent referrals to be allocated an appointment was within seven day of the referral. Both the single point of contact and single point of access teams passed referrals to the core teams on the day they arrived. Staff in the core teams determined the urgency of the referral and saw patients they assessed as very urgent within seven days. Other 'urgent' referrals were seen within two weeks. Managers told us they were assessing referrals as 'urgent urgent' and 'urgent' due to the volume of referrals they were receiving this was the best way to manage the workloads

The crisis team was available 24 hours a day seven days a week for referrals that were urgent. The crisis team had a dedicated number that people could contact and if no-one was available then they could leave information and staff would get back to them as soon as they were able. People could also access this service through their GP and by visiting their local accident and emergency department. They stayed involved until there was a resolution of the immediate crisis (usually within 72 hours). During the inspection a call came in from a young person who was threating to take their own life. Staff talked to the young person whilst a colleague alerted the police and they were able to help the young person to a place of safety.

Information from the trust prior to the inspection indicated that routine referrals were taking an average of 88.3 days to assessment and then a further average of 36.4 days to treatment. Assessment to treatments times were dependent on the pathway the patient was on. One patient had been waiting 269 days, another 259 days from their initial referral. They had been assessed on 14 November 2015 treatment, resources were allocated on the 20 November 2015 but the patient was still waiting. This is outside of the 2014-15 NHS Benchmarking data that shows the wait for a routine appointment is between 32 weeks and 26 weeks. The NHS Constitution states 18 weeks to treatment. Another patient had been waiting 52 days for their assessment and this had been carried out on the 31 March 2016. By the end of March 2016, they were able to achieve an 18-week time scale for meeting assessments.

The service manager had made the senior managers of the organisation aware of the delays, as they had not been meeting an 18-week target. Senior managers from the trust had approached the commissioner for further funds to help deal with the long waiting times. Until the trust receive a response from the commissioners they were funding the equivalent of 7.9 whole time equivalent staff over and above their regular compliment to ensure people who used the service could be seen in an appropriate time. Staff told us they were only dealing with urgent referrals, as they needed to be seen within a deadline of seven days. Patients were sent a holding letter explaining there would be long waiting times for an appointment. This issue was on the trusts risk register.

The commissioners for the Hull service had provided extra resources so that staff could achieve the 18-week assessment deadline. The service manager provided us with evidence that by the end of March 2016 people who used the service were being seen within the 18-week deadline.

Each area had a single point of contact or single point of access for the CAMHS service. In the last 12 months, staff in East Riding single point of contact had seen an increase from 100 to 200 calls made each month and in the Hull single point of access, the figure had risen to 500 calls a month. We observed staff on several of these calls and they were calm and reassuring. They were able to obtain relevant information on the triage assessment. In East Riding, staff had developed an appointment system to respond to calls. This meant they could ensure all the relevant people were available to discuss the referral. In Hull, they continued to try to contact people as and when the referral was made. The referral was passed to the Core CAMHS teams.

Crisis services also operated across the East Riding of Yorkshire and Hull seven days a week and 24 hours a day. The crisis team had to respond to urgent referrals within four hours of receipt of the referral. This had only been available since January 2016 and they were still developing their protocols including protocols for when they needed support from a doctor.

The trust was aware of these waiting times and had taken steps to mitigate risk and to clear the backlog of referrals. This meant contracting for extra staff to bring the waiting time down and other staff had been working six or seven days a week to ensure patients got an assessment. There was no evidence that the trust had taken steps to address the waiting time between assessment and treatment.

Are services responsive to people's needs?

Requires improvement

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

Patients who did not attend appointments were contacted by staff either by a telephone call or a letter. Staff told us they made two attempts to contact patients who did not attend appointments; the pressure of work meant they discharged them after a second unsuccessful attempt at contact. A letter explaining the discharge was sent to the person who had made the referral so that they were aware of the situation and could provide further support if needed. In the year 01 April2015 – 31March 2016 there were 768 for East Riding and 1471 for Hull appointments that patients did not attend.

Staff in the SPOC teams had clear criteria for the pathways offered by the service. In the Hull team, they were able to offer other services that young people could access whilst they waited for an assessment. This included a cognitive behaviour therapy service commissioned by MIND. The East Riding team did not offer any other service or provide information about services that may be beneficial to both young people and carers.

The facilities promote recovery, comfort, dignity and confidentiality

The waiting areas at all community venues were welcoming with a variety of leaflets and posters on display including how to complain, patient advice and liaison service (PALS), and treatments. There were a variety of toys and activities to occupy children while they waited.

The trust also had information on their web site about how to contact the service. Some of the information on this site was over two years old. Young people who used the service were developing a new web site with up to date information. Current information included who to contact in an emergency, access to other web sites including 'Kooth' an online counselling service and a self-help section called Mood juice. The managers showed us details of applications young people could access and use on their phones to provide extra help in help to calm their anxieties.

Meeting the needs of all people who use the service

All of the accommodation used to see young people who used the service was accessible to everyone. It was on the ground floor and entry was by a buzzer system so that only people who needed to access the service could get in. Both the Hull and East Riding service had introduced a gender identity pathway as they had identified this area of work as one that was growing.

Staff had access to translation services and language line to make sure information was provided in a way that was understood. Large print and pictorial information was also available.

Staff worked with school nurses, teachers, parents and siblings to explain the condition and how best to support the young person. If a worker from another discipline were already working with the young person then staff would work with them.

Aromatherapy was provided to patients by the trust. It was provided by a member of staff who had completed qualifications in the use of aromatherapy oils. The staff member provided aromatherapy as part of their CAMHS job plan. They had found it helpful for anxiety, low mood, insomnia, anger management and aches and pains.

Listening to and learning from concerns and complaints

The CAMHS service received 15 formal complaints in the period 01 January 2015 and 31 December 2015. Three of these were upheld. These complaints were about poor communication within the service. Four complaints were partially upheld again these were related to communication within the service. A team leader told us they spent some time dealing with informal concerns expressed by parents/carers and patients.

We saw that information was clearly recorded in case files to indicate who should receive information pertaining to the patient. Staff talked about a situation where a letter had been sent to the wrong address. The patient and their carers had been contacted and an apology had been made. We saw a Datix report in relation to this incident and the team leader told us they would bring the error up at the next meeting and when they had one-to-one supervision with the staff concerned.

In the same period the services had received two formal compliments.

Are services well-led?

Good

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

Our findings

Vision and values

Staff were aware of the trusts' vision which was acaring compassionate, and committed staff group. We saw the values embedded within the teams. Staff acted with compassion, were caring and worked to be the best they could with the patient using the service and their family. Open communication was taking place amongst colleagues and senior colleagues for advice and guidance.

Good governance

There were two service managers in place. They were clear about the pressures on their individual teams. They showed us evidence that they kept the children's and learning disability group director informed of the pressures. Increase in demand was common in both teams. In East Riding and Hull they had developed a gender identity pathway as this was a growing area of need.

Managers had the ability to add items to the risk register and they had added the waiting times for assessment for the Hull and East Riding CAMHS teams. One of the service managers had successfully approached their commissioner for extra funds to help deal with the increased workload and the trust was supporting the other team in obtaining 7.8 WTE extra staff to help with the backlogs. They were waiting for a response from their commissioner to their case for extra funds.

The staff in specialist community mental health services for children and young people had achieved 71% of their mandatory training and had booked in for training they had not completed. Of the teams we visited 100% of the non-medical staff had received an appraisal within the last 12 months. Both teams had access to administrative support that processed referrals and supported the wider team with other tasks.

Leadership, morale and staff engagement

In the last 12 months, the average staff sickness rate was 2.67%. Staff turnover rate in the teams that we visited in the 12-month period was 5.3%

Staff were very positive about working in the service; they were passionate about their role. They also felt that the pressure to complete assessments meant they could not carry out as much casework as they wanted to. They felt that their direct manager and service managers were supportive; they did not feel senior management understood the role of the CAMHS service.

Staff valued the meetings held to discuss casework and workloads. Learning was shared at team meetings and minutes confirmed this. Case discussions also took place for patients' assessed as high-level risk. Senior managers attended the business and governance meetings, where learning from experience was an agenda item and minutes showed the actions for senior managers to share the learning from serious incidents with their teams.

Commitment to quality improvement and innovation

Monitoring of patients progress from referral is via the outcome measures of strengths and difficulties questionnaire and the routine outcome measures. They discussed the possible introduction of tablets or an IPad to allow patients to respond to questionnaires to capture ratings in real time.

A member of staff had been recognised nationally for a peer support group for patients with attention deficit hyperactivity disorder. The group was called #.H.A.S.H.T.A.G. They won a £1000 grant to help with the group.

A patient participation group had worked with an external company to develop a new web page for the trust's web site. Because of this work, several former patients were offered employment.

The service had started a group for parents/carers of patients who had attention deficit hyperactivity disorder, feedback from the group was positive, and they found it supportive.

Hull CAMHS were able to refer patients with a low mood or anxiety to a service with MIND and they had found this to be a valuable service to patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The trust do not have sufficient staff to meet the high demands of the patient group with an average wait in excess of five months for the Humberside CAMHS service.**