Requires improvement

Cumbria Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Trust Headquarters,
Voreda,
Portland Place,
Penrith,
Cumbria,
CA11 7QQ
Tel: 01228 602000
Website: https://www.cumbriapartnership.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)
RNNDJ	Voreda	Child and Adolescent Mental Health Services (East), Carleton Clinic, Cumwhinton Drive, Carlisle	CA1 3SX
RNNDJ	Voreda	Child and Adolescent Mental Health Services (South), Fairfield Centre, Fairfield Lane, Barrow-in-Furness	LA13 9AJ

This report describes our judgement of the quality of care provided within this core service by Cumbria Partnership 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 Cumbria Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cumbria Partnership 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?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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 as requires improvement because:

- The service did not provide the full range of evidence-based interventions recommended by the National Institute for Health and Care Excellence (NICE).
- Risk assessments were not present or not updated in seven of the 27 care records we reviewed.
- There was no target time from assessment to first treatment intervention and no system in place to monitor or review risk for those people on the waiting list for first treatment intervention.
- Care plans were not present in eight of the 27 care records we reviewed. Where care plans were present, there was no evidence the people who used the service had been given a copy.
- There was no permanent consultant psychiatrist in the south team. A number of locums had filled this post. This had adversely impacted on continuity of care for people who used the service.
- There was no tool to calculate staffing levels or skill mix to respond to increasing caseloads
- There was no comprehensive out-of-hours CAMHS provision, or tier two service.
- Mandatory training figures showed non-compliance with trust targets, particularly Mental Capacity Act training.
- Appraisal rates for non-medical staff were below trust target.
- Clinical audit was not widely undertaken in the service.
- The majority of recommendations from the 2012 CAMHS review were still to be implemented.

However:

- Premises were clean and well maintained.
- Target times for referral to assessment were being met.
- Staff demonstrated a clear understanding of safeguarding policy and procedures.
- Prescribing was initiated and reviewed by appropriately qualified and competent staff.
- Staff were participating in the children and young people's improving access to psychological therapies programme, which would increase the range of access to evidence-based interventions.
- The service operated within a multidisciplinary team framework with a wide range of skill sets.
- We observed interaction between staff and people who used the service and noted that people were treated respectfully.
- People we spoke to who used the service and their parents or carers were generally happy with the service they received.

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:

- Risk assessments were not present or not updated in seven of the 27 records we reviewed.
- There was no target time for assessment to first treatment intervention, with no system in place to monitor or review risk for those people who were waiting for first treatment intervention.
- There was no tool to calculate staffing levels or skill mix to respond to increasing caseloads
- Mandatory training figures showed non-compliance with trust targets, particularly Mental Capacity Act training.

However:

- People who used the service were seen in premises that were clean and well maintained.
- Staff demonstrated a clear understanding of safeguarding policy and procedures.
- Prescribing was initiated and reviewed by appropriately qualified and competent staff.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Care plans were not present in eight of the 27 care records we reviewed.
- The service was not delivering the full range of evidence-based interventions recommended by NICE.
- Clinical audit was not widely used in the service.
- There were low rates of compliance with Mental Health Act training within the service.
- There was no permanent consultant psychiatrist in the south team. A high number of locums had filled this post. This had negatively affected continuity of care for people who used the service.

However:

- Staff were participating in the children and young people's improving access to psychological therapies programme, which would increase the range of access to evidence based interventions.
- The service operated within a multidisciplinary team framework with a wide range of skill sets.

Summary of findings

Are services caring?

We rated caring as good because:

- Staff interactions with people who used the service were respectful and caring.
- Most people we spoke to who used the service and their parents or carers were happy with the service they received.
- People who used the service and their parents or carers had opportunities to provide feedback on the service.

Good

Are services responsive to people's needs?

We rated responsive as requires improvement because:

- There was no target for the length of time between assessment and first treatment intervention being received. This meant that some young people waited more than 24 weeks before treatment commenced.
- There was no comprehensive out-of-hours CAMHS provision.
- There was no evidence that complaints about the service were being used to change how services were delivered.

However:

- The service had clear target times from referral to assessment and these were being met.
- Parents of young people who used the service told us they knew how to complain.

Requires improvement

Are services well-led?

We rated well-led as requires improvement because:

- There were elements of mandatory training with compliance rates below the trust target.
- Appraisal rates for non-medical staff were below trust target.
- Clinical audits were not widely undertaken within the service.
- The service was not using the trust's 'quality dashboards' as they were not relevant to the service.
- Many recommendations from the 2012 CAMHS review were still to be implemented.
- Sickness levels were 18% in the south and 22% in the east. The trust was not able to cover all vacancies with bank or agency staff.
- There was no effective tool in place to review skill mix or staffing levels.

However:

- Staff could describe the trust vision and values.
- Incidents were being reported appropriately.

Requires improvement

Summary of findings

- The trust was actively trying to recruit new staff to fill vacant posts.
- Staff were undergoing training to increase the skill set within the service.
- Staff morale was generally high and team managers were held in very high regard by staff.

Summary of findings

Information about the service

The child and adolescent mental health service (CAMHS) provides specialist and targeted services across levels 1- 3 of the emotional health and well-being pathway. CAMHS is delivered by multidisciplinary teams to promote the emotional and mental health and well-being of children and young people in Cumbria. The key functions of the service are:

- universal and level 1: to promote the prevention and early identification of emerging mental health needs through consultation and training with other professionals and through joint working within children's services and primary mental healthcare
- level 2: to provide assessment, early intervention or access to specialist mental health services for those children and young people with identified mental health difficulties and their families
- level 3: to provide medium and long term specialist treatment and intervention in response to assessed needs where children and young people have complex and persistent mental health needs.

The service also:

- provides an emergency response for children and young people who present a significant risk to themselves or others
- provides services to children in care to support their placement stability
- promotes smooth transition to adult mental health services where appropriate.

The trust had a statement of purpose (SOP) for CAMHS. The description of the service is taken from this SOP. Where the trust use the term 'level', this is synonymous with the term 'tier' to describe a staged model of care.

Cumbria CAMHS covers a large geographical area and is delivered by three locality teams based in:

• Carlisle, covering the east of the county

• Barrow-in-Furness, covering the south of the county

• Workington, covering the west of the county.

During the inspection, we visited south and east teams based in Barrow and Carlisle. Each service was made up of a multidisciplinary team of professionals who worked with children, young people and their families or identified carers.

The service did not provide any interventions for children diagnosed with autistic spectrum disorder (ASD), unless they also had a co-existing mental health condition. The paediatric service within the trust provided screening, diagnostics, treatment and support for ASD.

The trust commissioned an independent review of the CAMHS service in October 2012. This review outlined a number of recommendations to 'produce a properly resourced and clinically effective service which is fit to meet the needs of children and families in Cumbria.' At the time of the inspection the recommendations of the review had not been fully implemented.

This was the first comprehensive inspection for the trust under the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Our inspection team

Chair: Paddy Cooney

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leaders: Brian Cranna, Inspection Manager (Mental Health) Care Quality Commission

Sarah Dronsfield, Inspection Manager (Acute) Care Quality Commission

The team inspecting the specialist community mental health services for children and young people consisted of two CQC Inspectors and two clinical nurse specialists.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the two community teams selected for the inspection
- spoke with three children and young people who used the service and 13 parents or carers of people who used the service
- received 17 comments cards from people who used the service and their parents or carers
- spoke with the managers of the two teams we visited
- spoke with 13 other members of staff from the teams, including consultant psychiatrists, psychologists, nurses, social workers and administrators
- spoke with three senior managers from the trust
- attended and observed one initial assessment and two interventions
- attended a drop-in session with five parents, facilitated by the National Autistic Society
- looked at 27 care records of people who used the service
- looked at minutes from multidisciplinary team meetings
- examined policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We observed three interventions and spoke with three young people who used the service, as well as 13 parents or carers.

People who used the service and their parents or carers were encouraged to complete comments cards giving feedback on their experience of using the service. We received 17 completed comments cards.

We attended a drop-in group for parents, facilitated by the National Autistic Society. Four parents attended this drop-in.

People who used the service and their parents or carers provided feedback on their experience of the service. Some had experienced very positive care and spoke very highly of staff in the service. Others told us that waiting lists were too long and there had been inconsistencies in staffing due to high turnover. Two parents said that it had been difficult to access some interventions in the south team, particularly cognitive behavioural therapy.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- Risk assessments were missing or not up to date. The trust must ensure that risk assessments are completed fully and regularly reviewed and maintained for all people who use the service. This must include a system for monitoring risk for young people waiting for first treatment intervention.
- Care plans were missing or not updated. The trust must ensure that complete, accurate and contemporaneous records are maintained in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
- There was no evidence of learning from complaints about the service.The trust must ensure that feedback from people who use the service is evaluated and used to make improvements.
- Clinical audit was not widely undertaken within the service. The trust must ensure that an appropriate system of audit is in place to assess, monitor and improve the quality and safety of the service.

Action the provider SHOULD take to improve

- Mandatory training should improve in areas not reaching compliance. The trust should ensure that mandatory training is kept current and ongoing.
- The trust should monitor waiting times between assessment and first treatment intervention.
- The trust should provide the full range of evidence based interventions recommended by NICE to support people using the service.
- The trust should seek to implement the full range of recommendations as set out in the CAMHS review 2012.
- The trust should seek to develop a comprehensive CAMHS service including tier two and out-of-hours provision.

Cumbria Partnership 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
Child and Adolescent Mental Health Services (East), Carleton Clinic, Cumwhinton Drive, Carlisle	Voreda
Child and Adolescent Mental Health Services (South), Fairfield Centre, Fairfield Lane, Barrow-in-Furness	Voreda

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983 (MHA). We use our findings to help determine an overall judgement about the Provider.

Overall 47% of staff in the CAMHS had completed MHA training. Within this, 50% of staff in the south team and 36% of staff in the east team had completed the training.

The trust considered mental health legislation training to be mandatory, but staff were unclear about this. Some staff told us this was part of the mandatory training and required refreshing every three years. Other staff said this was not on the mandatory training list. Some staff said that the MHA training they had attended was focused on adult services, so had little relevance to CAMHS.

We discussed the MHA with staff, who displayed varying degrees of knowledge about it. Staff told us that the MHA was rarely used in relation to people who used the service. MHA legislation would usually only be appropriate for those young people who required inpatient services.

Team managers could not recall any audit of MHA being undertaken within CAMHS. We did not see any evidence that a MHA audit had been undertaken.

There were no young people in the service who were subject to a community treatment order.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

Overall 82% of staff in the CAMHS had completed MCA training. Within this, 79% of staff in the south team and 71% of staff in the east team had completed the training.

We discussed MCA with staff and found varying degrees of knowledge about MCA and its use.

All but one of the 27 care records we reviewed had recorded the patient's consent to treatment.

Treatment was agreed with the young people and their families. Attendance at the service was voluntary. For children under the age of 16, their decision-making ability is governed by the Gillick competence test. This concept of competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. As a result, when working with children, staff should be assessing whether a child has a sufficient level of understanding to make decisions regarding their care. Where a young person had decided they did not want their family to be involved, their competence would be assessed and a risk assessment carried out to ensure the safety of the young person.

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 premises we visited in Carlisle and Barrow were clean and well maintained.

Alarms were located within the buildings. In Carlisle, there were alarms located in interview rooms. There were no alarms present in interview rooms in Barrow. There were no personal alarms available for staff to use.

There was CCTV monitoring in the entrance to the Barrow service.

Furniture was found to be in good condition at each of the services.

Safe staffing

Listed below are the whole time equivalent (WTE) staffing levels for each team.

CAMHS East

Establishment Levels: qualified nurses - 6.8 WTE

Establishment Levels: nursing assistants - 1.0 WTE

Number of Vacancies* - 1.9 WTE

Staff sickness rate - 22%

Staff turnover rate - 14%

Posts filled by bank or agency staff - 1.1 WTE

Posts not filled by bank or agency staff - 0.8 WTE

CAMHS South

Establishment Levels: qualified nurses - 6.8 WTE

Establishment Levels: nursing assistants - 1.00 WTE

Number of Vacancies* - 7.0 WTE

Staff sickness rate - 18%

Staff turnover rate - 40%

Posts filled by bank or agency staff - 4.6 WTE

Posts not filled by bank or agency staff - 2.4 WTE

* The trust was unable to detail the number of vacancies by grade.

At the end of October 2015, CAMHS was working with 1,788 children and young people. Four hundred and forty-five were registered to use the service with the east team, and 687 with the south team.

There was no tool used by the service to calculate staffing levels. Managers were unable to say how staffing levels and skill mix would be reviewed based on increasing caseloads or needs of young people using the service. One manager told us that staffing levels had been reviewed as part of the 2012 CAMHS review, conducted by independent consultants. One of the recommendations of this review included increased staffing and review of skills mix in the teams, we saw that this had not been implemented.

Staff caseloads ranged from 20 to 52 young people. The exception to this was the ADHD nurse specialist in the south, who held a caseload of 147 young people. In the east, the team manager held a caseload of 126 young people with ADHD.

The trust used bank staff to cover vacant posts. The manager in the south team told us of difficulties getting suitably qualified bank and agency staff. For example, a nursing post had been difficult to cover, as the post required cognitive behavioural therapy (CBT) qualifications and CAMHS experience. This had resulted in young people in the service not being able to access CBT interventions.

Both teams had consultant psychiatrists within the team, so people using the service had access to psychiatric support. The consultant psychiatrist post in Barrow was filled by locums, due to difficulties in recruiting a permanent member of staff. Five locum consultant psychiatrists had worked at the service since April 2015. Staff told us this had resulted in a lack of continuity of care for people who use the service. Two parents commented on high turnover of staff impacting negatively upon care. The trust had actively tried to recruit into vacant posts including advertising consultant psychiatrist posts overseas.

The operating hours of the service was Monday to Friday, 9:00am to 5:00pm. After these hours and during weekends, the service operated a telephone helpline. Other professionals who required information and advice relating to mental health issues in young people could use the

Requires improvement

Are services safe?

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helpline. This helpline was not accessible to young people or their parents and carers. Staff from all three CAMHS teams resourced the helpline using a rota system. Access to records of people who used the service was not available outside of office hours, as all records were paper based.

Mandatory training figures were provided by the trust for CAMHS. The trust target for compliance with mandatory training was 80%. Data provided showed that as of October 2015 the average training rates for the teams were 63% in Barrow and Carlisle.

Elements of training identified as being less than 80% in the South were:

- Equality and Diversity
- Informed Consent to Treatment
- Mental Health Legislation Update
- Deprivation of Liberties - Level 1
- PMVA Level 2
- Safeguarding Adults - Level 1
- Risky Business
- Fire Safety
- Manual Handling Workplace
- Local Induction
- Basic Life Support with Defibrillator
- Clinical Records Keeping
- Infection Prevention and Control Level 2
- Hand Hygiene

Elements of training identified as being less than 80% in the East were:

- Equality and Diversity
- Informed Consent to Treatment
- Mental Health Legislation Update
- Mental Capacity Act
- PMVA Level 2
- Safeguarding Adults - Level 1
- Risky Business
- Fire Safety
- Manual Handling Workplace
- Local Induction
- Basic Life Support with Defibrillator
- Safeguarding Children - Think Family
- Clinical Records Keeping
- Infection Prevention and Control Level 2
- Hand Hygiene

Assessing and managing risk to patients and staff

Risk assessments were completed as part of the initial assessment. CAMHS used the galatean risk and safety tool (GRiST) to assess risk, which is a validated tool. GRiST risk assessments were completed electronically, and then printed off and a copy retained on care records. We reviewed 27 care records and found that four had no risk assessment present. Three care records had no updated risk assessment.

People who used the service and their parents and carers were involved in developing crisis plans. We found reference to crisis planning within care records, but these were not 'stand-alone' documents. This made it difficult to identify those actions agreed to support young people during episodes of crisis.

Referrals coming into the team were subject to an initial triage assessment, undertaken by staff within the service. We observed a triage meeting, with a clinical psychologist and clinical nurse specialist reviewing nine new referrals. We observed discussions between staff on the suitability of the young people for the service. Where young people were not deemed appropriate for CAMHS, we observed discussions taking place to identify other appropriate agencies that were better placed to provide support.

Staff told us that around one quarter of referrals to CAMHS were inappropriate. Many felt that this was due to the lack of a tier two mental health service within the county. In the east, we saw data showing 235 referrals to CAMHS during August to October, with 26% of these being rejected due to the inappropriateness of the referral. The trust had a statement of purpose for the service, which stated a tier two CAMHS service was provided. However, there was no

Requires improvement

Are services safe?

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

tier two service being delivered when the inspection took place. The trust told us and we saw evidence of a procurement process for a tier two service being undertaken.

Young people who were accepted by the service were contacted by letter offering an initial appointment. All non-urgent referrals were offered an appointment within 35 days. Urgent appointments were offered within 48 hours. Non-urgent referrals for children in the looked after system were offered an appointment within 15 days. Both teams were meeting the targets for triage to assessment.

There were no targets set for the length of time between assessment and delivery of the first treatment intervention. Managers and staff told us that there were young people on 'assessment caseload' who had completed initial assessment but were waiting for their first treatment episode.

No review of risk or need amongst the group of young people waiting for first treatment intervention was undertaken. Staff told us that young people and their families were advised to contact CAMHS in the event of any significant change or decline in mental health. We saw a copy of the initial appointment letter sent to people and this did not provide any information on what to do in the event of circumstances changing.

Safeguarding training was mandatory within the service. Training data from the trust indicated that 56% of staff from CAMHS east team had completed safeguarding children 'Think Family' training. This was outside of the trust target of 80% compliance.

Staff demonstrated a clear understanding of the trust safeguarding policy and clearly outlined safeguarding procedures. Staff used the multi-disciplinary team meetings to discuss any safeguarding concerns relating to young people using the service. Team managers told us that staff were encouraged to seek advice and support from the safeguarding nurse lead within the trust as required. Data provided by the trust showed that of 525 safeguarding alerts raised since November 2014, 33 had been raised by CAMHS.

We saw the lone working policy for the trust. Staff explained lone working arrangements and it was evident that staff were aware of the trust policy and relevant safety considerations. Most people using the service were seen at the CAMHS premises in Carlisle and Barrow so lone working was minimal. Staff leaving the premises updated a whiteboard in the reception area so that other members of team knew of their location.

Prescribing was initiated and reviewed by appropriately qualified and competent staff within the service. In the south, this was undertaken by the consultant psychiatrist. In the east, the team manager was a non-medical prescriber and was responsible for prescribing of medication for young people on the caseload with an ADHD diagnosis.

Track record on safety

Data provided by the trust showed 17 incidents had been reported for CAMHS for July to October 2015. Of these incidents, 13 related to the south team. Seven incidents related to safeguarding issues. There had been one serious incident in the previous 12-month period. The serious incident related to an attempted suicide by a young person in the east of the county.

Both teams had a business continuity plan in place and team managers were aware of processes to follow should an adverse event occur.

Reporting incidents and learning from when things go wrong

The trust used an electronic incident reporting system to record incidents. All staff knew how to complete a report on the system and the circumstances under which a report should be made.

Staff showed a good understanding of the principles of duty of candour. However, no one we spoke to had attended any training on duty of candour. The trust had a duty of candour policy although not all staff were aware of this.

Some staff described processes for reviewing incidents. Team managers told us the managers from each locality team met regularly and shared information relating to incidents. Staff told us that they did not usually get feedback following incidents, and that only the most serious incidents would be discussed at the monthly team meeting.

Are services effective?

Requires improvement

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 assessments were completed during the initial appointment. We observed an initial appointment with a senior CAMHS practitioner. The assessment was clear, professional and a concise action plan was agreed with the young person and their parent during the meeting.

We reviewed 27 care records. Eight had no care plan in place. Staff told us that for some young people, care plans were documented via the care notes. However, this made it difficult to identify the agreed care plan and provided no evidence that people who used the service and their parents or carers had been involved in the development of the plan. This also meant that people who used the service had no copy of their care plan.

Where care plans were in place, the young person, their parent or carer, or both had signed these. We found one care plan that should have been reviewed in September 2015, with no evidence of a review taking place. One young person we spoke to did not think they had a care plan. We spoke to 13 parents of young people in the service, all of whom said their child had a care plan.

Care records were appropriately stored in both teams. At the time of the inspection, all care records were paper-based, which made it difficult for staff to access information when they were off site. In particular, the south team had two bases in Barrow and Kendal. This made it difficult for staff to access care records for young people in Kendal if they were in the Barrow premises for example.

We found some care records where GRiST risk assessments were missing. Staff told us this may have been due to a delay in printing off a copy of the risk assessment, which was completed electronically.

We saw records being tracked when they were removed from the secure storage area. This enabled staff to monitor where care records were and who had removed them.

Best practice in treatment and care

The national institute for health and care excellence (NICE) sets down guidance on evidence based interventions for children and young people experiencing mental health issues. We found that there the full range of NICE recommended interventions were not being delivered across the teams. The trust had identified this as a risk in their risk register with an action to review the range of interventions.

The consultant psychiatrist in the south team told us staff were aware of NICE guidelines and that these were followed where possible. However, it was highlighted that the team does not have the correct skills mix (family therapist, eating disorder therapist for example) meaning that some first line treatment interventions recommended by NICE were not being provided.

There was no systemic family practice available in either team. Cognitive behavioural therapy (CBT) interventions were available, but due to the low number of staff able to deliver CBT in the south, there was a list of young people waiting to start CBT. Staff told us there was limited access to dieticians for those young people with a diagnosed eating disorder. The trust risk register highlighted the lack of specialist dietetic input into the service. GPs and CAMHS practitioners were providing generalised advice around diet. The trust risk register recognised that this was insufficient to meet the needs of young people with eating disorders. Two parents completed comments cards in the south identifying long waiting times for CBT intervention as a problem.

The children and young people's improving access to psychological therapies (CYPIAPT) programme is a service transformation programme delivered by NHS England that aims to improve existing CAMHS working in the community. Staff from both teams were participating in CYPIAPT. In the east team, one member of staff was undertaking CBT training, one member of staff had qualified as a parenting supervisor and one member of staff was starting the family therapy training in 2016 as part of the CYPIAPT programme. In the south team, two members of staff were undertaking CBT training, with a further two staff due to start training in CBT and systemic family therapy in 2016. Both managers had attended the transformational leadership programme as part of CYPIAPT.

People who used the service could access psychological therapies. There was a part time consultant psychologist, 2.6WTE psychologists and a psychology assistant in the south team. There was also a consultant psychologist and psychologist in the east team.

Are services effective?

Requires improvement

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

The teams worked within a choice and partnership approach (CAPA) model, but managers acknowledged this was not yet fully developed across the service. CAPA is one of the service delivery models recommended for CYPIAPT.

We reviewed 27 care records and found that where NICE recommended interventions had been delivered, this was documented within records.

Basic physical healthcare monitoring around weight and height for some people who used the service was undertaken. For other people using the service, local GPs were undertaking physical health checks. Staff in the south told us it was difficult to get information from GPs on occasion, despite there being a formal shared care arrangement in place. One example was given where a GP had been reluctant to take bloods and had not been happy to share blood test results. We saw one care record of a young person who was prescribed medication for ADHD. No baseline height, weight or blood-pressure measurements were recorded on file.

A range of routine outcome measures (ROM) were used within the service. These included revised children's anxiety and depressions scale, a strengths and difficulties questionnaire. Managers told us that CYPIAPT trainees were more consistently using ROM, as outcome reporting was a requirement of the programme.

Clinical audits were not widely undertaken in the service. Managers and staff could not recall any audits being undertaken. The trust did provide information on two audits undertaken during 2014. These were an audit of clinical guideline 133 self-harm (longer-term management) which audited 46 care records from the service, and an audit of rejected CAMHS referrals, which audited 20 rejected referrals from the south team.

Skilled staff to deliver care

Both teams operated within a multi-disciplinary team framework. This included mental health nurses, consultant psychiatrists and psychologists. The skill mix of the teams varied. In the south, there was a CBT practitioner (temporarily vacant at the time of inspection) and counsellor. In the east, there was an occupational therapist. These staff all worked alongside CAMHS nursing practitioners. In the south, a social worker sat within the CAMHS team, employed by Cumbria County Council.

Staff within the service were qualified to carry out their roles. However, in the south, there was a high proportion of new staff who were less experienced.

In the south CAMHS team, consultant psychiatry input was being provided through locum consultant psychiatrists. Since April 2015, there had been five different locum consultant psychiatrists working in the service. Staff told us this had adversely affected continuity of care for young people who used the service and the quality of locums had differed greatly. The consultant psychiatrist told us that the level of psychiatry input into the team was not adequate to meet the needs of people who used the service. Staff told us that the trust had tried to recruit into this post for some time, but had not been able to make an appointment. Two parents of young people who used the service commented about the high turnover of staff in the south and how this had negatively impacted upon their child's care.

Four members of staff from across the two teams were completing CYPIAPT programme, which would develop skills within the team to deliver a wider range of NICE recommended interventions. Managers from the teams had participated in the transforming leadership programme as part of CYPIAPT. Staff participating in the CYPIAPT programme were required to attend university two days per week, for which backfill funding was available. Managers at both services told us that this had detrimentally affected capacity within the teams. Staff participating on the CYPIAPT programme held a smaller caseload of between eight to twelve young people.

In the south team, the qualified nurse who was a lead on ADHD was about to start a non-medical prescribing course.

Sixty-nine percent of CAMHS staff had an appraisal. Data provided from the trust showed the trust's appraisal rate overall was 46%.

Staff told us that they had management supervision monthly and we saw supervision records, which confirmed this. Locality team meetings took place monthly and the three team managers from across the county attended a monthly network meeting. Clinical supervision was provided from within the team, with all qualified staff having an identified supervisor. In the south, the consultant psychiatrist sourced clinical supervision externally.

Multi-disciplinary and inter-agency team work

Staff told us they attended regular multidisciplinary meetings and we saw minutes of these meetings. These

Are services effective?

Requires improvement

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.

occurred weekly in both teams. The multidisciplinary meetings reviewed cases and identified approaches to effectively manage identified risks. Care records of people who were discussed at these meetings were updated and we found evidence of this within records. Allocation of new cases was also discussed and agreed at this meeting.

We looked at care records for young people who had been admitted to out of area inpatient services. There was evidence of effective transfer of care between CAMHS and the provider of the inpatient service. Staff from CAMHS remained involved in the young person's care and attended care planning meetings using the care programme approach.

Links with external organisations were described by staff as 'varied'. In the east, staff told us of good relationships with social care and third sector providers. There were often difficulties in accessing appropriate 'tier two' mental health services for young people. We were told that there was a procurement exercise underway to commission a tier two mental health service. We saw evidence of this through the on-line procurement portal.

Staff from both teams attended 'team around the family' meetings and shared appropriate information on young people on the caseload.

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

The trust provided data which showed Mental Health Act (MHA) training for CAMHS overall was 47%. For the south team, 50% of staff had completed MHA training. In the east team, the MHA training rate was 36%.

The trust considered mental health legislation training to be mandatory, but staff were unclear about this. Some staff told us this was part of the mandatory training and required refresh every three years. Other staff said this was not on the mandatory training list. Some staff said that the MHA training they had attended was focused on adult services, so had little relevance to CAMHS.

We discussed the MHA with staff, who displayed varying degrees of knowledge about the MHA. Staff told us that the MHA was rarely used in relation to people who used the service. MHA legislation would usually only be appropriate for those young people who required inpatient services.

Team managers could not recall any audit of MHA being undertaken within CAMHS.

No young people in the service were subject to a community treatment order.

Good practice in applying the Mental Capacity Act

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

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

The trust provided data which showed that MCA training for CAMHS overall was 82%. For the south team, 79% of staff had completed MCA training. In the east team, the MCA training rate was 71%

We discussed MCA with staff and found varying degrees of knowledge about MCA and its use.

Of the 27 care records reviewed during the inspection, we found that all but one had documented consent to treatment.

Treatment was agreed with the young people and their families. Attendance at the service was voluntary. For children under the age of 16, decision making ability was governed by the Gillick competence. This concept of competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. As a result, when working with children, staff should be assessing whether a child has a sufficient level of understanding to make decisions regarding their care. Where a young person had decided they did not want their family to be involved, staff said competence would be assessed and a risk assessment carried out to ensure the safety of the young person.

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 three interventions across the two teams.

We observed a video recording of a parenting group which was part of the 'incredible years' programme. This is a NICE recommended parenting programme, which was facilitated by an occupational therapist undergoing CYPIAPT training. Seven parents attended. We saw that the group was well facilitated, with clear outcomes for the group being explained and boundaries including confidentiality agreed. Parents had access to appropriate resources and were given tasks to complete outside of the group activity. The facilitator was engaging and respectful and encouraged participation in discussions.

We also observed an urgent assessment appointment between a CAMHS nurse, a young person and their parent. The nurse was respectful and checked consent and capacity with the young person at the start of the session. Areas discussed and actions agreed were checked for accuracy and understanding with both the young person and their parent. The interaction was positive and supportive. We spoke to the young person and their parent at the end of the appointment and both said that they felt the session had gone well.

One interaction we saw between a nurse and young person appeared to be stilted and lacked rapport. After the intervention we spoke to the young person who said he liked his therapist.

We spoke with 13 parents or carers of young people who used the service and three people who used the service. For each location, the comments were mostly positive about the treatment and care received. A negative comment from one parent was in relation to the length of time it had taken to access the service. The parent also told us that her daughter was currently going through transition into adult mental health services and said they lacked confidence in this process and were concerned for the future.

The involvement of people in the care that they receive

We reviewed 27 care records and eight had no care plan on file. We found variation in the level of involvement of young people and their parents in the care plans we reviewed. Where there were care plans in records, not all showed evidence that a copy had been shared with the young person or their parents.

We read comments made by young people and their parents or carers in a comments book in the reception area of the east team. There were several comments in the book relating to the high volume of the music played in the reception area and requests that this is turned down. On the day of the inspection, we found that the radio was still being played very loudly. It was unclear how feedback influenced service delivery. None of the staff we spoke to could give an example of how feedback had been used to change how services were delivered.

One of the managers told us that it was trust policy to involve service users in recruitment for all posts at Band 6 and above. However, this did not happen for recruitment of CAMHS staff.

We saw comments boards in the reception areas of both services; a 'washing line' in Barrow and a tree in Carlisle where young people and their parents or carers could leave comments or suggestions about the service. Managers told us there were plans to provide feedback on each of the comments made, but at the time of the inspection, this was not happening.

In the reception areas, we saw information on advocacy services.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

The service had clear target times from referral to assessment. For non-urgent referrals, this was 35 working days. Non-urgent referrals for children in the looked after system were given an assessment appointment within 15 working days. Urgent referrals were given an assessment appointment within 48 hours. Both teams were meeting these targets.

A range of professionals could refer young people into the service including GPs, school nurses, social workers. Parents and young people could not self-refer.

New referrals coming into the service were subject to an initial triage assessment, undertaken by staff within the service. We observed a triage meeting, with a clinical psychologist and clinical nurse specialist reviewing nine new referrals. We observed discussions between staff on the suitability of the young people for the service. Where young people were not deemed appropriate for CAMHS, we observed discussions taking place to identify other appropriate agencies that may be better placed to provide support.

Young people who were suitable for the service were contacted by letter offering an initial appointment.

There were no targets set for the length of time between assessment and first treatment intervention being received. In the south team, there were 50 young people waiting for treatment to start. Five young people were waiting for treatment in the east. At the time of the inspection, the waiting times for first treatment intervention ranged from one week to 24 weeks. Fifteen young people had been waiting for eight weeks or more. At the time of the inspection, none of these young people had been given a date for their treatment to start.

There was no mechanism in place to review risk or need amongst the group of young people waiting for first treatment intervention. Staff told us that young people and their families were advised to re-contact CAMHS in the event of any significant change or decline in mental health. We saw a copy of the initial appointment letter which did not provide information on what to do in the event of circumstances changing.

Staff told us that if a young person did not attend their initial appointment, they would not be offered another appointment and would be referred back to the agency that had made the initial referral.

We reviewed the statement of purpose for the service. This stated that CAMHS was a comprehensive service providing both tier two and three interventions. However, there was no tier two service for young people in Cumbria. Staff told us that there was a procurement process underway to commission this service. We viewed the on-line procurement website and saw that the procurement process had commenced. The lack of tier two service meant that the CAMHS teams had high levels of referrals that did not meet the threshold for a tier three service. Staff told us that around one quarter of referrals to CAMHS were inappropriate. Many felt that this was due to the lack of a tier two mental health service within the county. In the east team, we saw data showing 235 referrals to CAMHS during August to October 2015, with 26% of these being rejected due to the inappropriateness of the referral. The trust undertook an audit of rejected referrals in November 2014. This reviewed 20 rejected referrals during August to September 2014. The audit found that 14 of the referrals required tier one or tier two interventions.

The lack of a tier two service also meant there was no 'step-down' service for young people leaving CAMHS. Young people who completed treatment were discharged back to the original referring agency. The trust had a transitional protocol for young people who required treatment beyond the age of 18. Staff told us there were often difficulties in the transition arrangements between CAMHS and the adult community mental health service. Sometimes young people leaving CAMHS did not meet the threshold for adult mental health services. We spoke to a parent who was concerned that her daughter, who was transitioning to adult services, would not receive the care she needed.

Staff told us there was no ADHD service for adults in the county. As a result, some young people with an ADHD diagnosis were retained in the service beyond the age of 18.

There was no out-of-hours CAMHS service in the county. After 5pm weekdays and during weekends, there was a telephone helpline for professionals to use if they needed advice from the CAMHS team. Staff from the three teams across the county covered the helpline on a rota system. As staff could not access records out-of-hours, no detailed or specific information relating to people using the service

Are services responsive to people's needs?

Requires improvement

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

could be shared with other professionals. For young people experiencing crisis in evenings and weekends, support was accessed from GP out-of-hours provision or through A&E departments. The trust had highlighted the lack of effective out-of-hours provision within their risk register.

The facilities promote recovery, comfort, dignity and confidentiality

Young people who used the services were seen on provider premises.

The rooms in both premises had adequate interview space for the delivery of interventions. There were also larger rooms to facilitate group interventions. The rooms we saw were clean and fit for purpose. At the premises in Barrow, we found that some of the interview rooms had inadequate sound proofing, and conversations could be heard outside of the room.

In Carlisle, the accommodation for the east CAMHS team was newly refurbished and provided a clean and welcoming environment. We did see comments from people who used the service that the radio in the reception area was too loud. On the day we inspected the service, the radio was being used and was playing loudly.

Information leaflets relating to treatment, complaints procedures and other services were available in reception areas of both services.

Meeting the needs of all people who use the service

All of the interview rooms in both premises were situated on the ground floor and the buildings had disabled access.

We saw information that was sent to young people and their parents or carers. This included information on how to contact the service and how to complain. The leaflets we saw were not in easy read format. The referral form did ask if there were literacy issues and staff told us letters could be sent in easy read format if required.

Interpretation and signing services were available and could be requested via the trust's intranet.

Listening to and learning from concerns and complaints

Data from the trust showed the service had 56 formal complaints during the period 1 November 2013 to 29 October 2015. Of these, 23 complaints were upheld. Two complaints were ongoing.

The main issues raised via formal complaints were in relation to:

- access and treatment being provided by CAMHS services
- staff in CAMHS including staff attitudes and staff changes
- breach of confidentiality and incorrect information on record
- communication
- transition arrangements between CAMHS and adult mental health services.

No complaints had been referred to the Parliamentary and Health Service Ombudsman.

Managers told us that complaints were dealt with in line with the trust policy. Formal complaints were recorded by the patient experience team. Staff told us that feedback from complaints was discussed in team meetings.

Parents of people who used the service told us they knew how to complain if they were unhappy with the service. One parent told us that she had complained and felt her complaint had been dealt with appropriately.

We saw no evidence of complaints being used to change how services were delivered.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

Staff we spoke to told us in their own words what the trust objectives and values were. These were displayed in the locations we visited and were the 'screen saver' on trust computers.

Staff knew who the senior managers in the trust were, although most could not recall a time when a senior manager had visited the service. One member of staff said the clinical services manager had visited two or three weeks prior to the inspection.

Good governance

Staff were receiving mandatory training, although there were many courses where compliance was below trust targets.

Appraisals and supervision were on-going, but non-medical staff appraisals were behind target with 64% being completed.

Incidents were being reported appropriately.

Staff and managers we spoke with could not recall participating in any clinical audits. The trust provided information on two CAMHS audits during 2014. These were an audit of clinical guideline 133 self-harm (longer term management) which audited 46 care records from the service, and an audit of rejected CAMHS referrals which audited 20 rejected referrals from the south team.

There was no evidence of feedback from people who used the service being used to change or inform service delivery.

The trust had implemented 'quality dashboards' and told us these were active for every service. However, almost all staff we spoke to were unaware of these dashboards. Managers told us that they were aware of a quality dashboard for the children and families directorate, but these did not contain any relevant information about the CAMHS service. Consequently, managers were not using or reviewing the quality dashboards.

Managers told us of the performance measures for the service, which related to target times between referral and initial assessment.

The trust provided a copy of their risk register, which had 887 risks identified. Of these, seven related to the CAMHS service.

There was no service level risk register. Managers were aware of the process to escalate risks to senior management. Locality managers highlighted risks to the monthly operation and communications meeting. The clinical services manager would review the risk and decide what to escalate to the children and families' network meeting. However, managers were not confident that appropriate action was taken to address risks.

There was an independent review of the CAMHS service in October 2012. The trust 2013/14 quality account under 'patient safety and clinical effectiveness' stated that the trust 'will fully implement the recommendations of the CAMHS review' to 'produce a properly resourced and clinically effective service which is fit to meet the needs of children and families in Cumbria'. At the time of the inspection, the recommendations of the review had not been fully implemented. The trust had made additional investments into the CAMHS service in the twelve months prior to inspection and had appointed a clinical director and dedicated service manager. Many of the actions identified in the review remained outstanding. These included:

- undertaking needs assessment to enable resources to be aligned appropriately
- discuss and clarify referral criteria with referral agencies
- audit of adherence to NICE guidelines
- provide 24-hour cover

Managers told us they had enough authority to do their job, but there was a mixed view on the support provided by their senior management.

Leadership, morale and staff engagement

Data provided by the trust showed sickness rates for CAMHS overall during the last 12 months of 15%. In the south team, sickness rates were 18% and 22% for the east team. Managers told us, and data provided by the trust confirmed, that not all vacant posts were covered by bank or agency staff. Some posts had been vacant for some time due to difficulties in recruiting. This had impacted on the ability of the service to provide the full range of interventions for young people on the caseload. In particular, there had been difficulties recruiting to the

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consultant psychiatrist post in the south team. As a result, there had been high usage of locums, which staff and parents told us had negatively impacted on quality and continuity of care.

Staff were undergoing training as part of the CYPIAPT programme, which would increase the skill set within the team to enable a wider range of interventions to be delivered in the future. However, the trust risk register had identified a risk to fail to deliver the CYPIAPT outcomes. CYPIAPT 'champions' had been identified within each team. However, the risk register stated there was no member of staff identified drive the programme forward.

There were no bullying or harassment cases reported and there was one ongoing investigation regarding a member of staff in the south team which was almost complete.

Staff morale was reported to be high. While staff acknowledged that their roles could be stressful, all talked of working within a good, supportive team.

The staff we talked to spoke very highly of the team managers in the south and east teams.

There was no effective tool being utilised within the service to review skill mix or staffing levels. We observed differences in staffing levels in the south and east teams which did not appear to be reflective of caseloads.

Commitment to quality improvement and innovation

The trust was participating in the CYPIAPT programme, which would improve the range of evidence based practice within the service if the expected outcomes of the programme were achieved.

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 Risk assessments were found to be missing or not up to date and there were no systems to review risk to young people on the waiting list for first treatment intervention. This is a breach of Regulation 12(2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Care plans were found to be missing or not up to date. This is a breach of Regulation 17(2)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Feedback from service users and learning from complaints were not being used to improve the service. This is a breach of Regulation 17(2)(e)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Quality assurance dashboards were not being used in the CAMHS service and there was limited evidence of clinical audit.

This is a breach of Regulation 17(2)(a)