Requires improvement

Cornwall Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Cornwall Partnership NHS Foundation Trust
Fairview House
Corporation Road
Bodmin
Cornwall
PL31 1FB
Tel:01796 291000
Website:www.cornwallpartnershiptrust.nhs.uk

Date of inspection visit: 14-16 April 2015
Date of publication: 09/09/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ8X7	Bolitho House, Penzance	West Cornwall CAMHS	TR18 2AB
RJ8X7	Heathlands, Liskeard	East Cornwall CAMHS	PL26 7DQ
RJ8X7	Sedgemoor Centre, St Austell	East Cornwall CAMHS	PL25 5AB
RJ8X7	Child & Family Centre, Truro	West Cornwall CAMHS	TR1 3LQ

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

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

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Outstanding** 
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 Cornwall Partnership NHS Foundation NHS Trust Child and Adolescent Mental Health Services as **requires improvement** because:

- It was not responsive to the needs of the young people as it did not have safe staffing levels to meet the volume of young people it needed to see.
- We were concerned with the arrangements for providing crisis care to young people out of hours with no CAMHS consultant cover. We recognise that this is something the trust has to address jointly with its commissioners.
- The service did not always provide families with copies of letters or care plans.
- Management supervision was inconsistent , however this appeared to be due to the workload pressure we observed staff to be under, rather than systemic failings.

However;

- The service was performing remarkably well despite the pressures of the volume of young people who needed its support with the resources it had available.
- We found a service that was caring and innovative in the way it delivered mental health services to young people, with areas of excellent clinical practice.
- The service delivered very effective interventions and worked hard to keep young people safe with a dedicated staff team who were valued by the young people and families who used it.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- There was not sufficient staffing to provide a safe service for the numbers of young people needing support
- This was having an adverse effect on the staff providing the service with high sickness rates and staff working long hours
- We had concerns over the physical environments at Bolitho House and Sedgemoor.

However:

- The service was very good at managing risks to young people and they had a good culture of learning from incidents.

Are services effective?

Outstanding

We rated effective as **outstanding** because:

- There was an excellent shared approach to risk taking and management which included very good multidisciplinary and interagency team work
- There was outstanding practice in relation to looking after families holistically by providing services for parents as well as the child. This was exemplified by the specialist parenting service for people with learning disabilities and provision of psychotherapy for parents of young people using the CAMHS service
- There was also innovative practice in relation to prescribing and how the service targeted clinical audits.

However;

- Some communication with other agencies could be improved.

Are services caring?

Good

We rated caring as **good** because:

- We observed all staff within the service providing skilled interventions in a caring and respectful way. Staff showed in-depth knowledge and understanding of all the needs of the young people and their families using the service. Young people and their families who used the service all gave positive feedback on the staff within the service
- There was good participation work in partnership with a local advocacy service to ensure the voice of young people was heard in service design

Summary of findings

- We observed care being designed in a collaborative way with young people and families.

However;

- We were concerned that young people and families did not always receive copies of their letters including their plans of care and that staff did not always lock their computers when away from their desks.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** because:

- Staff and families all expressed concern at the safety and suitability of out of hours arrangements. However, we recognise that this is something the trust has to address jointly with its commissioners
- There were no clear arrangements for young people aged 16 and 17 who were experiencing a delay when requiring admission to an inpatient Tier 4 child and adolescent facility. This group of young people could be admitted to any ward within the general hospital. However there were clear arrangements for young people under 16 who could be admitted to a paediatric ward whilst waiting. The trust were not commissioned to provide Tier 4 CAMHS inpatient beds.
- Families told us they had difficulties in accessing the service initially, although we did see that the service had plans to address this.

However:

- We saw that the service was proactive in managing the risks of young people on waiting lists. We saw records of one of the locality managers reviewing all of the young people on the waiting lists every week, including, where appropriate, contacting referrers for an update on the current presentation. We also saw evidence in the clinical meetings of young people being assessed more quickly as a result of those reviews identifying heightened risk.

Are services well-led?

Good

We rated well-led as **good** because:

- We saw a service that had clear vision and values
- There were good governance structures which had clear learning and service development outcomes
- There was good local support from managers and clear clinical leadership.

Summary of findings

However;

- We were concerned that a significant proportion of staff did not feel they would be able to raise concerns with the executive or senior management team.

Summary of findings

Information about the service

Cornwall Partnership NHS Foundation NHS Trust provides tier three specialist community child & adolescent mental health services (CAMHS) for the whole of Cornwall. The service helps children and young people deal with emotional, behavioural or mental health issues. The service includes specialist mental health teams, specialist teams for children with a learning disability and a special parenting service. The service also provides some tier two services through primary mental health workers attached to schools. The service operates out of eight locations across the county.

We have not previously inspected this service.

Our inspection team

The inspection team was led by:

Chair: Michael Hutt, Independent Consultant

Head of Inspection: Pauline Carpenter, Head of Hospital Inspection, CQC.

Team Leader: Serena Allen, Inspection Manager, CQC.

The team that inspected specialist community mental health services for children and young people was led by a CQC inspection manager and was comprised of a CQC inspector and four specialist advisors experienced in CAMHS provision. The specialist advisors included a social worker, CAMHS service manager, psychologist and a nurse.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Visited four of the clinic bases CAHMS services were delivered from and looked at the quality of the environment and whether it was suitable for young people to use
- Spoke with seven young people who were using the service
- Spoke with 22 carers/parents of young people using the service
- Spoke with the service manager and clinical director
- Spoke with 53 other staff members; including doctors, nurses, occupational therapists administrative staff and psychologists both individually and in groups, including a focus group open to all CAMHS staff
- Attended and observed two multi-disciplinary meetings and a clinical governance meeting
- Observed 11 clinical appointments with young people, including clinic appointments, home visits and an appointment in a local secondary school

Summary of findings

- Looked in detail at 24 treatment records of patients
- Observed three clinical supervision sessions
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Children and young people who use the service and their families and carers were very positive about the service they received. They told us that the staff were very good at understanding their needs and that they offered practical help which was effective in helping young people to recover.

They also described staff as down to earth and able to engage at the appropriate level for the child, or young person's needs, while also keeping the parents/carers informed and involved appropriately.

Children and young people who use the service, and their families and carers, told us that they were very involved in their care and the decisions made.

However they also told us that there was a long wait sometimes to initially get into the service, with one family telling us they waited a year.

They also told us they didn't always get copies of care plans or letters about their care.

Good practice

The service had introduced a prescribing group which brought together both psychiatrists and nurse prescribers in the service. In this group they reviewed and compared their prescribing practice against the latest evidence base of clinical literature and NICE guidance to ensure consistency in their use of medication in line with best practice and effectiveness. The pharmacy inspector considered this to be a very effective and innovative example of best practice in prescribing

There was a specialist parenting service which worked with parents who had a learning disability to help safeguard the mental health of their children. Although the work was with parents the service worked very well investing the clinical time in the adults to get the children the best possible outcomes.

The service provided a psychotherapy service for parents of young people who used the CAMHS service. This provided parents with counselling to help with their emotional needs. This was provided by using external counsellors in GP surgeries which was overseen by a band seven psychotherapist in the CAMHS service. The psychotherapist coordinated the service and provided supervision for the counsellors. This helped with the resilience of families and improved the outcomes for young people and was valued by professionals and people who used the service.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there are sufficient competent staff to meet the needs of the population safely.
- The provider must engage with local commissioners to review staffing provision, in particular the out of hours crisis provision for young people.

Action the provider SHOULD take to improve

- The provider should work with the staff team to address that many staff expressed they would not feel comfortable to be able to raise a concern and that they did not feel engaged with change processes.
- The provider should ensure all young people and their families get copies of their clinic letters which includes their plan of care or separate care plans.

Cornwall Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
West Cornwall CAMHS	Bolitho House in Penzance and the Child and Family Centre in Truro
East Cornwall CAMHS	Heathlands in Liskeard and the Sedgmemoor Centre in St Austell

Mental Health Act responsibilities

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

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

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had received training related to the Mental Capacity Act and Deprivation of Liberty Safeguards. This is part of the e-essential training package. There was 98% compliance with this training. Staff within the service demonstrated good understanding of capacity in relation to treatment of children and young people.

Requires improvement

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Please see summary at beginning of report.

Our findings

Safe and clean environment

At Bolitho House in Penzance the service shared a building with adult mental health services. Although there were separate entrances, they shared the same car park. Internally there was a keypad door separating the services, although the CAMHS team did take young people through to use a clinic room on the adult side. There were no protocols or risk assessments in place to ensure that the shared usage of space was safe for children.

Families and young people told us that rooms at Bolitho House got very hot and windows had to be opened. This meant people coming in the entrance could hear what was being said.

At Sedgemoor the environment was stark and utilitarian, with furniture and carpets that were stained and threadbare.

Liskeard was well maintained and at Truro the service had provided a separate waiting are for teenagers.

Safe staffing

We were concerned at the level of staffing compared with the amount of work and cases staff were holding. Staff reported that they felt low staffing levels were putting pressure on the caseloads and level of responsibility they felt. Staff also felt they had been holding vacancies for some time and only recently had there been recruitment to fill those posts. The trust reported that there was a 26% vacancy rate for CAMHS nursing. Staff and managers told us that they felt the current tender process and the uncertainty it had created had impacted on their ability to attract people to the service.

The trust recognised the risk of the level of activity and had placed it on their risk register raising concern at: “Difficulty in meeting present demand for CAMHS services due to number of referrals and their acuity”. In the west Cornwall services we saw referral rates rising from 726 referrals in 2007-2008 to 1757 referral in 2013-2014. Currently there were 18 young people on the waiting list for west Cornwall. This was due to staff taking on open cases to ensure they were safe. One team based in Liskeard reported they had 4.5 whole time equivalent staff holding 420 open cases.

The trust was commissioned to provide 1900 episodes of care, but last year completed 5000 episodes.

Primary Mental Health Workers on average had to cover three secondary schools each and all the feeder primary schools. This was compounded by the large geographical area they had to manage. One primary mental health worker reported having a caseload of over 40 young people. This is higher than would be expected for a full time community worker which is 28. However primary mental health workers were supposed to spend a third of their time on education, a third on consultation and only a third on clinical contact.

One member of staff in a tier 3 specialist CAMHS team reported a caseload of 90 cases.

Staff from all disciplines felt concerned about the amount of responsibility and risk they were holding due to their high caseloads. This was having a significant impact on staff wellbeing.

Staff frequently reported working over their contracted hours to ensure their workload was met and young people were safe. The NHS staff survey showed us that staff in children's and young peoples services had the highest percentage of staff working extra hours in the trust at 79%. The staff survey also showed that 23% of staff felt pressure to attend work when feeling unwell. The CAMHS service had double the trust sickness rate of four percent with eight percent of staff off sick.

Management in the service had been proactive in reviewing posts that became vacant to maximise the amount of value it could provide. For example, rebanding a vacant band 8c family therapist post to a band 8a and using the savings with some funding from another post to create an extra Band 7 post.

Requires improvement

Are services safe?

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

The trust had been reviewing the referral criteria for accessing the service with Kernow Clinical Commissioning Group (CCG) . Staff were concerned that there would be limited services available to young people who did not meet this criteria.

There was also a concern within the service that the current tender process was affecting their recruitment.

The service did have good uptake of mandatory training with over 90% of staff compliant.

Assessing and managing risk to patients and staff

People using the service told us that staff gave practical advice on how to manage risky behaviour displayed by the child/young person. They also told us that the staff in CAMHS explained to them why it could be happening in the context of their mental health needs, providing education and reassurance on the issues.

The service had very good methods for shared risk management. We observed very proactive weekly multidisciplinary meetings which all clinical staff in the teams were expected to attend. During those meetings clinicians would present their cases with the most risk and the multidisciplinary team would discuss and agree the risk plan. This was then updated live onto the electronic clinical records system during the meeting. This ensured that no individual clinician was holding the risk surrounding complex young people's needs.

Staff we spoke with had a very good understanding of safeguarding procedures and what would constitute a concern. We observed administrative staff effectively identifying and addressing a safeguarding concern that had arisen in a referral.

We observed in clinical team meetings staff appropriately questioning whether safeguarding referrals needed to be made following a clinical discussion. There was then a detailed discussion about the rationale for the actions taken which showed a very good grasp of both the young person's situation and the thresholds and need for different agencies involvement in the safeguarding process.

Staff were being trained in the "signs of safety" training, this was detailed training that helped staff identify signs of abuse.

There was a well understood system for lone working in the community and staff had personal alarms.

Track record on safety

There had been no serious and untoward incidents in the 12 months prior to our inspection.

Reporting incidents and learning from when things go wrong

We saw evidence of the service learning from adverse incidents within the service but also from other parts of child health in particular an issue in health visiting that resulted in changes to how families and young people were treated on arrival in clinics.

We saw that the service used a robust electronic system to report incidents. Incidents were investigated by the relevant manager. We saw there were systems in place for learning to be reviewed by other senior staff and the learning points fed back to the staff team, through team briefings at team meetings. Learning from incidents was also published in a quality assurance newsletter called "confidence".

We saw an example of where there was a breach of confidentiality following letters going to the wrong address. There was targeted information governance training provided to staff following the investigation which resulted in no further incidents.

Are services effective?

Outstanding ☆

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.

Summary of findings

Please see summary at beginning of report.

Our findings

Assessment of needs and planning of care

All young people were assessed and given good explanations of the outcomes of assessments and agreed identified needs. However the service had recognised it needed to improve its case formulation following an audit of its records and we saw work progressing to address this. The 24 case notes we reviewed showed good risk assessments that were always up to date. Other parts of the records were of variable quality which appeared to be a result of both workload pressures and I.T. problems.

We observed very good safety plans for managing the care of a young person when in crisis, which were reviewed regularly as part of the shared risk management.

All records were kept securely on an electronic records system.

Best practice in treatment and care

The service had introduced a prescribing group which brought together both psychiatrists and nurse prescribers in the service. This group reviewed and compared prescribing practice against the latest evidence base of clinical literature and NICE guidance to ensure consistency in their use of medication in line with best practice and effectiveness. This also involved agreeing and developing targeted audits as a result of the meetings. For example, there was a current audit looking at the use of Melatonin (a medicine to assist sleep). Our pharmacy inspector considered this to be a very effective and innovative example of best practice in prescribing.

We saw good innovative practice and involvement of other services, for example, using the specific skills of a student occupational therapist and the voluntary sector to develop a support plan for a young person with social isolation.

We saw evidence of excellent clinical audit activity clearly linked to needs identified by the service, we saw that the service had developed a tool to help identify and target areas where audit would be helpful.

Learning outcomes from audits were being shared with all staff in the teams. We saw a summary of audit outcomes being presented by one of the psychiatrists to his colleagues in one of the clinical team meetings. These included audits on depression care, autistic spectrum care and a case formulation audit. We saw how the clinical team discussed the findings and put in changes to practice as a result of this. For example, we heard a psychologist in the team explain how following the case formulation audit she would provide training for staff on how to ensure case formulation is recorded to British Psychological Society (BPS) standards.

The service considered the physical needs of the young people in relation to their care, but requested that the majority of the checks were completed by the patient's GP surgery. Families told us that the communication on this could be better.

We saw the service working to deliver specific interventions for young people with eating disorders. Staff were trained in the Maudsley model, which is recognised best practice. Although still a pilot in the East Cornwall service, staff were enthusiastic about the new approach and able to demonstrate its clinical effectiveness with young people they worked with.

The service provided a psychotherapy service for parents of young people who used the CAMHS service. This provided parents with counselling to help with their emotional needs. This was provided by using external counsellors in GP surgeries which was overseen by a band seven psychotherapist in the CAMHS service. The psychotherapist coordinated the service and provided supervision for the counsellors. This helped with the resilience of families and improved the outcomes for young people and was valued by professionals and people who used the service.

There was a specialist parenting service which worked with parents who had a learning disability to help safeguard the mental health of their children. Although the work was with parents providing emotional resilience and parenting skills, the aim of the service was to ensure the children received the best possible outcomes in their emotional and educational development. We saw that this had effective outcomes.

Are services effective?

Outstanding ☆

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

In all teams we saw a mix of clinical disciplines including psychiatry, nursing, psychology, occupational therapy and psychotherapists that supported each other appropriately with a good knowledge base.

There was an acknowledgement by the service that there had not been sufficient family therapy staff for some time, but we saw that recruitment had occurred with staff appointed. There was concern that at times there were delays in the recruitment of posts with one team having no access to psychology for over a year prior to a recent appointment.

We saw staff used their skills in their specialisms. There was a specific service for children and young people with learning disabilities. This service had a range of specialist staff which met the needs of young people and families.

We observed two episodes of cognitive behavioural therapy (CBT) supervision as part of the improving access to psychological therapies (IAPT) program which demonstrated good reflective practice. We also saw that in clinical supervision risk management, safeguarding issues and safe practice were discussed.

All staff had evidence of appraisals and regular clinical supervision. However management supervision was inconsistent and we saw gaps in records we reviewed. We saw evidence in supervision records of action being taken to address performance issues.

The service had good uptake of mandatory training and offered further training with a current focus on getting staff developed to develop the IAPT program.

Multi-disciplinary and inter-agency team work

We observed two clinical team meetings where there were a range of professionals present. Staff told us that all clinicians in each clinical team were expected to attend. During those meetings clinicians would present their cases with the most risk and the multidisciplinary team would discuss and agree the risk plan. This was then updated live onto the electronic clinical records system during the meeting.

In the meetings we observed staff had very good understanding of the patients on their caseload with clinicians from other disciplines providing appropriate clinical advice on the cases discussed. We saw the teams worked effectively and collaboratively to review risks and develop effective care plans. For example a psychiatrist offering to review a young person where, although the case holder was successfully addressing an eating disorder, an underlying obsessive compulsive disorder was becoming more apparent.

We saw evidence of good working with other health colleagues outside the service, in particular some of the joint working with paediatricians.

We observed during a home visit with a practitioner from the learning disability team how they arranged for other agencies to become involved to support the family, with the agreement and involvement of the family.

Families told us that at times liaison with other services could be better. This included communication between the service and the local GPs. However we saw evidence of good multi-agency working with schools and other agencies. In one case we observed where clinicians raised an issue that social care had not responded to their concerns regarding a young person, the whole team agreed an action plan in the clinical team meeting to address this and ensure that immediate action was taken.

Good

Are services caring?

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

Summary of findings

Please see summary at beginning of report.

Our findings

Kindness, dignity, respect and support

Young people and families we spoke to were all positive about the staff within the service.

We observed staff treating children and young people with respect. Staff used skilled interactions to ensure engagement at the developmental level of the young person. This was evident throughout all areas we visited, including the administrative staff greeting families at reception and contacting them on the phone. Families told us how all staff including reception staff were very understanding and showed empathy.

We observed that clinical staff showed empathy to the situation and needs of the children and young people. There was a thorough clinical understanding of the presentation and social circumstances and support networks available to the young person under their care. We saw that staff provided effective tailored interventions appropriate to the young person's needs.

In multidisciplinary meetings where the young people were not present, there was a clear understanding of the needs of young people and their families and carers and discussions were respectful to the families needs and circumstances.

We were concerned that during our visit we saw that staff left their computers unlocked, with patient information visible on the screen, when away from their desks. This occurred in all of the locations we visited. Although these computers were in staff only areas, this was not keeping young people's information confidential.

The involvement of people in the care that they receive

Young people and their families told us that the young person was always involved in the consultations and decisions, including younger children, rather than the clinicians only discussing these with parents. We also observed this in the appointments we viewed. We observed care planning was done in conjunction with the young people and families in a collaborative way. Families told us that they felt involved and well informed.

However this involvement was not always clearly documented in the clinical records. For example, in 15 of the care records we looked at there was no evidence of informed consent recorded in terms of giving information or treatment options being discussed despite us observing staff doing this.

We saw evidence of care plans but copies were not routinely given to families, instead the service provided a summary of the care plan in the clinic letter. However in the 24 care records we reviewed there was no evidence young people were given a copy of their care plans or countersigned their agreement of them. Some families and young people told us they did not always get copies of letters, which would include the plan of care. For example, although we observed good clinical assessment and care when young people presented at the emergency department, they were not routinely provided with printed copies of the care plan following assessment, with a copy sent to the GP in line with the NICE guidance on the management of self-harm (2013).

We saw that the service provided very good support to the families of children and young people using the service.

The service had an effective participation program working in partnership with a children's advocacy service . This involved young people in staff interviews and service design.

We saw feedback boxes in all sites and evidence of issues raised being acted on. For example, at Bolitho House, families and young people had raised that the waiting area was in a conservatory which became very hot in the summer and cold in the winter. A heating unit had been installed that provided air conditioning and heating.

Young people had also been involved in producing an excellent video, which was on the trust website, explaining what CAMHS was in an accessible way for teenagers and how the CAMHS service could help.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

Please see summary at beginning of report.

Our findings

Access and discharge

The service had a target of assessing young people within 28 days if non urgent, they were currently seeing 70% of referrals in that time frame.

Staff reported problems with the volumes of referrals they have to screen, up to 15-20 referrals a day. Staff were concerned they had to screen these on their own with no support. This was leading to them feel isolated in holding the risk of the decision of how quickly a young person needed to have a service. Staff told us that if available local managers and other clinicians would help in the decisions for more complicated cases in the screening and that a screening tool had been introduced which was very useful. This ensured there was a system for reviewing urgency of cases on referral.

Staff also raised that on days when they are screening referrals they are also the duty worker dealing with emergency calls. This meant they were often working late to try and get both tasks done. We were told that there is some consideration to splitting these roles.

We also saw that the service was proactive in managing the risks of young people waiting lists. We saw records of one of the locality managers reviewing all of the young people on the waiting lists every week, including where appropriate contacting referrers for an update on the current presentation. We also saw evidence in the clinical meetings of young people being assessed more quickly as a result of those reviews identifying heightened risk.

Families told us that they felt the service was responsive when they called with emergencies or crisis in office hours.

However one family told us that they had waited for a year to get in to the service as their daughter was considered low risk, however they were happy with the treatment and service they received. Counselling was arranged by the school nurse whilst they waited to help in the interim. This was provided through the local authority and provided a 6 weeks intervention. We were also told by another family of a 6 month wait for an autism assessment. The service had been focussed on addressing the waiting times and reduced the number of young people waiting for the service from 103 in December 2014.

The service tried to manage waiting times proactively. One family told us that they were offered appointments in another team in the county which was able to see them quicker than their local team. The family stated it was a very positive experience for them and their child despite the one hour drive to the appointment.

The service was predominantly clinic based to maximise the use of resources given the large geographical area it had to cover. However we did see it was adaptable to meet the needs of the young people who could not access usual clinic based services. One family told us how their child would have appointments with the clinician in the family car in the car park until they were confident enough to enter the clinic building.

A service for young people with learning disabilities was part of CAMHS but operated as a separate service, split into teams in East and West Cornwall. This service visited young people in their homes and schools and worked collaboratively in those settings to meet the young people's needs. This service reported no concern with access or waiting times for young people.

The service faced difficulties with the geography of Cornwall, with travel time between sites being hampered by the infrastructure and traffic jams particularly in summer months. This particularly affected the capacity of the primary mental health workers and the learning disability teams who saw young people in the community.

Staff and families all expressed concern at the safety of out of hours arrangements. The service was commissioned to provide 24 hour 7 days a week on call CAMHS practitioner advice line and next day emergency assessment including a specialist community response to those children and young people who have self-harmed and who present to Royal Cornwall Hospital Trust. There was no CAMHS psychiatrist for out of hours cover including evenings and weekends. In these circumstances a young person could be seen by the on-call psychiatrist, who would be an adult specialist.

The CAMHS practitioner advice line was manned by a combination of Band 6 and Band 7 clinical staff on a rotation. These clinicians also worked 9-5 on weekends at

Are services responsive to people's needs?

Requires improvement

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

the Royal Cornwall Hospital in Truro. Young people who needed to be seen urgently would have to travel to the hospital for an appointment. The clinicians did not have psychiatry backup as they would be giving CAMHS advice to their adult psychiatrist colleagues. Staff who worked on the rota told us how they 'dread' their time on call as they feel it is a lot of responsibility and very stressful.

We saw that the trust had engaged with commissioners previously to attempt to review this with Kernow CCG. The trust had proposed an assertive outreach model to meet this need, but this was not taken forward by the commissioners.

The lack of CAMHS Psychiatrist cover out of hours affected clinical care and appointments during normal working hours, as the consultants had to follow up emergency cases the next day. We saw that there were 755 appointments cancelled out of 17849 appointments in the past year. The majority of these were due to psychiatrists responding to emergency cases.

The trust was not commissioned to provide tier 4 CAMHS inpatient beds. The nearest inpatient unit was in Plymouth, Devon. On occasions young people needing admission had to wait in the general hospital whilst a bed was found in an appropriate unit elsewhere in the country. There were clear arrangements for young people under 16 who would access the paediatric ward prior to admission to a tier 4 unit. However there were no clear arrangements for young people aged 16 and 17. This group of young people could be admitted to any ward within the general hospital, including one case we saw records for, who was admitted to a cardiac ward. The clinical teams on those wards would make a request to the CAMHS practitioner for the young person to be removed from those settings. This had put additional pressure on CAMHS practitioners working weekends who did not have access to psychiatrists with appropriate training or experience to aid in assessment of the young person to see if they could be discharged. This provision does not meet with the quality standards described by the Royal College of Psychiatrist's Quality Network for Community CAMHS (QNCC), specifically standards 6.3 'Young people who require inpatient care are referred to units that meet their individual needs with effective continuing care' 6.5.1 'CAMHS providing crisis response and/or planned intensive intervention can access a CAMHS bed in an emergency without delay, when required' and 8.12.2 'Staff providing crisis response and/or intensive intervention have access to a list of senior professionals who they can call for support or advice if required'

The facilities promote recovery, comfort, dignity and confidentiality

There was variation in the quality of facilities in relation to how comfortable and appropriate they were for children and young people. We observed there were some good facilities and some that needed improvement.

Liskeard was very well maintained and had been purpose built with the fixtures and colour schemes having been designed with young people's involvement.

Families told us that some of the toys and activities in the waiting areas were a bit young for teenagers. However at Truro we saw that the service had responded to teenagers' request for a separate space for the waiting area and this had been provided in a separate room which had been designed with young people's involvement.

One location, Sedgemoor, was not welcoming or young people friendly. This service was based in council buildings that had recently been vacated and had a reception and waiting area which was stark and utilitarian. Not all the meeting rooms had privacy windows to help respect people's confidentially. Furniture and carpets were stained and threadbare. There were plans to vacate Sedgemoor but there was not a clear action plan to address this.

Families and young people told us at Bolitho house that the rooms often got very hot and the windows had to be opened. This meant people coming in the entrance could hear what was being said.

Bolitho House and Truro did not have a clinic room or scales to measure young people's weight. These were in the corridor, which did not provide privacy for the young person.

Meeting the needs of all people who use the service

Families told us that the service responded promptly to messages and if they did not attend appointments then the clinician involved would ring them to check on their well being.

The service had appropriate information for people whose first language was not English available on its computer system which could be printed when required. This was not

Are services responsive to people's needs?

Requires improvement

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

often due to the population of the county, however we saw a case where the service sourced translators and arranged care appropriately meeting the young person's cultural needs and the parents language needs.

Listening to and learning from concerns and complaints

We saw evidence of a robust system for complaints and ensuring they were investigated and lessons learnt. This included outcomes of investigations being discussed in the service governance group and passing on learning outcomes through team meetings and communicated to all staff.

Families and young people knew how to raise a concern and told us that information on this was at the bottom of all clinic letters as well as advertised elsewhere as well as seeing it displayed in the waiting areas and on the trust website. Families told us they would be happy to raise concerns with the locality manager foe the team they were seeing.

We saw suggestions boxes in waiting areas and "you said… we did…." posters displayed showed evidence that concerns raised were acted on.

The service also provided young people with an online survey form and displayed results in the waiting areas.

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.

Summary of findings

Please see summary at beginning of report.

Our findings

Vision and values

All staff were aware of the trust's visions and values which had been encapsulated in "CARE" compassionate services; achieving high standards; respecting individuals; empowering people. Staff spoke positively about the engagement process the trust had shown in developing these values and how it had then been implemented into team level.

Some staff reported visibility of the trust board, in particular the chair of the board, and that there were drop in events available. However, staff felt they did not have time to attend these due to workload pressures.

Good governance

We observed robust governance structures for monitoring risks and developing the service in a responsive way. We observed a service governance meeting called the 'CAMHS forum'. This was attended by all managers within the service and senior clinical staff. We saw that this meeting was held on a regular basis and looked at both good practice within the service that could be shared and risks that had been identified.

The meeting also looked comprehensively at service development needs. One example of this was a presentation of work that had been completed by one of the psychiatrists on developing an audit map for care pathways, an audit programme structure which included a decision making process to aid the service's managers in the resource allocation to clinical audit and how to prioritise audits following intelligent monitoring of the service. The presentation of this work led to discussion on how feedback could be provided and then an implementation timetable.

We observed the forum discussing the outcome of a clinical audit in relation to care for young people with attention deficit hyperactivity disorder (ADHD) which led to an in-depth clinical discussion and creation of an action plan to address the issues identified.

We saw good evidence of learning from complaints and incidents. There was evidence of learning being discussed at the forum and this then being disseminated by managers to staff. However following a recognition that this was not always consistent, a newsletter had been developed to all staff in child health, sharing lessons from community child health as well as the CAMHS service. This was sent to all staff monthly and discussed in team meetings.

There was concern expressed by all staff at the reduction in the level of administrative staff. Within the two weeks prior to our visit the trust had removed reception staff from the bases and the medical secretaries now had to complete this role alongside their other work. Staff at all levels expressed concern at this. However it was acknowledged it was too soon to make an accurate judgement of the impact. When we visited Sedgemoor, we waited over 10 minutes before the secretary could greet us, as she was on the phone to a service user and there were no other staff available. In other bases we saw secretaries working on letters being interrupted by phone calls from young people and families and people arriving for appointments. Administrative staff we spoke to expressed concern at the volume of their workloads. This was also raised by clinical staff who were concerned that their letters were no longer being typed.

Staff reported good clinical supervision arrangements which we observed on three occasions for staff providing CBT under the IAPT program and we saw records of clinical supervision. However staff reported that management supervision was not regular although they reported their immediate line managers were supportive and accessible. Records we observed showed that this was inconsistent. We looked at six staff supervision records at random and found that none of them had the trust target of six weekly supervision and some had only had three episodes of management supervision in the previous year.

Staff reported their information technology systems were slow and frequently crashed, some computers we saw were over ten years old. We observed this on one visit when we went to review clinical records and were only able to view one record in a morning due to a very slow connection to the electronic record systems. Staff reported this was time consuming and affected their ability to record appropriately on the system.

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.

Leadership, morale and staff engagement

There was clear effective clinical leadership at all levels of the service.

All staff reported they were in good supportive teams with colleagues who helped each other. Staff reported they felt supported by their local managers. We observed good local management support, although staff felt there was not an understanding of the pressure they were experiencing by senior management within the trust.

All staff were positive about the clinical care they were delivering and passionate about the young people they were serving.

Staff reported that even when feeling unwell they felt they had to come in due to workload pressures on their colleagues, this was reflected in the NHS staff survey results. The sickness rates in the service were double the trust average of 4% sickness rate at 8% of the CAMHS workforce.

Staff reported excellent local support and management, but that higher management don't always listen or engage in consulting staff on changes. This was difficult at present due to the service going to tender. The trust was providing its response to this under commercial confidentiality, which had led to staff feeling not engaged. The uncertainty of the service going to tender had led to further impact on staff morale.

We were concerned that a significant proportion of staff within the service told us that although they would be happy to raise concerns about clinical care, they would not feel confident in raising concerns about management decisions within the trust or if there were concerns about bullying and harassment. We were also concerned that a significant number of staff did not want to answer when we enquired about this.

Commitment to quality improvement and innovation

The service monitors its outcomes through the national CAMHS Outcome Research Consortium (CORC). In 2014 the dedicated CORC administrative time was amalgamated into the Trust performance department as part of efficiency savings. However this did not provide consistency in the collection of data and the positive engagement with families and clinicians to get the data needed to submit. This led to the prospect of no outcome data for the past year. However this was recognised by the trust and we saw well advanced plans to replace the dedicated CORC worker and a letter from the Chief executive to CORC describing the action plan to address the issue. This showed us that the trust was able to be reflective and responsive to errors it had made.

Outcome data from 2013/2014 showed that the service was performing the same as comparable populations elsewhere in the country despite the recognised staffing pressures.

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 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient staff to meet the needs of the population and not safe out of hours cover. The provider must ensure that there are sufficient competent staff to meet the needs of the population safely. The provider must engage with local commissioners to review staffing provision, in particular the out of hours crisis provision for young people and access to appropriately experienced psychiatrist cover.