Good

Torbay and South Devon NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RA9	Torbay Hospital	CAMHS (Child and Adolescent Mental Health Services)	TQ2 7AA

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
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

Contents

Summary of findings

Overall summary

We rated specialist community mental health services for children and young people (CAMHS) as good because:

- Staff were caring and supportive. Patients, families and carers were satisfied with the service. They said their treatment helped them.
- Patients were assessed within target times of six weeks for a routine referral and could access urgent assessment and treatment if they needed it.
- Care was personalised, holistic and recovery orientated. Patients were given a choice of locations for their treatment appointments to help them feel comfortable.
- Staff had good access to training including training in different kinds of therapy and mandatory training.
- Evidence based therapies recommended by the National Institute for Health and Care Excellence (NICE) were available.
- Patients completed outcome measures throughout their treatment. These were used to understand patients' difficulties and to ensure patients were getting better. Patients could see graphs of their progress.
- The service actively worked with other agencies in health, social care and education to provide joined up and preventative care and involved those agencies in the redesign of the CAMHS service.
- The service was committed to innovation and aimed to prevent mental health problems in children and young people and reach them sooner when they were unwell.

However

- Waiting times for treatment were long at up to 36 weeks, although there was a clear strategy to bring this down to 18 weeks by the end of March 2016. Patients were not actively monitored to detect potential deterioration in their mental wellbeing or increases in risk whilst they were waiting for treatment.
- Four out of the nine care records we looked at had risk assessments and crisis plans which were not fully completed and updated.
- Patients' physical health was not consistently checked. When patients were weighed and measured this was not done in a private place.
- The provider was not ensuring staff were adhering to safe lone working practices and there was no fixed alarm system in the building for staff to seek urgent assistance.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There were long waiting times for treatment and patients did not have their risk monitored to detect potential increases in risk while they waited for treatment although patients could make contact with the service by telephone while they waited.
- The trust provided an overall percentage for staff's compliance with mandatory training but despite requests, did not provide a breakdown of percentages of staff who had completed specific mandatory training courses.
- Risk assessments and crisis plans were not always fully completed and updated.
- There was no fixed alarm system in the building and staff did not always use personal alarms when seeing patients on their own.
- The provider were not ensuring their lone working policy was enforced to keep staff safe.

However

- Though the service was having difficulties recruiting staff and had experienced an increase in demand for the service, they had undertaken a staffing review and had employed additional agency staff to help reduce waiting times and see urgent cases. The service was actively trying to fill vacancies.
- Patients were seen for routine assessment within six-weeks and this included a risk assessment. Patients in need of urgent or emergency treatment were prioritised and seen more quickly and by a psychiatrist if needed.
- Staff caseloads were a manageable size.
- Staff were trained in safeguarding and knew how to make alerts. They had regular safeguarding supervision.

Are services effective?

Good

We rated effective as good because:

- Patients were assessed in a timely manner.
- Care records were personalised, holistic and recovery-orientated.
- Evidence based therapies recommended by the National Institute for Health and Clinical Excellence (NICE) were available.
- Staff could access specialist training.

Summary of findings

- The service was using an array of outcome measures to monitor the severity of patients' symptoms and their improvements.
- There was very good liaison and joint working with relevant services such as paediatrics, social services, education, safeguarding, perinatal services and learning disabilities services.

However

- Physical health checks were not always undertaken.
- Not all staff had sufficient knowledge of the Mental Capacity Act and Gillick competence. Data about compliance with mandatory training in the Mental Health Act and Mental Capacity Act was not provided to us despite requests for this data from the trust.

Are services caring?

Good

We rated caring as good because:

- Patients, families and carers were satisfied with the service. There were very positive comments about the staff.
- Staff were respectful and kind and provided practical and emotional support.
- There was positive feedback about a group treatment being provided for parents of children and young people.
- Information was available about advocacy and how to complain.

However

- Care plans were not always completed to a high standard.
- Patients' privacy was not protected when they were being weighed and measured.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The service was meeting its targets for seeing patients for their initial assessment within six weeks for routine cases, one week for urgent cases and one day for emergency cases.
- The service was making active attempts to reduce the waiting time for treatment including offering group treatments and providing additional staffing.
- The service was running clinics in GP practices so they could see children and young people at an early stage and signpost

Summary of findings

them appropriately. This work in GP practices was also enabling GP's to learn about suitable treatment pathways for their patients and to have access to consultation with the primary mental health worker in their GP practice.
- There was evidence of learning from complaints.
- There were clear criteria for the service.
- There were disabled facilities and access at the Torbay Hospital team base.
- The service was flexible about seeing patients in their own homes, at school or in GP practices to enable children and young people to feel comfortable.

However

- Waiting times for treatment were long at up to 36 weeks although there was a clear strategy to bring this down to 18 weeks by the end of March 2016.

Are services well-led?

Good

We rated well-led as good because:

- There was good morale amongst the staff and teams worked together and supported each other.
- Governance structures enabled managers to ensure staff were up to date with mandatory training and that they were appraised and well supervised The service had a comprehensive risk register and risks could be escalated to senior management. The risk register was being monitored and updated.
- Staff described the management as supportive and approachable.
- The service was actively developing. They were setting up a crisis service was being established and additional funding secured as part of a national transformation strategy called 'Future in Mind' to improve children and young peoples' mental health services. The service redesign was being carefully planned and involved other key services in the process.
- The service showed a strong commitment to quality improvement and innovation.

However

- Managers were not aware of the team's lack of knowledge of the Mental Capacity Act and Mental Health Act. They relied on staff accessing supervision or involving consultant psychiatrists if there were questions about a patient's mental capacity.

Summary of findings

Information about the service

Torbay child and adolescent mental health service (CAMHS) helps children, young people up to the age of 18 and their families and is part of Torbay and South Devon NHS Foundation Trust. They treat patients with mental health difficulties, learning disabilities and serious emotional and behavioural difficulties. The service operates out of a base at Torbay Hospital and accepts referrals from professionals who work with children and young people, including GPs, health visitors, school nurses and social workers. The service covers the Torbay area including the towns of Brixham, Torquay and Paignton with a population of around 135,000 people including 21,000 children.

The service provides initial assessment and treatment with professionals trained in children and young people's mental health. Some members of the team work in schools and social services and there are plans to achieve a fuller integration the service with paediatrics. Torbay CAMHS operates a tiered model of provision as described in 'Together We Stand' (1995), providing tiers 2 and 3 of the 4-tier model. The primary mental health worker service is one of a few in the country to be co-commissioned by schools. A worker from CAMHS works in each school in Torbay with the aim of promoting, maintaining and improving the emotional well-being and mental health of children and young people from five to 18 years of age.

The service operates from Monday to Friday 8.00am to 6.00pm. A new crisis service has recently been commissioned and the service is in the process of recruiting professionals to staff it. Patients, carers and parents are seen at various locations, including the Torbay Hospital base, at home, school or at their GP practice.

The service has links with adult mental health services in Devon Partnership Trust and with Virgin Care who operate CAMHS services in south and north Devon.

There are plans to enhance this service as part of the national CAMHS transformation strategy. The service has secured funding and has a transformation plan to implement changes to the service with increased funding which will increase the capacity and efficiency of the service.

Torbay and South Devon NHS Foundation Trust, including this service have not been inspected previously.

Our inspection team

Our inspection team was led by:

Chair: Tony Berendt, Medical Director of Oxford University Hospitals NHS Foundation Trust

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team which inspected specialist community mental health services for children and young

people comprised two CQC inspectors, a specialist nurse and a psychologist.

Why we carried out this inspection

We conducted this inspection as part of our in-depth hospital inspection programme.

Summary of findings

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the service.

During the inspection visit, the inspection team:

- visited the team base and looked at the quality of the environment and observed how staff were caring for patients
- spoke with two patients who were using the service
- spoke with seven carers of patients who were using the service
- observed a member of staff visiting a patient at home
- observed a clinic appointment with a patient and a psychiatrist
- spoke with 18 other staff members including a practice manager, doctors, psychologists, psychotherapists, nurses and primary mental health workers
- looked at nine treatment records
- interviewed the service manager with responsibility for the service
- attended and observed two multi-disciplinary business meetings
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- 78% of people who completed the friends and family test said they would be either likely to or extremely likely to recommend the service to their friends and family.
- The service had undertaken a survey which showed that people felt listened to, able to talk to staff, that they were treated well, taken seriously and were confident the service could help them. However, there were three comments out of 23 responses which mentioned the lack of continuity of staff treating them.
- Patients, parents and carers we spoke with said their care was good. They told us the service communicated well with other agencies.
- People who attended a course run specifically for carers and parents found it very helpful and one person said they loved it.
- People liked being seen at a convenient location such as school, home or their GP practice.
- One person we spoke with said they would not hesitate to recommend the service. Another person said the service was brilliant. One patient we spoke with said their treatment was helping them.

However

- Several people said they found it difficult to access the service. They felt their problems had to be severe to be accepted into the service but once they got in it was good.
- People using the service said the main problem with the service was the waiting times.

Good practice

- The service worked closely with local services in health, social care and education. In-reach roles had been developed, including a team of primary mental health workers to work in schools, practitioners to work with social services and a perinatal specialist.

  Clinics were held in GP practices where patients could be booked in with a CAMHS practitioner instead of a doctor. This enabled patients to get the right help more quickly.
- All clinicians received safeguarding supervision every three months even if they had not needed to make a

Summary of findings

safeguarding alert. This ensured safeguarding was always high on the agenda, staff were supported and that the need to involve the local authority safeguarding team was considered for all patients.

- The service ran a group for parents and carers to enable them to learn about mental health and consider how best to help their children. The group was effective and received good feedback from participants.
- Children, young people, their families and carers were involved in the service and its development. Children were included in interview panels and given 50% weighting in the decision process. They were involved in creating videos that were going to be used on a new website for the service. There were forums for children and young people and for parents and carers where they could give feedback about the service. There was evidence that questionnaires completed by people who used the service were making a difference to how the service was delivered.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should ensure alarms are available for staff to activate in an emergency and ensure all staff follow lone working procedures.
- The trust should ensure patients' privacy and dignity is protected when they are being weighed and measured.
- The trust should ensure risk assessments and crisis plans are completed, updated and reviewed for all patients.
- The trust should monitor the risks of patients on the waiting list for treatment.
- The trust should ensure physical health monitoring is provided for patients who need it, including those prescribed antipsychotic medicine.
- The trust should ensure staff are fully conversant with the Mental Capacity Act, Gillick competence and the Mental Health Act Code of Practice.
- The trust should continue to work actively to reduce its waiting times to within its targets.

Torbay and South Devon 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 (Child and Adolescent Mental Health Services)	Torbay Hospital

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 service did not have any patients on community treatment orders and had little involvement with patients who were detained or with the process of detainment.

Mental Capacity Act and Deprivation of Liberty Safeguards

Data we received from the trust on staff compliance with training in the Mental Capacity Act did not provide an overall percentage of compliance or an indication of how often it should be completed. Records showed seven clinical staff had been trained in a course called 'safeguarding adults and Mental Capacity Act Level 1' in 2013. Staff's knowledge of the Mental Capacity Act varied. They understood the importance of providing support for patients who lacked capacity in making specific decisions including their decision to come into treatment with the team. They would seek support from a consultant psychiatrist and families and carers to achieve this. We were told training in Gillick competence was mandatory but data was not provided. Some staff were unclear that children under 16 could access treatment without their parent or carer's knowledge if they were Gillick competent which could prevent children accessing treatment.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated safe as requires improvement because:

- There were long waiting times for treatment and patients did not have their risk monitored to detect potential increases in risk while they waited for treatment although patients could make contact with the service by telephone while they waited.
- The trust provided an overall percentage for staff's compliance with mandatory training but despite requests, did not provide a breakdown of percentages of CAMHS staff who had completed specific mandatory training courses.
- Risk assessments and crisis plans were not always fully completed and updated.
- There was no fixed alarm system in the building and staff did not always use personal alarms when seeing patients on their own.
- The provider were not ensuring their lone working policy was enforced to keep staff safe.

However

- Though the service was having difficulties recruiting staff and had experienced an increase in demand for the service, they had undertaken a staffing review and had employed additional agency staff to help reduce waiting times and see urgent cases. The service was actively trying to fill vacancies.
- Patients were seen for routine assessment within six-weeks and this included a risk assessment. Patients in need of urgent or emergency treatment were prioritised and seen more quickly and by a psychiatrist if needed.
- Staff caseloads were a manageable size.
- Staff were trained in safeguarding and knew how to make alerts. They had regular safeguarding supervision.

Our findings

Safe and clean environment

- The team had a base at Torbay Hospital and patients went there for appointments. The building was safe and clean. However, it was dusty, including in rooms where patients were treated. There was some damp on the ceilings and mould on some of the windows. The staff kitchen was in a poor state of repair and had been condemned. A new kitchen was going to be fitted.
- Interview rooms at the team base were not fitted with alarms. Some personal alarms were available if clinicians wished to use them and the manager was considering issuing clinicians with personal alarms. However, if staff needed assistance they would have to shout for help.
- Whilst there was a completed cleaning roster for clinical rooms, toys and sand were not included on it and staff did not know if they were cleaned.
- Data provided by the trust showed that staff across the Torbay Hospital site where the team were based were up to date with training in infection control.

Safe staffing

- The service had an establishment of 34 whole time equivalent staff including a service manager, practice managers, team leaders, primary mental health workers, community psychiatric nurses, psychotherapists, family therapists, an occupational therapist, consultant psychiatrists, clinical psychologists, social workers, an attention deficit hyperactivity disorder (ADHD) nurse, a learning disabilities nurse, and an advanced practitioner for perinatal and infant mental health. Establishment levels had been reviewed in 2015 using the choice and partnership approach (CAPA) model to consider staff capacity against activity levels. This followed an increase in demand for the service.
- There were six vacancies and the service was actively trying to fill them. These were in the primary mental health workers team, psychiatry team and the new crisis team. There was one vacant child and adolescent mental health service (CAMHS) practitioner post. A new consultant psychiatrist was due to start in July 2016 to

Requires improvement

Are services safe?

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fill a 0.8 whole time equivalent post. There was a 0.5 whole time equivalent consultant psychiatrist post which had not been filled. Both vacant posts were being covered by one full time locum.

- The staff sickness rate was 4.7% in the past 12 months. The trust target for sickness was 4% or below. The service found that agency staff were unwilling to cover short term sickness of less than three months duration so the team absorbed the work and dropped some activities which ewer not considered essential such as providing GP clinics.
- The staff turnover rate was 24% in the past 12 months. We discussed this with the service manager who explained that staff had left for personal reasons or to take jobs in alternative services because of their preferences. There were no service specific reasons why people had left their jobs. However, the service manager reported there had been a four to five year period of culture change which some staff had been resistant to. They reported this had greatly improved.
- The service was using the choice and partnership approach (CAPA) model to monitor staff capacity and activity levels. The first appointment a patient had with the team was their choice assessment where the patient could choose from available care options and partnership was the ongoing treatment. The CAPA model has been shown to improve user experience, accessibility and staff satisfaction in CAMHS services. The service had used the model to conduct a comprehensive review during 2015. A caseload analysis showed 30% of patients who were referred did not need ongoing treatment. 20% entered long term treatment and the average number of sessions offered to patients was 11. This meant the team could only keep up with the demand if they were fully staffed. With the support of additional agency staff, the team were making reductions to the waiting times for the service.
- The average caseload was 20 cases per care co-ordinator. York and Lamb in 'Building and sustaining specialist CAMHS workforce, capacity and functions of tiers 2, 3 and 4 specialist child and adolescent mental health services (2005), give a recommendation for an average caseload of 40 new referrals per year per whole team equivalent member of staff. Staff felt their caseloads were manageable. The Royal College of Psychiatry's (RCPSYC) recommendation for caseloads is 80 per whole time equivalent psychiatrist. The consultant psychiatrist had 48 patients on their caseload as a therapist and 42 as case manager. They were providing both functions for some of these patients.
- Caseloads were reviewed in management supervision where both complexity and volume of cases was considered. Tier two primary mental health practitioners offered brief interventions. Tier three clinicians would routinely do partnership work which offered the patient up to 12 sessions. The treatment contract could be extended following a review. In management supervision there was a discussion about how the clinician was managing their current and predicted workload.
- Sick leave was covered within the team. At times, this meant study leave was postponed and in-reach clinics in GP practices were cancelled. The team did not record these events as incidents. Patients who would have been booked in to see a CAMHS practitioner at a GP surgery on the day of their appointment were seen by a GP instead.
- The service had undertaken a scoping exercise which identified that the service was unable to improve current waiting times at current staffing levels due to the increase in demand. As a result, additional funding had been secured to provide two agency staff to reduce waiting times. This was helping to reduce psychiatrists' caseloads. The trust did not have a bank of mental health clinicians to support temporary staffing needs. This meant additional staffing could only be sourced through agencies.
- The team had been commissioned to provide a new crisis service which would begin as soon as it could be staffed. The two temporary agency staff were offering emergency appointments in the meantime. The planned crisis service would provide emergency assessments, provide treatment options according to need, facilitate early discharge from hospital (physical and mental health) and support police welfare checks. It was planned to operate 7 days per week 8.00am to 10.00pm Monday to Friday and 9.00 am to 5.00pm at weekends and bank holidays.
- When the service received a referral for a case which needed an urgent assessment, for example, because of potential risk, the team could provide urgent appointments. Urgent cases were seen within a week and one of the carers we spoke to confirmed there was immediate access to a psychiatrist. Psychiatrists could

offer urgent appointments to new patients who needed them or to current patients whose condition had deteriorated, for example, they were in danger of serious self harm. The patient could be booked into an appointment with a psychiatrist and there were two urgent appointments available per week. If more than two were required this would be done but would involve rearranging routine appointments.

- The trust told us the average mandatory training compliance rate for staff was 89%. However, despite requests, they did not provide a list of what mandatory training courses were provided or a breakdown of compliance with specific mandatory training courses.

Assessing and managing risk to patients and staff

- The team triaged written referrals within a day of receipt. Urgent cases were assessed within one day. Risk assessments were completed at the first assessment using the functional analysis of care environments (FACE) risk assessment and risks were rated. The service manager and psychiatry lead held a waiting list meeting every week to review cases that were red flagged because of the patient's risk. Around 85% of referrals were seen and the others were signposted to other services. Patients who presented to accident and emergency were treated as emergency cases and did not have a choice assessment.
- The inspection team looked at nine patients' treatment records. Five of these patients had up to date, good quality risk assessments. However, in one case the risk assessment was missing, and in two cases it had not been updated. In one case, a patient had been referred for self-harm but their risk assessment was incomplete and did not mention self-harm. In one case a crisis plan was not completed.
- Crisis management plans were created for those patients whose risks were high. Whilst in most cases crisis plans were created appropriately, in one case reviewed, urgent treatment had been commenced for a patient who was at risk of self-harm but no crisis or contingency plan had been developed.
- A letter was sent to patients to tell them they were on a waiting list and this advised them to make contact with the team if their situation deteriorated. Patients were also signposted as appropriate, for example, to self-help materials online, school counselling and participation groups. However, patients on the waiting lists were not proactively monitored. This meant the team were dependant on patients and carers contacting them if their risk increased. During the phase between receipt of the referral and the first appointment, the referrer maintained responsibility for their risk of the patient. Following assessment there could be lengthy delays before treatment would begin. During this time patients could telephone the service for advice during working hours, though it was for the patient to identify if or when additional help was needed.
- Safeguarding adults and safeguarding children training was provided at different levels according to need. For those requiring adult safeguarding, level two training was below compliance at 63% completion, level three was below compliance at 71% completion, level four was below compliance at 16% and level five was below compliance at 0% (one person). At a meeting we attended, staff said there were no dates available to book in for adult safeguarding training. This meant staff were not able to obtain training they needed in order to identify and respond to signs there was a need to involve adult safeguarding services for the protection of adult family members. The service manager was aware and dealing with the matter. The compliance rate for safeguarding children training was 97%.
- All staff received supervision with the safeguarding team every three months regardless of whether they had a safeguarding concern. The social worker in the team was the link to the trust safeguarding lead. Safeguarding leads were on call and could be contacted by staff as required. The team could also make direct referrals to the multi-agency safeguarding hub.
- The trust had a lone working policy which placed the responsibility on the individual employee for taking reasonable precautions in their work. The employer was not taking adequate responsibility for ensuring lone working practices were embedded. Lone working protocols were available including the use of a code word to summon help, and staff had been offered personal alarms. However, lone working practices were seen as optional with staff choosing whether or adhere to the policy. Whilst there had not been any incidents related to lone working, this approach put the safety of staff at risk.

Requires improvement

Are services safe?

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

Track record on safety

- The service had experienced one serious incident which was specific to the service and this was a patient death at the end of December 2015. The death was reported and a forthcoming serious case review was commencing to ensure future learning.

Reporting incidents and learning from when things go wrong

- Staff had access to an electronic incident reporting system. They were able to tell us the type of events that should be reported as these were highlighted during information governance training, conflict resolution training and health and safety training. One member of staff told us they had reported an incident. They reported feeling supported and felt there had been learning from the incident.
- There were seven incidents reported between 1 December 2014 and 30 November 2015 which included one serious incident – the death of a patient in the community. There were two incidents relating to bed shortages at tier four. Apart from the death, the reported incidents referred to other services.
- Managers reviewed all incidents, discussed them in their leadership group. Learning was then fed back at team meetings. The team had met following a serious incident last year. We talked to a member of staff who had been involved in the incident and they said they had received immediate and robust support. The team had been debriefed and senior managers had supported those involved.
- We reviewed an example of another incident which had led to appropriate adaptations to the way a child's treatment was delivered to safeguard both the child and clinician.
- Staff understood the Duty of Candour – the importance of being open and transparent and of explaining to patients when something went wrong. They would apologise to patients and carers if, for example, they had to rearrange their appointment. There was a leaflet in reception called 'being open about patient safety incidents'. This explained that the service signed up to the principles of being open, which meant acknowledging an incident as soon as it happened, apologising, communicating, listening to and treating people with sympathy, understanding and respect.

Are services effective?

Good

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

Summary of findings

We rated effective as good because:

- Patients were assessed in a timely manner.
- Care records were personalised, holistic and recovery-orientated.
- Evidence based therapies recommended by the National Institute for Health and Clinical Excellence (NICE) were available.
- Staff could access specialist training.
- The service was using an array of outcome measures to monitor the severity of patients' symptoms and their improvements.
- There was very good liaison and joint working with relevant services such as paediatrics, social services, education, safeguarding, perinatal services and learning disabilities services.

However

- Physical health checks were not always undertaken.
- Not all staff had sufficient knowledge of the Mental Capacity Act and Gillick competence. Data about compliance with mandatory training in the Mental Health Act and Mental Capacity Act was not provided to us despite requests for this data from the trust.

Our findings

Assessment of needs and planning of care

- We reviewed the care records for nine patients who were using the service. The team saw patients for their initial assessment within six weeks of the referral. Care plans were present in all the records we reviewed.
- Families attended an initial choice assessment to share their story with a member of the team to determine the best care pathway for them. The nine care plans we looked at were all personalised and holistic but three were not to a good standard. All nine care plans were recovery orientated. In one case the care plan was not personalised and physical health was not assessed. Four care records showed patients had been given a copy of their care plan. In the other cases it was not documented whether they had been offered a copy. In one case a care plan had not been signed and there was very limited documentation about risk. We raised this with the manager who noted it and said they would use it as future learning for staff?
- The service used an electronic records system. Staff had laptops and some had tablet computers to enable them to access and update records whilst working in the community. All staff had received training in the system. Outcome measures could be completed electronically, stored in the system and graphs could be generated to show patients their progress over time. The service did not keep any paper records. The service had full access to information required to assess and plan the care of patients. They had read only access to paediatrics and safeguarding records within the trust and to the on-call nurses out of hours service provided by another provider.

Best practice in treatment and care

- There were protocols in place for the prescribing and monitoring of lithium therapy. The protocols and guidance referenced National Institute for Health and Care Excellence (NICE) guidance.
- The team offered psychological therapies recommended by the National Institute for Health and Care Excellence (NICE) and the Royal College of Psychiatrists including cognitive behavioural therapy, systemic family therapy, pharmacotherapy, eye movement desensitization and reprocessing (EMDR) and interpersonal psychotherapy. A clinical audit and governance group reviewed changes in national guidance. The team used standard treatment pathways for diagnoses such as for depression, anxiety, trauma and eating disorders and these pathways had been developed using NICE guidance. The children looked after practitioner referred to the Rees report which outlined recommended interventions for looked after children.
- We saw two examples of physical health checks being recorded in our review of patient records but in seven cases physical health had not been reviewed. The trust physical health monitoring guidance recommended regular checks at specific intervals depending on the medicine. Records did not show these were being completed, including where antipsychotic medicines were prescribed. There was no standard section on the choice assessment form for physical health to be

Are services effective?

Good

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

recorded. In one case physical health was being monitored by the consultant psychiatrist including blood pressure and weight and these were sent in a letter to the GP for their records.

- The service did not have a dedicated clinic room so GPs or paediatricians completed physical care. The weight and height measures were not cleaned or calibrated regularly. This meant there was a risk of patients' weights being measured inaccurately and their treatment being adversely affected. The service manager told us patients with eating disorders and those having medicines should all be having regular blood pressure checks, their height and weight recorded, and they believed psychiatrists were doing this however, this was not subject to audit., . A psychiatrist told us physical health checks were undertaken but that they were not always recorded. Patients with eating disorders were also treated by the paediatric team. If required, the psychiatrists could request electrocardiograms, electroencephalograms and blood tests from the patient's GP. The service had raised a query with the clinical commissioning group because not all GPs were prepared to undertake these tests. Paediatrics would undertake blood tests if the GP could not do it.
- The service was using a variety of outcome measures depending on the patient presentation. There was guidance on which outcome measures and assessment pro forma to use at each stage of the patients care pathway. They routinely used the strengths and difficulties questionnaire (SDQ), revised children's anxiety and depression scale (RCADS), and the session rating scale (SRS). Patients were sent information sharing consent forms, RCADS and SDQs to bring along to their first appointment. Patients could start their appointment by filling in a 'how are things?' form and there were different versions depending on the condition including behaviour difficulties, traumatic events , panic, generalised anxiety disorder, social anxiety, separation anxiety, depression and low mood. All clinicians completed routine outcome measures with their patients and this was checked in line management supervision. The information gathered from outcome measures was also shared with the patient in evaluating their progress.
- The service had completed three baseline assessment tools for National Institute for Health and Clinical Excellence (NICE) guidelines for depression in children and young people, psychosis and schizophrenia in children and young people and conduct disorders in children and young people. The baseline assessment tools enable the service to consider which recommendations the service is meeting and which they are not. They were planning to conduct further baseline assessments in future. On review of the NICE guidance on psychosis and schizophrenia, the service noted it was not undertaking and recording baseline investigations such as height and weight before prescribing antipsychotic medicines. The baseline assessment showed this was a priority for implementation but no actions or deadlines had been set to ensure it was achieved. The review of the guidance on antisocial behaviour revealed unmet criteria for taking baseline measurements before starting risperidone which is an antipsychotic medicine, providing information about services and interventions and local pathways for children. Managers also conducted a quarterly clinical records audit to assess for quality and completion.
- The service was working with the Anna Freud centre and the Clinical Outcomes Research Consortium (CORC) on producing a system to enable them to report on their treatment outcomes. This would enable them to evaluate the efficacy of the treatment being provided.
- The service had contributed to a series of audits conducted by Torbay Safeguarding Children Board's Multi Agency Case Audit during the previous year. These included audits of looked after children, sexual abuse, child sexual exploitation and interrelated issues of domestic violence, mental health and alcohol or substance misuse. CAMHS had received reports from the audits and were using them to evaluate the service and to make changes. The looked after children audit showed only one looked after child was accessing a CAMHS service although all had been referred to it. The looked after children practitioner for the CAMHS service was now screening all children and young who became looked after, after four weeks for mental health difficulties. Clinical staff were not actively participating in clinical audits at the time of our inspection.

Skilled staff to deliver care

- The team included a range of mental health disciplines required to care for the patient group including managers, a community psychiatric nurse, child and adolescent psychotherapists, occupational therapists,

Are services effective?

Good

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family therapists, psychiatrists, clinical psychologists, an attention deficit hyperactivity disorder (ADHD)nurse, a learning disability nurse, and an advanced practitioner in perinatal and infant mental health. Staff were qualified and experienced.

- Staff received a two-day trust induction followed by training locally within the team including basic life support and paediatric basic life support, anti-radicalisation, child protection, adult safeguarding and training in the use of the IT systems. One new member of staff we met was being given time to orientate themselves to their work.
- Agency workers had a trust induction and had mandatory training through the employment agency they worked for. We spoke to one of the agency workers and they described their training as robust.
- All staff received regular supervision. Staff received line management supervision every four to six weeks depending on their experience. This followed a pro forma which prompted the manager to consider safeguarding issues, leave, training and appraisals. The tool also looked at potential stress and work commitments over the forthcoming period. Staff had individual clinical supervision monthly (pro rata). All cases on a care plan were discussed with the safeguarding nurse supervisor. There was also a peer supervision group and staff could book in for consultation with a clinical lead for psychiatry who had a weekly appointment slot. There was external psychotherapy and line management supervision for the service manager. In addition to supervision, 100% of non-medical staff had had an appraisal in the last 12 months. Performance was being addressed effectively and where appropriate this included providing additional training and monitoring.
- The service held weekly team and business meetings which staff were invited to attend.
- Staff could access specialist training through local universities. Staff could do training in cognitive behavioural therapy, systemic family practice parenting courses, enhanced evidence based practice, leadership and supervision. Some staff had undertaken 'thrive' training which was an attachment based training for practitioners and schoolteachers. Staff could apply for funding for other professional development training.

Multi-disciplinary and inter-agency team work

- The team held weekly multi-disciplinary team meetings and all staff were invited and expected to attend.
- There were effective handovers between teams within the trust. The service took part in a variety of meetings with other services. The consultant psychiatrist undertook weekly ward rounds on paediatric wards and had provided training to the paediatric team. In addition, the manager was working on improving communication with the trust's paediatric service and had begun having meetings with them to review, for example, the appropriate service for patients with attention deficit hyperactivity disorder (ADHD). In accordance with National Institute for Health and Care Excellence (NICE) guidance, the paediatric service admitted children and young people who presented to hospital following self-harm. The service was working with paediatrics to create an acute care pathway as part of their new crisis service, which would enable those patients to be seen for urgent assessment within the Torbay child and adolescent mental health (CAMHS) team. We saw an example of a patient who was being treated urgently by the service and this showed good interagency working with paediatrics. It was also clear in this case who was accountable for follow-up and health screening.
- The service had good working relationships with an array of organisations outside of the trust. They were beginning to embed the 'Ready Steady Go' system into adult services which involved identifying and flagging patients who would be transitioning from CAMHS to adult services. We reviewed a draft protocol 'Torbay Protocol: preparing for adulthood from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS). CAMHS would identify all young people aged 17 for transfer or at aged 16 if they had complex needs. There were good links with the care provider who provided the out of hours telephone service. The team were part of an early help system provided by Torbay Council called the 'Early Help Panel'.There were links with social services and the CAMHS team provided a monthly group to support foster carers and a monthly group for parents of children with learning disabilities. The practitioner for looked after children was based in social services and also provided training to social services. Two practitioners spent a day a week within the safeguarding team on a consultative basis and undertook some joint visits. The service was working closely with GPs. They ran clinics in

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GP practices where patients could see a CAMHS practitioner instead of a GP if the triage determined this would be more effective. The service manager said the clinics were enabling GPs to learn more about the criteria for the CAMHS Service and about alternative services they could refer to. There were links with school nurses via the primary mental health workers who were based in schools. CAMHS provided group supervision every three months to health visitors. The team were part of an early help system provided by Torbay council called 'The Decider' which families could refer themselves to. The family would be allocated to the most appropriate person in the meeting to ensure they were always offered something. One patient fed-back that there were excellent links between services and said that they are all communicate with each other Including social services and schools.

Adherence to the MHA and the MHA Code of Practice

- Despite requests, the trust did not provide us with a percentage of staff who had been trained in the Mental Health Act. We were therefore unable to ascertain whether staff were receiving this training and how often. Staff told us there was in house training available.
- Devon Partnership Trust provided approved mental health practitioners so the team were not routinely involved in using the Mental Health Act.
- There were no patients on community treatment orders being treated by the service.
- Patients had access to Independent Mental Health Advocacy (IMHA) and there was information about how to access the service in the team base reception.

Good practice in applying the MCA

- Despite requests, the trust did not provide us with a percentage of staff who had been trained in the Mental Capacity Act. We were therefore unable to ascertain whether staff were receiving this training.
- Only one member of staff we asked was able to describe the five statutory principles of the mental capacity act although other staff had some limited understanding. The Mental Capacity Act policy was available on the staff intranet.
- A nurse told us that if a young person seemed to have impaired capacity and required support with a decision, the psychiatrist or paediatrician would provide assessment and support with specific decision-making. Parents and carers were also engaged in making best interests decisions.
- The service manager was unsure whether the team were competent in the Mental Capacity Act but said they could access support from the psychiatrist and adult safeguarding leads. The consultant psychiatrist made themselves available to the team for consultation on the Mental Capacity Act via a dedicated 1 hour supervision slot each week.
- The service manager told us training in Gillick competence was mandatory but there was no evidence of completion rates, despite requests we made to the trust. There was some confusion about the rights of children under 16 to access treatment without their parent or carer's knowledge if they were Gillick competent. This could result in Gillick competent children who wished to access treatment confidentially being refused.
- Care records did not explicitly show that patient's capacity to consent to treatment was being assessed. Consent to treatment was demonstrated by patients being involved in writing their care plans and signing them. Staff said they would routinely engage patients by sharing information about and explaining treatment options to all patients.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- Patients, families and carers were satisfied with the service. There were very positive comments about the staff.
- Staff were respectful and kind and provided practical and emotional support.
- There was positive feedback about a group treatment being provided for parents of children and young people.
- Information was available about advocacy and how to complain.

However

- Patients' privacy was not protected when they were being weighed and measured.

Our findings

Kindness, dignity, respect and support

- We observed patients receiving care during our visit and we found staff to be respectful and supportive. We observed a choice assessment appointment. The patient was given time to describe their difficulties and preferences about treatment. They talked about their goals and were given information about their condition and empowered to work on it. The manager told us waiting times were always discussed with patients and that they were encouraged to contact the service while they were waiting. However, during the appointment we observed, a patient was told they were being put on a waiting list for treatment but they were not told how long they would be waiting.
- Patients, families and carers told us staff were respectful, caring and nice. One young person said they had been given treatment options and were encouraged to work on their problem at their own pace.
- Staff understood that patients had different needs. One practitioner used music and art to enable patients to talk about their difficulties. However, some people using the service said they had not been told what to do if they needed support between appointments or while they were waiting.
- Patient confidentiality was being maintained. All patients were asked for their consent to share information with other professionals on a "need to know" basis.A leaflet in reception explained that information would not be shared without consent unless there were concerns that a child or young person could be at serious physical or emotional risk.

The involvement of people in the care they receive

- Care records showed some degree of patient's involvement in their care plans. The service had a 'jigsaw' care plan template and was using it in some cases to make the care planning process age appropriate. One clinician said children and young people were always involved in their care plans and in setting objectives but this was not clear from some records. It was not always clear if patients had been offered a copy of their care plan. Clinicians encouraged patients to be active in their care by signposting them to websites to do their own research.
- Patients' families and carers were involved in their care as appropriate. There was a specific group available for them to attend while they were waiting for treatment.
- Advocacy was available and there were leaflets in the waiting room for people to self-refer to an advocate.
- Children, young people and their carers were invited to take part in interviewing staff and were encouraged to give feedback. There was an experience of service questionnaire which enabled people to give feedback about the service. Children and young people were invited to join interview panels. Children and young people took part in the staff induction and ongoing training for the team. They had contributed to videos for a website which was being constructed. Children were part of the shadow board for children and young peoples' improving access to psychological therapies (CY IAPT) and had quarterly meetings. There was also a parent forum which met monthly and parents could take part in interviewing and training of the team.
- The service had received 23 responses to the NHS England's Friends and Family Test for April 2015 to April 2016 at the time of our inspection. They had also commissioned Young Devon, a third sector organisation, to facilitate service user participation. There was a 'have your say' group for people aged 11-25 which met weekly. The group aimed to improve mental health services in Torbay for young people. The group had assessed the service and made some

Good

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recommendations. These were considered carefully and some changes were made, for example, ensuring there were tissues in all the rooms and that display boards had up to date information on them. There was a new family forum for families and carers. In 2014 the service took part in a 'mystery shopping' exercise where some experienced young people, who had previously accessed the service, acted as new patients so they could feedback to the team about their journey from referral to the summary of their first appointment. This study had led to several changes including a new drinks machine being put in the waiting room and removal of "you can do it " type posters which were felt to be overly positive. People could give feedback directly to the service by anonymously completing the Commission for Health Improvement Experience of Service Questionnaire (CHI- ESQ) after they were discharged.

Are services responsive to people's needs?

Good

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

Summary of findings

We rated responsive as good because:

- The service was meeting its targets for seeing patients for their initial assessment within six weeks for routine cases, one week for urgent cases and one day for emergency cases.
- The service was making active attempts to reduce the waiting time for treatment including offering group treatments and providing additional staffing.
- The service was running clinics in GP practices so they could see children and young people at an early stage and signpost them appropriately. This work in GP practices was also enabling GP's to learn about suitable treatment pathways for their patients and to have access to consultation with the primary mental health worker in their GP practice.
- There was evidence of learning from complaints.
- There were clear criteria for the service.
- There were disabled facilities and access at the Torbay Hospital team base.
- The service was flexible about seeing patients in their own homes, at school or in GP practices to enable children and young people to feel comfortable.

However

- Waiting times for treatment were long at up to 36 weeks although there was a clear strategy to bring this down to 18 weeks by the end of March 2016.

Our findings

Access and discharge

- Referrals were triaged on the same day they were received. The waiting time for routine assessment was six weeks. The longest waiting time from referral to treatment was 39 weeks. The team was actively working on reducing its waiting times and had employed locums. Data showed that since September 2015 the waiting time for treatment had fallen from 44 to 39 weeks and the number of patients waiting for treatment had fallen from 80 to 64. Group interventions were being offered to try to reduce waiting times. There was a pilot outreach group for young people aged 15 to 17 who were waiting for treatments for anxiety disorders. The group would offer six sessions for up to nine people. A group for eight to 12 year old patients was already in existence.
- Twenty-three patients had not been allocated an appointment with a clinician to begin treatment. These had been waiting up to 29 weeks. A further 14 were awaiting treatment but had an appointment to start their treatment. These had been waiting up to 39 weeks. A further 22 were awaiting a further 'choice' assessment appointment. This happened when the patient needed further assessing, perhaps after a period of watchful waiting or a trial intervention. There was a wait for this of up to 11 weeks. The service was working on reducing these times.
- The service manager told us there had been 100% increase in demand for the service over the past two years and that self-harm referrals had greatly increased. The service had been successful in securing transformation funding although these had not yet been allocated. Additional funding would enable the service to become more efficient, for example, they planned to develop more group delivered interventions. There was a comprehensive plan to improve reduce waiting times.
- The target to assess emergency referrals was 24 hours and for urgent referrals it was one week. The target for routine assessment was six weeks. These targets were being met. The target for treatment was within 18 weeks of referral and the service was aiming to achieve this by the end of March 2016. There was a prioritising system which enabled patients to be seen fast tracked from assessment to treatment if they needed it urgently.
- Practice managers provided a duty on call telephone service between 8.00am and 6.00pm. They could arrange for patients to have their risk reassessed if this was felt to be necessary. People using the service told us they could get telephone advice from the team during working hours. The service also provided telephone advice to the hospital emergency department during working hours.
- The service had clear referral criteria which included referral pathways and useful contact numbers for alternative agencies if the referral was not suitable for CAMHS. All relevant mental health difficulties were covered by the referral criteria document and gave guidance to referrers to help them recognise mental health difficulties.

Are services responsive to people's needs?

Good

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

- The service was careful to try to engage patients who missed an appointment. If there were known risks they would liaise with the referrer to assertively engage the patient and if they were unsuccessful, they would ensure other professionals who were engaged had access to the team for consultation. The rate of patients not attending appointments had reduced with the last three months of 2015 showing the lowest rates of the year.
- Appointments with the service were offered between the hours of 8.00am and 6.00pm Appointments outside of school hours were popular. They were prioritised for working families and children doing exams.
- Staff told us appointments were rarely cancelled and only when necessary, such as if there were an emergency, however, they did not audit cancellations. Staff said if an appointment was cancelled, the reason was explained to the patient or their carer and the appointment was rearranged as soon as possible.

The facilities promote recovery, comfort, dignity and confidentiality

- There were good facilities at the team base at Torbay Hospital. Rooms were welcoming, had comfortable chairs and were large enough to see families in. They had natural light and toys in them. Some of the rooms at the team base had interactive white boards. Staff could upload what they had written on the board to electronic patient records and also use the boards to display outcome measure graphs from the patient record system. Interview rooms were sound proof. However, we did note that the rooms were dusty and that toys were not being cleaned.
- There were rooms which had video cameras in them to record sessions. Patients and their families and carers could take home a DVD of their session and was a technique commonly used in family therapy.
- There was no clinic room. This meant patients were weighed and measured in the corridor where a height measure and weighing scales were placed. The service manager said they did not have space for a designated room for this equipment. However, this could compromise patients' dignity and confidentiality.
- There were notice boards in the waiting room. One board was dedicated to 'have your say' which was a group which enabled service users to influence services. The board showed the group's achievements, plans and reasons why people should join. There was a photo board of the executive team but not of the staff working in this service. There was information about rights, advocacy and third sector agencies. There was a useful leaflet called 'CAMHS in brief: a young person's quick guide to child and adolescent mental health services'. The leaflet was colourful and had pictures. It was written in plain English. Carers we spoke to said they were given information about mental health problems, physical health issues, treatment, local services, patients' rights, helplines, how to complain and advocacy services.

Meeting the needs of all people who use the service

- The building was accessible to people with disabilities and had disabled toilets. The service could access an interpretation service through PALS if required but rarely needed to do so.Staff told us they had recently been assisted by the national deaf CAMHS service to help with provision of a signer for a family with hearing impairment.

Listening to and learning from concerns and complaints

- There were five complaints to the service between 21 January 2015 and 21 January 2016. Three were not upheld, two were partly upheld and none were referred to the ombudsman.The managers investigated complaints. Staff knew how to advise patients to make complaints if they wish to. Staff received feedback about complaints they were involved in and managers disseminated general learning in team business meetings. The service manager gave examples of learning from complaints and actions they had taken, such as supporting the complainant, apologising, debriefing staff and providing staff with supplementary training
- Complaints were made to patient advice and liaison service (PALS). One young person we spoke to did not know how to complain and their parent did not know how to either. People were told how to complain if it was thought they wished to do so and information about how to complain was displayed in the waiting area.
- The manager of the service did not know how many of the complaints had been upheld. They were not keeping any data on unofficial complaints but they said they were resolving issues before they became official complaints.

Are services well-led?

Good

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

Summary of findings

We rated well-led as good because:

- There was good morale amongst the staff and teams worked together and supported each other.
- Governance structures enabled managers to ensure staff were up to date with mandatory training and that they were appraised and well supervised The service had a comprehensive risk register and risks could be escalated to senior management. The risk register was being monitored and updated.
- Staff described the management as supportive and approachable.
- The service was actively developing. They were setting up a crisis service was being established and additional funding secured as part of a national transformation strategy called 'Future in Mind' to improve children and young peoples' mental health services. The service redesign was being carefully planned and involved other key services in the process.
- The service showed a strong commitment to quality improvement and innovation.

However

- Managers were not aware of the team's lack of knowledge of the Mental Capacity Act and Mental Health Act. They relied on staff accessing supervision or involving consultant psychiatrists if there were questions about a patient's mental capacity.

Our findings

Vision and values

- Staff had the trust's values on the back of their identity badges. They told us the values were new. Staff had been informed of the new values via bulletins but had not been involved in creating them. One member of staff saw the trust vision as the integration of health and social care. The vision for CAMHS was being developed through the transformation plans.
- Staff did not know if the team's values and objectives reflected the trust's but they could see a sense of direction which was about child and adolescent mental health services (CAMHS) becoming more accessible and more joined up with other services such as paediatrics. Some staff thought there was a vision to provide briefer care in future in order to treat more patients.
- Staff knew who the most senior managers in the organisation were. The chair of the trust board had visited the team and there were future plans for the executive team to spend time with the team in different settings.

Good governance

- The governance structures in the service were ensuring the service was running smoothly and that staff were equipped to do their jobs. There were clear targets for when patients should be assessed and treated and the service manager was leading a carefully researched project to reduce waiting times. There was a system for reminding staff to complete their mandatory training on time but no data was available from the trust about individual training compliance rates. Most staff did not have a thorough understanding of the Mental Health Act or the Mental Capacity Act although they were able to work to the principles. Staff had an array of supervision to cover the different aspects of their work. They had all received an appraisal unless they were off sick, had only just started in post or were on long term leave. Incidents were reported and responded to appropriately. There was evidence of learning from feedback, complaints and incidents. There was a risk register but there was no specific mechanism for the team's risk register to be reviewed by the board or for their risks to be considered for entry on the trust risk register. There was no evidence to show learning was being shared between services. There was no specific trust oversight of the performance of the service. The service manager was liaising directly with the commissioners of the service to obtain additional funding to increase service capacity. The Safeguarding procedures were robust. However, staff complained of spending too much time doing administrative tasks. We noted that none of them were taking part in clinical audit activities but recognised the service was under pressure because of issues of demand and capacity. Managers were doing some audits, including one on record keeping to ensure care records were being completed thoroughly.

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- The service had a risk register and the service manager could escalate risks to senior management. The risk register was updated and showed risks were being rated, worked on with meaningful actions and deadlines.

Leadership, morale and staff engagement

- The service manager had been in post for seven years and was very experienced at running a service of this nature. They had sufficient authority and administrative support to undertake their duties. However, they had a large volume of work and they were working additional hours. This presented a risk to the individual due to stress, morale and long working hours. They did say they had good support from other managers and that senior management were considering providing a them with a deputy.
- We asked staff whether there had been any bullying or harassment in the service and we were told of one case which was being managed in accordance with trust policy and procedures. Staff were aware of how to raise concerns if they had them.
- Most staff said they felt able to raise concerns without fear of victimisation. However, staff also knew how to whistle blow and said there was a leaflet providing information on the process. People felt supported by their colleagues and said they would feel confident whistle-blowing.
- Morale in the service was generally good and the team functioned well despite pressures and changes. One member of staff said morale in the team fluctuated and described their job as a treadmill with not enough thinking time. One member of staff complained of feeling under pressure to discharge patients more quickly. Staff were clearly under pressure and some of them said they felt stressed or overwhelmed. Managers also felt pressured but said they were well supported. Some staff we spoke to felt there were not enough staff at tier three where they felt particularly stretched. Some tier three staff had expected that the role of primary mental health worker would reduce the pressure but had found that, in practice, they were uncovering cases that would not have been known about and therefore demand had increased.
- There were challenges for the service in recruiting staff which meant some posts were vacant but there was active recruitment activity. The service manager recognised they were competing for work forces across the region and NHS England were involved in discussions about this issue in relation to the forthcoming release of transformation monies. The service's recruitment strategy had been altered to focus more on skills than on profession. Staff were reassured about efforts to recruit staff in the business meeting we attended.
- One member of staff who had been involved in an incident said that they had been supported by their line manager and that they continue to feel safe in their job and that the environment was contained. Several of the staff spoke of the team and its members having resilience and being dedicated and committed. One member of staff said there was vision and direction. Staff were passionate about their work.
- There was a leadership course available for staff to apply for and there were opportunities for leadership development if staff wanted it.
- All staff spoke of the supportive nature of the teams and enjoyed working with their colleagues. Comments about the team included it being warm, nurturing, friendly and helpful. Staff were happy with the supervision they were receiving. We observed two business team meetings and saw the teams were functioning well and people were working together. During team meetings staff problem solved together and shared ideas about the service and how to develop it in future.

Commitment to quality improvement and innovation

- The service had been successful in securing transformation monies although these had not yet been released. In order to look at how best to use the investment, the service was part of a CAMHS redesign group which included representatives from community services, children's services at Torbay council, schools, paediatrics, commissioners, other local providers and public health. The group aimed to oversee the design and implementation of a sustainable CAMHS Service, review the skill mix within the service, improve access to services, treat more children, deliver an acute care pathway, and ensure continued user involvement within the service.
- The service was not part of the Quality Network for Community CAMHS (QNIC) because of the costs involved. However, they were using National Institute for

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Health and Care Excellence (NICE) baseline assessment tools to implement action plans to ensure the service was delivering good quality care and many of the items had been fulfilled.

- The service was keen to innovate and had developed new roles and interventions in order to reach more of people in need of the service and to work closely with other agencies. The primary mental health service, which had been jointly commissioned by Torbay schools, enabled each school to have a dedicated CAMHS mental health worker to work with children and young people, provide assessments and interventions. They also provided training and direct consultation to school staff and school nurses.
- The team provided in-reach services to some GP practices where patients were booked straight into clinics with the primary mental health worker instead of a GP where triage identified this as appropriate. This had improved working relationships with GP surgeries and eased access for children, young people and their families.
- The CAMHS service had developed an evidence based 'understanding your child's mental health' workshop. The workshop was delivered over a five-week period with each session lasting two hours and aimed to enable attendees to improve their knowledge of mental health and to learn about containment, risk and resilience. The workshops enabled parents and carers to develop their own resilience, understand how they influence their children and to engage meaningfully with their children. The workshops, which were delivered by experienced CAMHS practitioners. We asked staff, parents and carers about the group and their feedback was unanimously positive. Staff also said that it had helped to reduce the waiting list because sometimes it was the only intervention needed to help the child or young person.
- Two roles had been developed to outreach into other services. The perinatal and infant mental health practitioner was part of the multi-disciplinary and multi-agency perinatal team including adult mental health services, midwifery, health visiting and children's social care. They had a particular focus on the parent relationship with the unborn and newborn for up to two years of age, and provided clinical supervision, consultation and training. They could provide a rapid response to referrals with initial consultations, assessments and treatment where indicated. The role of the dedicated practitioner for looked after children had been developed to work within health and social care teams. They provided consultation to social workers and foster carers as well as responsive assessments and treatment. The role was specifically developed to support children with unidentified needs. A screening process had been developed to review all children and young who became looked after, after four weeks for mental health difficulties.