Inadequate

Cornwall Partnership 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)
RJ8H5	Head Office	Specialist community mental health services for children and young people - Mid teams	PL31 2QN
RJ8H5	Head Office	Specialist community mental health services for children and young people - East teams	PL31 2QN

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

Summary of findings

Ratings

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

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

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

This inspection was a focussed inspection so therefore did not provide a rating. The purpose of the inspection was to see if the provider had made significant improvements to the service following the issuing of a section 29 warning notice in April 2019.

- The trust had recruited to all but two of their vacancies. The trust had employed more than 30 additional clinical associate psychologists to support assessments and an additional quality lead to provide oversight and assurance for team leaders to make the required improvements following the section 29a warning notice. The trust had developed and implemented an escalation plan for managers to use should staffing incidents pose a threat to the safe running of the service. This was being implemented effectively at the time of our inspection. Staff morale was much improved with increased engagement and development opportunities being provided by the trust.
- Since our inspection in March 2019, every young person on the waiting list had been contacted and their risk reviewed. Urgent and emergency cases were being followed up by the CAMHS crisis team or early intervention in psychosis team as required. The crisis team undertook a thorough assessment including an assessment of risk after the first appointment. Urgent cases were seen within 48 hours. Young people on the waiting list were being contacted regularly to ensure staff were aware of any change in presentation or risk.
- The trust had developed and implemented new electronic caseloads, with reporting functions, to ensure appropriate management of waiting lists within teams. Waiting times in the mid teams had reduced significantly and were improving in the east teams. The trust had developed an operational plan to address the long waits for a first assessment.
- Individual staff caseloads were now much lower due to the increase in staffing and transparency in viewing caseloads on the new electronic system. New managers no longer held a clinical role and therefore did not hold the large caseloads we saw during our last inspection.
- The trust had developed processes which meant they had complete oversight of the key issues raised in the warning notice. Operational managers and other senior members of staff monitored and audited a live waiting list to ensure wait times were reducing and high risk young people were being seen. Staffing issues were now known to the senior management team via a new escalation process and incident reporting and complaints were being monitored through operational governance meetings.
- All staff had received training and ongoing support in incident reporting, processing complaints and learning from adverse events. Incidents and complaints were now a standing agenda item during team meetings.

However:

- At the time of our inspection, 73% of young people in the east teams had breached the trust's target of being seen within 28 days for an initial assessment. Current wait times for a first assessment was 117 days (17 weeks) in the east teams. There were 47 young people waiting for treatment in the east teams who had been waiting for an average of 37 weeks. 54% of young people had breached the trust's target of 84 days of being seen for treatment following their assessment.
- The manager for the east teams had several overdue incident reports to review.
- Some staff in the east teams were not keeping the wait list up to date.

Summary of findings

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

Are services safe?

Inadequate

This was a focussed inspection so we did not rate this domain. We found that:

- Since our inspection in March 2019, the trust had invested in a significant recruitment drive and on the day of our inspection, we found that most clinical vacancies had now been filled. In addition to filling their vacancies, the trust had appointed 31 clinical associate psychologists who worked in local schools and also supported the locality teams to complete assessments.
- The trust had developed and embedded an escalation plan for locality team managers to follow should any staffing incidents occur that might impact on service delivery. This was being monitored and supported by the operational managers and other senior staff members.
- The trust had developed and implemented new electronic caseloads, with reporting functions, to ensure staff and managers knew how many young people were waiting and how many had been allocated a care co-ordinator. Although overall team caseloads remained high, individual staff caseloads were now much lower due to the increase in staffing and transparency in viewing caseloads on the new electronic system. The trust had reviewed the team manager's job description to enable them to concentrate on the safe running of their service rather than having an active clinical role. This meant that new managers would no longer carry a caseload.
- Since our inspection in March 2019, every young person on the waiting list had been reviewed and contacted. Urgent and emergency cases were being followed up by the CAMHS crisis team or early intervention in psychosis team as required. The crisis team undertook a thorough assessment including an assessment of risk after the first appointment. Urgent cases were seen within 48 hours. Young people on the waiting list were being contacted regularly to ensure staff were aware of any change in presentation or risk.
- All staff had received training on incident reporting and there had been a significant rise in reporting incidents since our last inspection. Reviewing and learning from incidents was a standing agenda item on team meeting minutes and we saw evidence of incidents being discussed in these and other meeting minutes.

However:

Summary of findings

- The manager for the east teams had several incidents reports waiting for a response which were overdue.

Are services effective?
Since our inspection in March 2019 we have received no information that would make us re-inspect this key question.

Requires improvement 

Are services caring?
Since our inspection in March 2019 we have received no information that would make us re-inspect this key question.

Good 

Are services responsive to people's needs?
This was a focussed inspection so we did not rate this domain. We found that:

- At the time of our inspection, 73% of young people in the east teams had breached the trust's target of being seen within 28 days for an initial assessment. Current wait times for a first assessment was 117 days (17 weeks) in the east teams.
- Fifty four per cent of young people in the east teams had breached the trust's target of 84 days of being seen for treatment following their assessment. There were 47 young people waiting for treatment at the time of our inspection. They had been waiting for an average of 37 weeks.
- Some staff in the east teams had not kept the new electronic spreadsheet up to date which meant their waiting list was inaccurate.

However:

- Since our inspection in March 2019, the trust had developed and implemented a new electronic spreadsheet, with reporting functions, to ensure appropriate management of waiting lists within teams. This new system was risk based, easily accessed and transparent. The spreadsheet was embedded into the trust's shared electronic database which meant staff could click onto a young person's name and directly access their care records. This meant that staff were more aware of the young person's level of risk, all previous contact and how long they had been waiting for, when reviewing the waiting list.
- The trust had developed an operational plan to address the long waits for a first assessment. The waiting list recovery trajectory described the current and future waiting list profiles, showing those expected to be waiting more than 28 days and the median length of wait on the last day of each month.

Inadequate 

Summary of findings

- The teams in the mid had significantly reduced their wait times for an initial assessment and there were only 16 young people who had waited longer than 28 days for an initial assessment. The teams had reduced their average wait down to 26 days for an initial assessment.
- The teams in the mid had significantly reduced their wait time from assessment to treatment and there were only six young people who had breached the trust's target of waiting 84 days for treatment. At the time of our inspection, there were 15 young people waiting for treatment who had waited for an average of 13 weeks.
- Complaints were all now logged with the Patient Advice and Liaison Service (PALS). Managers could access complaints made to PALS and learning from complaints was now documented in team meeting minutes.

Are services well-led?

Inadequate

This was a focussed inspection so we did not rate this domain. We found that:

- Since our inspection in March 2019, the trust had created additional posts to provide increased support and oversight for the locality team managers. Team managers had received additional training and supervision. The trust had reviewed the team manager job description and removed the clinical aspect of their role for new managers. This meant that team managers could concentrate on the safe running of their service and implementing critical changes to the service they provided, rather than having to conduct assessments for young people due to having insufficient staff in their teams.
- Staff morale had increased and staff said they felt safer working in their teams due to having filled their vacancies.
- The trust had developed systems and processes which meant they had complete oversight of the key issues raised in the warning notice. Operational managers and other senior members of staff could immediately access a live waiting list which they monitored and audited to ensure waiting times were reducing and high risk young people were being seen. Staffing issues were known to the senior management team via a new escalation process and incident reporting and complaints were being monitored through operational governance meetings.
- The operational manager carried out regular audits such as auditing regular telephone contact for young people on the waiting list, case record audits to check risk had been updated and caseload management for staff during their supervision.

Summary of findings

- Staff received increased engagement and health and wellbeing support was now provided to their teams. Wellbeing leads had visited the teams and staff were given more time to focus on their welfare.
- The trust had developed ways for staff to become more engaged. For example, a CAMHS staff clinical board had been created for further ward to board discussions with a focus on innovative change and development throughout the service. Champion roles were being developed within the teams and staff were taking part in surveys to feedback about the quality of their service and leadership.

Summary of findings

Information about the service

Cornwall Partnership NHS Foundation Trust provides specialist community child and adolescent mental health services (CAMHS) for the whole of Cornwall and the Isles of Scilly. The service provides care and treatment to children and young people with emotional, behavioural or mental health issues. The service includes specialist mental health teams and specialist teams for children with learning disabilities and eating disorders. The service also provides primary care services, crisis teams and clinical associate psychologists based in local schools and local teams. The service is divided into three geographically based teams located in the east, mid and west Cornwall. The three teams deliver services from seven bases across Cornwall.

The service was last inspected in March 2019 when we rated the core service as inadequate overall. We rated the key questions, are services safe, are services responsive and are services well-led as inadequate. We rated the key question, are services effective as requires improvement, and the key question, are services caring as good. Following our inspection in March 2019, we issued the trust with a section 29a warning notice under the Health and Social Care Act 2008. The reasons for the warning notice were as follows:

Children and young people in the mid and east teams were not getting safe care and treatment due to:

- not having sufficient staff
- risk not being considered appropriately
- a lack of governance and oversight of these issues at both the service level and at trust level.

Since the inspection in March 2019, the trust has worked closely with stakeholders and commissioners to make significant improvements to the care provided and the systems to deliver this care safely. The trust have continued to report on their improvements during regular engagement meetings with the Care Quality Commission and have also delivered assurances to their Board of Governors and NHS England.

During the unannounced focused inspection on 02 October 2019, we found that the trust had met all the requirements of the warning notice.

Our inspection team

The team that inspected the service comprised two CQC inspectors.

Why we carried out this inspection

We inspected this service to follow up on the improvements required in the section 29a warning notice issued to the trust in April 2019.

How we carried out this inspection

As this was a focussed inspection to assess the improvements required following the issuing of a warning notice, we did not inspect all key lines of enquiry.

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of findings

- spoke with the two service managers, the operational manager and the head of psychology
- spoke with two nurses and one consultant psychiatrist
- reviewed a range of meeting minutes and documents

and

- reviewed the records for 17 young people.

Areas for improvement

Action the provider MUST take to improve

- The provider must continue to work towards reducing wait times for young people to be assessed and then seen for treatment in the east teams. (Regulation 9)

Action the provider SHOULD take to improve

- The provider should monitor that incident reports in the east teams are reviewed and recommendations sent back to staff in a timely manner.
- The provider should check that staff in the east teams are keeping the waiting list spreadsheet up to date following appointments and discharges.

Cornwall Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Specialist community mental health services for children and young people	Head office

Inadequate

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 staffing

- Since our inspection in March 2019, the trust had invested in a significant recruitment drive and on the day of our inspection, we found that most clinical vacancies had been filled. There was only one part time band six vacancy in the mid teams and one band six vacancy in the east teams. There had been 31 new clinical associate psychologists appointed, 11 in the mid and eight in the east, who worked with the local teams and in local schools. A new operational manager had been appointed alongside the current postholder, to provide support and oversee the recruitment drive in each of the teams. Additional support posts, such as a quality lead and a data analyst had been created and appointed to.
- The teams comprised psychologists, registered mental health nurses, family therapists, an art therapist, primary mental health workers and psychotherapists. There was a dedicated consultant psychiatrist for the mid team in St Austell. There was a vacancy for a consultant psychiatrist in the east team but this was temporarily being supported by locums.
- Over the past 12 months, there were a total of 7.2 full time equivalent staff who had left the organisation. However, these figures included leavers from the west team, who we did not inspect and there was no turnover in five out of seven months. In the remaining months, as a percentage of staff in post, turnover rates varied between 0.50% and 2.49 % per full time equivalent.
- Escalation plans had been established which provided direction for managers when they could not meet staffing levels due to acuity levels or staffing numbers. The escalation plan was colour coded and gave specific instruction of when to escalate a staffing concern and how. They detailed triggers, actions and response expectations. Managers shared monthly staffing updates with teams to accurately reflect staffing levels across the county. Since most vacancies had been filled, the teams had moved from amber to green.
- Any staffing related incidents were reported via the trust's incident reporting system. The CAMHS risk register also picked up any themes. During our inspection, there was a staffing related incident on the team's risk register which had been reviewed by the operational manager. A control was in place and the incident was due to be reviewed again the following day.
- Since our inspection in March 2019, managers had been given control of a budget so they were able to manage their own staff establishment and could request more admin support when required.
- Staff we spoke to said the teams felt safer as a result of the successful recruitment drive and due to the fact that their manager had more time to support them.
- Since our inspection in March 2019, the trust had developed and implemented new electronic caseloads, with reporting functions, to ensure appropriate management of young people using the service. Although overall team case loads remained high, the trust had made significant improvements with their ability to oversee these young people since the last inspection.
- In the mid teams, there were 509 young people on the team caseload in total. 348 of these young people had been allocated a care co-ordinator. The remaining 161 had been seen and had been referred for either assessment or treatment. Eighty-seven of these young people were waiting for an initial assessment and 12 who had received an initial assessment were awaiting therapy. Sixty-two of these young people were on the primary mental health team's caseload. The team manager for the mid teams had 10 young people allocated to their caseload on the trust's shared electronic system, but this was a data inputting error which the manager contacted the appropriate team to remove that day. The average number of people on a full time member of staff's caseload in the mid teams was 15 young people.
- In the east teams, there were 399 young people on the whole team case load. 211 had been allocated and were being seen. This left 188 young people; 120 were waiting for their initial assessment and 68 had been initially assessed and were awaiting follow up.
- The manager in the east had 42 young people on their caseload, who had been assessed and were receiving treatment. This was due to the manager still retaining

their clinical function and needing to oversee more complex cases. These young people were already on an allocations list in preparation of the manager for the east teams leaving and the new manager being non-clinical. Staff in the east teams had higher caseloads as they were holding caseloads for locum consultant psychiatrists, due to the consultant vacancy in the team. However, the average number of people on a full time member of staff's caseload was only 11 young people.

- Caseload reviews were completed as part of the clinical supervision process which took place approximately every 6 weeks as the trust policy indicated. Where the date range fell outside of this policy, we saw this was due to annual leave or manager absence due to illness.
- All staff were expected to hold one day per week for assessments, which left four days a week for interventions and admin tasks. Teams held assessment clinics where there was between six and 12 assessment slots per week in each locality. Managers routinely held one slot per week open for emergency or urgent cases to be seen.

Assessing and managing risk to patients and staff

- We looked at 17 care records. Urgent and emergency cases were being followed up by the CAMHS crisis team or early interventions in psychosis team as required. The crisis team undertook a thorough assessment including an assessment of risk after the first appointment. Urgent cases were seen within 48 hours. Young people in crisis were given contact information for telephone and online services they could contact if they were in crisis. Staff from primary mental health teams had a booked slot in the CAMHS team meetings which gave them the opportunity to discuss complex and urgent cases.
- Care records included discussions about young people from multidisciplinary team meetings.
- There was evidence that young people or families received regular calls from the CAMHS team while they were waiting. These were called wellbeing or welfare calls. These structured calls were completed by administrative staff who would arrange for contact to be made by the duty clinician if the young person or carer required it. Administrative staff had not received specific training to undertake these calls. However, the operational manager explained to us that administrative staff were experienced in speaking to young people and their families and they followed a script to help structure the calls. These calls took place at a frequency agreed with the young person or their family on a weekly, fortnightly or monthly basis. It was not always clear on the care records how often the call should take place. In some cases, this information was displayed on a pop-up upon entering the care record.
- Since April 2019, most young people that had not been risk assessed and had waited an extended length of time had crisis and contingency plans. The reason a formal risk assessment had not been completed was due to the fact staff had not yet met the young person so therefore did not have adequate information to complete a full assessment. One young person from the east teams should have had a crisis and contingency plan but did not. The young person had received a call from the administration team but only after their case was identified by the operational manager during an audit. They had been waiting since June 2019 and were high priority.
- The operational manager told us they audited at least five cases per month. Two cases that had been waiting for an extended length of time in the east teams had been identified by the operational manager during an audit. One was provided with a welfare check and another was prioritised. On finding concerns, the operational manager had reviewed every case on the waiting list in a recent audit.

Track record on safety

- Following our inspection in March 2019, the trust carried out three serious case reviews on the urgent cases we found and identified as high risk during our random care record review. All three had received a thorough review, root cause analysis and we saw that duty of candour had been applied. The trust had shared the lessons learned from these cases across the organisation and with NHS England. We saw that all urgent and high risk young people were now being seen in a timely manner.

Reporting incidents and learning from when things go wrong

- Since our inspection in March 2019, the trust had delivered training relating to risk and incident management to all CAMHS teams, with ongoing support provided.
- The education and training for the CAMHS teams consisted of a focus group approach, as each team had their own concerns and challenges that they wished to

discuss. The format of the sessions included; what constituted an incident, how it affected young people, staff and the organisation and how to report using the incident management system in a timely way. The serious incident process and duty of candour was covered, as were essential skills and techniques for managing an incident, including escalation. This linked with risk identification and management and the correlation between incidents and complaints.

- Staff confirmed that the risk team had attended their multi-disciplinary team (MDT) meetings to deliver training and develop understanding around reporting incidents. Staff had since increased their understanding around looking at themes and understanding the most appropriate pathways for young people. Staff said they were now more open and transparent when it came to reporting incidents.
- The operational manager received daily, weekly and monthly reports of all incidents. The team managers received an email notification when each incident was reported. They then reviewed the incident and made recommendations before sending it back to the staff member. At the time of our inspection, the manager for the east teams had several incident reports that were waiting for a response.
- All incidents were reviewed at the teams' weekly MDT. We reviewed MDT meeting minutes and saw that incidents review was now a standardised agenda item. Minutes from MDT meetings were sent out to all staff by a member of the admin team. Incidents were also analysed by the operational manager who presented themes and trends at monthly operational governance meetings. Following this discussion, action plans were developed for the teams to adopt. These action plans were discussed at MDT.
- We reviewed graphs relating to the reporting of incidents over the past 12 months and saw that there had been a sharp rise in incident reporting since our inspection in March 2019.

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

Since our inspection in March 2019 we have received no information that would make us re-inspect this key question.

Good

Are services caring?

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

Our findings

Since our inspection in March 2019 we have received no information that would make us re-inspect this key question.

Are services responsive to people's needs?

Inadequate

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

Our findings

Access and discharge

- Since our inspection in March 2019, the trust had developed and implemented new electronic caseloads, with reporting functions, to ensure appropriate management of waiting lists within teams. This new system was clear, showed everyone on the team's caseload and showed easily how long people had been waiting for and how urgent their case was. The spreadsheet was embedded into the trust's shared electronic database which meant staff could click onto a young person's name and directly access their care records. This meant that staff were more aware of the young person's level of risk and all previous contact when reviewing the waiting list.
- Although this new system was in place, some staff in the east teams were not keeping records up to date. For example, there was a function on the wait screen to remove a young person when they had been seen. Some clinicians had not completed this task, which meant the figures on the spreadsheet were not accurate. However, this did not impact on the safe oversight of young people on the list.
- The trust had developed an operational plan to address the long waits for a first assessment. This was supported by a waiting list model which described the way in which both the numbers waiting for assessment and the length of that wait would reduce over the coming weeks and months. This plan was discussed at the trust's 'quality and governance committee' meeting in September 2019. The waiting list recovery trajectory described the current and future waiting list profiles, showing those expected to be waiting more than 28 days and the median length of wait on the last day of each month.
- The number of young people on the waiting list waiting longer than 28 days had reduced by more than 50 young people since the additional clinical associate psychologists had been in place.
- Despite the trust putting new systems and plans in place and wait times reducing from our last inspection, there were still long wait times from referral to assessment in the east teams. Out of a total caseload of 399 young people in the east teams, there were 120 young people waiting for an initial assessment, who had been referred into the service. 87 of these young people had exceeded the trust's target of 28 days to be seen and only 11 out of these 87 had an appointment booked. At the time of our inspection, the wait time for a first assessment was 117 days (17 weeks) in the east teams.
- Out of a total caseload of 509 young people in the mid team, there were 87 young people waiting for an initial assessment. Sixteen of these young people had breached the trust's target of 28 days from referral to initial assessment. At the time of our inspection, the wait time for a first assessment was 26 days (4 weeks) in the mid teams.
- There were long waits from assessment to treatment in the east teams. At the time of our inspection, there were 68 young people who had been assessed and were waiting for treatment. 37 of these had exceeded the trust's target of 84 days waiting. The average wait time from assessment to treatment at the time of our inspection was 37 weeks.
- From 1 April to 30 September 2019, 58 young people had been seen and had waited more than 126 days for treatment. At the time of our inspection, this had reduced to four young people who had been seen and had waited over 126 days for treatment.
- In the mid teams, there were 12 young people who had been assessed and were waiting for treatment. Six of these had breached the trust's target of 84 days. The average wait time from assessment to treatment at the time of our inspection was 13 weeks. From 1 April to 30 September 2019, 41 young people had been seen and had waited over 126 days for treatment. At the time of our inspection, no one had waited over 126 days for treatment in the mid teams.
- The trust had put safety protocols into place to monitor any changes to risk for young people on the waiting list and this was being overseen and audited by senior managers. Therefore, the risk was being managed and overseen even though the wait time for treatment was still breaching the trust's targets.

Listening to and learning from concerns and complaints

- Since our inspection in March 2019, we saw that complaints had been added as a standing agenda item to both teams' meeting minutes template. Managers

Are services responsive to people's needs?

Inadequate

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

could now access PALS to review any complaints made and PALS contacted the teams if they received a new complaint. PALS also followed up on any complaints that had breached the trust's response time. The trust's governance team had oversight of any complaints the teams received. Managers could add a complaint onto the team's incident management system so it was logged and reviewed.

- Recent training provided by the trust offered an opportunity to discuss how the governance and PALS team could support staff in practice and the patient experience lead offered support with local resolution and facilitation if required.

Are services well-led?

Inadequate

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

Leadership

- Since our inspection in March 2019, the trust had appointed a second operational manager, meaning there was increased support and oversight for the locality team managers. Team managers had received additional training and supervision. The trust had reviewed the team manager's job description and removed the clinical aspect of their role. This meant the team managers could concentrate on the safe running of their service and implementing critical changes to the service they provided, rather than having to conduct assessments for young people due to having insufficient staff in their teams.

Culture

- Staff said that the increase in staffing numbers and the introduction of clinical associate psychologists had increased the teams' morale and made them feel like they were providing a safer service.
- Staff were encouraged to access one hour of 'wellbeing time' per fortnight.
- Staff in the east teams had created a 'box of joy' in the staff office which contained items designed to match staff interest. Staff could contribute and take away items as they pleased.

Governance

- Since our inspection in March 2019, the trust developed systems and processes which meant they had complete oversight of the key issues presented to them in the warning notice. Operational managers and other senior members of staff could immediately access a live waiting list which they monitored and audited to ensure waiting times were reducing and high risk young people were being seen.
- The trust now had oversight of staffing vacancies and any issues that might affect the delivery of the CAMHS service via monitoring tools, the staffing escalation process and via regular audits and reports to the board.
- The trust had direct access to incident reporting data for each team, which included themes, trends and action plans. Any incidents relating to unsafe staffing were escalated straight onto the risk register. Complaints were also monitored more thoroughly with support from PALS.
- We reviewed a number of audits completed by the operational manager. One audit, completed in September 2019, monitored the frequency of telephone contact with young people on the waiting list for an initial assessment. The audit found that the teams were 97% compliant in their agreed and attempted calls to young people and listed a number of recommendations, such as ensuring all attempted contact is recorded on the trust's shared electronic database. Where contact was attempted but not successful, records showed that the teams then made contact with another party, such as the school, GP or family member to ensure they knew the status of the young person's wellbeing.
- We reviewed audits completed following a review of random care records within the teams. The auditor checked if essential information was contained in the care plan and up to date. If the information was not adequate, the auditor made a comment which the care co-ordinator was then responsible for actioning.

Engagement

- Staff received increased engagement and health and wellbeing support provided to their teams. Wellbeing leads had attended a team away day and staff were given more time to focus on their welfare. We reviewed governance meeting minutes for August and saw that a 'staff health and wellbeing' discussion had been recorded and that a member of the wellbeing team had attended the meeting. Staff had been trained in mental health first aid and there was a wellbeing page on the intranet.
- Staff had recently taken part in a staff survey and created a cultural barometer as a result, which detailed what staff thought of the service and their managers. The operational manager had identified that relationships could be improved and so has organised a whole team away day to bring the whole county together.
- A CAMHS staff clinical board had been created for further ward to board discussions with a focus on innovative change and development throughout the service.

Are services well-led?

Inadequate

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.

- Managers had developed champion roles within the teams. For example, a safeguarding champion in each location who provided safeguarding supervision about children on protection plans. Managers were developing wellbeing champions and had booked people into continuous professional development slots in the weekly MDT.

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 9 HSCA (RA) Regulations 2014 Person-centred care Young people were not receiving appropriate care and treatment due to being on a long waiting list in the east teams. This was a breach of regulation 9 (1) (a) (b) (c)