Good

Dorset Healthcare University NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Sentinel House, 4-6 Nuffield Road
Nuffield Industrial Estate
Poole
Dorset
BH17 0RB
Tel: 01202303400
Website: www.dorsethealthcare.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RDYNM	Sentinel House	Lynch Lane – Weymouth and Portland community CAMHS. Shelley Clinic – Bournemouth and Christchurch community CAMHS.	DT4 9DN BH1 4LB

This report describes our judgement of the quality of care provided within this core service by Dorset HealthCare University 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.

Summary of findings

Where applicable, we have reported on each core service provided by Dorset HealthCare University NHS Foundation Trust and these are brought together to inform our overall judgement of Dorset HealthCare University NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good 
Are services safe?	Good 
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 found that the trust had made good improvement and that risk was now managed well. We have changed the rating of requires improvement given at the comprehensive inspection in June 2015 and have now rated specialist community mental health services for children and young people as good because:

- The trust had appointed a transformation lead and held meetings with local managers to ensure consistent practice in the teams. They had ensured the implementation of the action plan the trust created following our last inspection.
- The trust had put in place processes to help ensure practice was standardised across the teams.
- The trust had implemented a risk assessment procedure for children and young people on the waiting list for treatment. Staff now considered risk as a team across the pathway.
- The trust had put in place robust systems to ensure staff were up to date with mandatory training; 93% of staff had completed, mandatory training which met the target the trust had set.
- The trust had set up meetings between local team leads and senior managers within the trust. This allowed practice to be shared.
- Staff in the service were enthusiastic about the changes and were fully engaged in the improvements in the service.

However:

- Although the trust had made progress and hired another 9.8 whole time equivalent staff and had more posts advertised, there were still significant waits for some children and young people.
- While caseloads were now being reviewed, we found that some staff still had high caseloads.
- While the trust had set a five day target for communication to carers, staff told us that they struggled to meet this target.

Summary of findings

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

Are services safe?

Good

At the comprehensive inspection in June 2015 we rated safe as inadequate. At this inspection we have raised that rating to good because:

- The trust had recruited another 11 people (9.8 WTE equivalents) to work in community child and adolescent mental health services and was still advertising for more posts.
- The trust had ensured that staff were almost completely up to date with mandatory training.
- The trust had implemented a risk assessment process to ensure that staff routinely assessed the risk of children on the waiting list.
- All letters sent to children, young people and their families had information on how they could access support in a crisis.

However:

- While the trust had started to review staffs' clinical caseloads, there were still members of staff with high caseloads.

There were inconsistencies in the quality of recording in some risk assessments.

Are services effective?

Good

At the comprehensive inspection in June 2015 we rated effective as requires improvement. At this inspection we have raised that rating to good because:

- Staff had access to different types of clinical supervision, including safeguarding, clinical psychology and family therapy supervision.
- Staff had received additional training to aid them in their role, such as training on autism spectrum disorders and care planning training.
- Staff reported good links with external services.

However:

- Care planning was not recorded in a consistent format.

Are services caring?

Good

Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

Summary of findings

Are services responsive to people's needs?

Requires improvement

At the comprehensive inspection in June 2015 we rated responsive as requires improvement. At this inspection we retained that rating because:

- While the trust had started to review caseloads, we still found that some children and young people were waiting longer than the targets the trust had set.
- While the trust had set a five-day target to send information to carers, staff said they were struggling to meet this.
- We saw that confidential information was being discussed in the presence of staff that were not involved in care.

However:

- There was disabled access and information leaflets available at both team bases.
- The clinical areas of both team bases were clean and maintained.

Are services well-led?

Good

At the comprehensive inspection in June 2015 we rated well-led as requires improvement. At this inspection we have raised that rating to good because:

- The trust had acted on the action plan they had made following the last inspection.
- The trust had introduced robust systems to manage mandatory training rates.
- The trust had recruited a transformation manager to oversee changes within child and adolescent mental health services.
- The trust had set up meetings to help ensure practice was standardised across the teams.
- Local managers had access to key performance indicators and monitored team performance.
- Staff felt supported by their team and local manager

However:

- Systems to ensure managerial supervision caseloads were manageable were still being developed.
- While the trust had set a target to send communication out to carers within five days, staff were struggling to meet this target.

Summary of findings

Information about the service

Dorset HealthCare University NHS Foundation Trust provides specialist community mental health services for children across Dorset from six community teams. These teams are: Bournemouth and Christchurch, East Dorset; North Dorset, Poole, West Dorset, and Weymouth and Portland.

The community child and adolescent mental health services (CAMHS) offer assessment and treatment to children and young people up to the age of 18 years (and their families/carers) who are suffering significant mental health difficulties, which have not been helped by interventions at primary care, and prevention and early intervention levels.

The community CAMHS teams offer services divided into two tiers, tier two and tier three. Tier two services offer services for mild to moderate emotional wellbeing and mental health problems. Tier three services offer specialist services for young people with moderate and severe mental health problems that are causing significant impairments in their day-to-day lives. The main working hours are 9-5 Monday to Friday, although the service did offer some appointments outside these hours for families who could not make the appointments during those times. The community CAMHS teams also offer crisis and out-of-hours services.

Our inspection team

Team leader: Gary Risdale, Inspection Manager CQC

The team that inspected this service comprised: a Care Quality Commission (CQC) inspection manager, a CQC inspector and a specialist professional advisor (a mental health nurse with experience in child and adolescent mental health services).

Why we carried out this inspection

We carried out this focused short notice announced inspection to review the progress the trust had made following our comprehensive inspection in June 2015. In that report we rated three key questions for specialist community mental health services for children and young people as requires improvement. We rated the key question for Safe as inadequate. We published the report from the comprehensive inspection in October 2015.

At that inspection, we issued three requirement notices because inspectors found a number of breaches of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 as detailed below:

- Regulation 12 Safe care and treatment
- Regulation 18 Staffing

We told the trust that it must take action to address the problems that we had identified.

- The trust must ensure that a consistent risk assessment process is put in place for all cases of children and young people waiting for assessment or treatment.
- The trust must ensure there are sufficient numbers of suitably skilled staff employed in the specialist community mental health services for children and young people.
- The trust must ensure that staff are up to date with their mandatory training.

At the previous inspection, we also suggested that the provider should take action to address the problems we had identified.

- The trust should ensure that caseloads are reviewed regularly to ensure that they are manageable and young people receive appropriate treatment.

Summary of findings

- The trust should ensure the action plans they produced following our visit to the community CAMHS teams are implemented without delay.
- The trust should ensure that all care plans are up to date.
- The trust should ensure that correspondence to carers and young people relating to their treatment plans is sent to them promptly.
- The trust should ensure that correspondence referring children and young people to other services is sent promptly without delaying their treatment.
- The trust should ensure it has systems in place to deliver greater consistency in the standards and working practices across the different community CAMHS teams.

These findings were mainly based on the evidence gathered at two community CAMHS teams, Bournemouth and Christchurch, and Weymouth and Portland. These were the teams inspected in the current inspection.

This inspection reviewed the progress the trust had made.

How we carried out this inspection

We undertook a focused inspection of the areas where we had identified the need for improvement. We only reinspected the key questions that we had rated as requires improvement or inadequate and this report details our findings related to;

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

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

During the inspection visit, the inspection team:

- visited two of the four community teams and looked at the quality of the clinical environment
- spoke with three carers
- spoke with the managers for the two teams
- spoke with 16 other staff members; including administrative staff, psychiatrists, nurses, social workers and a psychologist
- interviewed the operational director with responsibility for these services
- attended and observed one team meeting and one daily supervision group and two daily intake meetings.
- Looked at 31 treatment records of patients.
- 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

Carers of children and young people who used the service said that staff in the community child and adolescent mental health teams were understanding, polite, helpful and respectful. Carers we spoke with said that they had been received a lot of information on courses for the young person they cared for and on books that might help and had been involved in care planning.

Good practice

All letters to young people and their families had a clear description of how to access help in a crisis or emergency, both during the working week and at evenings and weekends. This was printed clearly at the bottom of each letter in bold print.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that waiting times are reduced further.

Action the provider SHOULD take to improve

- The trust should continue to review caseloads to ensure they are manageable.
- The trust should ensure that all risk assessments are of a similar high quality.

Dorset Healthcare University 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
Weymouth and Portland community CAMHS	Sentinel House
Bournemouth and Christchurch community CAMHS	Sentinel House

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.

Staff understood the Mental Health Act as it applied to young people. However it was rarely used in either service. Managers and psychiatrists said that the Mental Health Act office in the trust provided good assistance when necessary.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act does not apply to young people under age 16. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. In all of the records we reviewed, we saw capacity and consent recorded and where appropriate, reviewed. Staff we spoke with were aware of the concept of Gillick competence.

Good

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

- Facilities in the bases of both teams we inspected were clean and maintained in clinical areas.
- Staff in both teams had access to personal alarms should they require assistance.
- Medication was not stored onsite in both teams.

Safe staffing

- Since the last inspection in June 2015, the trust had employed an additional 9.8 whole time equivalent staff (WTE) in community child and adolescent mental health services (CAMHS). In the Bournemouth and Christchurch team this included a project support worker, four primary mental health workers (one due to start the week after inspection, all on temporary contracts) an administrator, a psychiatric liaison role and a part time nurse prescriber. In the Weymouth and Portland team, this included a behavioural practitioner and a lead clinical psychologist. Both teams had more posts they were recruiting to, a psychiatric liaison post in Weymouth and Portland, and two community nurses in Bournemouth and Christchurch. Staff in the Bournemouth and Christchurch team reported that staffing levels had improved, although they still felt they were understaffed.
- The Bournemouth and Christchurch CAMHS team had 14 WTE qualified clinical staff and 3.9 WTE unqualified clinical staff. The Weymouth and Portland team had five WTE qualified clinical staff and 3.8 WTE unqualified clinical staff. They were advertising for another one WTE qualified nursing vacancy
- In February 2016, the sickness rates were 5% in the Bournemouth and Christchurch team and low (2.8%) in the Weymouth and Portland team. The staff turnover rates (percentage of staff who had left the team) were 13.3% in the Bournemouth and Christchurch team and 8% in the Weymouth and Portland team.
- Caseloads varied within both teams we inspected. The trust had put in place measures to manage caseloads, such as reviewing them in supervision. However, we identified that some members of staff who were not full time in the Weymouth and Portland team still had caseloads that were high. For example, one part time employee had a caseload of over 28 and a full time employee had a caseload of over 50. Staff at Weymouth and Portland had set aside a day to ensure that all people on their waiting list who were rated as having amber risk (medium risk) were assigned to a member of clinical staff 's caseload.
- Staff we spoke with at Weymouth and Portland said that they felt there had been a lot of positive change in the senior team, such as having five locum consultant psychiatrists over six years and changes in the team leader role.
- Overall, staff in CAMHS had completed 93% of their mandatory training in February 2016. The only training where less than 85% of staff had completed it was child protection level 3. Seventy-seven percent of staff in the Bournemouth and Christchurch team had completed it and 75% of staff had completed it in the Weymouth and Portland team.

Assessing and managing risk to patients and staff

- Two dedicated members of staff discussed a patients risk upon referral at a daily intake meeting, and prioritised them on the waiting list according to their risk level. Specific senior members of the team did this and each referral was given a rating of either: green (low risk), amber (medium risk) or red (high risk). Staff told us that they also rated the urgency of the referral and whether the child or young person needed to be seen within four to eight weeks, within a week, or that day. A dedicated member of staff checked the waiting list daily. They went through the list by date order and used part of their shift to call children and young people to see if there had been any changes with that person. If risks had escalated, staff took action swiftly to offer an appointment. For example, staff had recorded regular contact with a young person's parents and when there had been an escalation of risk, the young person was seen the next day by the crisis nurse. We saw that appropriate action had been taken to safe guard children in the 31 records we reviewed.

Good

Are services safe?

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

- When staff had assessed children and young people, they discussed the children and young people with high levels of risk at team meetings and monthly case management discussion groups. We saw evidence of this in the team meeting minutes.
- We reviewed 31 records, 28 of them contained risk assessments. The three that did not were all patients who were only seen once every 6-12 months for reviews of their medication for attention deficit hyperactivity disorder. We found that 18 of the risk assessments were of good quality, the others were variable but 24 were up to date. However, four had not been updated following changes to treatment plans or following significant risk events such as an assessment where psychosis was noted. In this case there were detailed discussions elsewhere in the notes identifying how to meet that young person's needs. Clinicians completed risk assessments on the electronic record system. The level of detail varied with some providing detailed concerns, others only constituted boxes being ticked. Assessments focussed on recorded risk and did not routinely record other contributing issues such as protective factors, although these were considered and recorded elsewhere in the clinical notes. Managers were aware of this and were arranging further training for staff.
- Staff and managers told us that since our last inspection there had been a culture change in how risk was thought about and recorded. Training on risk assessments had been provided and staff were being supported in how they changed their practice. In Weymouth and Portland the team manager had organised regular audits of risk assessments. Where there were concerns about the quality of risk assessments in a young person's record, the case holder was emailed and asked to revise or update them. Audits had only recently started in Bournemouth and actions to act on them had not yet been taken.
- All letters to young people and their families had a clear description of how to access help in a crisis or emergency both during the working week and at evenings and weekends. This was printed clearly at the bottom of each letter in bold print. This included appointment and referral letters, not just letters following assessment and appointments.
- Staff held a daily meeting to discuss the clinical visits they had each day and there was a designated member of staff to check that staff were safe at the end of each day. Staff's visits were tracked on a notice board so that other staff could see if they were in the building or out on a visit. The trust had a trust wide lone working policy and staff carried mobile phones should they need to call for assistance.
- Staff told us that they had rapid access to a psychiatrist when this was required. There was out of hour's access to a psychiatrist via a trust wide on call system as well as a CAMHS out of hour's service between 5pm and midnight. One carer was critical of the out of hours service saying they did not answer or did not have the information to help them.

Track record on safety

- There had been two serious incidents in community CAHMS teams since the last inspection in June 2015. There was clear learning from these for example staff had agreed how they would pass along information within the team about serious incidents in the future.

Reporting incidents and learning from when things go wrong

- Staff were able to demonstrate they knew how to report incidents. Staff discussed serious incidents with team managers or other staff. Staff told us that they discussed learning from incidents in team meetings weekly.

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

- Staff in both teams used the trusts' electronic record system (RIO) to store care records. However, staff at Weymouth and Portland told us that there was a well-documented problem with their connection to the internet. This meant that when there were a lot of the team trying to access the system as it was very slow. The trust had put in place a system, which allowed staff to download records securely, but this required them to know they needed them beforehand, which was not always possible. The trust had put this location as the priority for the next upgrade in internet service.
- The trust had provided training to community CAMHS teams on writing care plans and at Bournemouth and Christchurch there were shared tools that staff could use. Learning sessions on care planning also took place at Weymouth and Portland, where staff audited their own care plans and discussed learning from that.
- In 31 records reviewed, all young people had plans of care. However, staff did not record them in a consistent format. Some care plans were on the RIO care planning system, others were in the letters to young people or their families, others were in scanned documents. Staff did not routinely link a young persons' care plan to their risk assessments. For example, in two records reviewed at the Bournemouth and Christchurch team there were comprehensive detailed care plans written in a creative visual format by the clinician and the young person. The care plans addressed serious suicidal risk and how the young person could manage it and what CAMHS would offer in support. These were exemplar care plans that fully captured the young person's views as they had co-written them. However, they were scanned into the documents folder of the electronic records and not linked to the risk assessments or mentioned in the care plan section of the electronic record and were only found when our inspectors were looking at something else. The lack of a consistent format of where care planning was kept was a potential risk if other clinicians who may not know the young person were asked to take over the young person's care or in an emergency when the case holder is not available. The managers were currently working with the team to change the contents of the clinic letter so that a persons' information was not only written in the letter.

Best practice in treatment and care

- The trust had employed a second clinical lead (who was a psychologist) in January 2016; part of their role was to raise awareness in the staff of guidelines for treatment provided by the National Institute for Clinical Excellence. These guidelines include recommending certain psychological therapies for different mental health issues. Staff said that they did not always have enough staff trained to provide these therapies, but that some staff were training in order to provide those therapies. Staff had been released to complete the young people's improving access to psychological therapies training.
- Interventions were tailored to meet individual young people's needs and staff told us followed best practice guidance. For example, in the prescribing and monitoring of medication for children with hyperactivity disorder.
- Staff at the Weymouth and Portland team had held a day event where they reviewed and audited the care plans they had written. This day had also involved a learning segment so that staff could understand what made a good care plan. The team also had a temporary assistant psychologist assisting them in undertaking clinical audits. In addition, Bournemouth and Christchurch had a clinical psychologist trainee who was conducting research on the quality of referral information in the team

Skilled staff to deliver care

- The team at Weymouth and Portland community CAMHS comprised a number of professions, including a psychologist, mental health nursing, social workers, family therapists, behavioural therapists and occupational therapists.
- Staff at Weymouth and Portland received caseload supervision with the team psychiatrist. Staff had rotating schedule of group supervision, so that they received supervision on safeguarding concerns, family therapy and other clinical supervision. Staff could also access supervision informally, and the team at Bournemouth and Christchurch held a supervision group four days a week where they could discuss children and young people.

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.

- The trust had provided staff with additional training, such as in drug and alcohol awareness, crisis supervision, clinical governance training and had received in house training on autism spectrum disorders and gender differences.

Multi-disciplinary and inter-agency team work

- Staff in both teams reported good working links with local social care services and schools, as well as good working links with services in the voluntary sector. Staff in the Weymouth and Portland team had set up a monthly meeting with a local charity to help improve referrals to them. Staff also reported good working links with other teams within the trust. Medical staff reported that they attended monthly meetings with the paediatrics team
- Staff said that should a young person require adult services approaching their 18th birthday, they would begin transitioning them into adult services over a three to four month period before their birthday. Staff would attend young peoples' first appointment with adult services.

Adherence to the MHA and the MHA Code of Practice

- Staff understood the Mental Health Act as it applied to young people. However, it was rarely used in either service as it was rarely required. Managers and psychiatrists said that the Mental Health Act office in the trust provided good assistance when necessary.

Good practice in applying the MCA

- The Mental Capacity Act does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the patients where possible in the decision making regarding their care.
- Staff had used a standardised form at the start of their engagement with CAMHS. We saw staff had used this form, and had recorded further discussions of mental capacity in all of the 31 records we reviewed.

Good

Are services caring?

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

Our findings

Not inspected. See previous report of the June 2015 inspection published in October 2015 where this key question was rated as Good.

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

- Staff risk assessed referrals when they received them and allocated them different levels of urgency (the same day, within a week or between four and eight weeks) for assessment. After assessment, the child or young person would wait until treatment could begin. The trust had set waiting time targets of eight weeks for tier 2 assessments and four weeks for tier 3 assessments. The target wait for both tier 2 and tier 3 treatment was 16 weeks.
- We reviewed the monthly performance dashboard and saw that the teams we inspected rarely met their targets for waiting times and this was a problem in the other community child and adolescent mental health (CAMH) teams as well. Across all of the community CAMH teams there were 434 young people waiting longer than the trust target for appointments.
- Average waiting times were longer than the trust target for tier 2 assessment at 9.8 weeks in the Bournemouth and Christchurch team. They were closer to the trust's target at the Weymouth and Portland team (4.2 weeks).There were 67 young people who had been waiting longer than 8 weeks for tier 2 assessment in the Bournemouth and Christchurch team and four in the Weymouth and Portland team.
- The average wait times for longer than trust targets for tier 3 assessment (which was four weeks). The averages were 7.5 weeks in the Bournemouth and Christchurch team and 5.5 weeks in the Weymouth and Portland team. There were 50 young people who had been waiting longer than the trust target of four weeks for tier 3 assessments in the Bournemouth and Christchurch team and 10 young people in the Weymouth and Portland team.
- Children and young people also had to wait longer than the trust target for treatment. The average waiting time for tier 2 treatments was 26.7 weeks in the Bournemouth and Christchurch teams. The average waiting time was nearer the target in the Weymouth and Portland team at 16.7 weeks. There were 29 young people waiting for tier 2 treatment in the Bournemouth and Christchurch team and 21 in the Weymouth and Portland team.
- Children and young people had to wait longer than the trust target for tier 3 treatment as well. The average waiting time for tier 3 treatments was 18 weeks in the Bournemouth and Christchurch team, and 18.6 weeks in the Weymouth and Portland team. Thirty-three young people had been waiting over 16 weeks for tier 3 treatments from the Bournemouth and Christchurch team. Thirteen young people had been waiting over the target for treatment from the Weymouth and Portland team.
- The trust had identified that, since it had started reporting waiting times on a weekly basis to teams, staff had reduced the number of young people waiting longer than the target by 18% since August 2015. They had done this by hiring more staff to conduct assessments and ensuring that there were allocated duty workers to conduct urgent assessments.
- One carer said that they had tried to get an appointment for a child in their care, but that they felt the team had not given the child enough time to open up. They said staff had stopped appointments because the child would not open up. Another carer said that it was difficult to get in contact with the consultant psychiatrist between appointments though they could contact their support worker. However, another carer of a child reported that they did not have to wait too long to see a clinician and it was easy to get in contact with them.
- Staff told us that the trust had implemented a five-day target for them to write to carers to confirm the outcome of the assessment. Staff at Weymouth and Portland said that it was difficult for them to do this because they prioritised doing the designated work of being a duty worker (following up on patients waiting, taking emergency calls and checking staff had returned from visits). This was more difficult as staff preferred to write longer letters that are more comprehensive. The local manager in the Weymouth and Portland was monitoring this target and they were working on implementing shorter assessment letters. Staff had planned a change in the system for designated duty workers, so that they had more time to allocate to this role.

The facilities promote recovery, comfort, dignity and confidentiality

- Whilst we were observing a supervision group at the Bournemouth and Christchurch team, we noticed that staff members that were not in the team were entering and exiting the room. Staff held the meeting in the staff kitchen and members of non-clinical staff not in the

Are services responsive to people's needs?

Requires improvement

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

team were using the room as an entrance to the building, rather than using the appropriate entrance. This meant that children and young people were being discussed while staff not involved in their care could overhear and so confidentiality could be compromised. We brought this to the attention of the team manager and they agreed to address this.

- A carer we spoke with said that the team base for the Weymouth and Portland team was clean, welcoming and had toys and books for children and young people to use.

Meeting the needs of all people who use the service

- A carer we spoke with said that the team at Weymouth and Portland had been accommodating when they had needed to bring their grandchildren to an appointment.
- Both team bases had access for people with mobility issues and had information leaflets on a variety of topics for people using the service.

Listening to and learning from concerns and complaints

- Staff told us there was a trust policy for responding to complaints, and that they discussed any complaints at team meetings and in supervision. They said that complaints were always brought to the team leader who would contact the complainant and try to resolve their concerns.

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

- Staff knew and agreed with the organisation's values, they felt that the trust had responded to our previous inspection well and had initiated positive changes.
- Staff knew who the directors within the trust were, and had complimented them on their support and input into the changes that had been made. Senior managers within the trust had set up processes in order to increase their oversight so that they could better support the local teams. These processes included setting up monthly performance dashboards, conducting audits and regular meetings of the child and adolescent mental health service (CAMHS) transformation team.

Good governance

- The trust had put in place measures to ensure staff completed mandatory training. At the time of this inspection the trust had ensured staff had completed 93% of their mandatory training across the community CAMHS teams. However, staff told us that they had attempted to obtain extra training in risk assessments but that the training had been originally been booked for after the current inspection but had been cancelled. We made the trust aware of this and they took action to address it.
- The trust had put in place new structures to ensure that the quality of the service provided to children and young people improved. For example, it had developed standardised letters with information for children and young people in a crisis. The trust had developed a leaflet that explained the services they could provide that they planned to send out with that letter. The trust had also established a protocol for managing young people's risk while they were on the waiting list that helped to ensure that staff contacted young people who were waiting and checked in case their risk escalated.
- The trust had placed an interim manager at the Weymouth and Portland team whilst it was considering the management structure. This manager was still managing another team, and as such had to split their time between the teams. This meant that they were supervising around 30 people. This led to delays in managerial supervision as there were not appropriate structures in place at the time of inspection to ensure that supervisors had an appropriate number of people they were supervising. The interim manager had started plans to alleviate the situation by delegating to the deputy team leads.
- The trust had acted upon the action plan agreed following the last inspection in June 2015. This had led to changes within the service. The trust had put systems in place to manage risk on the waiting lists and hire more staff, the trust had put robust systems in place to staff were up to date with mandatory training, and that there were systems in place to ensure regular clinical supervision on a variety of topics. However, these changes were not always embedded. For example, the 5 day target for sending out communications to carers, that staff were finding difficult to meet. Also, staff caseloads were still high and there were still people on the waiting list that had been waiting longer than the target time.

Leadership, morale and staff engagement

- The trust had appointed a new CAMHS transformation lead to help guide the changes at a trust level. They had also instituted monthly meetings with local management and trust senior managers to discuss the changes. This helped to make standardised practice across teams.
- There was strong local clinical leadership in both teams. For example, in the Bournemouth and Christchurch there was a strong senior leadership team across clinical professions.
- Staff at both teams reported enjoying coming to work with their team as they felt the team were very dedicated and passionate. They also said staff in the team were very supportive. Staff also spoke positively of the local senior management within the team, for example the team leaders.
- Staff told us that they although they accepted the findings of the previous inspection report it had been hard for them to take. Staff were keen to demonstrate the progress and improvements made and we were impressed with the motivation of the teams to deliver changes. All staff spoke of their commitment to the young people they worked with and this was evident.
- The trust had monthly dashboards that measured teams across several key performance indicators such as whether staff had completed mandatory training,

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.

waiting times for assessment, and waiting times for treatment. These dashboards were sent to local team leaders and helped to identify where performance was worsening or improving.

- Staff in both of the teams we inspected reported an increase in administrative staff that helped with the workload.
- Staff told us they were aware of how to whistle-blow and were comfortable raising concerns if they had any.

The trust risk register had demonstrated that the concerns with the service had been noted and the trust had an action plan to address the risks within the service.

Commitment to quality improvement and innovation

- Bournemouth and Christchurch had a primary mental health worker who was conducting research on the quality of referral information in the team.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust did not ensure there were sufficient numbers of suitably qualified, competent, and skilled staff to meet the needs of the people using the service. In the Bournemouth and Christchurch service and the Weymouth and Portland service we visited they were unable to provide a service to children and young people within target waiting times due to vacancies and staff sickness. This was a breach of regulation 17 (1) (2) (a).