Requires Improvement

Leeds Community Healthcare NHS Trust

Specialist community mental health services for children and young people

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Leeds Community Healthcare NHS Trust	RY6X6	Parkside Community Health	LS11 5QL
Leeds Community Healthcare NHS Trust	RY6X6	Pudsey Community Health	LS28 7XP
Leeds Community Healthcare NHS Trust	RY6X6	Kirkstall Community Health	LS5 3DB
Leeds Community Healthcare NHS Trust	RY6X6	Armley Moor Health Centre	LS12 3HD
Leeds Community Healthcare NHS Trust	RY6X6	East Leeds Health Centre	LS9 9EF

Summary of findings

Leeds Community Healthcare NHS Trust	RY6X6	St James University Hospital	LS9 7TF
Leeds Community Healthcare NHS Trust	RY6X6	Reginald Centre	LS7 3EX

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

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

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

Summary of findings

Ratings

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

Overall rating for Specialist community mental health services for children and young people.	Requires Improvement 
Are Specialist community mental health services for children and young people. safe?	**Requires Improvement** 
Are Specialist community mental health services for children and young people. effective?	**Good** 
Are Specialist community mental health services for children and young people. caring?	**Good** 
Are Specialist community mental health services for children and young people. responsive?	**Requires Improvement** 
Are Specialist community mental health services for children and young people. 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 found there had been a significant reduction in staff, within each of the CAMHS teams and this had affected services. Some of the changes had been due to influences outside of the trusts control. The staff had responded to the reductions by implementing a triage and priority appointment system to make sure people were seen promptly if needed. However this had reduced access to the service and had increased the wait for appointments. In addition the trust had started to respond to the long waiting lists and was aware of the impact of reducing access through use of the risk based approach. They were now engaged with and working with the local clinical commissioning groups (CCGs) to make improvements. But the long wait for appointments and the reduced access to the services had the potential to impact on people's mental health.

The staff had followed the local safeguarding procedures for children and incidents were reported. Staff had assessed the potential risks to people and staff. However we found some staff had failed to record peoples initial risk assessments on the electronic records.

We found the CAMHS teams provided people with the care, treatment and support they need based on the best available evidence. Information about people's care and treatment, and their outcomes, was routinely collected and monitored. Staff had the supervision and training they needed to carry out their roles effectively, although this was not always recorded on the computer data system. All of the multi-disciplinary staff team were involved in the assessment and planning of peoples care and treatment.

We found the service offered to young people, children and families was compassionate, kind and respectful. Young people, children and families made extremely positive comments about the service and the staff that had supported them. Young people, children and families were asked about their views of the service and were informed about and involved in decisions about their care and treatment.

Staff were motivated and dedicated to give the best care and treatment they could to young people and children. We found that within the parameters of the resources and increased demands on the service at local level; the teams were well managed and had good governance. Staff described strong leadership at team level and felt respected, valued and supported. However, staff said the reduction in staff and the constant reviews of the service had affected their morale. The staff were committed to the service's quality, improvement and innovation.

Summary of findings

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

Are services safe?

Requires Improvement

At the time of the inspection we judged the safety of services required improvement. Staff had assessed the potential risks to people. However we found some staff had failed to record peoples initial risk assessments on the electronic records.

There had been a significant reduction in staff within each of the CAMHS teams and this had affected services. Some of the changes had been due to influences outside of the trusts control. The staff had responded to the reductions by implementing a triage and priority appointment system to make sure people were seen promptly if needed.

The staff had followed the local safeguarding procedures for children and incidents were reported.

Are services effective?

Good

At the time of the inspection we judged the effectiveness of services as good. The CAMHS teams provided people with the care, treatment and support they needed based on the best available evidence. Information about people's care and treatment, and the outcomes, were routinely collected and monitored. Staff had the supervision and training they needed to carry out their roles effectively, although this was not always recorded on the electronic records. All of the multi-disciplinary staff team were involved in the assessment and planning of peoples care and treatment.

Staff followed the Mental Health Act 1983 and the Code of Practice. We found staff were aware of and followed the Mental Capacity Act code of practice and guidance relating to Gillick competence. Consent for care was sought from the young people, children and families using the service.

Are services caring?

Good

At the time of the inspection we rated caring as good. The service offered to young people, children and families was compassionate, kind and respectful. Young people, children and families made extremely positive comments about the service and the staff that had supported them.

Young people, children and families were asked about their views of the service and were informed about and involved in decisions about their care and treatment. The service had also accessed services from external agencies to support people with their needs.

Summary of findings

Are services responsive to people's needs?

Requires Improvement

At the time of the inspection we rated the responsiveness of the service as requires improvement. This was because; the long wait for appointments and the reduced access to the services had the potential to impact on people's mental health.

The trust had identified and begun to respond to the issues of long waiting lists, staff had followed a risk based approach to determine when people had appointments. In addition, some of the demands on the CAMHS service were out of the trusts control and the trust were now fully engaged with and working with the local clinical commissioning group (CCG) to make improvements.

Patients could make a complaint or raise a concern. There was evidence these were responded to in a timely way and listened to. Improvements had been made to the quality of care as a result of complaints.

Are services well-led?

Good

At the time of the inspection we rated how well led the service was as good. Staff were motivated and dedicated to give the best care and treatment they could to young people and children. We found that within the parameters of the resources and increased demands on the service at local level; the teams were well managed and had good governance. Staff described strong leadership at team level and felt respected, valued and supported. However, staff said the reduction in staff, and the constant reviews of the service had affected their morale. The staff were committed to the service's quality, improvement and innovation.

Summary of findings

Background to the service

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

Tier 1 - Consists of practitioners who are not mental health specialists, for example GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. Practitioners offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.

Tier 2 – Consists of CAMHS specialists working in community and primary care settings. Practitioners offer consultations to identify severe or complex needs which require more specialist interventions and assessments.

Tier 3 –Consists of community mental health team or clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders.

Tier 4 –Consists of services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units.

Leeds Community Healthcare NHS Trust is responsible for providing healthcare services in the Leeds and Humber region. The trust provides a range of community services for adults and children including community nursing, health visiting, physiotherapy, community dentistry, primary care mental health, Child and Adolescent Mental Health Services, smoking cessation and sexual health services. It has 3,000 staff that deliver a service to approximately 800,000 people a year

Leeds CAMHS had three multi-disciplinary teams that worked across ten locations at Armley Moor health centre, Bramley clinic, East Leeds health centre, Garforth clinic, Kirkstall health centre, Parkside Community health centre, Pudsey health centre, the Reginald centre, Seacroft clinic, and St James University Hospital. Leeds CAMHS was a tier 3 service.

Our inspection team

Our inspection team was led by

Chair: Fiona Stephens, Clinical Quality Director, Medway Community Healthcare

Team Leader: Adam Brown, Head of Hospital Inspections, Care Quality Commission

The team who inspected CAMHS consisted of one CQC inspector, a nurse specialist and a Mental Health Act Commissioner.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive community health services inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Summary of findings

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced inspection on 25 and 26 November 2014. During and after the visits, we talked with six relatives of people who used the service. We spoke with 13 members of staff, including team leaders, nurses, consultant psychologists and psychiatrists, junior doctors and ward administrators. We reviewed ten electronic care records.

This is the first inspection of the specialist community mental health services for children and young people since registration.

What people who use the provider's services say

Young people, children and families completed questionnaires about the service on admission and on discharge and were invited to make comments about the service by the trust. Of the questionnaires received between September and November 2014:-

- 132 out of 135 parents and 91 out of 97 children stated they were given enough information about the help available at CAMHS.
- 133 out of 135 parents and 95 out of 97 children stated they felt listened to.
- 133 out of 135 parents and 92 out of 97 children had responded that the help was good.

Where the questionnaire asked what could be improved the majority of the comments were about the waiting times. For example “waiting time to be seen was too long, when my child needed to be seen”, “waited eight months for our first appointment and now will wait another five to eight months to see a therapist to work on the issue”, “more staff as appointments and clinics were sometimes hard to get and the time it takes to do everything e.g. referrals taking months”.

These comments were echoed by the families we spoke with. They told us it was an excellent service but it had been difficult to access and they had to wait a long time to get an initial appointment and then to receive therapy. One family told us they had been referred to the CAMHS service but then told their children were not at sufficient risk, it was only when one of their children attempted serious self-harm that they were offered help. They said they thought that children should not have to self-harm to receive help.

Good practice

Staff had designed and followed the Leeds CAMHS service delivery model. This provided staff with a step by step clinical guide to enable them to assess and implement treatment and care. It was based on good practice guidelines and included a range of therapeutic interventions in line with National Institute of Health and Care Excellence (NICE) such as family therapy, dialectical behavioural therapy (DBT) and cognitive behavioural therapy (CBT).

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must make sure people are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them in their records. Staff had not always recorded peoples risk assessments on the computer system.
- The trust should make sure that young people, children and families are able to access the services they need within a reasonable time frame.

Summary of findings

- The trust should ensure training is recorded on the computer data system.

Leeds Community Healthcare NHS 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
Kirkstall Community Health	Trust Headquarters Stockdale House Victoria Road Leeds West Yorkshire LS6 1PF
East Leeds Health Centre	Trust Headquarters Stockdale House Victoria Road Leeds West Yorkshire LS6 1PF

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 reported they had regularly up dated Mental Health Act 1983 and Code of Practice training.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) does not apply to people under the age of 18 years. If the issue of depriving a person, under the age of 18, of their liberty arises other safeguards must be considered. These would include the existing powers of the court, particularly those under s25 of the Children Act, or use of the Mental Health Act.

The Mental Capacity Act does apply to young people aged 16 and 17 and mental capacity assessments should be carried out to make sure the patient has the capacity to give consent.

For children under the age of 16, decision making ability is governed by Gillick competence. This concept of competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. As a consequence, when working with children, staff should be assessing whether a child has a sufficient level of understanding to make decisions regarding their care.

At Leeds CAMHS we found staff were aware of and following the Mental Capacity Act code of practice and guidance relating to Gillick competence. Consent for care was sought from the young people, children and families using the service. This was demonstrated by speaking with staff and examining peoples' records.

Requires improvement

Are services safe?

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

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

Summary of findings

At the time of the inspection we judged the safety of services required improvement. Staff had assessed the potential risks to people. However we found some staff had failed to record peoples initial risk assessments on the electronic records.

There had been a significant reduction in staff within each of the CAMHS teams and this had affected services. Some of the changes had been due to influences outside of the trusts control. The staff had responded to the reductions by implementing a triage and priority appointment system to make sure people were seen promptly if needed.

The staff had followed the local safeguarding procedures for children and incidents were reported

Our findings

Are Specialist community mental health services for children and young people 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.**

At the time of the inspection we judged the safety of services required improvement. Staff had assessed the potential risks to people and staff. However we found some staff had failed to record peoples initial risk assessments on the electronic records.

There had been a significant reduction in staff within each of the CAMHS teams and this had affected services. Some of the changes had been due to influences outside of the trusts control. The staff had responded to the reductions by implementing a triage and priority appointment system to make sure people were seen promptly if needed.

Staff had assessed the potential risks to people and staff. However we found some staff had failed to record peoples initial risk assessments on the electronic records.

The staff had followed the local safeguarding procedures for children and incidents were reported.

Safe staffing

We found there had been a reduction in staff and increase in demand within each of the CAMHS teams that had affected the delivery of services. There were multiple reasons for this, including;

- Reduction in budgets.
- Changes to funding arrangements that had affected teams mainly affected in the South and East teams.
- A staff vacancy not filled promptly within the transition service.
- A number of staff who were attending a yearlong training programme.
- Increased demand on the service due to the loss of the tier two services in Leeds, which had operated within schools.
- An increase in urgent referrals from A&E, when patients presented with self-harm.

Work plans we reviewed recognised that clinical capacity had reduced as cost improvements were implemented. In addition to this other evidence provided by the trust demonstrated that there had been increases in the caseloads held by staff. This was also confirmed during our conversations with staff.

The staff we spoke with said they were busy and pressured at work and unable to meet all of their commitments. This was confirmed in information provided to us by the trust, in the children's management team performance meeting in October, where managers raised concerns that there was 'more demand and not enough staff' and that staff were too busy to report incidents promptly.

However, the management team had responded to the reduction in staff to ensure the service was safe. They had put systems in place to review all of the patients who were referred to the teams daily and held a weekly referral

Requires improvement

Are services safe?

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

meeting to enable them to risk assess each person and agree an appointment time. Staff informed people of the dates of their appointments and instructed them to go back to their GP should their illness worsen.

The reduction of staff had impacted upon the length of time a person had to wait to access the services. We have therefore reviewed this in the domain which covers whether the service was responsive.

Assessing and managing risk to patients and staff

Safeguarding vulnerable adults, children and young people was a priority, appropriate systems were embedded. Staff had received safeguarding training and had a clear understanding of safeguarding and their responsibilities in relation to identifying and reporting allegations of abuse and gave us examples of when they had done so. All the staff we spoke with knew who was the safeguarding lead for their area and felt able to contact them for advice when needed. Safeguarding concerns were also reviewed as part of the group and individual supervision. Information provided by the trust demonstrated the community teams compliance with safeguarding training was between 88% and 100%.

We found each of the three CAMHS teams had a duty system. The duty staff triaged the referrals, reviewed the information and prioritised them according to potential risks, signposting people to other services or making appointments for assessments where necessary. Similarly, when a young person was admitted to an A&E department duty staff would attend and carry out an initial assessment of their needs within a four hour timescale.

We saw across the teams that staff discussed the actions they would take when young people did not attend appointments. We saw evidence this was discussed at the safeguarding children's operational group meeting which was attended by the safeguarding lead for CAMHS and the head of services for CAMHS,

Young people were asked to attend an initial consultation meeting where staff and the young person completed a risk assessment called 'My plan'. Staff indicated that risks to individuals were effectively assessed and managed, including clinical and health risks, and risks of harm to the person and to others. They said people were involved in and agreed to their risk assessments. The staff said they completed the risk assessments as written documents and then transferred them to the computer database (carenotes). However, when we looked at the notes on computer we found six risk assessments had not been completed. In addition we were provided with information from the trust of 'the CAMHS risk and current view documentation audit for August 2014', which demonstrated staff had not always completed risk assessments. Staff we spoke with told us that administration staff had been tasked with the role of data cleansing and reminding staff to complete the risk assessments on the computer system. We therefore concluded the systems to ensure that staff adhered to defensible documentation were not robust.

Staff we spoke with said the CAMHS teams did not store or administer medicines. They would telephone the emergency services if someone required immediate physical assistance.

The staff said they followed the lone working policy and when they carried out home visits they kept other staff informed of their whereabouts.

Reporting incidents and learning from when things go wrong

We found incident recording and reporting was effective and embedded across all teams. The records demonstrated and staff confirmed that when things went wrong incidents were investigated, learning was communicated and action was taken to improve matters. The incidents were collated and reviewed to look at trends and patterns, so that staff could reduce potential risks to people who used the services. The staff team had learnt from external events, such as serious case reviews.

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.

Summary of findings

At the time of the inspection we judged the effectiveness of services as good. The CAMHS teams provided people with the care, treatment and support they needed based on the best available evidence. Information about people's care and treatment, and the outcomes, were routinely collected and monitored. Staff had the supervision and training they needed to carry out their roles effectively, although this was not always recorded on the electronic records. All of the multi-disciplinary staff team were involved in the assessment and planning of peoples care and treatment.

Staff followed the Mental Health Act 1983 and the Code of Practice. We found staff were aware of and followed the Mental Capacity Act code of practice and guidance relating to Gillick competence. Consent for care was sought from the young people, children and families using the service.

Our findings

Are Specialist community mental health services for children and young people effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

At the time of the inspection we judged the effectiveness of services as good. The CAMHS teams provided people with the care, treatment and support they needed based on the best available evidence. Information about peoples care and treatment, and the outcomes, were routinely collected and monitored. Staff had the supervision and training they needed to carry out their roles effectively, although this was not always recorded on the electronic records. All of the multi-disciplinary staff team were involved in the assessment and planning of peoples care and treatment.

Staff followed the Mental Health Act 1983 and the Code of Practice. We found staff were aware of and followed the mental capacity act code of practice and guidance relating to Gillick competence. Consent for care was sought from the young people, children and families using the service.

Assessment of needs and planning of care

Once the team had received and accepted a referral, young people, children and families were mostly seen in the consultation clinic. In the clinic a clinician would work with the young person or family to think about their difficulties and what might help them. People were offered up to three consultations spread over about six weeks. For many people that would be all that was required. For others, they may get referred from the consultation group to individual or family therapy, group sessions, specialist assessments for autism or attention deficit disorder (ADHD), or specialist clinics such as eating disorder or learning disability.

We saw the teams followed the same delivery model which provided staff with a step by step clinical guide to the different care pathways such as infant mental health, anorexia nervosa or diagnosed ADHD. This meant peoples' care and treatment records were specific to their care pathway and were mostly consultation notes with a plan of actions that had been agreed with the young person or the family. After referral or on discharge, detailed letters were sent that included the risks and what actions had been agreed. When people needed more frequent appointments or longer periods of individual therapy, some had individual protocols or plans to meet specific needs. We looked at the care records of ten people and found they were comprehensive, personalised, holistic and recovery focused.

The care pathways maximised the benefits of the multi-disciplinary team input, and clinicians used individual or group clinical supervision to explore options. Staff we spoke with said that they would often consult colleagues or co-work with colleagues. We found that clinicians had a range of professional skills, and included consultant psychologists, consultant psychiatrists, clinical psychologists, junior doctors, nurses and social workers.

Best practice in treatment and care

People received care, treatment and support that achieved good outcomes, promoted a good quality of life and was based on the best available evidence. This happened because staff had designed and followed the Leeds CAMHS

Are services effective?

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service delivery model. This provided staff with a step by step clinical guide to enable them to assess and implement treatment and care. It was based on good practice guidelines and included a range of therapeutic interventions in line with National Institute of Health and Care Excellence (NICE) such as family therapy, dialectical behavioural therapy (DBT) and cognitive behavioural therapy (CBT).

The service outcomes were routinely monitored to evidence whether people improved following treatment and care. Different measures were used dependent upon the interventions. Tools used included the National Child and Maternal Health Intelligence network (Chi) experience of service questionnaire, the strengths and difficulties' questionnaire, goal based outcome measures, child outcome rating scale, child session rating scale and revised anxiety depression scores. The child outcome rating scale for November 2014 showed over 85% of parents and children thought that the staff were working together to help them.

The learning disability team within the CAMHS had developed a range of interventions to make sure people with learning disabilities had equal access to the full range of CAMHS assessments and interventions. For example, the development of a care pathway for learning disabilities and a training course for staff on puberty and sexuality for young people and children with a learning disability.

The service offered a range of groups and specialist clinics to meet peoples' needs such as incredible years, eating disorders and learning disabilities.

Skilled staff to deliver care

We concluded that staff were appropriately qualified and competent at the right level to carry out their work, based on the information provided by the trust and what staff told us. For example, the trust had recognised that they were not meeting the national target for staff trained as high intensity workers or psychological wellbeing practitioners (IAPT) and had seconded staff to commence the course. The training improved access for patients to psychological therapies.

Staff told us they were supported by their managers to access a range of training to enable them to meet the needs of people. However, the information provided to us by the trust indicated some areas of training fell short of the target range for compliance, such as 77% for cardiopulmonary resuscitation (CPR).

Staff told us there was effective supervision and appraisal in place. Both group and individual clinical supervision were available to staff. Weekly clinical supervision and group supervision was provided and this was treated as a priority and staff were expected to attend. However, the information provided to us by the trust showed that 12.5% of the South team and 40% of the East team staff had received the necessary supervision.

The information provided by the trust about staff supervision and mandatory training from ESR (a computer database which recorded staff training) showed low levels of staff compliance. However, the ward manager told us the trust had only issued the requirement to record clinical supervision on ESR on 20 October. They said they were on track to becoming fully compliant with supervision and appraisal but the information on the ESR was not up to date and may show lower rates of compliance.

Multi-disciplinary and inter-agency team work

Staff described a multi-disciplinary and collaborative approach to care and treatment. Staff said they would discuss cases at both individual and group supervision and would seek out and ask advice from the specialists in the team. The teams could include consultant psychiatrists, consultant psychologists, junior doctors, social workers, nurses, and clinical psychologists.

Staff followed the Leeds CAMHS service delivery model, where one of the aims was to maximise the benefits of multi-disciplinary working.

In patients notes we saw examples of referral and discharge letters which informed the receiver about the patients care and their changing needs.

We were told there was a good working relationship with the transition team. The transition team helps when young people who had received assistance from Children and Adolescent Mental Health Services (CAMHS) reached the age of 17 to 18 and needed to move on to get the support they needed from Adult Mental Health Services.

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.

Also the MDT had good relationships with the outreach team, whose role was to focus exclusively on young people who were acutely unwell. The primary functions of the outreach team were preventing inpatient care and facilitating early discharge.

Adherence to the MHA and the MHA Code of Practice

Staff reported they had regularly up dated Mental Health Act 1983 and Code of Practice training.

The Deprivation of Liberty Safeguards (DoLS) does not apply to people under the age of 18 years. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. These would include the existing powers of the court, particularly those under s25 Children Act, or use of the Mental Health Act.

The Mental Capacity Act does apply to young people aged 16 and 17 and mental capacity assessments should be carried out to make sure the patient has the capacity to give consent.

For children under the age of 16, decision making ability is governed by Gillick competence. This concept of competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. As a consequence, when working with children staff assessed whether a child had a sufficient level of understanding to make decisions regarding their care.

At Leeds CAMHS we found staff were aware of and followed the Mental Capacity Act 1983 code of practice and guidance relating to Gillick competence. Consent to care was sought from young people, children and families using the service; and this was evidenced by speaking with staff and looking at peoples' records.

Good

Are services caring?

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

Summary of findings

At the time of the inspection we rated caring as good. The service offered to young people, children and families was compassionate, kind and respectful. Young people, children and families made extremely positive comments about the service and the staff that had supported them.

Young people, children and families were asked about their views of the service and were informed about and involved in decisions about their care and treatment. The service had also accessed services from external agencies to support people with their needs

Our findings

Are Specialist community mental health services for children and young people caring?

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

At the time of the inspection we rated caring as good. The service offered to young people, children and families was compassionate, kind and respectful. Young people, children and families made extremely positive comments about the service and the staff that had supported them.

Young people, children and families were asked about their views of the service and were informed about and involved in decisions about their care and treatment. The service had also accessed services from external agencies to support people with their needs.

Kindness, dignity, respect and support

We spoke with three relatives who said their families had been treated with dignity and respect. They described the staff as excellent and extremely professional and felt the key workers had gone the extra mile to help them.

We were provided with the people's feedback from the period between September and November 2014. This showed 133 out of 135 parents and 92 out of 97 children had responded that the help was good.

Examples of the comments made about the care and treatment were '"invaluable support and your involvement has ensured my relative mental health has improved", staff "really listened to my problems", "excellent service from start to finish and really helped with my child's problems" and "invaluable".

The involvement of people in the care they receive

All staff involved young people, children and families as partners in their own care and in making decisions, with support where needed, including support from advocates. This was recognised by managers and staff as central to ensuring appropriate consent was sought, and that choice and control was shared during treatment and care. Families were involved as appropriate and according to the person's wishes. This was demonstrated in people's records, from the patient questionnaires and in our discussions with staff.

Verbal and written information was available to meet people's communication needs, including the provision of information in different accessible formats and the use of interpreting services. This enabled people who used the service to understand their care.

Leeds CAMHS was commencing a focus group for young people, parents and carers, to provide them with an opportunity to look at how they may like the service to improve.

Young people, children and families completed questionnaires about the service on admission and on discharge and were invited to make comments about the service. In the questionnaires between September and November, 132 out of 135 parents and 91 out of 97 children stated that they were given enough information about the help available at CAMHS. In addition 133 out of 135 parents and 95 out of 97 children stated they felt listened to.

The trusts website also invited children and young people to share their experience of the service.

Are services responsive to people's needs?

Requires Improvement

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

Summary of findings

At the time of the inspection we rated the responsiveness of the service as requires improvement. This was because; the long wait for appointments and the reduced access to the services had the potential to impact on people's mental health.

The trust had identified and begun to respond to the issues of long waiting lists, staff had followed a risk based approach to determine when people had appointments. In addition, some of the demands on the CAMHS service were out of the trusts control and the trust were now fully engaged with and working with the local clinical commissioning group (CCG) to make improvements.

Patients could make a complaint or raise a concern. There was evidence these were responded to in a timely way and listened to. Improvements had been made to the quality of care as a result of complaints.

Our findings

Are Specialist community mental health services for children and young people responsive?

By responsive, we mean that services are organised so that they meet people's needs. The service was able to respond promptly to emergencies.

At the time of the inspection we rated the responsiveness of the service as requires improvement. This was because, the long wait for appointments and the reduced access to the services had the potential to impact on people's mental health

The trust had identified and begun to respond to the issues of long waiting lists, staff had followed a risk based approach to determine when people had appointments. In addition, some of the demands on the CAMHS service were out of the trusts control and the trust were now fully engaged with and working with the local clinical commissioning group (CCG) to make improvements.

Patients could make a complaint or raise a concern. There was evidence these were responded to in a timely way and listened to. Improvements had been made to the quality of care as a result of complaints.

Planning and delivering services

Any child or young person who presented with self-harm at accident and emergency (A&E) would be seen within four hours by CAMHS clinicians, we were told the majority of children were seen within this time. To facilitate this two staff from of the CAMHS teams would be on duty each day to cover all of the referrals from A&E.

Other referrals would normally come from other professionals, such as GP's, teachers and social workers. These would be reviewed each day and prioritised by a member of the team in each of the three areas. Once the team had received and accepted a referral, young people and families were mostly seen in the consultation clinics. In the clinic, a clinician would work with the young person or family to think about the difficulties and what might help them. People were offered up to three consultations spread over about six weeks. For most people this would be sufficient but for others with more complex or specialist needs they would be referred to therapies, groups, specialist clinics or for specialist assessments.

We concluded that services for young people, children and families could not always provide care in line with their clinical need and preferences promptly. This was because;

- Although the trust provided information to show an average waiting time of 7.4 weeks for a consultation clinic appointment. Staff told us and records demonstrated where people had waited from 14 to 17 weeks where they had been found to have been at a low risk of self-harm or risk to other people.
- Staff said the waiting time for young people to access the attention deficit hyperactive disorder (ADHD) clinic was about 26 weeks. This was confirmed by information provided by the trust which showed there were 42 people on the waiting list and 22 had waited longer than 18 weeks.
- Staff said the waiting time for young people to access autistic spectrum disorder assessments was over 40 weeks and one person had waited 61 weeks. This was confirmed by information provided by the trust that showed there were 106 on the waiting list and 59 had waited over 18 weeks.

Are services responsive to people's needs?

Requires Improvement

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

- The waiting list for young people and children and families to waiting to access the incredible year's group was 33. Six had waited over 18 weeks. Staff informed us that the number of groups had recently been reduced from two each school term time carried out by the three teams to two over all of the three teams. As a consequence they had expected the waiting time to increase. The Incredible Years programme is one identified by NICE (National Institute For Health and Clinical Excellence) as effective for the treatment of conduct disorders
- The waiting list for further help (general intervention) following the consultation appointments had 59 people and 13 had waited over 18 weeks.
- The waiting time for specialist learning disability consultations was between eight and ten weeks.
- The waiting time for play therapy was an average of 17 weeks.

When we spoke with staff they said that systems in place to triage the referrals meant more urgent cases were seen quickly and could be seen within seven days. They explained that the reduction of staff, the loss of the tier two services, and extensive staff training (IAPT) had increased the waiting lists.

The trust provided us with patient satisfaction questionnaires, between September and October. When asked what could be improved the majority of the comments were about the waiting times with "waiting time to be seen was too long, when my child needed to be seen", "waited eight months for our first appointment and now will wait another five to eight months to see a therapist to work on the issue", "more staff as appointments and clinics were sometimes hard to get and the time it takes to do everything e.g. referrals taking months".

These comments were echoed by the families we spoke with who told us it was an excellent service but it had been difficult to access and they had to wait a long time to get an initial appointment and then to have therapy. One family told us they had been referred to the CAMHS service but were told their children were not at sufficient risk, it was only when one of their children attempted serious self-harm that they were offered help. They said they thought that "children should not have to self-harm to receive help".

The children's' business unit had identified that CAMHS was experiencing high levels of waiting time for consultation clinics and other multi-disciplinary assessments. In addition there were growing waits for therapeutic interventions. They stated this was due to rising referral rates, more complex presentations and a response by the service to identify cost efficiencies as part of an organisation-wide cost improvement programme. In response, in November 2014 they had reviewed what actions they could take and were considering a quick win action plan. This was designed to reduce waiting lists and had seven actions. The actions included increasing the number of staff and reorganisation of the duty systems. In addition, a further discussion paper had been written by the senior management team with long term solutions to respond to the unacceptable time young people and adolescents had to wait to access the service. The commissioner from the local clinical commissioning groups (CCG) confirmed that some of the issues had been outside of the trusts control and the trends showed the situation was worsening but the trust were now fully engaged and working with them to make sure improvements were made to the waiting lists and access to the service.

The length of time young people, children and families had to wait for a service and the adoption of a risk based approach to all appointments had the potential to impact on their health.

Meeting the needs of all people who use the service

People who used the service were asked about their spiritual, ethnic and cultural needs and their health goals, as well as their medical and nursing needs. Their care and treatment was planned and delivered to reflect these needs, as appropriate.

We found there were different therapies to meet the different needs of individuals. For example, play therapy, family therapy, specialist clinics and incredible years.

There was also information about sexual health information, which had been written for people with a learning disability.

However, many of the appointments were during school times and two relatives told us this was disruptive to the children and the children found it difficult explaining to their peers where they were going.

Listening to and learning from concerns and complaints

We concluded that the staff were listening to the concerns and complaints of patients and families This was because

Are services responsive to people's needs?

Requires Improvement

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

the trust had a complaints procedure and guidance about it was summarised and advertised in the waiting rooms. Information about the Patient Advice and Liaison Service (PALS), which supported patients to raise concerns, was also displayed. Staff said most concerns were resolved within the teams. If unresolved they would be escalated to the management.

CAMHS had a patient participation group (PPG). The role of the group was to promote partnership working between people who used the service and the staff to highlight peoples' concerns and needs. People were also provided with a survey on discharge that provided the opportunity for people to make comments about the service. We saw these were collated and reviewed each month. For November 2014 when the questioned about what needed improving about the service, most of the responses were about waiting times.

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.

Summary of findings

At the time of the inspection we rated how well led the service was as good. Staff were motivated and dedicated to give the best care and treatment they could to young people and children. We found that within the parameters of the resources and increased demands on the service at local level; the teams were well managed and had good governance. Staff described strong leadership at team level and felt respected, valued and supported. However, staff said the reduction in staff, and the constant reviews of the service had affected their morale. The staff were committed to the service's quality, improvement and innovation.

Our findings

Are Specialist community mental health services for children and young people well-led?

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

At the time of the inspection we rated how well led the service was as good. Staff were motivated and dedicated to give the best care and treatment they could to young people and children. We found that within the parameters of the resources available and increased demands on the service at local level the teams were well managed and had good governance. Staff described strong leadership at team level and felt respected, valued and supported. However, staff said the reduction in staff levels, and increasing demand, along with the review of the service had affected their morale. The staff were committed to the service's quality, improvement and innovation.

Vision and values

Staff were motivated and dedicated to give the best care and treatment they could to young people and children. We saw in the monthly satisfaction survey, that most people said they felt the staff were working together to help them.

Two staff described where their contribution had not been included in the first review of the service. However, they said this had recently changed and they were taking part in the current review.

Good governance

We found within the parameters of the resources and increased demands on the service at local level the services were well managed and had good governance. We concluded this because staff had received the training and support they needed to carry out their role. Although there were demands on the service that could not be met, the staff had implemented a system to make sure people who were at most risk were seen promptly. Incidents were reported and there was evidence of staff learning from incidents. Staff reported they were supported and had clinical supervision. There were robust systems in place to monitor the quality and performance of the services provided.

Leadership, morale and staff engagement

Staff described strong leadership at team level and said they felt respected, valued and supported. However, staff said the reduction in staff, and the constant reviews of the service had affected their morale.

The staff we spoke with said that the engagement with senior managers had improved and they were now engaging with the staff about the service review. All the staff we spoke with were aware of what they were responsible for and the limits of their authority.

The opportunities for staff to engage were at individual and group supervision, as part of their annual appraisal, at team and leadership meetings.

Commitment to quality improvement and innovation

The staff monitored the quality of the service they provided and were innovative. We concluded this because they monitored the service using;

- The Chi- experience of service questionnaires
- The strengths and difficulties questionnaire
- The goal based outcome measures
- Child outcome rating scales
- Child session rating scales
- Child anxiety and depression scales

Staff had taken the initiative of producing the Leeds CAMHS service delivery model.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records We found that the registered person had not protected people against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them in their records. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must make sure people are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them in their records within the community child and adolescent mental health service. Staff had not always recorded peoples risk assessments on the computer system.