Requires improvement

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)
RJ8X7	Trust Headquarters	West Cornwall CAMHS	TR18 2AB
RJ8X7	Trust Headquarters	East Cornwall CAMHS	PL26 7DQ

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

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Cornwall Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cornwall 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?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Good** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated specialist community mental health services for children and young people as **requires improvement** because:

- The service was not able to respond to the needs of all children and young people who might benefit, because the criteria for access were so high that children and young people had to be seriously ill before they were accepted. There had been a significant increase in the number of referrals over the previous two years but no increase in funding. As such, in discussions with Kernow Clinical Commissioning Group the trust had to raise the criteria for when to accept children and young people into the service.
- All referrals were triaged through a single hub by members of the CAMHS team. If the child or young person did not meet the criteria for CAMHS, they would then be signposted to a range of other services. Staff, children, young people, and their families all said that the other services, despite being of good quality, could not always meet the needs of children and young people and as such, their mental health would deteriorate. Once their mental health had deteriorated to a level where they met the criteria, they would then be accepted into CAMHS. If a child or young person went into crisis, they would be seen quickly.
- Waiting times varied across the teams. The longest waiting times were in the east team where one young person had been waiting five months for an initial assessment. The trust did not meet the 28-day referral to assessment set by commissioners. The waiting time across the service was between two and three months.
- The physical environments at Bolitho House, Truro Health Park and St Austell needed improvements. None of the waiting rooms were child and young person friendly and they offered no age-appropriate books, toys, games or information leaflets. At St Austell 26 staff had to use one toilet in a facility that smelt damp and needed redecoration.
- Staff members had not ensured that the scales used to weigh children and young people and blood pressure monitors were calibrated in the east or west sites.
- Children and young people had unsupervised access to knives and other dangerous objects in the staff kitchen in the Truro site.
- The service did not always provide families with copies of letters or care plans.
- The trust did not ensure cleaning fluids were always stored safely.

However:

- Children and young people and their families were extremely positive about the care they received once they had accessed the service. Children and young people in crisis received a prompt service.
- Teams ensured there were detailed assessments of children and young people's needs. Care plans reflected the assessed needs and, in the main, were recovery focused.
- Staff provided an out-of-hours advice service to colleagues in other organisations should they be worried about the mental health of a child or young person. They were commissioned to provide an on-call clinician to provide advice to professionals working with young people out of hours.
- The staff we met were conscientious, professional and committed to doing the best they could for the children and young people in their care.
- Senior managers in the service were well aware of the impact that increasing the threshold for access to services was having and had a detailed knowledge of all of the risks in the services. These risks had been escalated to the trust senior leadership team and were high on the trust agenda. The senior leaders and service managers were addressing staffing shortfalls by having an active recruitment programme to fill vacancies. The trust senior leaders were actively working with Kernow Clinical Commissioning group to find a resolution to all of these issues.
- At the time of the inspection staff felt under pressure due to vacancies of some key disciplines such as

clinical psychologists. However, the trust recruited a psychologist in the east team who started work shortly after the inspection. Staff felt this would alleviate some of the pressure they were under.

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:

- The physical environments at Bolitho House, Truro Health Park and St Austell needed improvements, which included some basic maintenance. In Truro Health Park children and young people could easily access a kitchen with a variety of dangerous objects and alarm systems were not consistently used. At Bolitho House children and young people could be seen in a clinic rooms in the adult service but no risk assessment had been completed regarding this. At St Austell 26 staff had to use one toilet in a facility that smelt damp and was in need of redecoration.
- Clinicians across all terms, children and young people and their families said the service was understaffed and this affected access to the service, waiting times and staff morale. It was difficult to identify exactly what the staffing establishments should be for each team, as the trust could not provide us with any consistent information about staffing levels.
- Caseloads were variable across the service. In the east, caseloads were high, with up to 85 children and young people to each full time clinician. Staff stated that they were very busy and they felt these numbers were not manageable. Caseloads were smaller in the west (16 to 30 to each clinician).
- Staff members had not ensured that the scales used to weigh children and young people were calibrated in the east or west sites.
- All staff that we spoke with knew how to report incidents. Staff were able to describe learning from incidents that had taken place.
- Staff were trained in safeguarding and knew how to make a safeguarding alert.

Are services effective?

Good 

We rated effective as **good** because:

- Children, young people and carers were very positive about the CAMHS learning disability service and the eating disorder service. They told us they valued the service they received and found it beneficial.

Summary of findings

- Staff teams ensured there were detailed assessments of children and young peoples' needs, which were holistic and recovery focused.
- Children and young people were provided with a variety of different therapies and treatments recommended by the National Institute for Health and Care Excellence and staff were extremely skilled at working with children, young people and their families.
- We saw evidence of good working with other health colleagues outside the service, in particular some of the joint working with paediatricians.
- Staff had a good understanding of the Mental Health Act and the Code of Practice and Gillick competency.

However:

- At the time of the inspection, there were psychologist vacancies in the east team that influenced staff morale.

Are services caring?

Good

We rated caring as **good** because:

- Staff within the service were caring and respectful. Staff showed in depth knowledge and understanding of all the needs of the young people and their families, using the service.
- Staff were conscientious, professional and committed to doing the best they could for the people in their care. Staff often worked over their hours to ensure children and young people received a service.
- Children, young people and their families who used the service all gave very positive feedback about the staff within the service.
- Children, young people were actively involved in staff recruitment.

However:

- The majority of records in the west teams did not detail whether or not children and young people had been involved in completing the care plan or had received a copy of their own care plan.

Are services responsive to people's needs?

Requires improvement

We rated responsive as inadequate because:

Summary of findings

- The service was not able to respond to the needs of all the children and young people who might benefit from the service because the access criteria was so high children and young people had to be seriously ill before they were accepted. There had been a significant increase in the number of referrals over the last two years but no increase in funding.
- All referrals were triaged through a single hub by members of the CAMHS team. If the referral did not meet the criteria for CAMHS they would then be signposted to a range of other services. Staff, children, young people and their families all said that the other services, despite being of good quality, could not always meet the needs of children and young people and as such their mental health would significantly deteriorate.
- Waiting times varied across the teams. The longest waiting times were in the east team; one young person had been waiting five months for an initial assessment. The trust was not meeting the 28-day referral to assessment set by commissioners. The waiting time across the service was between two and three months.
- There were 19 children and young people waiting to see a psychiatrist in the west. The longest waits were experienced by children and young people in the autistic spectrum disorder (ASD) service. Those we spoke with said the wait was long. One young person waited 24 months for a service.
- Staff in the east team frequently had to cancel appointments to prioritise seeing children and young people in crisis and were then unable to offer another timely appointment due to the workload.
- The waiting rooms were not child and young people friendly and did not offer a range of age appropriate books, toys, games and information leaflets.
- There was an inconsistent range of information provided for children and young people who visited each location.

However:

- There were clear arrangements for children and young people under 16 who could be admitted to a paediatric ward whilst waiting for an assessment.
- There were plans in place to develop a tier four CAMHS (inpatient service) by 2019.

Summary of findings

Are services well-led?

Good

We rated well led as good because:

- Senior managers were making every effort to ensure the service was delivered to a high standard. Staff, children, and young people that we spoke with confirmed that once they accessed CAMHS the service they received was of a high quality and delivered by skilled and experience practioners.
- Senior managers in the service were well aware of the impact of increasing the threshold for access to services. They had a detailed knowledge of all of the risks in the services. These risks had been escalated to the trust senior leadership team and the risks were high on the trust agenda. The senior leaders and service managers had an active recruitment programme to fill vacancies. The trust senior leaders were actively working with Kernow Clinical Commissioning group to find a resolution to all of these issues.
- All staff we spoke with were familiar with the trust's visions and values.
- There was good local support from managers and clear clinical leadership.
- Staff appraisal and supervision rates were good across the service.
- Managers ensured that opportunities for involving children and young people in the running of the service and learning from feedback were optimised.
- Staff knew how to use the trust's whistle-blowing process. Staff told us that they felt able to raise with the trust any concerns they might have about patient care or treatment.
- All teams were enthusiastic, passionate about their work, hardworking and mutually supportive of each other.

However:

- The governance systems in the west team were not effective as they had not ensured that all young people's files had a risk assessment.
- Morale was low in some of the staff teams.

Summary of findings

Information about the service

Cornwall Partnership NHS Foundation NHS Trust provides tier three specialist community child and adolescent mental health services (CAMHS) for the whole of Cornwall. The service helps children and young people deal with emotional, behavioural or mental health issues. The service includes specialist mental health teams and specialist teams for children with a learning disability andeating disorders. The service also provides some tier two services through primary mental health workers attached to schools. The service is split into three teams (east mid and west Cornwall teams) and operates from three main sites although there are seven bases from which the team delivered care. Since the last inspection in 2015 the service has been reorganised and the mid Cornwall team has now moved to Truro Health Park.

Our inspection team

The inspection of Cornwall Partnership NHS Foundation trust was led by:

Karen Bennett-Wilson, head of hospitals inspection, supported by Michelle McLeavy, inspection manager, mental health and Mandy Williams inspection manager, community health.

The team that inspected specialist community mental health services for children and young people comprised of a Care Quality Commission (CQC) inspector, Jackie Sullivan (inspection team lead), the head of hospital inspection, two specialist advisors with clinical experience of working in children and young people's mental health services and one expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them.

Why we carried out this inspection

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

The trust merged with Peninsula Community Healthcare NHS Trust in April 2016 and as such, we always undertake a comprehensive inspection at an appropriate time following a merger.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about this service, asked a range of other organisations for information and sought feedback from children and young people at three focus groups.

During the inspection visit, the inspection team:

- visited four of the clinic bases CAHMS services were delivered from and looked at the quality of the environment and whether it was suitable for young people to use
- spoke with 32 young people and children who used the service
- spoke with the managers for each team
- spoke with 36 other staff members; including psychologists, nurses and in-reach practitioners
- interviewed the clinical lead with responsibility for these services

Summary of findings

- attended and observed three multidisciplinary meetings
- collected feedback from 12 children and young people/carers using comment cards.
- looked at 28 treatment records of young people
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Children and young people and their families and carers were very positive about the service they received. They told us that the staff worked hard, understood their needs and offered practical help and support to help children and young people recover.

They said staff kept the parents and carers informed and involved appropriately.

Children and young people, and their families and carers, told us there was a long wait to initially get into the service. Twelve young people and carers we spoke with said they had to be unwell to get a timely service and were often referred several times before they met the threshold set by the service for treatment. Some talked about having to self-harm before the service saw them.

The longest waits were experienced by children and young people waiting for treatment in the autistic spectrum disorder (ASD) service. Those we spoke with said the wait was long. One young person waited 24 months for a service.

Areas for improvement

Action the provider MUST take to improve

- The trust must continue to work with commissioners to review access to tier 3 CAMHS provision across Cornwall to ensure that all children and young people receive a service in a timely manner.
- The trust must ensure all areas accessible by staff and children and young people at the locations inspected are safe, well-maintained and age appropriate. Children and young people must not have unsupervised access to knives and other dangerous objects in the staff kitchen in the Truro site.

Action the provider SHOULD take to improve

- The trust should ensure staff consistently use their personal alarms.
- The trust should ensure that equipment like weighing scales and blood pressure monitors were well maintained.
- The trust should ensure cleaning fluids were stored safely.
- The trust should take steps to ensure staff record their assessments of young people's physical healthcare needs.
- The trust should ensure children and young people were involved in developing their care plan and that they have received a copy as appropriate.
- The trust should ensure that there is a range of relevant information provided at each location for children, young people and their families.

Cornwall 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
West Cornwall CAMHS	Bolitho House, Penzance
East Cornwall CAMHS	Heathlands, Liskeard

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

All community staff had attended training related to understanding of the Mental Health Act.

Staff within the service were aware of how to access support and guidance within the trust if necessary.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had completed decision specific capacity assessments for patients lacking the capacity to do so themselves. Staff recorded best interest decisions in patient records detailing the five statutory principles. The teams attended best interest meetings where necessary and family and carers were invited

Gillick competence assessments were referred to and completed for young people. Children under 16 years need to be assessed whether they have enough understanding to make up their own mind about the benefits and risks of treatment – this is termed 'Gillick competence'.

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

- Interview rooms in Truro did not have alarms or panic buttons to enable staff to summon help in an emergency or respond quickly should an emergency arise whilst undertaking therapy sessions with children and young people. Staff had access to personal alarms but did not always use them.
- Environments on some site, accessible by staff and children and young people were not well maintained. For example, in the St Austell site, in the east of the service, the waiting room was small and cramped. It was used as a thorough fare for staff from other services to go upstairs. The staff used a building a few minutes' walk from the clinic. This was in need of redecoration and crowded. It smelt damp and 26 staff shared one toilet.
- The Liskeard site was well maintained but excess stock, such as cleaning fluid were not locked away securely. It was stored in the toilets in the waiting room and in various rooms throughout the clinic.
- In the Truro site, the team shared an office space with children's services. They had a small interview room and two clinic rooms which had to be booked prior to use. The rooms were stark and not child/young people friendly. Staff members told us that last year, on four occasions; young people had left the interview room in a distressed state and easily accessed the GP waiting room on the same site. On leaving the upstairs interview room they could access a kitchen which, on the day of inspection, was open and unattended. In the kitchen there was a variety of dangerous objects including knives. There were no risk assessments about this issue. At Bolitho House in Penzance the staff team shared a building with adult mental health services. The CAMHS team escorted young people when they needed to use the clinic room on the adult mental health side. At the last inspection in 2015 we recommended that risk assessments were in place to ensure that the shared usage of space was safe for children. At this inspection we saw that these were still not in place. Staff, children and young people continued to use this area in the adult services.
- The scales, in the east and west sites, used to weigh children, and young people had not been calibrated correctly. There were no records that blood pressure monitors were regularly calibrated and in good working order. There were no consistent cleaning schedules for equipment.

Safe staffing

- At the time of the inspection, staff told us repeatedly that they felt under pressure due to vacancies of some key disciplines such as clinical psychologists. This was particularly evident in the east team. Clinicians across all terms, children, young people and their families said the service had been understaffed and this impacted access to the service, waiting times and staff morale.
- However, the trust had an active recruitment programme and had recently filled a number of vacancies. For example, a psychologist started work in the east team shortly after the inspection.
- The team manager could not tell us what the staffing establishment for each team was. However, managers in both the east and mid teams told us that at the point of inspection, they did not have enough staff to accept all the children and young people that they felt needed CAMHS, and to undertake an initial assessment to decide what specialist input a child or young person might need. They recognised that the new staff would have a positive impact on some teams.
- The specialist teams such as the learning difficulty team, the eating disorder team and the primary mental health care team were all fully staffed. However, the eating disorder and primary mental health care team were staffed by staff from the east, mid and west CAMHS teams which impacted on the staff available to provide a generic CAMHS service.
- The autism spectrum disorder team had a clinical psychologist and consultant psychiatrist vacancy.
- Clinicians across the teams said that caseloads in some teams had reduced since our inspection in 2015. The

severity of the illness of the children and young people being treated had increased. Caseloads were smaller in the west of the service (16 and 30 per clinician). In the east of the service caseloads were much higher, up to 85 per full time clinician. Staff stated that they were very busy and they felt these numbers were not manageable.

- Staff members in each team made their own arrangements to cover sickness and leave and there was low use of bank staff.
- Staff members across all the teams were up to date with their mandatory training. This training included areas of learning essential for safe practice such as safeguarding children and basic life support. The trust's training records showed that 85% of staff across the teams had completed mandatory training.

Assessing and managing risk to patients and staff

- Children and young people had up to date risk assessments. We looked at 28 care records across the teams inspected. In 25 of the 28 files risk assessments were in place and were generally up to date. In the west team only three of the six files we reviewed had a risk assessment, but in all other teams risk were consistently assessed and recorded, and where necessary a risk plan was in place. Crisis plans were completed as necessary as part of the recorded risk assessment.
- Staff saw and assessed urgent and crisis referrals quickly and every effort was made to respond to less urgent referrals according to identified risks. Although we found staff were assessing and managing risks appropriately, staff in each of the teams said they felt that managing risk effectively was becoming increasingly difficult. Staff, from each of the teams, told us that in the last two years there had been an increase in the level of risk and severity of illness of the children and young people they saw, following the decision to raise the criteria/eligibility for the service.
- Clinicians, carers and young people we spoke with were concerned that the health of children and young people had to deteriorate so significantly before they met the criteria to be seen by CAMHS.
- Staff were trained in safeguarding and knew how to make a safeguarding alert. The east team had a staff member on secondment from the trust's central safeguarding team to help them learn about safeguarding, liaise with local authorities. They were working with the local authorities to develop learning about why some safeguarding referrals were not accepted.
- Appropriate systems were in place to help keep staff safe and secure. Staff followed clear lone working and personal safety protocols, which helped to ensure their safety when out in the community or when supporting children and young people back at the community bases. For example, in St Austell the reception staff kept a log of staff movements and staff called in if they were delayed. Staff members said the system worked well.

Track record on safety

- The trust reported that there had been no serious incidents involving children and young people being seen by the service in the 12 months prior to our inspection.

Reporting incidents and learning from when things go wrong

- All staff spoken with knew how to report incidents. The service used an electronic system to report incidents and these were investigated by the manager of each team. Learning was feedback to the team via team meetings.
- Staff members were able to provide examples of how they had been open and transparent with children, young people and their carers when something went wrong. For example, one team explained they had apologised to a young person about sharing of information (without consent) and the impact that this has had upon them. Staff members in the east recorded long waiting times as incidents. There were many examples of staff writing to children, and young people and carers to apologise for their wait for treatment.
- Staff received feedback from investigation of incidents externalto the service. For example, following a serious incident in the west, a local school had increased its referrals.The west team had worked closely with the school to ensure the referrals were appropriate. Staff members discussed incidents at their team meetings and reviewed their practices accordingly.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We looked at 28 care records of children and young people. Although we found some variance in the quality of completion and detail in files in the west team. The other teams ensured records were complete and up-to-date. Detailed assessments of needs were completed, and these were holistic and recovery focused. Care records contained evidence of specific outcomes, treatment goals and children and young people' strengths. The records seen in the learning disability service were of particularly high quality.
- Staff used the trust's computerised system for storing children young people's records. Records were stored securely and were available to all staff when required.

Best practice in treatment and care

- Locality teams had a strong therapeutic focus, and children and young people were provided with a variety of different therapies and treatments recommended by the National Institute for Health and Care Excellence (NICE) and staff were extremely knowledgably and skilled at working with children, young people and their families.
- The service had a prescribing group which brought together both psychiatrists and nurse prescribers. This group reviewed and compared their prescribing practice against the latest evidence base of clinical literature and NICE guidance to ensure consistency in their use of medication in line with best practice. In the west there was parent counsellor who provided support to parents in treatment. There was a specialist parenting service, which worked with parents who had a learning disability to help safeguard the mental health of their children.
- Across all the teams staff felt the lack of staffing over the previous year had impacted on their ability to provide a good spread of therapies like cognitive behavioural therapy (CBT). In the east staff stated that little specialist therapy took place as there had been no psychology input. However, a psychologist had recently been appointed and staff felt this would address this issue.
- Staff members gave either advice or signposted young people for support about applying for housing and benefits to other agencies.
- Children and young people's physical health care needs were mostly met by the service. For example, physical health care checks were carried out every six months for children on attention deficit disorder medication and children on antipsychotic medication. The records of children and young people with learning disabilities had very detailed information about regular health checks. Records of other children and young people were less detailed but the teams worked closely with GPs to ensure that children and young people's healthcare needs were monitored.
- Staff members used outcome measures like child and young person improving access to psychological therapies and young people's global assessment scale.
- Staff took part in a variety of audits. For example, they completed monthly audits of waiting lists, and caseload management. There was also an attention deficit hyperactive disorder (ADHD), prescribing audit and one relating to young people experiencing depression. Managers attended monthly operational assurance groups where audits were discussed and reviewed.

Skilled staff to deliver care

- Each team included psychiatrists, psychologists, nursing staff and support workers. However, the availability of these different disciplines varied across teams. There were psychology vacancies in the autistic spectrum disorder (ASD) team and at the time of inspection in the east Cornwall teams. A newly appointed psychologist was starting work in the east team shortly after our inspection. The clinical lead described how psychologists had looked at where gaps were in provision and had prioritised provision across the whole service. They stated that the impact of not having a psychologist in every team was that specialist psychology assessments had not been done. However they felt the introduction of the new psychologist would address these issues. There were also no occupational therapists in the west or mid teams. However, the occupational therapists form other teams worked across the service.

Multi-disciplinary and inter-agency team work

- Staff members in all teams engaged well in multidisciplinary team working and regular meetings to discuss children and young people were held. They covered a spread of different agenda items essential for service delivery, such as caseloads reviews, risk level,

Are services effective?

Good

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

safeguarding and learning from incidents and events. Clinicians also presented individual cases, particularly those with high levels of risk and the multidisciplinary team agreed the risk plan. This was then updated live onto the electronic clinical records system during the meeting. Recommendations from the in-reach team were brought to the meeting. There was a team based in each area and they worked with children, and young people admitted overnight to hospital. Children and young people assessed by the in-reach team as requiring immediate work were allocated quickly to the team.

- Staff demonstrated a good understanding of the needs of the children and young people on their caseload, with clinicians from other disciplines providing appropriate clinical advice on the cases discussed. The teams worked effectively and collaboratively to review risks and develop effective care plans.
- The teams also worked well with other health colleagues outside the service. The joint working with paediatricians was particularly of note. The teams had developed effective working arrangements with a wide range of agencies, including schools, local authorities and a variety of organisations commissioned to deliver counselling and low level therapy services.

Adherence to the MHA and the MHA Code of Practice

- There was a system in place for checking Mental Health Act (MHA) documentation.
- Staff had a good understanding of the MHA and the Code of Practice. The in-reach team had a good level of knowledge as it came across detained young people more often that the community teams. It used its skills to train others with the help of case studies. The in-reach nurses would also support new practitioners.
- Consent to treatment and capacity requirements were completed in the majority of files reviewed.

Good practice in applying the MCA

- Ninety six percent of staff had completed training in the Mental Capacity Act, 2005 (MCA). Staff generally demonstrated a good understanding of theAct.
- Staff had completed decision specific capacity assessments for patients lacking the capacity to do so themselves.
- Staff recorded best interest decisions and detailed the five statutory principles. The teams attended best interest meetings where necessary and family and carers were invited.
- Gillick competence assessments were referred to and completed for young people. The assessments look at whether children under 16 have enough understanding to make up their own mind about the benefits and risks of treatment.

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

- Children, young people and their carers told us they were treated with kindness, dignity and respect. Staff were described as very caring.
- The staff we met were enthusiastic, conscientious, professional and committed to doing the best they could for the children and young people in their care. Staff displayed detailed knowledge of the children and young people they worked with. Staff spoke respectfully about young people when in clinical discussion with colleagues.
- Observations of staff interactions with children, young people and their families showed warmth, appropriate humour, compassion and respect.

The involvement of people in the care they receive

- Care plans did not specifically detail that children and young people were fully involved in the planning of their own care. There was inconsistent approach across the service. The majority of records in the west did not detail whether or not children and young people had been involved in completing the care plan or had received a copy of their own care plan. However, in other teams there were more details of this in care records. . However, all the children and young people that we spoke with said they had been involved in planning their own care.
- Children, young people and their families were able to give feedback on the service via surveys, questionnaires in waiting rooms and experience of service feedback forms given at the end of treatment. We saw feedback boxes at all sites and evidence of issues raised being acted on. For example, at Bolitho House, families, children and young people had raised a concern that the waiting area in a conservatory became very hot in the summer and cold in the winter. A heating unit had been installed that provided air conditioning and heating. Carers, children, young people spoken with were very positive about this improvement.

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

- There had been a significant increase in the number of referrals over the previous two years but no increase in funding. As such, in discussions with Kernow Clinical Commissioning Group the trust had to raise the criteria for when to accept children and young people into the service. Referrals to the service had increased from 1900 to 2400 over the last two years. The service was not commissioned (had not received any additional funding) for this increase in demand. All clinicians spoken with said that the threshold for access to CAMHS had been raised in recent years. Children and young people were now more acutely ill before they were seen which often made care and treatment more difficult and lengthier. They expressed concern that some children and young people, who did not meet the eligibility criteria for CAMHS, were referred to one of the other services. They said that these other services, despite being of good quality, could not always meet the needs of children and young people and their mental health would sometimes deteriorate and they would then need the CAMHS service. Several young people told us that it was only when they had self-harmed that they met the criteria to receive a service.
- Families told us that they felt the service was responsive when they called with an emergency or crisis during office hours. There was a duty system in each team running from 9am until 5pm to take calls and could provide advice or arrange urgent referrals, including on that day if needed. Out of hours there was an inreach (crisis team) who worked with children, and young people admitted overnight to hospital. They would carry out assessments and take recommendations to MDT who would follow up children and young people admitted to the paediatric ward.
- Waiting times from both referrals to assessment and assessment to treatment varied across the service. The longest waiting times were in the east team; one young person had been waiting five months for an initial assessment. The trust was required to meet a target of 28 days from referral to assessment (set by commissioners) but the average waiting time was approximately three months. Although waiting times were shorter in the mid and west teams they were still outside the 28-day target; the average wait was approximately two months. There were 19 children and young people waiting to see a psychiatrist. Children and young people waiting for treatment in the autistic spectrum disorder (ASD) service experienced the longest waiting times. Those we spoke with said the wait was long, with one young person waiting 24 months. However, the trust was only commissioned to provide a small ASD service.
- Staff were proactive in taking steps to re-engage with children and young people that did not attend appointments. The teams monitored those that did not attend appointments. Staff phoned them and contacted other health and school services in contact with the children and young people.
- The service had responded to the needs of children and young people that could not attend for daytime appointments and arranged evening visits or could meet children and young people at school.
- Staff members in the east of the service stated that they frequently had to cancel appointments In Truro staff said they frequently had to cancel appointments due to lack of staff and then they were not able to offer a replacement appointment. In the mid and west Cornwall teams appointments were rarely cancelled.
- All teams, children, and young people and carers spoken with confirmed that clinic appointments ran on time and that they were kept informed if there were any delays.

The facilities promote recovery, comfort, dignity and confidentiality

- Generally, at the locations inspected where children and young people were seen there was a range of different rooms and equipment to support treatment and care. This included rooms for interviews and therapy, and larger communal rooms for group activities. However, the quality of these was mixed across the service. For example, in Bolitho House in the west the waiting area had a range of toys although these were predominately for the younger children. One interview room had been made into a quiet, relaxing sensory space for use with children and young people. They had recently (April 2016) put privacy window film on interview room

Are services responsive to people's needs?

Requires improvement

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

window making them more private. However, the location did not have a clinic room so scales used to measure young people's weight were in the corridor, which did not provide privacy for them.

- In 2016 the Truro CAMHS team moved to smaller premises in the large Truro Health Park. The team occupied a shared office space with children's services and had a small interview room and two clinic rooms. The clinics were not solely for the service and had to be booked prior to use. They were not child/young people friendly or age appropriate environments. There was a very small sign in the main reception directing children and young people to the upstairs waiting area by the clinics. On the day of inspection a young person sat alone in this area out of sight of the receptionist downstairs. The waiting area could be used by anyone in the Health Park as could the toilets. The waiting area was stark and utilitarian. Access to and from the upstairs interview room was through the waiting room for the GP surgery. Staff members told us the service would be moving to more child friendly premises within the Health Park in the next year or so but did not know exactly when this would be and there were no interim plans to improve the environments.
- In St Austell the trust owned the building. The waiting room was small and had no age specific toys, books or facilities. It was a thorough fare to staff from other to go upstairs. There was no sensory room or painting areas. The clinic in Liskeard was used solely to see children and young people accessing the CAMHS or the autistic spectrum disorder (ASD) service. Although it was clean and there were toys, books and age-appropriate facilities, the therapy rooms (other than that the one used for art therapy) were plain and functional.
- There was a limited range of information available in each location. In Bolitho House, St Austell and Liskeard, there was information on different conditions and treatments, patients' rights, local support projects including advocacy, and how to make complaints. In Truro there was no information at all in the waiting area.

Meeting the needs of all people who use the service

- At the locations inspected buildings had been adapted to ensure disabled access. This included flat surfaces and ramps for wheelchair users, disabled adapted toilets and lifts.
- Staff members told us they were able to obtain information in different formats and languages if needed, to support patients' different communication needs. Staff were also able to access the support of interpreters for children and young people whose first language was not English.

Listening to and learning from concerns and complaints

- Children and young people and carers we spoke with told us they knew how to complain and would be confident doing so if they needed to. However, the majority we spoke with had not made a formal complaint despite describing the difficulties with access to CAMHS and the long waiting times. They stated they were just a happy to get the service and once they did they were pleased with it.
- Information supplied by the trust identified that the service received one complaint during the 12 months from April 2016 to the end of March 2017. The complaint had been partially upheld. No complaints were referred to the parliamentary and health service ombudsman.
- Staff we spoke with described the complaints process and were aware of what steps required to make a formal complaint.
- We saw good information on how to complain displayed in most sites and this was sent out within information packs.
- Staff told us they fed back any informal complaints in team meetings, MDT meetings and governance meetings. The clinical lead described recent learning from a complaint from a young person that had increased joint working with schools to ensure there was consistent support for young people.

Are services well-led?

Good

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

Our findings

Vision and values

- All staff we spoke with were familiar with the trust's visions and values. Team values aligned with the trust visions and values. Staff we spoke with felt that this reflected their own team's philosophies and attitudes to care and treatment of the children and young people.
- Most staff we spoke with knew who the most senior managers were in trust and some staff confirmed that they had seen members of the executive team visiting the teams.
- There were plans in place to develop a tier 4 CAMHS (inpatient service) by 2019.

Good governance

- The trust ensured there were governance systems but local teams applied them differently. For example, there were systems in place to review care records but in the west team the reviews had not picked up the lack of risk assessments that we identified during the inspection. In the other teams the local governance systems were more effective.
- Senior managers in the service were well aware of the risks in the services such as the waiting times and they had ensured these risks were escalated and known to the trust.
- Both the senior leadership team and the service leaders were concerned about the current commissioning arrangements and were in discussion with their commissioners about it. They said that commissioners had not taken into account the increase in demand over the last two years. For example, the service was commissioned to provide a service for 1900 referrals in 2015. In 2017 they received an extra 600 referrals, but they did not receive any additional funding. The service had tried to address this by raising the threshold for children and young people to access the service; this has resulted in children and young people having to be very unwell before being able to access the service.
- There was a robust recruitment programme to increase staffing levels and every effort was being made to be creative in how staff moved between teams to respond to the increased demand. For example, sharing psychologist time across the whole team, although this had put increased pressure on staff. However, the trust recruited a psychologist in the east team who started work shortly after the inspection. Staff felt this would alleviate some of the pressure they were under.
- All staff were optimistic about the future and the positive impact that the development of tier four (inpatient) service could have.
- The number of staff completing mandatory training had improved across all teams over the last year. Training was identified at supervision sessions and booked in advance. Managers said the trust would provide extra training if staff couldn't access the available courses. For example, there had recently been additional level three safeguarding training available to accommodate the staff needs.
- Staff appraisal and supervision rates were generally good across the service. All staff had received a yearly appraisal. Clinical supervision took place regularly and staff described this as valuable and of high quality.
- The staff teams reported incidents appropriately and there was learning to improve practise.
- Managers ensured that opportunities for involving children and young people in the running of the service.
- Staff took part in a range audits.
- Safeguarding practice and knowledge was good across all teams and was aided by dedicated safeguarding staff that were integrated into the teams.
- The managers monitored the teams compliance with the key performance indicators (KPI) set by commissioners. It was clear when, where and why these weren't being met; this was escalated appropriately and the trust was making every effort to address the issues with commissioners.
- The team managers had sufficient authority and administrative support.Teams also had dedicated administrative support.
- Staff had the ability to submit items to the service line's risk register. The majority of staff spoken with felt trustknew about the issues and we are trying to support them.

Leadership, morale and staff engagement

- The trust senior leadership team and local managers were seen as being open and transparent and this cascaded to staff being open and transparent with children, young people and families if things went

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wrong. All children and young people who used the services told us that they had good relationships with the staff in the teams. They trusted staff to share with them when problems occurred or things went wrong with their care and treatment.

- Teams were enthusiastic, committed, passionate, hardworking and mutually supportive of each other. All staff we spokewithwere positiveabouttheleadership and support they receivedfrom managersatalocal level.Staff spoke positively, without exception, of the support they received from their team managers and colleagues.
- However, some of the staff told us they felt morale was low. The complexity of children and young people on caseloads and high caseloads in some teams impacted on their morale. Staff members said they felt the service was just about coping and it would not take much for the teams to be overwhelmed. However, staff worked hard andchildren, young people and their carers spoken with said they got a good service once they were seen by CAMHS.
- There were opportunities for staff members to get involved in developments of the service. For example, staff were invited to come up with and share ideas about the new inpatient service. Two leadership days had been held to support managers and clinical leaders develop their skills. They looked at how the whole team could work together to influence future service development.
- Sickness and absence rates were in line with the trust average of 4 %.
- There were no instances of bullying and harassment reported. Staff confirmed that there was a culture were this would not be tolerated. Staff showed a high level of regard and respect for each other.
- Staff knew how to use the trust's whistle-blowing process. Staff told us that they felt able to raise with the trust any concerns they might have about patient care or treatment.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The locations from where a number of CAMHS services were delivered were unsafe. They were not well maintained and did not have a range of age appropriate items in the waiting rooms. This was in breach of Regulations 15(1) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The threshold for accepting children and young people into CAMHS had been raised – meaning that some children and young people did not get a service (or got a service that did not meet their safety and care needs) until they were seriously ill. This was in breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.