Care Quality Commission

Rotherham Doncaster and South Humber NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Woodfield House, Tickhill Road site, Weston Road,
Balby, Doncaster, DN4 8QN
Tel:01302 796000
Website: www.rdash.nhs.uk

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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)
RXE00	Trust Headquarters - Doncaster	CAMHS Community Services St Nicholas House (Scunthorpe CAMHS)	DN4 8DE
RXE00	Trust Headquarters - Doncaster	CAMHS Community Services Balby (Doncaster CAMHS)	DN15 6NU
RXE00	Trust Headquarters - Doncaster	CAMHS Community Services Kimberworth Place (Rotherham CAMHS)	S61 1HE

This report describes our judgement of the quality of care provided within this core service by Rotherham Doncaster and South Humber NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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 Rotherham Doncaster and South Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Rotherham Doncaster and South Humber NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement	
Are services safe?	**Requires improvement**	
Are services effective?	**Requires improvement**	
Are services caring?	**Good**	
Are services responsive?	**Good**	
Are services well-led?	**Good**	

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Rotherham Doncaster and South Humber NHS Foundation Trust as requires improvement because:'

- Risk assessments on the electronic system were found to be poorly completed, incomplete or missing.
- Care records were found to be missing, incomplete, or poorly completed on the electronic system.
- Electronic records did not reflect the content of paper records, and information had not been scanned, as per procedure, into the electronic system though scanners were available.
- Appraisals for non-medical staff had not been completed.
- Mandatory training figures for the service showed non-compliance with trust targets in relation to equality and diversity and conflict resolution.
- Mental Capacity Act (MCA) considerations did not fully show adherence to its principles.

However:

- The trust had taken positive actions to try to reduce gaps in record keeping by the recent employment of a safeguarding advisor with a remit to ensure that all records in the service were maintained at a high standard.
- Safeguarding supervisors were also in place, offering supervision to staff to help deal with issues relating to record keeping and to support clinical safeguarding decision making.
- Access to psychological therapies was available, and the skill set of staff within the service reflected the needs of the people who used the service.
- The therapeutic relationship between staff and people who used the service was seen to be excellent. The interventions observed were professional and caring.
- Referral to assessment, and assessment to treatment times, had improved. The introduction of a re-configuration of Rotherham CAMHS showed improvements accessing the service.Key performance indicators (KPIs) were closely monitored to ensure that improvement was maintained across the service.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

Requires improvement

- Risk assessments on the electronic system at Rotherham CAMHS were found to be poor, incomplete, or not updated.
- There was no system in place to monitor or give a point of contact for those people who had been referred and were waiting for assessment.
- Mandatory training figures showed non-compliance with trust targets, especially in relation to equality and diversity and conflict resolution training.

However:

- the trust had employed a safeguarding advisor with a remit to ensure care plans for all open cases were checked regularly. Safeguarding supervisors were also used to monitor records and support work with on-going cases.
- Safeguarding training was at a high level across the service.
- Locations where people who used the service were seen were clean and well maintained.
- A good liaison service existed with school nurses.
- The duty system and out of hours service allowed for excellent coverage in the event of an emergency or crisis call.

Are services effective?

We rated effective as requires improvement because:

Requires improvement

- Care plans at Rotherham CAMHS were examined and found to be missing, poor, or not updated.
- Electronic records did not reflect the content of paper records, and had not been updated or scanned into the electronic system, even though scanners were available.
- Appraisals for non-medical staff showed only a small number (32 out of 103) had been appraised in the last 12 months.
- Use of the Mental Capacity Act showed no formal consideration of the five principles in care records.

However:

- The skill set of the staff within the service was excellent, with easy access to psychological therapies.
- Specialist training was available to staff to improve their skills.
- There were peer support workers in place to assist in transition to adult services. Their work was observed and noted to be excellent.

Summary of findings

- MHA and MCA training level attendance was high, as it was included as a two day part of the trust induction.

Are services caring?
We rated caring as good because:

Good

- We observed interaction between staff and people who used the service, and noted that whilst professional, the interactions and interventions created trust.
- The patients showed a willingness to engage.
- People who used the service were generally very impressed with the service they received, and were happy with the positive effects this had on both their carers and themselves.
- There were opportunities for comment and complaint after each session or intervention, and this was monitored closely by the trust.

Are services responsive to people's needs?
We rated responsive as good because:

Good

- Referral to assessment, and assessment to treatment times, were found to have improved. In Rotherham CAMHS 92% of referrals were seen within 3 weeks, and 96% of all treatment began within 18 weeks.
- The service re-configuration had helped with these improvements. These times were reflected in other locations.
- CAMHS provided a duty service that covered calls or cases received between 9 am and 5 pm weekdays. There was an out of hours service that covered from 5 pm till 9 am, with a 24 hour out of hours service at the weekend and bank holidays.
- Locations were well equipped to hold interviews and interventions with people who used the service.

Are services well-led?
We rated well-led as good because:

Good

- Staff were aware of trust values and objectives, and these were reflected in the team approach for the service.
- Key performance indicators were used to good effect by the trust.
- There was close monitoring of regular quality and performance reports outlining improvements and shortfalls within the service.
- Regular team meetings were held and minutes taken.
- Leadership training was available for staff, as well as specialist training for skill development.

Summary of findings

Information about the service

The specialist community mental health services for children and young people in Rotherham, Doncaster and South Humber Foundation Trust covered a large geographical area. Services were based in Rotherham, Doncaster and Scunthorpe. Each service comprised of a multidisciplinary team of professionals who work with children, young people and their families or identified carers. Where a child or young person was experiencing mental health issues or emotional difficulties, their GP made a referral to the service based within the specific geographical area.

The community services provided assessment and interventions for young people and their families. The aim was to gain an understanding of their difficulties, and find ways to manage, improve, and reduce the impact of their difficulties.

Examples of mental health conditions treated were:

- anxiety disorder
- depression/low mood
- bipolar disorder
- obsessive-compulsive disorder
- eating disorders
- self-harm / suicidal thoughts
- neurological-developmental disorders where an assessment is required, for example autism spectrum disorder and attention deficit hyperactivity disorder
- learning disabilities (with mental health presentation).

Each service provided a range of interventions as identified by the National Institute for Health and Care Excellence guidelines to address the identified needs of each child/young person/family. This included individual or group therapies, family work, medication where indicated and inpatient care if required. Joint working and provision of support to other agencies through consultation was also offered.

This was the first comprehensive inspection for this trust, and the first time this service has been inspected.

Our inspection team

The team inspecting the specialist community services for children and young people consisted of one CQC Inspector, one consultant psychologist, one clinical nurse specialist and one expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

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

Prior to the inspection we reviewed information that was held about these services, and contacted a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the three community teams selected for the inspection
- we spoke with 16 people who used the service, and 16 carers of people who used the service, spoke with three team managers and senior staff members of each service
- spoke with 20 other members of the service teams
- attended and observed four multi-disciplinary meetings, one initial assessment, and

three interventions

- reviewed feedback data from 82 people who used the service who had completed experience of service questionnaire results
- reviewed feedback data from 520 completed session feedback questionnaires from people who used the service
- looked at 21 care records of people who used the service
- examined policies and procedures.

What people who use the provider's services say

We observed three interventions and spoke with 16 people who used the service, as well as 16 parents/carers. We also saw feedback from people who used the service to the service, recorded in experience of service questionnaires and session feedback questionnaires. During the interventions we saw staff treat young people with compassion and respect, developing a therapeutic relationship. It was clear that staff listened to the thoughts both of people who used the service and their parents and carers, offering appropriate guidance and support. This was reflected in the comments we saw and heard, describing the service as "helpful", "excellent", "listened to", and "everything is fine". However, one comment from a carer in Rotherham said waiting lists were "diabolical". The waiting period for treatment in Doncaster was commented on by another carer.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- Risk assessments on the electronic system were found to be poor, incomplete, or not updated. The trust must ensure that risk assessments are completed fully and maintained for people who use the service.
- Care plans were examined and found to be missing, poor, or not updated. The trust must ensure that care plans are completed, holistic, up to date, and reflect the treatment for people who use the service.
- Electronic records did not reflect the content of paper records, and had not been updated or scanned into the electronic system, even though scanners were available. The trust must act to ensure that paper records and electronic records are synchronised to give a full reflection of care.

Action the provider SHOULD take to improve

- Mandatory training should improve in areas not reaching compliance, especially quality and diversity and conflict resolution.The trust should ensure that mandatory training is kept current and on-going.
- Appraisals of non-medical staff should be undertaken to improve current figures. The trust should ensure that non-medical staff have appraisals in line with guidelines.

Summary of findings

- MHA and MCA mandatory training is completed on induction training as a once-only session; the trust should ensure a more robust training schedule for MHA and MCA.
- The trust should improve communication with people who used the service who are waiting for assessment after referral, ensuring a point of contact whilst waiting for assessment.

Care Quality Commission

Rotherham Doncaster and South Humber NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CAMHS Community Services St Nicholas House Scunthorpe CAMHS	Rotherham Doncaster and South Humber NHS Foundation Trust
CAMHS Community Services Balby Doncaster CAMHS	Rotherham Doncaster and South Humber NHS Foundation Trust
CAMHS Community Services Kimberworth Place Rotherham CAMHS	Rotherham Doncaster and South Humber NHS Foundation Trust

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.

- The trust provided data that showed that 95% of CAMHS staff were trained in the MHA at the time of the inspection. The training was part of the trust induction, and was given as one-off training in conjunction with MCA training.
- We discussed the MHA with staff, who displayed varying degrees of knowledge about the MHA. We were told that the MHA was rarely used in relation to the people who used the service, being more relevant to those in tier four services.
- The clinical director at Doncaster CAMHS stated that she felt MHA training should be more focussed on its application to CAMHS.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust provided data that showed MCA and deprivation of liberties safeguards training for CAMHS at 95% at the time of the inspection. The training was part of the trust induction, and an explanatory leaflet was provided to all staff.
- We discussed MCA with staff and found varying degrees of knowledge about the MCA and its use.
- There was a trust policy on MCA and it can be found on the trust intranet; staff were aware of this.
- The clinical director at Doncaster CAMHS stated that she felt MCA training should be more focussed on its application to CAMHS.
- We were told that the Gillick Competence was in use within the trust, but there was no evidence produced to support this. Gillick competence can be used to decide if a child 16 years or younger can consent to medical treatment without permission or knowledge of their parent.

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

Our findings

Safe and clean environment

- The interview rooms at services in Kimberworth Place and East Laith Gate House (the off-site location for interviews at Balby Court) were fitted with alarm systems that worked. However, the interview facilities at St Nicholas House were not fitted with alarm systems.
- None of the services inspected had specific well-equipped clinic rooms for the examination of people who used the service. Each service had equipment for measuring weight and measuring the height of people who used the service, as well as access to blood pressure monitoring equipment. This equipment was maintained and audited.
- Equipment was checked, and equipment calibration logs were checked and found to be up to date. One blood pressure monitoring machine at East Laith Gate House had an old sticker on it stating "Do not use after July '07", but calibration logs showed that the equipment had been frequently and recently calibrated. The sticker was clearly old and was removed.
- The premises were clean and well maintained. St Nicholas House was being -modernised and an extension built on to the existing building. Staff had ensured that the building work had not affected the overall cleanliness of the unit. Furniture was noted to be in good condition at each of the services.

Safe staffing

CAMHS Rotherham

Establishment Levels: qualified nurses (Whole Time Equivalent)

15.2 WTE

Establishment Levels: nursing assistants

n/a

Number of Vacancies: qualified nurses

9.1 WTE

Number of vacancies: nursing assistants

n/a

Staff sickness rate (%) in 4 month period

5.1%

Staff turnover rate (%) in 4 months period

8.1%

CAMHS Doncaster

Establishment Levels: qualified nurses (WTE)

37.4 WTE

Establishment Levels: nursing assistants

n/a

Number of Vacancies: qualified nurses

1.3 WTE

Number of vacancies: nursing assistants

n/a

Staff sickness rate (%) in 4 month period

7.1%

Staff turnover rate (%) in 4 months period

4.5%

CAMHS Scunthorpe

Establishment Levels: qualified nurses (WTE)

9.8 WTE

Establishment Levels: nursing assistants

n/a

Number of Vacancies: qualified nurses

0.7 WTE

Number of vacancies: nursing assistants

n/a

Staff sickness rate (%) in 4 month period

3.9%

Staff turnover rate (%) in 4 months period

10.2% (1 WTE)

- Rotherham CAMHS was undergoing a re-configuration led by a consultancy firm brought in by the trust, with recommendations that would increase staffing levels at Rotherham CAMHS to 31 WTE.
- Doncaster CAMHS and Scunthorpe CAMHS staffing levels were estimated against commissioning needs and numbers of referrals. The team manager for Scunthorpe CAMHS stated that the re-configuration at Rotherham CAMHS would be eventually rolled out to the other services.
- Data provided by the trust showed that Rotherham CAMHS was regularly using 15 agency staff per week, ranging from 22.5 hours a week to 37.5 hours a week; Doncaster CAMHS was using seven WTE agency staff per week, with Scunthorpe CAMHS using 3.6 WTE agency staff per week. This was to cover vacancies and staff long term sickness. The operations manager for Rotherham CAMHS stated that the use of agency staff in their area was part of the strategy to bring down referral to assessment times, but was not considered a financially viable long term option.
- Data from the trust showed the caseload per team as of 26/08/2015 was: Rotherham CAMHS 1117 open cases; Doncaster CAMHS 910 open cases; Scunthorpe CAMHS 412 open cases. There was no case-holder breakdown provided for each team.
- A consultant psychiatrist was available during office hours. Out of hours staff had to contact the crisis team psychiatrist or contact Accident and Emergency departments for assistance. Some staff felt this situation needed to improve.
- Mandatory training figures were provided by the trust for CAMHS, and elements of training identified as being less than 75% were: equality and diversity (67%), fire safety (39% -however, a change in frequency from two yearly to annual training had given compliance rates a misleading figure), clinical record keeping (66%), conflict resolution (15%), violence and aggression Module D (42%).

Assessing and managing risk to patients and staff

- Risk assessments were completed in the initial assessment documentation. However, evidence on the computer system showed that at Scunthorpe CAMHS and Doncaster CAMHS risk assessments were present, appropriate and mostly up to date (11 care records viewed), whilst at Rotherham CAMHS the 10 records viewed showed only four risk assessment completed, and none of them were up to date. A safeguarding advisor had been employed by the trust to specifically check all care records at Rotherham CAMHS but had only been in post for three weeks at the time of inspection.
- Crisis plans involved carers and young people and it was clear how to access assistance when needed. The recently appointed operations manager at Rotherham CAMHS has started preliminary work introducing wellness recovery action plans aimed at both carers and young people who used the services.
- Should a young person within service notice a deterioration in their health, either physical or mental, there were routes that would alert services to take action. This included a good liaison system with school nurses, use of accident and emergency, as well as the duty system and out of hours service offered by CAMHS.
- We were told that the health of a young person during referral was monitored by their general practitioner (GP), family and school, but there was no evidence of this. We were also told that the appointment letter sent out by Rotherham CAMHS included contact details for anyone in distress to use. However, on viewing a copy of the letter it was found that contact details were not included.
- Safeguarding training was mandatory within the service, up to and including safeguarding level three data provided by the trust showed that safeguarding level two training stood collectively at 87% for CAMHS services, and 88% for safeguarding level three. Data specific to Rotherham CAMHS showed safeguarding level three training stood at 92%.Data provided by the trust showed that of 59 safeguarding alerts raised at the trust since April 2014, none had been raised by this service.
- Lone worker policy was discussed with service staff, and there was evidence that staff were aware of the policy and their safety considerations. We were informed that home visits were rare, and that if necessary then staff would go in pairs, and use their computer calendars, office whiteboards, and telephone system to keep

colleagues aware of their situation.Doncaster CAMHS stated they originally had personal alarms, but they were no longer in use and had been recalled by the trust.One staff member spoke of being on out of hours duty, and leaving hospital premises at 0100 hours; she felt frightened on that occasion.

- We were informed that the prescribing of medication within the service and monitoring of such was consultant led, and this was confirmed.

Track record on safety

- The trust serious incidents return data (1 February 2014 - 30 March 2015) showed no serious incidents reported from this service. There was one incident of restraint used at Rotherham CAMHS between 01/11/2014 – 30/04/2015, but there was no further information on this incident.

Reporting incidents and learning from when things go wrong

- The service used the incident reporting 1 system (IR 1) for reporting incidents. All staff interviewed knew how to complete a report on the system, and the circumstances under which a report should be made. Reports could be made by anyone who had access to the intranet system.
- The trust created a new duty of candour policy in April 2015, and staff and managers were aware of it.We were told that incidents would be initially verbally reported by people who used the service, with attempts to resolve the issue informally by staff. If this was not agreeable, then the duty of candour policy would be followed. The trust provided evidence of the policy, how it was to be recorded, and the necessary protocols to be followed, dispatched to all managers on 07/09/2015, including an instructional video.
- Feedback from incidents was given to staff by different routes, such as the organisational learning forum and team meetings. Feedback specific to an individual was dealt with more privately. We were informed of the “lessons learned forum”, a meeting specific to CAMHS within the trust, which met every two months. We were not able to see minutes of this meeting.

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

- Comprehensive assessment forms were completed in a timely manner. We witnessed an initial appointment with a consultant psychiatrist in which the ADHD pathway was followed. The assessment was clear, professional, and a concise action plan agreed with both the person who used the service and parents.
- Ten sets of care records at Rotherham CAMHS were inspected. In two cases, no care plan was recorded. Eight out of the ten care plans were not updated to reflect changes discussed in reviews. Two open care plans related to people who used the service who were 20 years old and 18 years old respectively. The records relating to the 18 year old had been opened prior to the electronic system, but no data from the paper records had been uploaded onto the system. Staff were not sure if the cases were still open to CAMHS or transferred to adult services.
- Paper records were not reflected in the notes on the electronic system. At Rotherham CAMHS there were at least three scanners available for scanning documents. We were told that paper records were to be scanned into the computer system to ensure continuity of records.
- The computer system used was Silverlink. This appeared to be a secure system for storage of records. However, whilst trying to access records, the system was slow and not efficient.

Best practice in treatment and care

- National institute for health and care excellence guidance (NICE) was considered best practice for the service. We saw evidence of the application of eating disorder guidance (CG09) at Doncaster CAMHS. There was also a nurse consultant who led on NICE guidance. Trust data provided showed access to NHS Sheffield CCG Framework of NICE Guidance and NICE Bites, and this was regularly updated.
- There was evidence of access to psychological therapies for people who used the service, with a psychologist and three assistant psychologists at Rotherham CAMHS, two clinical psychologists at Scunthorpe CAMHS, and a psychologist at Doncaster CAMHS.
- A theraplay intervention was observed at Rotherham CAMHS involving an eight year old child who used the service and two child mental health specialists. The session lasted 40 minutes and was noted to be an excellent psychological intervention.
- During initial assessment, physical healthcare checks were carried out on people who used the CAMHS service, and any concerns were raised with the relevant service. Scunthorpe CAMHS had a diabetic team who monitored any of the people who used the service and were diagnosed with diabetes. Annual health checks occurred for those people who used the service who were looked after children
- Outcomes were measured using a variety of tools, including routine outcome monitoring as part of children and young people improved access to psychological therapy. Other outcome measures used were strength and difficulties questionnaires and the revised child anxiety and depression scale.
- Clinical audit involvement was not widely used in the service, although the trust provided evidence of CAMHS involvement in the re-audit of Clinical Risk Assessment and Management Policy. This was completed and disseminated in quarter three of this year.

Skilled staff to deliver care

- The service had access to a full range of mental health disciplines, including mental health nurses, consultant psychiatrists and psychologists, social workers, occupational therapists family therapists, child psychotherapists, cognitive behavioural therapy therapists, and peer support workers.
- Staff working hours ranged from 18.75 hours to 37.50 a week; in the case of nursing staff this included out of hours work, a 12 hour out of hours on-call shift at the weekend.
- Staff within the service were well qualified to carry out their respective roles. Peer support worker roles were carried out by people who formerly used the service. Their skills and experience played a great part in the transition service from child to adult services.

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.

- There was a trust induction that staff were required to attend, and data provided by the trust showed that the CAMHS service compliance rate stood at 95%.There was a local service induction according to local service management, but figures for this were not provided.
- Specialist training was shown to be available for staff members of the service. A recently qualified family therapist was interviewed, also a staff member who was training to be an occupational therapist. Staff had access to children and young persons improving access to psychological therapies training.
- Data provided by the trust showed that in the last 12 months only 24% of non-medical staff had an appraisal; the figures provided showed 32 out of 103 non-medical staff.
- Personal development reviews for trained staff and supervision was noted to be in hand, with those who were due supervision booked onto electronic calendars for appointments. At Rotherham CAMHS, staff were appointed safeguarding supervisors, evidence showed that they were a first line of contact for staff with problems.
- Minutes for staff meetings showed that there were regular meetings being held within the service for staff.

Multi-disciplinary and inter-agency team work

- Staff held regular and effective multi-disciplinary team (MDT) meetings. At Doncaster CAMHS staff held three high risk assessment treatment meetings a week to discuss people who used the service and their care. Scunthorpe CAMHS held weekly, fortnightly and, in the case of looked after children, six weekly MDT meetings, dependent upon the cluster. Rotherham CAMHS had a weekly clinical MDT meeting every Tuesday, and an allocation meeting every Thursday; we attended and observed an allocation meeting.
- Handover within teams in the service was based on the reason for the handover. At Rotherham CAMHS, we were told that the amount of agency staff meant that often caseloads were handed over as agency staff moved on. During an allocation meeting, we saw re-allocation of a caseload; the cases were discussed and consideration given to the team member best placed to take the extra workload.
- The use of peer support workers within the teams allowed a more structured and involved transition for people who used the service as they moved into adult services.
- Links with external organisations and liaison was said to have improved recently, according to local service management.Rotherham CAMHS operations manager said channels to access social workers from the accident and emergency department had improved, so prompt action was being taken in regard to safeguarding issues.
- The Doncaster CAMHS team manager stated that links with external organisations had improved due to joint training sessions, but no example of such joint training was given.

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

- The trust provided data that showed MHA training for CAMHS at 95% at the time of the inspection. The training was part of the trust induction, and was given as one-off training in conjunction with MCA training.
- We discussed the MHA with staff, who displayed varying degrees of knowledge about the MHA. We were told that the MHA is rarely used in relation to the people who used the service, being more likely applicable to those in tier four services.
- The clinical director at Doncaster CAMHS stated that she felt MHA training should be more focussed on its application to CAMHS, and that this also applied to MCA training.
- We were told that rights under the MHA would be explained by the approved mental health practitioner and should further notification be required then it would fall to the CAMHS staff.
- There was a central contact for enquiries relating to both the MHA and the MCA, a MHA administrator who was named by a number of staff.
- The trust was asked to provide data relating to MHA audits within CAMHS, but no data was provided at the time of reporting.

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.

- People who used the service could access advocacy services if required, either as part of their on-going treatment or if directed to advocacy by the duty service or out of hours service.

Good practice in applying the Mental Capacity Act

- The trust provided data that showed MCA and deprivation of liberty (DoLs) training for CAMHS at 95% at the time of the inspection. The training was part of the trust induction, and an explanatory leaflet was provided to all staff.
- We discussed MCA with staff and found varying degrees of knowledge about the MCA and its use.
- There was a trust policy on MCA and it was on the trust intranet; staff were aware of this.
- Of the 21 care records reviewed during the inspection, only three were found to have capacity taken into consideration and recorded, and these were deemed poorly considered.
- Six records out of 21 care records showed evidence of informed consent.
- Staff could obtain guidance on the MCA from the MHA administrator.
- We were told that the Gillick Competence was in use within the trust, but there was no evidence produced to support this. Gillick competence can be used to decide if a child 16 years or younger can consent to medical treatment without permission or knowledge of their parent.
- There was no evidence provided by the trust to show that MCA use within CAMHS was audited.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed a theraplay intervention involving an eight year old child who used the service, his parent and two members of staff. Levels of interaction were very high, the person who used the service was clearly enjoying the intervention and appeared to gain high levels of comfort from the intervention. Staff were professional but also clearly relaxed and enjoying the interaction.
- An initial appointment was observed involving a nine year old child who used the service, his parents, and clinical staff.Interactions were meaningful, parents were concerned about the number of different professionals who had seen their son, and felt there was a lack of continuity. This was discussed, and a concise action plan was agreed with the parents and the person who used the service.
- We spoke with 16 carers of people who used the service, and 16 people who used the service. For each location the comments were positive about the treatment their sons and daughters had received. Some carers mentioned the difficulty they had getting their children into the service, but once they were in service they were thankful to the staff that they worked with.
- Experience of service questionnaires (ESQs) results were viewed for the service from the period January 2015-June 2015.Rotherham CAMHS had a total of 11 ESQs returned in the period; five from parent/carers, four from people who used the service aged under 12, and two from people who used the service aged 12-18 years of age. The responses were generally positive, with the two people who used the service aged 12-18 stating they were fully listened to and felt happy with the service. One parent/carer was highly critical of the service provided.
- Doncaster CAMHS received 71 ESQs in the period January 2015 - June 2015; 38 from parent/carers, five from people who used the service aged 9-11, and 28 from people who used the service aged 12-18 years of age. The responses were generally positive, with 75% of the 12-18 age group feeling well treated and 60% of under 12s felt they were well treated and found it easy to talk to the people they were treated by. There were no highly critical comments about the service from parents or carers.
- Responses on ESQs for Scunthorpe CAMHS were all positive, with only one request for improvement from a person who used the service aged 12-18 years, requesting more "talking to" if people are upset.
- Session feedback questionnaires (SFQs) were used at the end of each session with people who used the service and their parent/carer. SFQ results were viewed for each location within the service. Rotherham CAMHS had 321 SFQs for the period January 2015 – June 2015, with excellent results relating to people feeling listened to, and understanding what was talked about, as well as feeling included in the intervention.
- The results from interviews conducted during the inspection, coupled with the comments of parents/carers and people who used the service, gave a positive view concerning the relationships between staff and the people who used the service.

The involvement of people in the care that they receive

- We observed a seven day follow up review, and it was noted that full involvement of both the parent and the person who used the service was evident. Excellent engagement skills were used by staff, an action plan was agreed at the end of the session. It was collaborative, with strategies agreed with a robust safety plan. A copy of the agreed plan was shared with the parent and person who used the service.
- We were told that young people who used the service were involved in the recruitment of staff, some had training in interview techniques. We were also told that if people who used the service were not available at interview, they could offer questions to be asked by interviewers. This was shown by viewing monthly trust newsletters that spoke of the inclusion of people who used the service and their experiences.
- With the use of ESQs and SQFs there were many opportunities for parents, carers or people who used the service to give feedback on their care. This was monitored closely by the service locations.

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

- At Rotherham CAMHS, there was an agreement in place with the care commissioning group (CCG) that the target from referral to triage/assessment should be no longer than three weeks; we saw evidence from the trust dated 19/08/2015 that 92% of all referrals were being assessed within three weeks. It was also noted that 83% of all treatment commenced within eight weeks of the assessment, and 96% within 18 weeks.
- Doncaster CAMHS aimed to triage on the same day of referral (24 hrs) for urgent referrals, with 28 days for a routine assessment and 56 days to treatment. The trust target was 95%, and data provided by the trust for the month of July 2015 Doncaster CAMHS was at 88% for the 28 day target, and 95% for August 2015.
- Scunthorpe CAMHS was identified by trust data meeting target times for all cases for referral to assessment and on to treatment within 12 weeks.
- Youth offender service was run by the local authority, with one Doncaster CAMHS member attached to the team; referral targets from April 2015-July 2015 showed 100% of referrals seen within four weeks.
- Data provided by the trust showed that urgent referrals were seen within 24 hours, and that the service was seeing 100% of its urgent referrals within 24 hours.
- Waiting times for learning disabilities, autistic spectrum disorder and attention deficit hyperactivity disorder assessment and interventions show average waiting times of 15.8 days for assessment (target of 15 days) and 43.3 days for treatment (target of 56 days).The pathways for these services were being reviewed.
- CAMHS provided a duty service that covered calls or cases received between 9 am and 5 pm weekdays. There was an out of hours service that covered from 5 pm till 9 am, with a 24 hour out of hours service at the weekend and bank holidays.
- Criteria for inclusion in the service was found to be clear and defined, and outlined in the service specifications for CAMHS.
- The service had clear steps for re-engaging with people who used the service if those people did not attend appointments. This included contact via telephone, school, family, and external agencies. Should attempts not be successful, then consideration would be given to refer the person who used the service back to their general practitioner (GP).
- As the service was office hours, appointment times were limited in flexibility due to the majority of those people who used the service being at school for most of the day. However, the service was observed to be as flexible as possible during interventions with people who used the service.
- Appointments were rarely cancelled: the main cause of cancellation was staff sickness, where possible this was covered by other staff access to electronic calendars allowing adjustments to be made.

The facilities promote recovery, comfort, dignity and confidentiality

- People who used the services were seen on provider premises for each location. At Doncaster CAMHS staff and people who used the service travelled to an external building at East Laith Gate House.
- Each location was found to have interview rooms that were equipped to support the therapies and interventions that were being provided. At East Laith Gate House there were eight large, clean interview rooms, electric sockets had protective covers to prevent access.
- The interview rooms at Scunthorpe CAMHS had been freshly decorated as part of on-going refurbishment. The building was being fitted with solar panels to provide heating and hot water. There was an education room for complex and medical needs education team, to meet the needs of those people who used the service and were struggling with education.
- Rotherham CAMHS was based in a former school building, and the interior had been completely refurbished. It was very modern, fully air-conditioned, with interview rooms on the ground floor (these had to be booked due to the number of interventions taking place).All rooms had high ceilings, very light, recording rooms were available, as well as rooms that covered all age groups within CAMHS.
- Whilst observing a theraplay session within a recording room, it was noted that from the monitoring booth the

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session in the room on the other side of the wall could be clearly heard; this could have been due to the nature of the recording requirements for the monitoring room. Other rooms throughout the service were well insulated and soundproofed.

- Leaflets pertaining to treatment, local services, how to complain were visible throughout the service, mostly in reception areas.

Meeting the needs of all people who use the service

- There was disabled access to all of the service buildings providing therapies. Ramps, lifts, and toilets for disabled people were available. At Rotherham CAMHS the doors to the interview rooms had the room numbers embossed in braille as well as numerals.
- Leaflets in sight were printed in English at the service locations. However, each leaflet/booklet had a section on the back allowing for alternative language forms to be ordered from patient advice and liaison services. The selection of alternative languages numbered 14, ranging from Amharic to Vietnamese. The leaflets could also be made available in large print, braille or audiotape.
- We were told that there was an agreement with a specific company to arrange access to interpreters or signers, but we were not given the name of the company.

Listening to and learning from concerns and complaints

- Data from the trust showed the service had 18 formal complaints over the period 1 November 2013 - 30 April 2015 and seven of these complaints were upheld.
- At each location of the service, there were leaflets available giving opportunity to make complaints.
- Data from experience of service questionnaires and session feedback questionnaires was audited monthly.
- Feedback from complaint investigations was given through team meetings, organisational learning forums and, if required, personal briefings.

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

- In discussion with staff, it was clear that the trust objectives and values were known. It was agreed by staff that this vision was the way forward.
- The trust objectives were followed by each team.
- Staff members knew the details of senior management, they knew the name of the new chief executive, however it was stated that senior management had not visited the service locations for some time.

Good governance

- Staff were receiving mandatory training, although a number of courses such as equality and diversity, fire safety, conflict resolution, clinical record keeping, and violence and aggression Module D were recorded as being below trust targets
- Staff appraisals and supervision were on-going, but non-medical staff appraisals were behind target with only 24% having been completed.
- The shift pattern used by the service locations, including the duty shift and out of hours care means that shift time was maximised to deal with people who used the service.
- Incidents were being reported using the IR1 system.
- Staff had taken part in clinical audit, but this was not a regular occurrence.
- There was evidence that staff were reflecting on feedback from incidents, complaints and service user feedback.
- Safeguarding was addressed well in training. MHA and MCA training figures showed that the trust had ensured a high completion rate for training by including it in the trust induction.
- KPIs were used by the service and reported on each month in a performance and quality report, provided by the trust. The format for presentation of figures was not complex, using a spread-sheet format that clearly stated the KPI and the relevant figures. Rotherham CAMHS KPIs had shown a clear improvement, proving that their actions in relation to performance had helped to improve the service they provide.
- The team managers all said they felt that they had sufficient authority to do their job, as well as support from senior management.
- Staff did have the capability to submit items to the trust risk register, but managers stated that team discussions would happen before such action. It would normally be up to the manager to raise the issue with higher management before an issue was registered. Data provided by the trust relating to the CAMHS trust risk register showed 14 items on the register, an operations manager was the most junior staff member to have registered a risk.

Leadership, morale and staff engagement

- There was no available local staff survey data available for this core service. The NHS Staff Survey data 2014 was available for the trust as a whole, but it was not broken down into core services, and the estimated response rate was only 11%.
- Data supplied by the trust showed sickness rates for the service for the last 12 months at 5% for Doncaster CAMHS, 2% for Scunthorpe CAMHS, and 10% for Rotherham CAMHS. However, data for the last four months supplied by the trust showed that Rotherham CAMHS sickness rate had fallen to 5.1%.
- There were no bullying or harassment cases reported by any of the service locations, but it was reported that there was one on-going investigation regarding a staff grievance against a previous manager at Rotherham CAMHS.
- Staff knew how to use the whistle-blowing process.
- Staff morale appeared high, except when it came to out of hours duty; staff said they did not feel it was handled well, that it was divisive, and one staff member said she did not feel safe when operating late at night.
- Leadership development was available to staff, with courses available to improve their skill set. For managers there was the trust fit for future course.

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- Staff spoke of the difficulty of having so many agency staff working with them as it did not give continuity of care. They were aware of the difficulties of recruitment within the trust.
- Informing patients when things went wrong was important to staff, as it helped to build the therapeutic relationship. People who used the service reported a good level of trust with staff.

Commitment to quality improvement and innovation

- The service followed a commissioning for quality and innovation programme.
- Restructuring of the Rotherham CAMHS service with a consulting agency was designed to assist in taking the service forward in a more efficient and productive manner.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: At Rotherham CAMHS risk assessments on the electronic system were found to be poorly completed, incomplete, or missing. This is a breach of Regulation 12 (2) (a) The things which a registered person must do to comply … include assessing the risks to the health and safety of service users of receiving the care or treatment

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