

Nottinghamshire Healthcare NHS Foundation Trust Specialist community mental health services for children and young people

Quality Report

Nottinghamshire Healthcare NHS Foundation Trust
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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)
RHA03	Duncan Macmillan House, Porchester Road Mapperley Nottingham Nottinghamshire	Child and Adolescent Mental Health Community Services	NG3 6AA

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

Summary of findings

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

Specialist community mental health services for children and young people:

- young people and their families felt listened to, respected and treated with dignity
- young people and their carers told us staff involved them in planning, reviewing and updating their care
- the service provided access to advocacy and plenty of age appropriate leaflets and posters in the waiting area
- the service involved young people in the recruitment process for new staff
- there were enough rooms for young people to meet with professionals
- rooms were clean, bright and created a relaxed, therapeutic environment
- staff told young people if things went wrong
- people with disabilities, including wheelchair users, could access the unit
- the multi-disciplinary team consisted of a good range of disciplines, who were happy working in the team.
- the service had systems to ensure staff received mandatory training, appraisal and supervision
- staff received specialist training in recognised and recommended psychological interventions
- staff had a working knowledge of the Mental Health Act and Mental Capacity Act
- staff received safeguarding training and had a clear understanding of their responsibilities in relation to this
- risk assessments were comprehensive and up to date

- staff used clinical outcome measures to monitor young people's progress
- the service had a process for dealing with complaints and made sure staff learned lessons from them
- staff could describe the duty of candour and the importance of it
- staff informed us they felt confident raising concerns without fear of victimisation
- staffing levels were adequate, and at the levels commissioned. Vacancies were actively being recruited to
- staff knew who the senior managers were within the organisation
- managers were supportive and visible
- staff understood and followed the procedures on lone working.

However:

- Four out of seven care records we reviewed did not contain a current plan of care.
- Six out of seven records were incomplete and inconsistent with limited up to date information and, in some cases, gaps of up to two years in the notes
- care plans were not recorded electronically, which made it difficult to access all information
- staff recorded notes on an electronic system so each young person had two sets of notes making it difficult to access all the information. The different types of notes put young people and staff at risk because vital information could be missed
- there were no records of face to face contacts, assessments or therapy sessions.

Summary of findings

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

Are services safe?

- the environment was clean, welcoming and brightly decorated in an age appropriate manner
- staffing levels were adequate, and at the levels commissioned. Vacancies were actively being recruited to
- staff completed mandatory training and we saw the service had processes to manage this
- staff had a working knowledge of the Mental Health Act and Mental Capacity Act
- risk assessments were comprehensive and up to date
- staff received safeguarding training and had a clear understanding of their responsibilities in relation to this
- staff reported incidents and we saw the processes to review and cascade any learning to the teams
- staff understood and followed the procedures on lone working.

Are services effective?

- Four out of seven care records we reviewed did not contain a current plan of care.
- Six out of seven records were incomplete and inconsistent with limited up to date information and, in some cases, gaps of up to two years in the notes
- care plans were not recorded electronically, which made it difficult to access all information
- staff recorded notes on an electronic system so each young person had two sets of notes making it difficult to access all the information. The different types of notes put young people and staff at risk because vital information could be missed
- there were no records of face to face contacts, assessments or therapy sessions.

However:

- the service was delivered in line with national guidance. The national institute for health and care excellence informed practice
- detailed reports from psychologists and doctors were present that included formulation, goals and interventions
- the multi-disciplinary team consisted of a good range of disciplines
- the service supported staff through monthly caseload management and clinical supervision
- staff received specialist training in recognised and recommended psychological interventions

Summary of findings

- clinical staff took part in monthly clinical audits
- clinical outcome measures were used.

Are services caring?

- young people and their families felt listened to, respected and treated with dignity
- young people and their carers told us staff involved them in planning, reviewing and updating their care
- the service provided access to advocacy and plenty of age appropriate leaflets and posters in the waiting area
- the service involved young people in the recruitment process for new staff
- young people and their carers were very complimentary of the staff
- surveys and feedback from young people and carers was positive. The service had received 17 compliments.

Are services responsive to people's needs?

- there were enough rooms for young people to meet with professionals
- rooms were clean, bright and created a relaxed, therapeutic environment
- staff told young people if things went wrong
- people with disabilities, including wheelchair users, could access the unit
- the reception area was calm with age appropriate music playing in the background and a screen displaying information
- the service offered young people appointments in a range of settings giving them and their parents/carers more flexibility and choice
- a process was in place for dealing with complaints. Learning from complaints took place
- each day the service allocated a duty worker who screened all referrals meaning they prioritised those with the greatest.

Are services well-led?

- the multi-disciplinary team consisted of a good range of disciplines, who were happy working in the team.
- the service had systems to ensure staff received mandatory training, appraisal and supervision
- staff received specialist training in recognised and recommended psychological interventions

Summary of findings

- staff had a working knowledge of the Mental Health Act and Mental Capacity Act
- staff received safeguarding training and had a clear understanding of their responsibilities in relation to this
- risk assessments were comprehensive and up to date
- staff used clinical outcome measures to monitor young people's progress
- the service had a process for dealing with complaints and made sure staff learned lessons from them
- staff could describe the duty of candour and the importance of it
- staff informed us they felt confident raising concerns without fear of victimisation
- staffing levels were adequate, and at the levels commissioned. Vacancies were actively being recruited to
- staff knew who the senior managers were within the organisation
- managers were supportive and visible
- staff understood and followed the procedures on lone working.
- staff took part in research studies

Summary of findings

Information about the service

Nottinghamshire Healthcare NHS Foundation Trust provides specialist community mental health services for children and young people (CAMHS). The CAMHS service is a specialised multi-disciplinary service for severe and complex child and adolescent mental health problems and neurodevelopmental disorders.

The aim of CAMHS service is to improve the mental health of all children and young people, from birth to their 18th birthday by providing a timely, integrated, high quality, effective, multi-disciplinary county wide service following the recommendations of the National Service Framework (NSF) for Children (Standard 9: Child & Adolescent Mental Health Services).

The CAMHS service core purpose is to work with children and young people from the age of 0-18 years (to include transition to adult services under the Care Programme Approach where applicable) and their families / carers who may be experiencing severe and/or complex mental health problems and neuro-developmental disorders that have a significant impact on the child's development and cause distress to the child and / or their carers.

The service was last inspected between 29 April - 2 May 2014.

Our inspection team

The team was comprised of:

- one inspection manager,
- two CQC inspectors, and
- a specialist advisor.

Why we carried out this inspection

We inspected this core service as a follow up to a previous comprehensive inspection. Areas previously identified where the provider should take action were:

- The trust should ensure steps are taken to permanently fill those CAMHS managerial positions that are currently interim or acting roles.
- The trust should ensure a review takes place of the multi-disciplinary input into some community CAMHS teams and into the Thorneywood inpatient unit.
- The trust should continue to work with commissioners to ensure every young person who had been referred to the community CAMHS team received prompt initial assessment and treatment.
- The trust should review their current systems for the effective monitoring and management of individual community CAMHS team caseloads.
- The trust should ensure all their CAMHS community care and treatment records are reviewed for consistency and completeness.

Of the identified areas an on-going issue remained regarding the consistency and completeness of CAMHS community care and treatment records.

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?

Summary of findings

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

Before the inspection visit, we reviewed information we held about these services.

During the inspection visit, the inspection team:

- visited two community teams
- looked at the quality of the environments
- spoke with two patients
- spoke with three carers
- spoke with one senior manager

- spoke with eight staff of various grades and professions, including medical staff, psychology, nurses, and a medical secretary.

We also:

- looked at seven care records
- attended a triage review
- attended a multi-disciplinary meeting
- looked at a range of policies, procedures and other documents relating to the running of the service
- observed interactions between staff and service users.

What people who use the provider's services say

Young people and their carers were very complimentary of the staff. They told us staff treated them with dignity and respect. They said they felt listened to and involved. They also said staff were caring and helpful. Family members said there was always someone available during working hours if they needed advice or support. One parent told us the consultant responsible for her child was very individualised in relation to care planning.

Young people and carers told us the service provides lots of relevant information, which included written and verbal information.

Good practice

The CAMHS self-harm team fostered strong working relationships with the local paediatric team. This resulted in joint working initiatives to enhance the understanding of general nurses about young people and self-harm. The

service developed a training and mentoring programme. The team actively participated in research and were working with Nottingham University on a study into depression and self-harm.

Areas for improvement

Action the provider **MUST** take to improve

- It must ensure all young people have a current up to date plan of care to manage their care effectively.
- It must ensure all information relating to young people is easily accessible and kept in a chronological order.

- It must ensure notes are complete, current and thorough and there are no gaps in the recording of information. Vital information could be missed creating a risk to young people and staff.

Action the provider **SHOULD** take to improve

- Continue to work with commissioners to meet and improve waiting times for treatment from the point of assessment.

Nottinghamshire Healthcare 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)

Child and Adolescent Mental Health Community Services

Name of CQC registered location

Duncan Macmillan House,
Porchester Road
Mapperley
Nottingham
Nottinghamshire

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.

- 86% of staff had received training in the Mental Health Act (MHA).
- Of the case records we reviewed only one young person was subject to the MHA. All necessary paperwork was present and up to date. There was evidence of discussion having taken place regarding treatment options. There was evidence of informed consent being obtained. This meant legal obligations were being met.

- The trust has a central team that supported the application of the MHA.
- Staff informed us of the referral process to the independent Mental Health Act service. Staff told us advocacy would be discussed at the point of assessment. There was no information displayed regarding advocacy services. This lack of information may have resulted in young people not being fully aware of this service to support them and to ensure they were aware of their rights.

Detailed findings

- Staff told us they felt specialist training in relation to the MHA would be beneficial in relation to CAMHS services. The MHA is rarely used and this could result in errors due to the infrequent usage.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act (MCA) act does not apply to young people aged 16 or under. For children under the age of 16, the young persons' decision making ability is governed by Gillick competence. The concept of Gillick competence recognises some children may have sufficient maturity to make some decisions for themselves. One doctor was familiar with the principles of Gillick competence. They stated this was used to include the young person where possible in the decision making regarding their care.
- 86% of staff had received training in the Mental Capacity Act (MCA).
- Staff we spoke with had a good understanding of MCA. They were able to share knowledge regarding the five statutory principles
- Staff were aware of policies and guidance available on the Trust intranet and how to access this.
- One set of notes had a clear age appropriate MCA present. Other notes contained letters sent to young people containing their treatment plans.
- Staff told us young people were encouraged to make their own decisions regarding their care and treatment. When a young person lacked capacity decisions were made in their best interests, with family involvement.

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 waiting area provided a large open bright space. It had clean and comfortable furniture. The walls were brightly painted. There were lots of notice boards containing age appropriate information.
- We observed the waiting area and clinical rooms were clean and tidy. No cleaning records were displayed.
- The building had a small clinic room which contained a couch and physical health monitoring equipment. We were told the room was occasionally used for the administration of depot medication or by the eating disorder team for physical health monitoring.
- Medication and emergency equipment was stored at the inpatient unit. We were informed staff would use the emergency equipment at the inpatient ward or call emergency services. The ward was several minutes away which could cause a delay to someone receiving potentially lifesaving treatment.
- There were no panic buttons in assessment rooms for staff or young persons to activate in the case of an emergency. This could place members of staff and young people at risk.
- The waiting area had books and toys present which could have created an infection control risk.

Safe staffing

- The staffing levels of whole time equivalent (WTE) staff for the south CAMHS team were:
one apprentice,
nurses (band five 2, band six 4.73 and band seven 2.7),
two professional and technical staff (band six 1.9 and band seven 0.5), and
two psychotherapists (band seven 0.6 and band eight 0.8).
There was one vacancy for a band six nurse that was being recruited to.

The staffing establishment for the CAMHS self-harm team was:

one nurse consultant, band 8b, and

Two part time community nurses, band 7 (1 WTE).

- The service did not use bank or agency staff. This meant occasionally sessions were cancelled at short notice due to sickness. If this happened a face to face apology would be given to the young person and the opportunity to have a brief interaction if needed. A duty clinician was available daily to take calls and give advice to young people and family members. Family members we spoke with said there was always someone available during working hours if they needed advice or support.
- There was a recorded sickness of 1.2% for July 2015, an improvement from June's figure of 6.04% and the lowest since March 2015.
- One member of staff was on maternity leave. Maternity leave was not backfilled. We were informed of further planned maternity leave. Staff were concerned about the impact of this. It would mean posts would be vacant for a period of time. Staff would be under greater pressure without additional resources. This could impact on the safety and delivery of care to young people.
- Full time staff were expected to complete 54 contacts per month and part-time staff 30 contacts per month. We saw these contact figures were met.
- There was adequate medical cover day and night with an on call system. Staff could contact doctors for advice when required. Doctors were available to attend for emergencies.
- Training records we reviewed showed the majority of training was above 90% compliance. Exceptions were breakaway training at 69%, Mental Health Act training at 86%, Mental Capacity Act training at 86% and Care Programme Approach at 71%. We saw plans were in place, and dates booked, for staff to complete CPA and breakaway training.

Are services safe?

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

- The team manager had an up to date white board in his office showing daily staffing and staff disciplines. This meant the manager had a daily overview of staffing.

Assessing and managing risk to patients and staff

- Seven care records were reviewed. Six of the seven records contained risk assessments. These were of a good standard, with detailed and up to date assessments. This meant risks were effectively managed
- We saw letters were written to the young person and copied to others involved in their care. A copy remained in the file. This demonstrated a collaborative and open approach.
- All care records demonstrated the clear involvement of the young person in their care. Three of the sets of notes included the views of the young people, carers or family members and evidenced holistic working.
- All team members were level three trained in safeguarding. We saw evidence of this on the training matrix. Policies and procedures were in place for safeguarding. These were available on the trust intranet and discussed at management supervision sessions. We saw records to reflect discussions.
- No medication was stored in the community building. If there was a need for medication it was stored on the inpatient unit.
- There was no 136 suite available on site. This service was provided at a nearby hospital.
- A lone working policy was available on the trust intranet which all staff had access to. A signing in and out system was present in the receptionist's office. This established which staff were on duty and their whereabouts. Staff members were given a password in case of emergency. If staff felt in danger or at risk they could say the password to alert others of any potential concerns. A buddy system operated to ensure staff safety.

Track record on safety

- The CAMHS community teams had reported 22 incidents since April 2015. One incident was classified as

moderate or serious harm this was in relation to self-harm. All other incidents were either classed as minor, low harm, or no harm. There was one near miss incident recorded.

- Of the incidents reported five related to violence, aggression or disruptive behaviour. Four incidents related to security issues. Four incidents related to information governance. Two incidents related to prescription pads not being appropriately stored, this could have led to the misappropriation of the prescription pads. There were reports of notes not being available or missing on two separate occasions. One incident was under investigation as a serious untoward incident.

Reporting incidents and learning from when things go wrong

- Incident reporting was via an online reporting system. Staff were aware of how to input incidents and were able to describe what should be reported. We saw records of reported incidents.
- The team manager was familiar with the duty of candour. He informed us information had been shared via team meetings and emails. He gave examples of when this should be used. It had not been used up to the date of the inspection.
- We were given recent examples of debriefing sessions following incidents. This information was discussed individually and at team meetings to ensure lessons were learnt.
- In the team meeting we attended we observed a discussion regarding a potential breach of confidentiality. This had been raised after a member of the team was able to hear confidential information in the waiting area. Staff were informed and made aware of the potential risks. This demonstrated the team identify learning and take actions. No complaint had been received.

Are services 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.

Our findings

Assessment of needs and planning of care

- We reviewed seven care records. Four care records did not contain a current plan of care. Three records contained a current plan of care. This information was not formatted as a care plan but provided relevant information. We found no care plans were recorded electronically. This meant the service did not effectively manage the care of the young people.
- Of the seven records examined we found six of the seven records were incomplete and inconsistent. There were gaps or information missing in the care records. There was limited up to date information. Different formats were used to record information. This included letters, care plans and multi-disciplinary working notes. Standardised forms were not used. Notes were not in chronological order. This made it difficult to access information.
- We found gaps of up to two years in the notes. There were no records of face to face contacts, assessments or therapy sessions. Professional notes were recorded on an electronic system. This was confirmed by a psychologist we spoke with. This made accessing information difficult as two sets of information were recorded for each young person. This meant vital information could be overlooked creating a risk to young people and staff.
- The recording of information across the two systems meant to effectively follow a young person's care it would be necessary to access both paper records and the electronic system which. This could be a potential risk as important information may get lost or overlooked. This would take time to complete thoroughly.
- Detailed reports from psychologists and doctor's that included formulation were present. Identified goals and interventions were present. These were of a very high standard demonstrating good multi-disciplinary working to meet patient's needs.

Best practice in treatment and care

- All staff within the looked after children team were trained in direct development psychotherapy and

dialectal behavioural therapy. The main interventions for treating attachment issues in line with national institute for health and care excellence (NICE) guidelines.

- Staff were trained in cognitive behavioural therapy (CBT). They provided group sessions and talking therapies to young people suffering with anxiety and depression as recommended by NICE guidelines.
- Eye movement desensitisation and reprocessing was available. A new psychotherapy technique which has proved successful in helping people who suffer emotional difficulties. This was in conjunction with NICE guidelines.
- The service delivery model CAMHS operates is improving access to psychological therapies. This is recommended by NICE guidelines to support services treating depression and anxiety.
- Clinical outcome measures were used. We were shown a scale used to rate anxiety and depression which, was completed by parents to rate anxiety and depression. This then produced a graph. The graph demonstrated symptoms and changes. It was an easy to read tool.
- Clinical staff actively participated in monthly clinical audits. These were overseen by the team manager and followed up with individual staff. Areas audited included safe guarding, G.P. correspondence, risk management and quality. This helped the team to improve their practices.

Skilled staff to deliver care

- The multidisciplinary team consisted of a good range of disciplines. Made up of psychology, nurses, therapists, trained counsellors, a nurse prescriber and medical staff.
- Staff received monthly management and, or clinical supervision. Staff had access to monthly team meetings and fortnightly peer support groups. We saw documents and minutes evidencing this. This meant staff were effectively supported in their roles.
- We saw evidence staff performance was continually assessed through supervision and clinical audits. Concerns were promptly addressed through management supervision. This included staff development, meeting targets and training needs.

Are services 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.

- The Learning & Development department for the trust provided generic training. Staff said accessing this training was not an issue and requests were supported by managers. However, there was no training in relation to higher level specialised CAMHS work.
- Two staff told us there needed to be a better structure for new staff joining the team in relation to training. Particularly in relation to working with young people. This would ensure all staff were adequately trained and skilled to meet the needs of all young people's using the service.
- Two staff members said the service needed more administrative support. They felt this negatively impacted on the time clinicians could spend with young people in the service.

Multi-disciplinary and inter-agency team work

- We attended a multidisciplinary team meeting which, involved a team manager, a psychiatrist, four community psychiatric nurses and a CBT therapist. Part of the discussion involved a potential away day which would involve staff from other professions this demonstrated multidisciplinary relationships existed.
- We met a range of professionals on the inspection. They were all complimentary of other staff teams. They were supportive of each another. This created an effective cohesive team for the young person.
- We explored transitional arrangements from CAMHS services to adult. CAMHS remained involved and provided joint working until the age of 18. The aim to provide a smooth and effective journey for the young person through their involvement with services. The CAMHS team proactively made referrals in advance of the transition. We were told the transition for young persons from CAMHS to adult services could vary dependent on the adult service.
- A consultant from the looked after children's team described to us the positive relationships that existed with the police, local authority, schools and local mental health teams. This highlighted effective inter-agency working to meet the young person's needs.
- The team manager told us the relationship between social care and health care could be improved. They

believed this could create a block on a young person's pathway. This could mean a delay increasing the waiting time for admission and increases the distress or risk of the young person.

- One family member told us their daughter had to wait to be seen by a dietician. She said it felt a long time at the point of referral. She was now happy with the care received and felt all appropriate professionals are involved.

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

- 86% of staff had received training in the Mental Health Act (MHA).
- Of the case records we reviewed only one young person was subject to the MHA. All necessary paperwork was present and up to date. There was evidence of discussion having taken place regarding treatment options. There was evidence informed consent had been obtained. This meant legal obligations were being met.
- The trust has a central team that supported the application of the MHA that staff knew how to access.
- Staff informed us of the referral process to the independent Mental Health Act service. Staff told us advocacy would be discussed at the point of assessment. There was no information displayed regarding advocacy services. This lack of information may have resulted in young people not being fully aware of this service to support them and to ensure they were aware of their rights.
- Staff told us they felt specialist training in relation to the MHA would be beneficial in relation to CAMHS services. The MHA is rarely used and this could result in errors due to the infrequent usage.

Good practice in applying the Mental Capacity Act

- The Mental Capacity Act (MCA) act does not apply to young people aged 16 or under. For children under the age of 16, the young persons' decision making ability is governed by Gillick competence. The concept of Gillick competence recognises some children may have sufficient maturity to make some decisions for

Are services 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.

themselves. One doctor was familiar with the principles of Gillick competence. They stated this was used to include the young person where possible in the decision making regarding their care.

- 86% of staff had received training in the MCA.
- Staff we spoke with had a good understanding of MCA. They were able to share knowledge regarding the five statutory principles
- There were policies and guidance available on the Trust intranet. Staff were aware of the guidance and how to access this.
- One set of notes had a clear age appropriate MCA present. Other notes contained letters sent to young people containing their treatment plans.
- Staff told us young people are encouraged to make their own decisions regarding their care and treatment. When a young person lacks capacity decisions are made in their best interests, with family involvement.

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

- Young people and their carers were very complimentary of the staff. They told us staff treated them with dignity and respect.
- Young people and their carers said they felt listened to and involved. They felt their views were valued and heard.
- We were told staff were caring and helpful.
- One parent told us the consultant responsible for her child was very individualised in relation to care planning. Family members were involved in decision making from a family perspective.
- From the interactions we observed staff were respectful and treated young people with kindness.
- Young people and carers told us lots of relevant information was provided. This included written and verbal information. We saw numerous posters and leaflets.
- Staff we spoke with had a good understanding and knowledge of individual needs of young people. They verbalised the importance of treating people with dignity and respect.
- The service had received 17 compliment letters. Thanking staff for their support and advice whilst receiving care and treatment.
- The friends and family test score is the proportion of patients who are extremely likely or unlikely to recommend the service. In the latest quarter 91% would recommend the service. This compares with 88% in the previous quarter and 86% in the previous four quarters.

The involvement of people in the care that they receive

- Copy letters of treatment plans were sent to young people and their carers.
- Young people and their carers told us young people were involved in care planning. There were regular reviews and updates regarding care. This demonstrated joint working and effective therapeutic relationships.
- There was access to advocacy. Staff members were able to inform us of the referral process. Information was not displayed in the waiting area.
- Young people were involved in the recruitment process of staff members. In the latest interviews a young person was part of the panel. This demonstrated collaborative working with young persons who use the service.
- Information was displayed from questionnaire feedback including outcomes and what has changed as a result of the young person's experiences and views. We saw the waiting area had been redecorated following "you said" feedback in July 2014, which said it needed brightening up.
- There were service user care experience questionnaires advertised in the waiting area. These were also given out during assessments. The questionnaire encouraged people to share their experience of the service. This included whether they were involved in decision making regarding their care and medication. 72% of people who responded to the questionnaire said they "felt involved in care".
- There was evidence of parent/ carer feedback. We saw posters in the waiting area promoting self- help groups and carer involvement. However, two of the parents we spoke with said there wasn't a lot of support for parents.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- On a daily basis a duty worker was allocated to screen all referrals. The duty worker then allocated referrals to the appropriate team.
 - One parent we spoke with said she had always received responses to messages within the same day. They would feel confident to contact the team regardless of the time of day. Two parents we spoke with said waiting times were too long. They said they were happy with the service once their child was referred to the appropriate team.
 - Appointments were offered in a range of settings such as: community centres, schools, and libraries to give young people and their parents/carers more flexibility and choice.
 - The team tried to actively involve young people who are reluctant or difficult to engage. They tried to be welcoming and informative. They tried to engage young people via emails and text messages. If a young person was unwilling to engage the team would inform the G.P, family/carer and young person. Contact details of the service would be provided.
 - The team manager informed us young people are offered flexibility. At the post triage discussion meeting we attended, one young person was not offered the option of an out of hour's appointment despite attending college. This could mean the service was not as flexible as it could have been to meet young people's need.
 - Appointments ran on time and were rarely cancelled. If this did happen the service apologised to the person face to face and offered the option of another appointment. The person was given the opportunity to discuss any concerns they may have at that time.
 - The team manager told us young persons can wait over 20 weeks for treatment. This was under review by Nottingham City Commissioners.
 - CAMHS services are delivered at different levels called tiers. Tier two services concentrate on working with young people with mild to moderate emotional wellbeing and mental health problems. Tier three services concentrate on moderate and severe mental health problems that are causing significant impairments in young people's day-to-day lives.
 - All seven, tier two CAMHS teams had waiting lists. 237 young people were waiting from the point of referral to treatment. 62 were waiting up to four weeks. 99 young people were waiting more than five weeks. 48 young people were waiting more than nine weeks. Two young people were waiting more than eighteen weeks. No one was waiting more than 25 weeks.
 - We saw nine of the fourteen CAMHS tier three teams had waiting times from referral to treatment. The teams with the highest numbers of young people waiting for treatment were: CAMHS North team (62), CAMHS South team (37) and CAMHS learning disability (LD) team (16). One young person had waited in excess of 25 weeks to access treatment with the CAMHS LD team.
- Of the current 152 referrals, 37 had waited less than 2 weeks. 35 had waited between two and four weeks. 50 had waited between five and eight weeks. 17 had waited between nine and twelve weeks. 10 had waited between thirteen and eighteen weeks. 2 had waited between nineteen and twenty-five weeks. This meant young people experienced a delay in accessing treatment and their health could suffer or deteriorate.
- Referrals for people with eating disorders were targeted to be seen within 10 working days. However three young people had waited between two and four weeks to access treatment.
 - A referral including self-harm was targeted to be seen within 14 days as recommended by CAMHS guidance. One young person was waiting between two and four weeks to be seen. This meant not all young people were being treated in a timely manner.
 - Urgent referrals aimed to be seen within eight weeks. On the day of the inspection three young people were on a waiting list. They had received an initial assessment and remained on the list waiting for further intervention.
 - The target for assessing young people who had self-harmed was within 24 hours. This target was not always met due to the increased demand of referrals. Referrals to the service had doubled in 2014 to 297.
 - Staff from the self-harm team told us waiting times in other parts of the service affected their workload. The

Are services responsive to people's needs?

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

young person was held on their caseload until transition was completed. This could sometimes take up to 3 months until a follow up appointment was given. The staff felt this negatively impacted on their ability further to meet their own workload.

The facilities promote recovery, comfort, dignity and confidentiality

- The building had many rooms for young people to meet with professionals. There were quiet areas away from the main reception waiting area. The rooms were clean and bright creating a relaxed and therapeutic environment.
- A fully equipped sensory room and garden was provided for young people to use.
- The reception area had a calm and relaxing atmosphere with age appropriate music playing in the background.
- The clinic room had a clinical bed and physical health monitoring equipment. This was used to record a young person's height, weight and blood pressure. We were informed this was rarely used other than by the eating disorders team or for depot injection administration.
- The waiting area had numerous leaflets on display. These included information on: sexual orientation, self-help groups, research, discrimination/abuse, medication, treatments and the services available. A television screen displayed varying information. This meant information was available in various formats.
- Leaflets on how to complain via PALS were displayed.

Meeting the needs of all people who use the service

- The building was wheel chair friendly. We saw evidence of individual rooms to meet patients' particular needs.

- The information leaflets on display were in English only. We were advised leaflets were available in other languages and could be printed off when required.
- The procedure for interpreters is through an online booking system. Staff told us this was an easy accessible service and described how to access it. We were informed there had been some difficulty accessing translators for some Eastern European languages.

Listening to and learning from concerns and complaints

- The staff were aware of how to deal with complaints and who to escalate concerns to.
- There was a process in place for dealing with complaints. Complaints were logged and investigated by the team manager. They were escalated to senior managers and forwarded to service liaison. Any lessons learned and sharing of outcomes were discussed at the CAMHS leadership, quality and risk group. Wider learning was taken to specialist services directorate quality and risk meeting. This meant a process was in place to deal with complaints and to feed back any learning to the teams.
- Learning from complaints was disseminated via the monthly team meeting. Learning would then feed into clinical/management supervision. Emails were sent to team members of learning identified.
- Since April 2015, seven complaints have been made regarding CAMHS community services. Of these one was resolved locally. The remaining six are subject to a full on-going investigation.

Are services 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.

Our findings

Vision and values

- The staff were aware of who the senior managers were within the organisation.
- Staff told us senior managers were approachable and visible within the service. On the day of the inspection senior managers were available and offered us the opportunity to meet with them.
- The team vision and values were underpinned by the 6's of nursing care; a national initiative to improve the quality of care. An annual review took place. This was to reflect on their work and set objectives. To ensure these values are implemented and translated into improved patient care.

Good governance

- We found there were effective systems to ensure staff receive mandatory training, appraisal and supervision.
- The community team was covered by sufficient staff of the right grade, experiences and skills to meet patient need.
- Staff were actively encouraged to report incidents. Processes were in place to facilitate learning from incidents and complaints. This was to improve the service and create a transparent and open culture.
- The staff we spoke to had a good understanding of Mental Health Act, Mental Capacity Act and safeguarding procedures. However, staff felt this could be improved by the provision of specialised training in relation CAMHS.
- The team manager had sufficient authority to manage the service and the authority to raise issues at trust level.
- The team manager was involved in planning and delivering new initiatives and models of care. Such an initiative being the single point of access service, due to be implemented in September 2015.

Leadership, morale and staff engagement

- Staff were aware of the whistleblowing process.

- Staff informed us they would feel confident to raise concerns without the fear of victimisation. One staff member said they would be confident to escalate concerns. They said they would be happy to raise any issues with the team manager.
- We were told there is an open culture within the team. Staff felt informed of incidents and new initiatives.
- We were told young people were advised if things go wrong. Staff were aware of the duty of candour.
- Staff reported they felt very supported by their colleagues and management team.
- Staff said they were happy working in the team. They felt team members were committed and supported each other. They felt communication was effective. We saw the team functioned well during our observations of an multidisciplinary team (MDT) meeting.
- During team meetings staff were able to give comments and suggestions for improving the service and delivery of patient quality care. This demonstrated effected MDT working.
- There were no current bullying or harassment cases in the team.
- Staff spoke of the inevitable stress levels at work due to the nature of the job. They also identified the pressures to deliver interventions to support young people and their family/carers.

Commitment to quality improvement and innovation

- Research into depression and self-harm was being carried out in conjunction with Nottingham University. This was to look at whether a talking therapy could help in reducing levels of distress for people who had self-harmed. The study invited young people who used or had used the service to be involved in the research.
- A nurse consultant we spoke with said the self-harm team had positive links with the local paediatric assessment suite, with good working relationships. This included joint attendances at conferences and joint research projects for improving the skills of paediatric nurses when working with young people who self-

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harmful. The service provided mentoring opportunities for student nurses to experience working in CAMHS. Training packages for student nurses had been developed.

- We saw evidence the service was committed to improvement with a new model of care due for

implementation. The choice and partnership approach and improving access to psychological therapies will underpin the new model of care. This will evidence care and treatment and create a more robust service.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- Not all young people had a current up to date plan of care to effectively manage their treatment.
- Not all information relating to young people was easily accessible and kept in a chronological order.
- Notes were not complete, current or thorough. There were gaps in the recording of information. Vital information could be missed creating a risk to young people and staff.

Regulation 17(2)(c).