Good

Virgin Care Limited

Specialist community mental health services for children and young people

Quality Report

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Date of inspection visit: 16 - 19 January 2017
Date of publication: 30/06/2017

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-673822558	St David's Hill, Exeter (Capital Court)	Autism spectrum assessment team/pathway	EX2 7FE
1-673933279	Lescaze Court	Southern Devon CAMHS team	TQ9 6JE
1-673142083	Springfield Court	Northern Devon CAMHS team	EX31 3UD
1-673822558	Evergreen House, Exeter (Capital Court)	Eastern Devon CAMHS team	EX2 4NU
1-673822558	Capital Court	Learning disabilities team	EX2 7FE
1-673822558	Tiverton Business Park (Capital Court)	Assertive outreach team	EX16 6TG

This report describes our judgement of the quality of care provided within this core service by Virgin Care Limited. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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

Where applicable, we have reported on each core service provided by Virgin Care Limited and these are brought together to inform our overall judgement of the organisation..

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

Contents

Summary of findings

Overall summary

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

Buildings were clean and maintained and had alarm systems, with the exception of Evergreen House.

Parents and young people were involved in service development and commented positively on the skills of staff and inclusion of staff. This was supported and facilitated by the countywide involvement lead.

There were innovations across the service. The eating disorders pathway had been recognised as national good practice by NHS England. The assertive outreach team was shortlisted for awards from the British medical journal and the health service journal 'value in healthcare' award in January and February 2017.

Staff were skilled and adopted evidenced based practices recommended by the National Institute for Health and Care Excellence (NICE). Staff were positive about the organisation and passionate about their work. The organisation demonstrated commitment to staff development and supported staff to undertake accredited training. Workforce planning included succession planning for staff that were due to retire and vacancy rates were highlighted in the service wide risk register. There were still 18 staff vacancies at the time of our inspection. Staff had job plans, which were plans to help ensure staff workloads were manageable. These plans were monitored in staff supervision. However, the commitment to specialist training had led to short term gaps in staffing.

Services worked well with other partners to develop effective pathways. Outcomes from evidence-based practices had improved experiences for young people, such as the eating disorders service and specialist assertive outreach teams that had reduced admission to tier 4 inpatient psychiatric services and length of stay. CAMHS, learning disabilities and specialist CAMHS were developing pathways across the county and the provider was starting to recruit by pathway rather than geographical location and staff were specialising in clinical areas.

The CAMHS team, which had received transformational funding, were meeting the referral to treatment targets and waiting lists were reducing despite the increase in demand. However, we were concerned that some waiting times were still too long. Parents and carers commented negatively about the waiting times in all areas, but in particular the autistic spectrum assessment service pathway where there were concerns that young people's education had been adversely affected by the delays in receiving a potential diagnosis. Parents were critical about the waiting times across all services and once they had been seen there were sometimes further waits for therapies, such as internal waits for cognitive behavioural therapy in Eastern and Southern Devon.

We were concerned that the autistic spectrum assessment service was not meeting the 18 week target and staff felt pressure working in an area with long waiting lists and frustrated parents and families.

We found that some systems were not fully embedded that could improve waiting times and staffing, such as staff working across clinical pathways rather than geographical locations.

We saw that the CAMHS team had implemented changes following recent serious incident reviews. However, we were concerned that these had not adopted service wide.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Caseloads were monitored through regular caseload supervision and job planning.
- Teams worked together to support each other and allocation of new patients was agreed jointly with staff and managers depending on staff capacity at the time.
- Nationally accredited risk assessment tools were used in the CAMHS teams.
- The service monitored vacancies through team and service wide risk registers and was creatively recruiting to vacancies, particularly the harder to recruit to areas, such as rural Northern and Southern Devon.
- The provider had recently offered a more flexible style of work base, which meant that staff could be based for some of the week in Exeter and Eastern Devon where recruitment had been easier and spend some of the week in the more rural areas where recruitment was more challenging.
- Safeguarding champions supported safeguarding practices and staff worked with the local authority to safeguard and promote the welfare of children and young people.

However:

- There were concerns with the cleanliness of the environment at Evergreen house and personal safety of staff with no alarms in the buildings or outbuildings.
- The learning disabilities services did not have always have risk assessments in place for children and young people.
- Turnover was high in some areas, for example, the autistic spectrum assessment service and Southern Devon CAMHs and some posts were difficult to recruit to, such as psychology.
- Some staff reported that they carried higher caseloads than they could manage.
- Lessons learnt were shared across the organisation through formal governance frameworks. However, improvements to risk assessments in CAMHS had not been implemented across the learning disability service and the autistic spectrum conditions team.

Are services effective?

Good

We rated effective as good because:

Summary of findings

- Staff offered psychological therapies and support as recommended by National Institute for Clinical and Health Care Excellence.
- The service supported staff to develop and train in evidence based psychological therapies.
- Evidence based support was provided to schools and was being rolled out to GP practices.
- Teams had good working links with primary care, paediatric services, social services and other teams external to the organisation.
- Staff received regular supervision and appraisals.

However:

- There was variability in recording consent in the learning disabilities and assertive outreach teams.
- Despite proactive recruitment into psychological therapies posts, shortages in psychology provision were affecting waiting times for children and young people.
- The learning disabilities team used the same electronic records system as the children with additional needs service which enabled them to share information. However, the learning disabilities team did not have direct access to CAMHS electronic records system and systems did not interface to enable information to be shared. This was on the risk register.

Are services caring?

Good 

We rated caring as good because:

- Young people and their carers were positive about the care and support they received once they were in the service.
- Children and young people were treated with dignity and staff showed empathy towards the child and their family.
- Young people participated actively in their care and there were opportunities to be part of the service development.
- A full time youth participation worker worked across the county to support young people to be involved in developing and participating in the service.

However:

- Some families and young people felt isolated and frustrated whilst waiting to be seen for a diagnostic test or treatment.
- Some families described difficulties with communications once they were in the system.

Are services responsive to people's needs?

Requires improvement 

We rated responsive as requires improvement because:

Summary of findings

- Two hundred of the 325 young people waiting for an assessment of autistic spectrum disorder were waiting over 18 weeks. Some young people were waiting over a year. There remained long waiting times for some children and young people. Parents expressed frustration about waiting times for psychological therapies.
- Young people requiring cognitive behavioural therapy (CBT) in Eastern Devon had to wait a further 19 weeks after assessment before treatment began. In Southern Devon young people had to wait a further 16 weeks. This meant that they would be waiting 24 weeks and 22 weeks respectively from referral to treatment. Three young people had been waiting 39 weeks for psychotherapy. The service provided brief intervention at the time of assessment to mitigate the risk until the CBT treatment could begin.
- There was a lack of access to drinking water in some waiting areas and some furnishings and facilities were tired and worn.

However:

- The service had worked hard to address waiting times and been successful in reducing waiting times across all services despite the increase in demand. The service had met key performance indicators set by their commissioners despite an increase in referrals. The service were tackling and monitoring internal waiting times and were ahead of target.
- The eating disorder and assertive outreach work had reduced length of stay and inpatient admissions to tier four psychiatric inpatient services.
- Young people's artwork was displayed at Northern Devon and young people could comment and doodle on 'graffiti boards' in Southern and Eastern Devon waiting rooms.

Are services well-led?

Good

We rated well-led as good because:

- Staff showed commitment to their core values and were positive about the organisation and passionate about their work.
- Systems were in place to monitor compliance with mandatory and statutory training and staff appraisals.
- Systems to measure performance and information were in place.
- Staff were committed to quality improvement and innovative practice to improve experiences for young people.
- New managers recruited to Southern and Northern Devon CAMHS teams had made a positive impact on staff.

Summary of findings

However:

- Staff felt under pressure from vacancies rates, high turnover and waiting lists.
- Teams were in the process of forming and developing and some new systems were still embedding.

Summary of findings

Information about the service

The organisation is commissioned to provide specialist multi-disciplinary community child and adolescent mental health services (CAMHS) and children's learning disabilities services across Devon.

The CAMHs services are split into three main location areas: Northern Devon, Southern Devon and Eastern Devon. Learning disabilities, autistic spectrum assessment service and assertive outreach services are Devon wide.

Services include specialist CAMHS, service around the child, journey after child abuse trauma, assertive outreach team, paediatric psychology, neurological development pathway and learning disabilities.

The organisation provide tier three services where specialist multi-disciplinary community child and adolescent mental health services support young people and their families with mental health problems, including severe and complex needs and learning disabilities in the community.

The organisation also provide tier two CAMHS services across Devon, which is where individual CAMHS specialists worked in community and primary care settings with young people who have less complex needs and includes early help for mental health services in schools and communities.

An assertive outreach team provides crisis and intensive home treatment for children and young people in Devon to help prevent admission or enable young people to be discharged more quickly from tier four inpatient services.

The autistic spectrum disorder service and the learning disability service are part of the Devon children with additional needs service.

The CAMHS service is divided into a number of care pathways, to which children and young people access following a clinical assessment and referral via the single point of access.

Our inspection team

The inspection team was led by:

Chair: Graham Nice: Independent Healthcare Management Consultancy

Team Leader: Helen Rawlings, Care Quality Commission

The team included CQC inspectors and an assistant inspector. We were joined by the following specialist advisors: specialist children's community nurse, children's physiotherapist, consultant paediatrician, school nurse, children's end of life nurse, children and adolescent mental health practitioners, learning disability practitioners, psychologist, and a director of human resources. An expert by experience who had experience of caring for children and adults with complex needs spoke with children, young people and families who use the services to gain their views.

Why we carried out this inspection

We inspected Virgin Care Limited - Integrated Children's Services Devon as part of our comprehensive independent community health services inspection programme.

Summary of findings

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Visited six of the community and business locations in Eastern, Northern and Southern Devon in Exeter, Tiverton, Barnstaple and Dartington and looked at the quality of the environment for young people and their carers.
- Spoke with operational managers and clinical directors about child and adolescent mental health services (CAMHs).
- Interviewed the head of strategic business development and the county autistic spectrum assessment service manager about the autistic spectrum assessment service.
- Interviewed the county wide service lead and professional lead nurse for learning disabilities about the learning disabilities service.
- Interviewed the three service lead managers for the Northern, Southern and Eastern CAMHS teams.
- Observed three clinical assessment meetings with children, young people and their carers.
- Observed a multidisciplinary discussion and screening of referrals.
- Spoke with six young people who were using the specialist CAMHs services.
- Spoke with eight parents of young people using the services.
- Collected feedback from 17 children, young people, parents and carers using comment cards.
- Carried out a service wide focus group of young people and parents and carers across Devon.
- Carried out service wide focus groups of clinicians and managers across the county.
- Looked at 26 care and treatment records of children and young people.
- Spoke with six separate groups of practitioner staff in different locations across Devon. This included therapists, psychologists, assistant psychologists and nurses.
- Spoke with five separate groups of clinical leads across services and geographical areas.
- Spoke with 18 other staff such as psychiatrists, family therapists, psychologists, nurses.
- Looked at 12 staff personnel files.
- 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

We spoke to four young people and eight parents and carers. We observed three clinical meetings with parents and children. We collected feedback from 17 children young people and carers using comments cards. We also gathered views from children and young people through a focus group held across the service.

People were mainly very positive about the support they received. Individual staff were singled out for praise by young people and their parents. For example, one person told us that a staff member had helped them 'beyond words.' Another was described as 'fantastic' in their approach with one young person. Staff were generally described as having expert skills to support young people and there was a high level of satisfaction. Most young people described very positive relationships with the staff. Young people felt staff understood them and that they had time to discuss their concerns.

However, two people expressed concerns about the frequency of staff changes and having to repeat their story, which had adversely affected building a therapeutic relationship.

Parents and carers expressed concerned about waiting times to be seen and waiting for services once the young person had been assessed.

Summary of findings

Parents and carers expressed frustration at the length of time young people waited to receive an autistic spectrum assessment. Parents reported that the long wait for a potential diagnosis had meant that educational resources and opportunities were missed.

Comments on the environment were mixed. Some young people told us that environments were comfortable and well designed. However, two people told us that waiting areas looked tired and that you could sometimes hear people talking in private consultation rooms. We received two comments that waiting facilities did not have a facility to access tea, coffee or water.

Good practice

The eating disorder pathway model was developed in collaboration with consultant paediatricians at the local acute trust and had been successful in reducing the need for tier 4 inpatient beds. The eating disorder pathway started in Exeter and Eastern Devon had been recognised as national good practice by NHS England and published in the British Medical Journal in May 2016. This was embedded in Exeter and East Devon and this good practice had been rolled out across the county.

The Devon wide assertive outreach team became operational in October 2014. The service provided intensive community CAMHS support. Since this service was in place the number of children admitted to inpatient services had significantly reduced. The team was shortlisted for a health service journal 'value in health care' award in January 2017 in recognition of their work.

Areas for improvement

Action the provider MUST take to improve

- Reduce waiting times from referral to assessment in the autistic spectrum conditions diagnostic pathway and for internal waiting times for treatment across all services.
- Ensure that all patient areas are clean and well maintained.
- Ensure there are alarms and security for staff in community buildings.
- Ensure patient risk assessments are completed and regularly reviewed.
- Ensure individual caseloads do not exceed the limits agreed in teams and on job plans.
- Ensure consent to treatment is recorded consistently across all services.
- Ensure children and young people are offered a copy of their care plan.
- Share learning from incidents across all the services and ensure the learning is embedded.

Action the provider SHOULD take to improve

- Ensure all services are fully staffed.

Virgin Care Limited

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
Autism spectrum assessment team/pathway	Capital Court
Southern Devon CAMHS team	Lescaze Court
Northern Devon CAMHS team	Springfield Court
Learning disabilities team	Capital Court
Assertive outreach team	Capital Court

Mental Health Act responsibilities

Staff within the service were aware of how to access support and guidance with the Mental Health Act when necessary. Staff used the Mental Health Act office of the local mental health trust for support and guidance when needed.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act applies to young people aged 16 or over. 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 young people where possible in the decision making regarding their care.

Staff had received training related to the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

- Community premises were dedicated to children and young people's services and were not shared with adult services.
- Young people were usually seen in the service community premises in Eastern, Northern and Southern Devon. Young people were also seen in a range of other community premises, such as GP surgeries across the county. Young people were also seen at home if this was assessed as the most suitable place for the child to be seen. Physical examinations were the responsibility of the GP and were carried out by the GP in the community.
- We visited four community premises in Dartington, Barnstaple and two sites in Exeter where young people are seen. Most premises had alarms in the interview rooms and main areas. However, Evergreen House did not have any alarms in the building.
- Most patient areas we inspected were visually clean. Parents at Springfield Court in Northern Devon commented that the building and rooms were always very clean. However, cleaning records were not consistently in place across the county and some areas at Evergreen House were not visually clean, such as one of the interview rooms and the waiting area. Services had toys which were mainly wipe clean in style and age appropriate, although systems to ensure regular cleaning were not always in place.
- Health and safety audits of buildings assessed obvious ligature risks, such as blind cords and pull cords in the toilets of the main buildings. Actions had been taken from these audits, for example, the blinds at Lescaze Court in Dartington had all been replaced. Risk was mitigated by children and young people not being left unaccompanied and most reception areas were manned and had CCTV in the waiting areas. However, there were still health and safety maintenance risks at Evergreen House in Exeter. For example, a missing cover from a water pipe in the coach house meeting room and loose wires on the landing.
- Staff adhered to infection control principles and regular hand wash audits were undertaken.

Safe staffing

- Across the services children, young people and their carers said they felt children and young people felt safe using the service.
- Current vacancy rates across the service in January 2017 were 18 whole time equivalent posts and staff were being recruited to fill these vacancies through an ongoing recruitment programme. Recruitment and vacancy rates were highlighted in the service wide risk register. A staff recruitment strategy was in place and recruitment drives were planned. Since September 2016 the service had recruited to 31 posts. However, there were still gaps in the provision of family therapy, psychology and nursing due to unfilled vacancies.
- Some staff reported feeling under pressure due to waiting lists, high caseloads and vacancies and turnover.
- The assertive outreach team had experienced difficulties recruiting to band six posts due to a lack of applicants. Until fully staffed the team was unable to operate on Sundays and was employing locums and continuing to try to recruit new staff.
- Teams had particular difficulties recruiting in the Southern for CAMHS and the Northern for learning disabilities, psychotherapy and psychology. The service was in the process of recruiting across clinical pathways rather than geographical locations to help reduce geographical vacancies.
- Southern Devon CAMHS team had experienced a higher turnover than other CAMHS locations. The team had experienced changes in team management and staff perceived a lack of support from countywide senior management with management issues in the team at that time. At the time of our inspection, a new manager had been in place for two weeks, which had already had a very positive effect on the team who felt more supported.
- A number of staff were due to retire or had recently retired. Succession planning was in place across the services.
- Vacancies were an item on individual team risk registers the service wide register and corporate risk register. This was reviewed regularly with staff teams and senior

Good

Are services safe?

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

management. Managers were working creatively to recruit to geographical areas by new staff being offered flexible bases and working in areas where staff were needed most.

- Caseloads were managed and reassessed regularly through individual supervision and team meetings. Caseload management was considered in teams by considering the number of cases and complexity of cases on each caseload. Staff each had job plans to help ensure staff staffing levels and these were monitored in staff supervision and caseload weighting tools were used across the teams.
- Caseloads in CAMHS teams varied in size. All multi-disciplinary staff had job plans to help plan their clinical and non-clinical time. However, there were pressures on the teams due to sickness, training and vacant posts. The assertive outreach team had a capped team caseload of 30 patients. However, at the time of our inspection there were 36 cases on the team caseload. The average caseload was six and the highest individual caseload was 11. The average caseload for the learning disability team was nine patients, with two members of staff having higher caseloads of 20 and 21.
- Management of the single point of access referrals had recently improved with clinical staff from each specialism reviewing referrals daily to safely manage the first point of access on the waiting list for referrals to mental health and learning disabilities services. Whilst this was a positive improvement to ensure referrals were effectively allocated children and young people's community services staff reported that this had impacted on time with existing caseloads.
- There was access to a psychiatrist in each CAMHS team, which was shared with the learning disabilities teams. The assertive outreach team had its own psychiatrist. The assertive outreach team provided psychiatric on call cover during its hours of operation Monday to Saturday. The local authority emergency duty team provided on call psychiatry out of hours. All teams accessed urgent psychiatry via the urgent pathway.
- The overall training compliance rate for services including CAMHS was 84%, which included staff that were off sick or on maternity leave. Managers of services held individual logs of training. Staff and managers received reminders when training renewal was due. This was red, amber and green rated and was monitored in supervision and management meetings. We reviewed a sample of records and saw that gaps were mainly due to staff being off sick or on leave and available staff were up to date with mandatory training, such as safeguarding. Some gaps were explained by waiting for training courses to be available. Staff training was incorporated into job plans and staff told us that the organisation supported staff to undertake training. However, staff across the service reported being out of date with some mandatory training due to staffing pressures in teams.

Assessing and managing risk to patients and staff

- We reviewed 26 records of children and young people and with the exception of the learning disabilities and the autistic spectrum assessment service, risk assessments were in place. Risk assessments showed evidence of risk management planning and risks included historical, social and current risks. FACE risk assessments were used which were recording and measurement of mental health risk assessments that were accredited by the Department of Health.
- Staff across the CAMHS teams described learning and improvements to risk assessments and recording following a recent serious incident in the CAMHS service.
- However, the learning disability service did not have risk assessments in place for each patient. Only one of the four learning disabilities records we sampled contained a risk assessment. The manager advised that the team only completed risk assessment where a risk was indicated. However, we also reviewed a care record where a risk was indicated and found that the risk assessment had not been regularly reviewed.
- The single point of access team screened all referrals and checked records held by the local authority and CAMHS. For the autistic spectrum assessment team, the single point of access team completed a risk assessment before the patient was accepted on to the waiting list. During screening all referrals were rated and triaged according to risk. For example if a child was in care, had mental health issues or were unable to attend school they were prioritised. CAMHS teams had recently strengthened this initial triage and risk assessment by attending a daily referral meeting. This was managed by a clinician with a clinical duty worker allocated on a daily basis in each geographical team.

Good

Are services safe?

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

- Once young people were referred from the single point of access team, waiting lists were monitored to detect increases in level of risk. This was undertaken by clinical staff within team meetings and waiting lists could be reprioritised according to risk.
- Psychiatrists followed the service protocol for prescribing and monitoring medication. There was a nurse prescriber in place in the assertive outreach team who followed the prescribing protocol guidelines. The organisation had planned to train more nurse prescribers across Devon.
- Staff followed safeguarding procedures and safeguarding champions supported safeguarding practices. Staff worked closely with the local authority to safeguard and promote the welfare of children and young people.
- All teams followed the lone working protocol which detailed safety procedures when visiting children and young people in the community. Teams were at various stages of developing this further to local geography and rurality and lack of mobile phone signal in places. Staff used buddy systems and an emergency list of staff car details. Next of kin details had been compiled for each location so that this information was more easily available out of hours. Although no adverse incidents had occurred during lone working, teams were aware that it was not always possible to receive a signal for mobile phones in some areas. All teams were clear about risk and did not visit an unknown family on their own and worked in pairs where there was a known risk.

Track record on safety

- There were two serious incidents (SIRIs) in the last 12 months in Eastern CAMHS service. Each team had developed and implemented actions plans following this. There was evidence of learning across the CAMHS service. This included improving care plans and risk assessments, the introduction of monthly audits of care and risk records and improvements in the waiting list letters. Waiting list letters invited families to get in touch if they felt that the situation had changed or if there was deterioration in the young person's health so that teams could respond promptly.

Reporting incidents and learning from when things go wrong

- Monthly good practice meetings included incidents and learning and the meeting fed back to the quality and safety committee.
- The assertive outreach team gave examples of incidents that had taken place which had resulted in learning. In the learning disabilities team, the manager gave an example of a recent incident that had led to improvements in safety including learning shared with the local authority.
- In CAMHS across all the geographical areas, there was evidence of learning from two recent SIRIS in the Eastern team. For example, each team had completed an action plan that had included changes such as initial letters to families, risk assessments and care plan monitoring and improvements.

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

- Initial assessments were completed through the single point of access team who screened, rated and triaged referrals.
- The autistic spectrum assessment team used the autism diagnostic observation schedule, a semi-structured assessment to diagnose children with autistic spectrum disorders. They also used other recognised assessments to assess the severity of symptoms and the level of behavioural adjustment.
- We looked at 26 care records in total. Three of the twenty six records we reviewed did not have a care plan or goal setting. We saw examples of clear goal setting and how this would be achieved, for example in the CAMHS teams and the assertive outreach service. However, we found that there was a lack of goal setting and regular reviews in the learning disabilities team where two records we reviewed did not have a formal care plan. We found one record in Eastern Devon CAMHS that did not have a care plan.
- We also found some variability in care plans, for example, consent to treatment was not always clearly documented.
- However, we found examples of detailed progress notes, diaries and care plans that were personalised to include the views of the young person or carer. We saw some examples of a copy of care plan being given to the young person, for example in the Northern Devon CAMHS team, but this was not consistently recorded across teams.
- All information on each site was stored securely. The CAMHS services used an electronic recording system that could be accessed across the pathways regardless of geographical location or team.
- The learning disabilities service used a different electronic system to the CAMHS teams. Administrative staff had access to the system so they could check records held by all teams. The learning disabilities service's reduced access to information across the county wide services was highlighted as a governance and data issue on the risk register.

Best practice in treatment and care

- All the services provided a wide range of psychological interventions for children and young people by a team of therapists, including family therapists and psychotherapists. Treatments included dialectic behavioural therapy, systemic family therapy and cognitive behaviour therapy.
- Staff followed the National Institute for Health and Care Excellence (NICE) guidance and we saw examples of evidence based practice to improve outcomes for children and young people. For example, the eating disorder pathway service had improved care and treatment for people with eating disorders through effective partnerships with acute inpatient services. This was particularly well developed in Exeter and Eastern Devon and had been recognised as good practice by NHS England.
- The provider had improved access to evidence based psychological therapies by training staff through the children's improving access to psychological therapies programme. The service was actively developing its staff across the county to offer psychological therapies at certificate and post graduate level and had trained 40 staff since 2015 with a further 15 planned for 2017.
- The service monitored outcome measures, such as through their pathways.
- Evidence based support was provided to schools in Devon that had opted into an early help for mental health project with schools. The organisation was in the process of rolling out named mental health workers to GP practices to support them in making referrals to the service.
- The learning disabilities team had completed baseline assessments for challenging behaviour. They reviewed their practice against the National Institute for Health and Care Excellence guidance and developed an action plan.
- The county CAMHS and LD service did not undertake routine annual physical health checks. This was carried out by the young person's general practitioner, who held responsibility for their overall physical health management. All young people who had been prescribed antipsychotic medication were monitored by psychiatrists in the service.
- Staff actively participated in a range of clinical audits and there was an annual audit programme in place. This included medicines management, safeguarding, records and confidentiality.

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.

Skilled staff to deliver care

- The teams across Devon had a range of psychiatrists, psychologists, nurses and therapists providing a range of disciplines to support children and young people with specialist mental health treatment and learning disabilities. For example, the autism diagnosis service team had established a core staff qualified in autism diagnostic observation schedule and other autism diagnostic interviews. The team had recently recruited a Consultant psychologist full time.
- Following the recent transformational funding to increase capacity and reduce waiting times, the organisation was in the process of recruiting to a number of positions including band five and six nurses. This had been agreed to support succession planning and career development for staff.
- The countywide services were in the process of aligning interventions to clinical pathways. New staff were being recruited to pathways and existing staff were developing expertise and specialising in working across clinical pathways.
- We reviewed staff records and looked at induction and mandatory and statutory training plans. Staff received a full induction, including shadowing staff across the CAMHS service with shadowing opportunities across the care pathways. Systems for supervision were in place. Staff were supervised with a combination of clinical and managerial individual supervision, including group clinical IAPT supervisions. County wide supervision groups were in place, for example, managing emotions pathway supervision groups.
- We reviewed staff records which showed staff were supervised regularly, although there were some gaps. Some staff records showed staff were not supervised as frequently as once a month, as per their policy. However, staff told us that they felt supported by their managers.
- Each team had regular team meetings, which included clinical and business components on the agenda.
- Staff had good specialist training opportunities. All staff we spoke with confirmed that they received the necessary specialist training for their roles. Staff expressed satisfaction with the training offered. Staff had the opportunity for development training and three staff described the organisation as very supportive with developmental training, such as training in psychological interventions recommended by the National Institute for Health and Care Excellence. In the learning disabilities team staff had been trained in sleep management and positive behaviour support.
- The service wide commitment to support staff to develop in their roles meant that staff spent periods away from clinical work on specialist training courses. For example, Eastern Devon CAMHS had recruited staff on recruit to train programmes which meant there was an agreement to support the staff member to complete a post graduate qualification with periods of time away from the service.
- Staff confirmed they received an annual appraisal. Data showed 94% of staff had received a recent appraisal.
- Team managers confirmed they had dealt with poor staff performance promptly through the supervision structures and support from Virgin Care human resources. Managers described a clear policy on performance and capability which supported staff and managers with expectations about performance. We reviewed records and saw examples where performance that fell below the expected standards was addressed.

Multi-disciplinary and inter-agency team work

- There were examples of good joint multi-disciplinary and inter-agency team work. Each team had regular multi-disciplinary meetings each week and clinical case discussions.
- The service had recently introduced daily participation at the single point of access triage and allocation meetings. This was a recent improvement with daily clinical input from teams which had strengthened and improved the allocation triage and assessment process.
- Inter-agency team work was in place and was working effectively. For example, the CAMHS teams liaised with the paediatric services in Exeter, Eastern and mid Devon through the jointly developed care pathway. A patient with an eating disorder would be flagged to be seen immediately and staff would work with paediatricians at the acute hospitals. Staff reported that this worked particularly well where partnerships were well developed at the local acute hospital and were developing across the rest of Devon
- Staff attended regular transitions meetings, to support the pathway of young people in transition from child to adult services. Staff attended monthly meetings with adult services.

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.

- We observed effective discussions between locality and pathway teams within the organisation. For example, a clinical discussion between the single point of access service clinicians and the Northern CAMHS team. Information about the referrals were handed over well.
- The community teams had links with schools to help manage mild to moderate levels of mental health. Primary mental health workers engaged in multi-agency early help with 'team around the child' inter agency meetings. Observation of a 'team around the child' meeting with parents and external agencies was well conducted with respectful and genuine support for the parents of a young person. This included staff from the autistic spectrum assessment team. However, the CAMHS worker who knew the young person well did not attend the meeting. This resulted in a lack of information about what support the CAMHS team had provided and would continue to provide.

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

- Staff did not receive formal Mental Health Act training. However, staff described good support, advice and guidance from the Mental Health Act offices at the local mental health trust about the implementation of the MHA and Community Treatment Orders (CTOs).
- All CTO paperwork we reviewed was filled in correctly and appropriately stored. We did not see examples where patients' rights had been read to them.

Good practice in applying the Mental Capacity Act

- The Mental Capacity Act (MCA) does not apply to young people aged 16 and under. For children and young people under the age of 16, the young person's decision making ability is governed by Gillick competence and Fraser guidelines. The concept of Gillick competence and Fraser guidelines recognises that some children under 16 may have sufficient maturity to make some decisions for themselves.
- The provider had an up to date Mental Capacity Act (MCA) policy and MCA training was mandatory. Staff in all teams demonstrated a good understanding. Most staff were up to date with MCA training and the overall compliance was 83%. The learning disabilities team had a nurse champion for MCA and best interest's assessments.
- The staff we spoke to were conversant with the principles of Gillick and Fraser competence and used these to include the children and young people where possible in the decision making regarding their care. The service model was to always engage parents as this was considered best practice and safer. However, the managers described that they would accommodate a child wishing to have treatment without their parents or carers involvement, if appropriate and depending upon risk.
- Staff routinely engaged in discussions about consent with young people and their families in the clinical observations we observed. Capacity to consent to treatment was considered once a child reached 16 and from the age of 14 the team would consider Gillick competence. However, we found gaps in recording consent in the records from the learning disabilities team and assertive outreach teams.

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

- Parents, children and young people told us that staff were kind and caring and always treated them with dignity and respect.
- Families told us how all staff including reception staff were very understanding and caring.
- Staff were respectful and supportive when interacting with children and young people and in discussions about patient care. Reports by young people of how staff behaved towards them were mainly very positive. Children, young people and their parents told us that staff demonstrated clear understanding of their individual needs. Observations of care and multidisciplinary discussions confirmed this.
- We observed a pre assessment between a clinician and a young person and their carer which was respectful and supportive with clear information provided.
- Staff were aware of confidentiality and we saw that this was maintained. For example, notes were kept securely and children and young people were seen in private clinic rooms.
- Staff worked flexibly to support young peoples' individual needs. For example, if a patient wanted their parent with them or if a patient needed to be seen at home or at a GP practice.

The involvement of people in the care that they receive

- Most young people and their families described active involvement in planning their care and treatment. However, parents described a lack of involvement during the waiting time from accepting referral to treatment or diagnosis.
- Parents expressed concerns about a lack of communication while waiting for services. Seven carers expressed frustration about a lack of involvement and isolation when waiting to get into the service.
- The service had responded to supporting and communicating with parents and families more. Each team gave examples of improvements to involvement to young people on waiting lists. For example, letters to carers had been changed to encourage contact and requesting families to complete preparatory information. For example, in the learning disabilities service families were asked to support young people to complete sleep diaries whilst waiting for their first appointment.
- We observed care, therapy and treatment options being discussed with young people and families. Children and young people told us that they felt involved in their care or therapy. However, we did not always see that young people had been given a copy of their care plan clearly documented in the clinical records.
- Young people were encouraged to give feedback on their care and we saw that there were opportunities for people to comment on each of the sites we visited, such as comments boxes and friends and family tests.
- Each of the CAMHS services had user participation champions and parents and users on interview panels. A dedicated service user facilitator had developed a service user and carer participation group. The group were involved in staff recruitment and had made improvements to service design, such as displaying their artwork and installing 'graffiti' boards in services where children and young people could scribble their comments and ideas.
- There was recognition of voice of the child through the 'keeping child and young person at the heart of what we do' Devon Assessment Framework meetings (DAF).
- There was access to advocacy services for children in Devon and staff were aware of services they could recruit to. In the learning disabilities service there were Mental Capacity Act advocates for children aged over 16. Advocacy for children under 16 was provided in specialist schools.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- The provider worked closely with commissioners to manage and report waiting times from referral to treatment against the 18 week target. At the time of our inspection the provider was in the process of service redesign to pathways and had implemented improvements to waiting times waiting list management. This had been supported by transformation funding for CAMHS services.
- The autistic spectrum assessment waiting times were a key strategic priority for the provider and the commissioners for 2016/2017. The service was leading a multiagency task and finish group with key partners to streamline the diagnostic process.
- In line with the national trend, the autistic spectrum diagnostic and assessment service experienced a significant increase in demand. The provider reported a 54% increase in referrals from 2013/14 to 2015/16. The service had inherited a long waiting list in 2013 and this had improved significantly. However, waits were still long. At the time of our inspection there were over 325 young people waiting for an autism spectrum diagnosis assessment. The longest had been waiting for 68 weeks
- There were urgent appointments available for autistic spectrum assessments. For example, if a child was refusing school or if there were child protection issues or the child was in care. Whilst there were significant improvements, more than 200 young people were still waiting above 18 weeks from referral to assessment in December 2016. Parents and young people commented negatively on this.
- In line with national trends, the provider reported a rise in volume of referrals to CAMHS with an increasing complexity of need, such as, self-harm and eating disorders. The CAMHS service worked closely with clinical commissioning groups to meet the existing and projected increase in demand for CAMHS community services.
- In December 2016 95% of children and young people were seen and the service was exceeding the target of 92%. The average waiting time in December 2016 was six weeks compared to 14 weeks in April 2013. However, 28 people had waited more than 18 weeks in December 2016 for CAMHS services.
- As with the CAMHS service, demand had increased and the service estimated the increase in demand to be 22%. The service had reduced waiting times through increasing the numbers of people seen. In December 2016 the average wait was six weeks. There were 91 children and young people waiting at the time of our inspection.
- All the children's services assessed the starting time for waits after the referral had been through the single point of access rather than the actual time the referral was first received by Devon integrated children's services at the single point of access. This meant that referral times were one or two days longer than stated. However, CAMHS and learning disabilities services triaged children and young people promptly from the single point of access team as teams provided daily clinical input to the screening at single point of access. Waiting lists were then managed by teams.
- Staff reported further waiting lists for children and young people who required further treatment after a brief intervention. If more treatment was needed after four sessions, then young people had to wait for more intensive treatment. This approach was in line with the international 'choice and partnership approach.' Waits for cognitive behaviour therapy were an average of 16 weeks in Southern Devon and 19 weeks in Eastern Devon. There were longer waits for a smaller numbers of patients. For example, three children and young people had been waiting for an average of 39 weeks for psychotherapy in Southern Devon.
- Children and young people were offered some flexibility with appointments, for example, young people could have a choice of location and time. The service was not commissioned to provide home treatment but offered individual flexibility to visit young people at home. The teams also took a proactive approach to re-engaging with people who did not attend their planned appointments. Appointments were only cancelled when necessary, such as unexpected staff sickness that could not be covered.

The facilities promote recovery, comfort, dignity and confidentiality

- We looked at the environments in the community locations in Northern, Southern and Eastern Devon.

Are services responsive to people's needs?

Requires improvement

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

There were therapy rooms and clinic rooms to support treatment and care. Interview rooms were light and spacious and had adequate sound proofing. There were age appropriate toys available.

- There was good access to parking at the Southern and Northern team premises.
- Parents and carers and young people could not always access drinks in waiting areas. We did not see consistent access to water dispensers.
- In the Northern team office, there were a wide range of toys in the bright and cheerful waiting room and children's and young people's artwork was displayed throughout the building.
- There were good examples of appropriate materials and information for younger people displayed. A young persons 'graffiti board' was in place in the Southern and Eastern locations where young people could write, doodle, and make comments. This was an idea from young people that had been implemented. There was access to Wi-Fi for young people and families in the Southern team building at Lescaze Court.
- There were age appropriate leaflets for children on each site, such as information on treatments, local services and how to comment and complain.
- The buildings and furnishings at Dartington in the Southern and Evergreen House in the Eastern were worn in places.

Meeting the needs of all people who use the service

- Each building had been converted so that there was full disabled access including accessible toilet facilities and meeting rooms.
- We did not see the full range of information leaflets in an easy read format and in languages spoken by people who used the service, but staff confirmed that these were easily accessible through customer services. Access to interpreters and/or signers were arranged through a language line service.

Listening to and learning from concerns and complaints

- Complaints were recorded on the incident management system where they were reviewed by the team manager and discussed at leadership and team meetings.
- The CAMHS service had received a total of 31 complaints in the last 12 months, nine of which were upheld. There were no formal complaints to the learning disability service. No complaints were referred to the ombudsmen in the last 12 months.
- Two families we spoke with had made a complaint to Healthwatch, the the national independent champion for consumers and users of health and social care in England. Both families described the number of different appointments they had with professionals where they had to repeat the same information. One family described the service as patchy and inconsistent.
- The main themes for complaints were the length of time waiting for an appointment and poor communication from services. These themes were similar to comments we received from parents during the inspection. Managers also told us complaints were generally about the waiting times and the lack of someone to talk to while on the waiting list. The autistic spectrum assessment team had developed a case coordinator role to monitor and support people on the waiting list as a result of this feedback. CAMHS teams had improved the referral and appointment letters to encourage families to keep in touch while waiting for their treatment.
- All the services we visited were aware of complaints in relation to waits and the pressure that this caused on young people families and staff as a result of this. This had been identified as a risk on the overall risk register.
- PALS leaflets on how to complain were at each site and information about rights and responsibilities which also had information on how to give feedback. "You said, we did" boards were on display which showed improvements that had been made as a result of feedback and engagement.
- Services were open to complaints and learning from these. Complaints and compliments were discussed at business meetings and were on the standing agenda of business meetings on each site. We reviewed recent informal complaints and saw that there were learning and action points identified from these. In the Southern team, changes had been made to provide a later appointment to fit in with school.

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 organisational core values of 'striving for better' (think), 'providing a heartfelt service' (care) and 'working as a team' (do). These were values that staff were positive about and worked toward in their teams. The values and objectives formed part of the values based appraisal system in place.
- Staff knew who the most senior managers were and most staff agreed that the leadership team was visible and had regularly visited services. Most staff were positive about Virgin Care as an organisation to work for with values that they adhered to.

Good governance

- Systems were in place to monitor compliance with mandatory and statutory training and staff appraisals.
- Systems to measure performance and information were disseminated to teams. The service had invested in governance systems, such as a web based performance and information system that captured key performance indicators (KPIs) to monitor compliance and measure performance. The system captured information about each service on a clinical governance RAG rated scorecard. For example, waiting lists, incidents, risk, complaints and service user feedback. This was fed into team and leadership and governance meetings. However, the system was not fully embedded and some managers were not familiar with how to use and share the information collected.
- Each team manager had administrative support and managerial support from the service manager. Managers felt they had sufficient authority to carry out their role effectively, although there were pressures due to the waiting list and capacity issues.
- Each team submitted items to their local risk register and key risks such as waiting lists, lack of key staff vacancies, such as psychology were submitted to the CAMHS wide and service wide risk registers. The team risk register was reviewed in monthly management meetings and in weekly meetings with the head of operations. Risks were reviewed by the CAMHS risk board and clinical safety and effectiveness group.

Leadership, morale and staff engagement

- Staff surveys were carried out regularly and bi-annual staff surveys were published with response rates and survey results. Information was published in monthly ICS staff newsletters. Staff described systems for staff support and feedback as good. There were small things, such as buying staff tea and coffee and budgets that team managers could apply for to say thank you to their teams that staff told us they appreciated.
- The provider had an open culture and encouraged staff to report and learn from incidents, including safeguarding. There was evidence of learning from the two serious incidents that had filtered across the CAMHS services with team action plans in place.
- Staff were aware of the freedom to speak policy which had replaced the whistleblowing policy and told us that the culture in the organisation was open and transparent. Staff told us that they would be happy to raise concerns without fear of victimisation.
- Policies were available on the staff intranet system and a policy of the month was highlighted each month to enhance staff awareness. Duty of candour and freedom to speak up had recently been highlighted.
- Most staff were passionate about their jobs and were highly motivated to do their job well, but felt under pressure from turnover, vacancies, assessments and waiting lists. Morale was attributable to the pressures staff felt. For example, in the autistic spectrum assessment service where the waiting lists were high and turnover the morale was mixed. In Northern Devon CAMHS where there was a well-established and stable team, team morale was high. In Southern Devon, where management changes and lack of management support in the last few years had adversely affected the whole team and team morale. However, staff were very positive about the new manager.
- Staff felt able to raise concerns with their managers. Staff we spoke with were confident in how to whistle blow including in cases of bullying or harassment.
- All managers were nominated for leadership training as part of their development and were enthusiastic about the leadership and development opportunities provided by the organisation. Some managers were new to post and had not completed leadership courses yet, but

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Good

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opportunities were in place for all managers and service leads. The Eastern CAMHS manager had been nominated to join the advanced accredited leadership programme 'Inspire' run by Virgin Care.

Commitment to quality improvement and innovation

- The teams were committed to quality improvement and there were a number of examples of innovative practice or involvement in research to improve experiences for young people. For example, the Assertive outreach service had reduced length of stay and admissions to inpatient wards. The team was shortlisted for a health service journal 'value in health care' award in January 2017 in recognition of their work. The eating disorder pathway service in Eastern Devon CAMHS and the paediatric service in Exeter, Eastern and mid Devon had received Beacon status and were recognised as national good practice by NHS England. The pathway work has reduced inpatient stays in tier four psychiatric units.
- The service worked in partnership with the local university to develop accredited programmes, such as mindfulness and access to psychological therapies courses and delivering care though pathways.
- The service ran regular six week courses for parents and carers in the South of the county to learn about mental health. Anecdotal feedback from parents who had undertaken the psycho educational course had been very positive and formal measures were being collated before roll out across the county.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured that the environment at Evergreen House was clean and well maintained and had not ensured adequate security and alarms.** **This was a breach of Regulation 12.(1) (2) (a) (b) (d) (h)**

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 provider had not fully addressed the long waiting lists for patients to access services, including internal waiting lists and the autistic spectrum diagnostic pathway.** **This is a breach of Regulation 17(2)(a)**