

Good 

North East London NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

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Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/unit/team) | Postcode of service (ward/unit/team) |
|-------------|---------------------------------|---------------------------------------|--------------------------------------|
| RATX8 | Phoenix House | EWMHS Chelmsford | CM1 1QH |
| RAT | Trust Head Office | CAMHS Ilford | IG1 2PL |
| RAT | Trust Head Office | CAMHS Barking | IG11 7LZ |
| RATX8 | Phoenix House | EWMHS Harlow | CM20 1DG |
| RAT | Trust Head office | CAMHS Walthamstow | E17 3EA |
| RATX8 | Phoenix House | EWMHS Colchester | CO4 9YQ |

Summary of findings

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- There were strong and effective safeguarding processes in place throughout all of the teams and staff had the knowledge and skills to apply these processes effectively. All children and young people receiving care and treatment had access to specialist staff to offer treatment and care in a crisis and out of office hours. All children and young people in treatment had a risk assessment. All staff knew how to report incidents and received feedback in order to make changes to practice to prevent any re-occurrence.
- Teams delivered a wide variety of psychological therapy and interventions including those recommended by The National Institute for Health and Care Excellence (NICE). Staff received training and put their learning into practice in their daily work. The multi disciplinary teams had exceptionally strong links to external agencies such as schools, the local authority, primary care and voluntary sector organisations.
- Highly effective interventions were offered by passionate and committed staff. Staff were motivated and continually strived to provide the highest quality care and treatment for children and young people. We received feedback from children, young people and their families which was highly complimentary about the staff. Young people were actively engaged in a range of highly innovative participation projects.

- All referrals were made directly into the single point of access teams. All referrals were triaged and urgent assessments were prioritised. Staff offered to see children and young people in satellite clinics which were non institutional and community based. This made it easier for children and young people to access support. Staff developed innovative feedback systems with children and young people. This feedback helped teams to improve the services.
- Information about the newly re-commissioned services in Essex and the associated change process was comprehensive and inclusive. The trust senior managers and team managers were honest and transparent with staff and patients when discussing the services and challenges facing the teams. Managers used governance structures to make well informed decisions about service delivery.

However

- There was no pro-active system in place to assess the risks to young people whilst they were waiting for assessment or treatment. This meant that opportunities to manage risk could be missed.
- In the Walthamstow team nine children and young people did not have a care plan documented in their electronic care records.
- Morale was very mixed in the teams. However this was in the context of the trust winning a new tender and 229 staff being moved into the trust from four other organisations. The process was however being managed effectively.

Summary of findings

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

Are services safe?

We rated safe as good because:

- Teams used strong and effective safeguarding processes. Staff had the knowledge and skills to apply these processes effectively.
- All children and young people receiving care and treatment had access to specialist staff to offer treatment and care in a crisis and out of office hours.
- All children and young people who received support, had a risk assessment.
- All staff knew how to report incidents and received feedback from managers in order to make changes to practice to avoid any re-occurrence.

However:

- Teams did not have a pro-active system to assess the risks to young people while they were waiting for assessment or treatment. This meant that opportunities to manage risk could be missed.

Good



Are services effective?

We rated effective as requires improvement because:

- Nine children and young people in the Walthamstow service did not have a care plan in their electronic care records.

However:

- All teams delivered a wide variety of psychological therapy and interventions including those recommended by The National Institute for Health and Care Excellence (NICE).
- Staff received training and put their learning into practice in their daily work.
- The multi-disciplinary teams had exceptionally strong links to external agencies such as schools, the local authority, primary care and voluntary sector organisations.

Requires improvement



Are services caring?

We rated caring as good because:

- We observed passionate and committed staff delivering highly effective interventions.
- Staff were motivated and continually strived to provide the highest quality care and treatment for children and young people.

Good



Summary of findings

- We received positive feedback from children, young people and their families about the staff working in children and young people's services.
- We observed and heard from young people who were actively engaged in a range of highly innovative participation projects.

Are services responsive to people's needs?

We rated responsive good because:

- All children, young people, their families and any other agency or organisation could refer directly into the single point of access teams.
- Teams triaged all referrals and prioritised all urgent assessments.
- In Essex from November 2015 (at the start of the contract) through to February 2016, 91% of referrals met the 12 week target between referral and assessment and all children and young people had commenced treatment within 18 weeks. In the London services from September 2015 through to February 2016 (six months) all referrals met the 12 week target from referral to assessment and 95.5% of children and young people had commenced treatment within 18 weeks from referral. The Barking CAMHS service did not have a waiting list at all.
- Staff offered to see children and young people in satellite clinics which were non institutional and community based. This made it easier for children and young people to access support.
- Staff developed innovative feedback systems with children and young people. This feedback helped teams to improve the services.

Good



Are services well-led?

We rated well-led as good because:

- Information about the newly re-commissioned services in Essex and the associated change process was comprehensive and inclusive.
- The team managers were of high calibre. They were honest and transparent when they discussed the services and the challenges facing the teams.
- Managers used governance structures to make well informed decisions about service delivery.

However:

- Morale was very mixed in the teams. However this was in the context of the trust winning a new tender and 229 staff being moved into the trust from four other organisations.

Good



Summary of findings

Information about the service

North East London NHS Foundation Trust had been successful in the tender process to manage mental health services for children and young people in Essex. The trust already managed child and adolescent mental health services (CAMHS) in the London boroughs of Barking and Dagenham, Redbridge, Havering and Waltham Forest. As a result of the tender, 229 staff (not all full time) were transferred from four other organisations (North Essex Partnership NHS Foundation Trust, South Essex Partnership NHS Foundation Trust, Essex County Council and a voluntary sector organisation) into the trust from November 2015 to form the newly commissioned emotional wellbeing mental health service (EWMHS) in Essex. Redbridge local authority had announced its intention to re-commission children's mental health services in 2016/17. Implications of the actual and intended changes to children and young people's services across Essex and the four London boroughs meant no substantive staff contracts were recruited into on long term contracts.

At the time of our visit the trust had embarked on a large staff change process and complete transformation of community mental health services for children and young people. These changes included all staff having to re-

apply for their jobs, moving the seven Essex teams into trust or local authority managed premises and the roll out of a new electronic patient care record system. The new service structure in Essex was due to be in place in June 2016. The trust manages seven locality teams in Essex and four in London. The services include single points of access, of which three are in Essex (Essex, Southend and Thurrock) and four in London (one for each borough), access to specialist children and young people's crisis teams, substance misuse specialists, eating disorder specialists and learning disability specialists. Families and young people can self-refer into all services."

The community based mental health services for children and young people offers a range of community based treatments, psychological support and interventions, medication and advice across Essex and the four identified London boroughs. The community mental health services we inspected are based in urban settings and serve a diverse population, including significant areas of deprivation.

We have not inspected these services previously.

Our inspection team

The inspection team was led by:

Chair: Helen McKenzie, Executive Director of Nursing, Berkshire Healthcare NHS Foundation Trust.

Head of Inspection: Natasha Sloman, Care Quality Commission (CQC).

Team leader: Louise Phillips, inspection manager, Care Quality Commission.

The team that inspected the specialist community mental health services for children and young

people comprised six people, divided into three smaller teams which included: two Care Quality Commission (CQC) inspectors, one CQC inspection manager, one occupational therapist, one psychologist and one psychiatrist.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health 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, asked a range of other organisations for information and sought feedback from people using the services at two focus groups..

During the inspection visit, the inspection team:

- Visited six specialist community-based mental health services for children and young people. We looked at the quality of the environments and observed how staff were caring for people.
- Spoke with 15 children and young people who were using the service.

- Spoke with 12 relatives and carers of children and young people using the service.
- Spoke with six team managers.
- Spoke with 62 staff members including doctors, nurses, social workers, occupational therapists, psychologists, generic workers, psychotherapists, family therapists, drug and alcohol workers, counsellors, administrative staff and student nurses.
- Interviewed the senior management team with responsibility for these services, including the area managers and deputy director.
- Looked at 47 treatment records of children and young people using services.
- Received 12 comment cards from children, young people and their relatives.
- Attended and observed nine multidisciplinary clinical meetings.
- Attended and observed eight care review meetings.
- 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 with children, young people and their families who were very positive and complimentary about their experience of care from the community mental health services available for children and young people. They told us that staff were caring, kind, professional and supportive towards them. They told us that care and treatment interventions were highly effective in achieving recovery goals. Everyone we spoke with felt that staff

actively involved them when making choices about their care and treatment. People said that staff were particularly motivated, compassionate, skilled and developed good relationships with them to support recovery. Some families said that the waiting time from referral to assessment and then onto treatment was too long.

Good practice

- All teams joined the children and young people improving access to psychological therapies (CYP-IAPT) programme. This was a national service transformation programme delivered by NHS England to improve mental health services for children and young people. The programme involved the NHS and partners from the local authority, voluntary and community sector who

formed local area partnerships. The programme also trained staff in evidence based cognitive behaviour therapy, parenting approaches and systemic family therapy.

- The teams implemented the 'Thrive' model of service delivery which focused on outcomes and the engagement of children and young people to design services. The model aimed to work with families, schools and children themselves to promote mental

Summary of findings

health and wellbeing and to prevent problems becoming entrenched. The model did not use the traditional tier one through to tier two model of service delivery. For example, typically, tier one services were provided by a teacher, GP or health visitor and tier two services provided by specialist CAMHS staff.

- The Ilford team developed the Redbridge, 'You can' group made up of children and young people. The group was formed in June 2014 and had been met monthly to work on a variety of participation projects, including the design of a young person's recruitment training package. This was developed to train young people in staff recruitment. The group, in collaboration with Redbridge youth council, also worked with the Redbridge drama centre. It consulted with the writer and director of a new drama which focused on self-harm and general mental health awareness. This production was shown in all Redbridge schools at year 10 in

November 2015. To accompany the drama, colourful wrist bands were made highlighting mental health awareness. The group developed a young person's guide to mental health and also redesigned CAMHS template letters to make them more appropriate for young people.

- Redbridge CAMHS were involved in the 'puzzled out' national survey of CYP-IAPT CAMHS. CAMHS staff invited young people and carers to participate in this project. All teams joined the children and young people improving access to psychological therapies (CYP-IAPT) programme. This was a national service transformation programme delivered by NHS England to improve mental health services for children and young people. The programme involved the NHS and partners from the local authority, voluntary and community sector who formed local area partnerships. The programme also trained staff in evidence based cognitive behaviour therapy, parenting approaches and systemic family therapy.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure all children and young people have a care and/or treatment plan.

Action the provider **SHOULD** take to improve

- The trust should ensure that all risks to the health and safety of young people receiving care and

treatment is assessed to manage any such risks. There should be a more pro-active system in place to assess the risks to children and young people while they were waiting for assessment or treatment.

North East London 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 |
|---------------------------------------|---------------------------------|
| EWMHS Chelmsford | Phoenix House |
| CAMHS Ilford | Trust Head office |
| CAMHS Barking | Trust Head office |
| EWMHS Harlow | Phoenix House |
| CAMHS Walthamstow | Trust Head office |
| EWMHS Colchester | Phoenix House |

Mental Health Act responsibilities

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

The Mental Health Act was rarely used by the EWMHS and CAMHS teams. At the time of our inspection 83 staff which

equated to only 22% of all staff had received training in the Mental Health Act across the EWMHS and CAMHS team. The trust had recently re-categorised this training as mandatory for the EWMHS and CAMHS which accounted for the low figure across these services.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) act does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used

this to include the children and young young people where possible in the decision making regarding their care. There were no deprivation of liberty applications made in the previous 6 months. Staff were aware of the principles of the MCA and applied them in their work. Staff were aware of the existence of a mental capacity policy.

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

- Chelmsford and Colchester emotional wellbeing mental health services (EWMHS) did not see children and young people in their offices. Children and young people were seen in a variety of community settings such as family and children centres, schools and health clinics. These settings were called clinic hubs. In the other four teams, children and young people could access EWMHS and CAMHS centres to attend appointments and clinics. The centres had staffed receptions and comfortable waiting areas. The environments were safe and well maintained. All waiting areas had access to age appropriate toys and information of relevance.
- Staff did not have access to call alarms in the team and clinic bases and none were available for staff to use on home visits. Staff told us that they felt there had never been a need for alarms to be fitted because they did not feel at risk in the interview rooms. No incidents had occurred in the interview rooms. There was a lone working policy and all of the staff we spoke with knew about it and could describe how to stay safe while working in the community and in children and young people's homes. This policy did not state that alarms needed to be installed in the clinics. If staff had concerns about safety, they would visit in pairs or arrange to see people in safer alternative venues.
- Cleaning records were available for the six sites and the hubs we visited and demonstrated that the premises were regularly cleaned.
- Three of the centres had a clinic room with the necessary equipment to carry out physical examinations. Where there was no available clinic space, for example at Ilford, there was an examination couch in one of the meeting rooms which could be used.
- All services had clear information on good infection control.
- The staffing skill mix was reviewed as part of the newly commissioned EWMHS for children and young people in Essex in November 2015. As part of this process, 229 staff (not all full time) were transferred from four other organisations (North Essex Partnership Foundation Trust, South Essex Partnership Foundation Trust, Essex County Council and a voluntary sector organisation) into the North East London NHS Foundation Trust. The teams in Essex and London consisted of different professionals including doctors, nurses, psychotherapists, family therapists, social workers, occupational therapists, generic mental health workers, drug and alcohol workers and psychologists.
- Caseload numbers had been agreed during the re-commissioning of CAMHS in Essex using service mapping to assess and reflect the daily operations and future activity projections of all of the children and young people's community teams. The re-commissioned services agreed on the teams' safe staffing levels required based on population demands. Caseload numbers for team members ranged from 15 to 40 and numbers were monitored in team meetings and supervision. These caseload numbers were in line with the recommendations from the Royal College of Psychiatrists, building and sustaining specialist services to improve outcomes for children and young people. Caseload numbers for consultant psychiatrists were considerably higher. These ranged from 40 to 200 as children and young people were only be seen by their consultant in clinics two to four times annually. Clinics were planned and had started, to review the caseloads of consultants and re-allocate as necessary.
- Nursing recruitment was identified as a safety risk. This was listed on the trust's and CAMHS risk registers. At the time of our visit no posts were being recruited into on a permanent basis until the completion of the community staff consultation. This was the case for all six teams we visited. The impact of this was the increased use of temporary staff and fixed term contracts. We found however that temporary staff were being utilised effectively.

Safe staffing and key staffing indicators

Are services safe?

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- In the London teams, the Redbridge county council announced its intention to re-tender children and young people's mental health services in 2016/17. This meant that any vacant staff posts, funded by the local authority, could not be recruited to.
- Staffing figures across the London and Essex CAMHS community teams were 391 whole time equivalent posts. At the time of our visit 23% of posts were vacant across the London teams and no data was available for the Essex teams as vacant posts did not transfer to the trust when they started the service in November 2015. Vacant posts were filled by temporary staff with the exception of the Ilford team where the local authority was holding two social work posts vacant.
- Sickness absence rates for the year to November 2015 across the trust were 4.3%. Sickness absence rates for the year to November 2015 for the CAMHS community teams in London were 4% and in Essex data was not available as the new structures were not in place until June 2016.
- At the time of inspection, 87% of staff in the CAMHS teams received and were up to date with mandatory training. The trust target for compliance with mandatory training, covering 19 subject areas, was 85%. All teams had 100% compliance with basic life support and safeguarding training. Mental Capacity Act and Deprivation of Liberty Safeguarding training was 47%. However this training only became mandatory in the CAMHS community teams from November 2015.
- All teams had access to a consultant psychiatrist and approved mental health professional when required.

Assessing and managing risk to patients and staff

- We reviewed 47 care records across the EWMHS and CAMHS community teams. All care records had risk assessments.
- Risk assessments were completed and reviewed monthly, for example at multidisciplinary team meetings. The assessments used the care programme approach template and followed a zoning or, 'RAG (red, amber, green) rating' system to clearly identify the level of risk. Each child and young person's case was discussed at the regular staff handovers and their levels of risk and care plans were reviewed. We found the quality of risk assessments across the teams was variable. For example, at Barking CAMHS one risk

assessment was completed five months after the referral was received and another risk assessment had no dates against two separate entries. It was unclear which entry had been written first.

- Staff told us they discussed caseload management and risk management strategies in group and individual supervision, held every month.
- When staff identified risk issues, such as risk of aggression, they carried out joint visits. Staff undertook other precautions when required and these were supported by risk assessments which were reviewed regularly.
- All teams except Barking CAMHS had waiting lists for children and young people for assessment. The local managers told us that risks were assessed when new cases were triaged. Once taken on for treatment children and young people then received a full assessment and would be periodically reviewed at least once every six months. If new issues were raised or if they had been assessed as having higher risks, assessments would happen more frequently. Referrers, children, young people and their families were sent a letter asking them to make contact with the team if their mental health deteriorated.
- We found that the services did not have a pro-active system in place to assess the risks to young people while they were waiting for assessment or treatment, for example making regular calls to check on their welfare. Senior managers told us that the waiting lists were reviewed by the local teams in the weekly multidisciplinary triage meetings. We requested the minutes of the community EWMHS and CAMHS multidisciplinary team meetings and we saw that unless referrers raised any concerns about children or young people awaiting assessment and/or treatment there was no active risk management of these people. Because of these findings we were concerned that in these services, staff did not assess, monitor or manage risks for children or young people waiting to use the service. This meant that opportunities to prevent or manage harm could be missed.
- The trust had a safeguarding policy which followed the county-wide multi-agency safeguarding policy. All of the CAMHS and EWMHS staff had completed safeguarding training. Staff demonstrated that they could identify safeguarding concerns and knew what action to take in

Are services safe?

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

response. All teams had a safeguarding champion. There were safeguarding leads within or accessible by the teams and staff knew who they were and how to contact them for advice. In one team we observed a discussion about a safeguarding investigation and saw that staff highlighted additional safeguarding concerns. The local authority was contacted to discuss further action to be taken.

- Teams had a named doctor and a named nurse responsible for child protection. Staff protected children and young people from abuse through the use of clear safeguarding policies and procedures. Staff were able to confidently discuss the procedures and national guidance which supported the safeguarding process.
- The trust had a lone working policy. Staff were familiar with this and confidently gave examples of what they did to keep themselves and each other safe. For example, if they had particular concerns about a child or young person using services they visited in pairs or arranged for the young person to be seen at a clinic hub or family centre.
- The teams had suitable arrangements in place for the safe and appropriate management of medicines.

Track record on safety

- There were two serious incidents across the EWMHS and CAMHS community services within the previous year to April 2016. There were a total of 358 reported serious incidents across the trust during the same period.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the trust's electronic recording system (Datix). All incidents were reviewed by the managers, given a risk grade and forwarded to senior managers and the trust's patient safety team for further review. The system ensured that senior managers within the trust were alerted to incidents in a timely manner and could monitor the investigation and response to these. All actions taken were recorded on the electronic system.
- When serious incidents occurred within the teams, serious incident investigations were completed and dated action plans were implemented. For example, following incidents in the community teams, the process for dealing with children and young people who did not attend for their appointment was reviewed. Another example was an incident involving a young person with autism who became distressed as the interview room was overly stimulating for the young person. Teams developed low stimulus interview rooms for young people with autism. Significant incidents were discussed in staff meetings and handovers. Staff told us they were always offered debriefing sessions from their managers following serious incidents.

Are services effective?

Requires improvement 

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

Our findings

Assessment of needs and planning of care

- We reviewed 47 care records on the two electronic patient record systems which were different in Essex and London. The Essex teams used 'System One' and the London teams used 'RIO'. Comprehensive assessments were documented in each of the care records we reviewed and were carried out at the child or young person's first appointment. Nine out of the 47 care records we reviewed did not have care plans. We requested to see the care plans for these nine young people however staff were unable to locate them to show us.
 - Staff assessed children and young people's needs using a number of nationally recognised good practice assessment tools such as the 'strengths and difficulties questionnaire'. This was a behavioural screening questionnaire for three to 16 year olds. They also used the 'revised child anxiety and depression scale', goal based outcome measures, quality of life assessments and child outcome rating scales.
 - Where care plans were available, children and young people's needs were assessed and care was delivered in line with their individual care plans. However, we noted that there was a variable standard of care records. The care plans at Barking CAMHS were basic and not always personalised or recovery focused. The care plans for children and young people at Ilford CAMHS and the EWMHS at Chelmsford and Colchester were more detailed and the entries into the daily records were completed to a high standard.
 - All of the EWMHS and CAMHS teams held either daily or three meetings each week. We attended some of the meetings where the teams discussed children and young people's care and the support needs. Staff were aware of the needs of people and developed plans to address them.
- Records showed that all children and young people received physical health assessments by their general practitioner or by one of the teams' doctors. This was only done with their consent when they engaged with the community teams. We noted that risks to physical health were identified and managed effectively. Care plans were available for those children and young people with an identified risk associated with their physical health. The community teams offered physical health checks for the children and young people using services where this was considered more accessible and appropriate. The teams ran regular physical health clinics as well as monitoring the associated risks to children and young people's physical health.
 - Teams were members of the children and young people improving access to psychological therapies (CYP-IAPT) programme. This was a national service transformation programme delivered by NHS England that aimed to improve mental health services for children and young people. This programme involved the NHS and partners from the local authority, voluntary and community sector who together form local area partnerships. The programme also trained staff in evidence based cognitive behaviour therapy, parenting approaches and systemic family therapy.
 - Implementation of the 'Thrive' model of service delivery which focused on outcomes and the engagement of children and young people in designing services. The model aimed to work with families, schools and children themselves to promote mental health and wellbeing and to prevent problems becoming entrenched. The model did not use the traditional Tier one through to tier two model of service delivery. Tier one services are provided, for example, by a teacher, GP or health visitor and tier two services provided by specialist CAMHS staff.
 - Staff carried out clinical audits, for example, on good practice in prescribing for attention deficit hyperactivity disorder in children and young people.

Skilled staff to deliver care

Best practice in treatment and care

- The EWMHS and CAMHS teams carried out audits against the National Institute for Health and Care Excellence to monitor compliance against the national guidance on promoting good health and preventing and treating ill health with children and young people.
- The community EWMHS and CAMHS teams' staff establishment included a full range of mental health and social care disciplines including nurses, occupational therapists, psychologists, social workers and psychiatrists. There were vacancies in some key

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Requires improvement 

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posts, and these were frozen, for example, two social worker posts and a family therapist post at Ilford CAMHS. This meant temporary staff could not be used to support the posts.

- The Staff we spoke with commented on how well supported they were with learning and development needs and professional development. For example, all staff were trained in at least one evidence based practice modality, for example cognitive behaviour therapy.
- Temporary staff received a good induction to the service. Checks were made to ensure that temporary staff received the required training prior to starting work in the EWMHS and CAMHS community teams.
- All staff had received regular one to one supervision monthly and an annual appraisal. Some teams did report that due to the community teams change programme, some supervision slots had been delayed. Team managers told us that all staff had received an appraisal.
- Staff attended an induction course when they joined the trust which included covering all required mandatory training.
- The EWMHS and CAMHS were part of children and young people's improving access to psychological therapies (CYP IAPT) programme. This meant that many staff had been trained in cognitive behaviour therapy and systemic family therapy.
- Team managers said they monitored staff performance regularly and at the time of our inspection were managing a small number of cases where performance was being monitored for improvement.

Multi-disciplinary and inter-agency team work

- We observed six multi-disciplinary meetings which were all well planned and organised. We saw the use of computers enabled access directly into the care records during all meetings. Handover meetings were effective and each child or young person receiving care was discussed, highlighting the complexities of children or young people's needs. All staff worked well together and respected one another's contributions. We saw that a number of voluntary organisations provided specialist counselling, therapy and mental health education to children and young people using the services. This

support was fully integrated into the assessment, care planning and reviewing processes. One of these organisations called 'Fusion' attended the Ilford CAMHS referral meeting each week and offered assessments to children and young people with a dual diagnosis of mental ill health and substance misuse.

- We observed appropriate sharing of information to ensure continuity and safety of care across teams, including involvement of external agencies, for example the local authority, local schools, primary care services and the police.
- The community change programme in Essex started in November 2015 and was due to be completed by June 2016. While acknowledging the sizable changes the programme made, most staff said that they felt increasingly settled and integrated and that the new arrangements would work well once fully embedded. All staff commented on their main objective which was to cause as little disruption as possible for their children and young people using services.
- Each team allocated duty staff, including a named doctor, to work each day on a rota basis. This role was primarily to add additional support for care co-ordinators, triage phone calls, carry out urgent assessments and enable children and young people to be treated in a timely manner.

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

- The Mental Health Act was rarely used by the EWMHS and CAMHS teams. Eighty three staff which equated to only 22% of all staff had received training in the Mental Health Act across the EWMHS and CAMHS team. The trust had recently re-categorised this training as mandatory for the EWMHS and CAMHS which accounted for the low figure.

Good practice in applying the Mental Capacity Act

- The Mental Capacity Act (MCA) act does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. The staff we spoke to were conversant with the principles of Gillick and used this to include the

Are services effective?

Requires improvement 

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

children and young young people where possible in the decision making regarding their care. There were no

deprivation of liberty applications made in the previous 6 months. Staff were aware of the principles of the MCA and applied them in their work. Staff were aware of the existence of a mental capacity policy.

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

- In all of the EWMHS and CAMHS community teams we observed staff to be particularly kind, caring and compassionate. This was demonstrated by all staff we shadowed during our visits. When we spoke with children, young people receiving support and their families they were without exception, very positive about the support they had been receiving. All children and young people we spoke with and their carers reported that they were treated with respect and found staff to be very supportive and helpful. Children, young people and their carers commended individual staff highly and gave examples of how they had been cared for and assisted towards their recovery. Administrative staff were praised highly by carers we spoke with, particularly in regards to their helpfulness, professionalism and approachability.
- Staff demonstrated an excellent knowledge and understanding of children and young people using the services. In the meetings we attended, it was clear that staff had a good understanding of children and young people's needs. Staff communicated with people in a calm and professional manner using an empathetic approach at all times.
- Children and young people's confidentiality was maintained by all the community teams. When we accompanied staff on home visits or in meetings, the staff members asked if the person was content for a Care Quality Commission team member to be present prior to the visit. Staff were aware of the need to ensure a person's confidential information was stored securely. Staff access to electronic case notes was protected.
- All teams ran educational sessions for parents to provide information and support. For example, the EWMHS and CAMHS ran a programme for supporting parents with children with anxiety, another, cognitive behaviour therapy based parenting programme for managing children and young people who self-harm.

The involvement of people in the care they receive

- The trust widely advertised methods for children, young people and their carers to provide feedback. This included well-advertised messages, some written by the

chief executive which asked and encouraged comments for people to feedback their views on the service received by EWMHS and CAMHS community teams. For example, we saw an easy to read leaflet was designed with the help of young people using services to encourage feedback.

- Suggestion and comment boxes and electronic devices seeking feedback were available in all of the community bases or clinic hubs. We saw some particularly innovative ways of gaining feedback from children, young people and their families. For example, the 'Listening to you' initiative. In a number of the team bases visitors and those using services could place tokens into a feedback box answering a 'question of the week'. For example, "were you kept waiting for your appointment?" or "were you treated with kindness today?" All of the questions were developed by the children and young people. The feedback was communicated to young people via a large poster board in the waiting room. Since starting this initiative, improvements have been made to the waiting areas and communal spaces at the team bases. Positive feedback has been received from young people about this.
- During our visits in the community we saw that carers were invited to and attended discussions with their relatives. The meetings provided an opportunity for the carer to be involved with any potential changes to care planned. All carers we spoke with had been fully involved in developing their relatives care plans.
- Children and young people who used services told us they were familiar with their care plan and had been involved in the development of it.
- We discussed the goals which had been set and the involvement that children and young people had in their care planning. We heard that they had a good deal of involvement, for example one person told us they were asked on each visit whether their needs had changed and whether they were happy with the recovery goals set.
- People were offered a variety of therapies both individually and on a group basis which actively included their involvement. For example we spoke to

Are services caring?

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

people who had participated in groups to help with mood stabilisation, others who had joined groups to learn about recovery principles, health and wellbeing and to help build self-esteem and confidence.

- We attended eight care review meetings and saw that these involved the child and young person receiving care. Records showed that children and young people had received at least a six monthly review of their care under the care programme approach protocols.
- One example of a particularly innovative participation scheme was the Redbridge 'you can' group made up of children and young people. The group was formed in June 2014 and had been meeting monthly. The participants in the group were working on a variety of projects, including the design of a young person's recruitment training package, which was developed to train young people in staff recruitment. The group, in collaboration with Redbridge youth council, worked with the Redbridge drama centre consulting with the writer and director of a new drama focussing on self-harm and general mental health awareness. This production was shown in all Redbridge Schools at year 10 in November 2015. To accompany the drama, colourful wrist bands were made highlighting mental health awareness. The 'you can' group developed a young persons' guide to mental health and also redesigned CAMHS template letters making them more appropriate to young people. Redbridge CAMHS were involved in the 'puzzled out' national survey of CYP-IAPT CAMHS. Young people and carers were routinely invited by CAMHS staff to participate in this project.
- Another innovative example of participation in Walthamstow was the involvement of young people in the design and creation of the CAMHS messenger app. The CAMHS counsel (participation group name) designed the graphic and some of the code and will test the app during all stages of release. The group was also involved in the i-Thrive service redesign. Later in the summer, the council and CAMHS is working with community contacts to put on a local music festival.
- EWMHS offered discussion events to all children and young people using services in Southend, Essex and Thurrock, providing free pizza and a space for young people and their parents to discuss service improvements. There were seven events held in total.
- Barking and Dagenham run a participation group called the 'listen' group. This group offers a forum for young people to develop ideas about service improvement, health promotion and general issues relating to the service. The group is facilitated by two CAMHS workers. The group had developed a variety of projects including the development of training sessions for staff on the engagement of and working with young people from the perspective of the young person. This training has been delivered to a number of staff within the youth offending and CAMHS teams. The young people have undertaken an innovative service transformation activity, by developing a video on mental health awareness which was completed in early April 2016 and will be used as part of future training. It will be part of a wider mental health experience which contributes to reducing the stigma of mental health, and working towards a more accessible service which is in keeping with feedback from service users.
- The trust carried out monthly friends and family tests which help the service understand their areas of strength and weakness and drive improvements in service delivery. The friends and family test is a nationally used feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.
- We looked at the work plan for a number of participation groups across all of the teams and saw that groups were developing a CAMHS website. This was to decrease the stigma around mental health, share recovery stories, work with the youth council and local schools to further the mental health project (co-projects), re-design CAMHS poster, leaflets, appointment cards, logos, including parents in participation, training for staff by young people on issues such as the internet, social media and having participation embedded in all staff job descriptions.
- Children, young people and their families had access to a wide and range of relevant information which included information on employment support services, bereavement support, alcohol and drugs advisory service, and the care programme approach explained. Leaflets were also available on mental health fact sheets as well as many community groups and resources.

Are services caring?

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

There was access to leaflets in different languages if needed. Interpreting services and advocacy services were available if required and contact numbers were advertised.

- Children and young people had been trained and participated with staff recruitment processes in CAMHS and EWMHS services.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- Referrals into the EWMHS and CAMHS services came from a variety of sources which included; primary care doctors, social care, the non-statutory sector, accident and emergency departments, schools, self-referrals, the police and the criminal justice system.
- In Essex, from November 2015 to February 2016, 4,861 referrals were made and in London from September 2015 to February 2016, 4090 referrals were made.
- The trust had developed a single point of access and assessment. All children and young people referred to the community teams were triaged through the access and assessment teams, this meant people would have already received a detailed assessment of their emotional, psychological and social needs before being seen by the community teams.
- Teams held a daily or weekly referrals meeting where all prospective children and young people were discussed based on the information received by the access and assessment service. We noted in the Ilford team that one overarching referrals meeting took place daily and included representatives from external agencies such as a drug and alcohol voluntary sector organisation and a counselling and therapy service. Urgent referrals were prioritised and processed by the duty staff member on a daily basis if required.
- The EWMHS and CAMHS offered a treatment model based on individual care and treatment pathways. These included pathways for mood and anxiety, neurodevelopment, complex and behaviour and conduct. This model ensured that children and young people received the most appropriate interventions, treatments and support which best met their needs. Interventions were provided by suitably trained and qualified staff.
- Staff followed clear procedures if children and young people did not attend their appointments. For example, staff telephoned, sent text messages, made home visits and sent letters to people who failed to attend appointments. Staff were aware of and followed contingency plans.
- Children and young people had access to a specialist eating disorder team.
- Crisis teams for children and young people were available across Essex and the London boroughs with services managed by North East London Foundation Trust.
- Interventions offered to children and young people included; medication monitoring and review, support with physical health needs and ongoing monitoring, support with engaging at school, a wide range of psychological therapy, advice on coping with symptoms of illness and support with accessing community facilities and resources.
- In Essex from November 2015 (at the start of the contract) through to February 2016, 91% of referrals met the 12 week target between referral and assessment and all children and young people had commenced treatment within 18 weeks. In the London services from September 2015 through to February 2016 (six months) all referrals met the 12 week target from referral to assessment and 95.5% of children and young people had commenced treatment within 18 weeks from referral. The Barking CAMHS service did not have a waiting list at all.
- Feedback we received from local stakeholders was critical of the wait for treatment that children and young people had to experience after referral to community EWMHS and CAMHS. Five out of the 12 parents of children and young people who used the community EWMHS and CAMHS services we spoke with told us that they were not satisfied with the amount of time their child had to wait for assessment and treatment after the initial referral. However, although stakeholders felt waits were too long the teams were performing well in relation to NHS benchmarking data 2015, the Centre Forum data 2015 and the Children's Commissioner data 2016.

The facilities promote recovery, comfort, dignity and confidentiality

- The facilities in all of the community bases and clinic hubs we visited promoted recovery, dignity and confidentiality. All areas that children and young people had access to were clean, tidy and well maintained. Furniture was in good condition and most areas were decorated to a good standard.

Are services responsive to people's needs?

Good 

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

- There was an array of relevant information on display in all of the reception areas in the community bases and clinic hubs. Information leaflets were available regarding local services, medication and how to make complaints.

Meeting the needs of all people who use the service

- All of the community EWMHS and CAMHS services had disabled access.
- Information leaflets about services were provided by the trust and children and young people had contributed to the information content and design. Age appropriate information was contained in all of the leaflets. Information about how to contact advocacy and how to make a complaint were included in information. All team bases and clinic hubs had toys and books available for children to use in waiting areas and therapy rooms. Facilities had been enhanced to feel comfortable and accessible for young people such as availability of music and soft furnishings such as cushions and bean bags. Each team base or clinic hub had a low stimulus room for those children and young people with autism. Accessible information booklets regarding health issues and conditions were also available.
- The trust widely advertised information explaining why information about people using services was collected and the ways in which it may be used, for example in the teaching and training of healthcare professionals.
- Interpreters and signers were available to staff.

Listening to and learning from concerns and complaints

- There were 10 complaints in total received by the trust from May 2014 up to December 2015 about EWMHS and CAMHS services. Of these, three were upheld and four partially upheld by the complaint investigation. In the same period of time 32 compliments were received.

- Information about how to complain was displayed in all community site reception areas and on the trust's website. Reception areas also had information available about the patient advice and liaison service which supported people in raising concerns. Children, young people and their carers using the community services were given information about how to make a complaint.
- Staff were able to describe the complaints process and how they would process any complaints. Staff knew how to respond to anyone wishing to complain and team managers demonstrated how both positive and negative feedback was used to improve the quality of services provided. For example, we heard that one team had received a complaint about incorrectly addressed mail and the process for checking address accuracy was changed.
- All of the children, young people and their families we spoke with told us they were confident to raise any concerns or complaints and that they thought they would be listened to and their complaints taken seriously.
- We looked at some of the complaints received and the related correspondence. We found complaints were taken seriously and responded to promptly in adherence to the trusts complaints policy and associated procedures. All complainants received an individual response to their complaint as well as contact details of other bodies they could approach if they were unhappy about the outcome. Local resolution of complaints in the teams was always attempted although a record of this was not always documented.
- We read in staff team meeting minutes that complaints were discussed and actions were taken to ensure any lessons highlighted were learnt. Discussions took place in one team meeting regarding a complaint about a change in a care co-ordinator and how changes could be kept to a minimum.

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

- The trust's vision and values were on display in all of the community sites. Staff were familiar with these however some staff in Essex, who had only been employees for the trust for six months, told us they were not all 'signed up' to the vision.
- We saw that a newly developed clinical model had been implemented as part of the community changes in Essex and although staff were positive about improving the quality of services provided, they did not all think the new model would necessarily improve services.
- Staff shared their views about the services and the Essex change programme in an open, constructive and balanced way. They consistently showed a professional, caring and passionate approach to their services and the quality of the experience of children and young people using them.
- Most staff knew who the senior managers and executive directors were. They met representatives from the trust board from time to time. Staff said they had raised issues with very senior managers, however felt they had not been always been heard and action had not been taken. All staff said they could raise issues with their manager if required and action would be taken at a local level whenever the manager had authority to do so.

Good governance

- Key performance indicators and performance data was available via the team managers relating to waiting times from referral to assessment and onto treatment.
- Supervision, appraisal rates and mandatory training records were completed for all staff.
- Information on performance in key areas was collated and summarised by senior managers and published monthly.
- There was not an effective system in place to assess the risks to young people whilst they were waiting for assessment or treatment.

- The multi-disciplinary leadership teams at the EWMHS and CAMHS services worked very well and enabled those teams to deliver high service standards. Clinical and managerial supervision was taking place regularly.
- Teams could raise items for the risk register when necessary. For example staff from the Ilford CAMHS team had raised concerns about frozen posts which were adversely affecting their ability to avoid breaches in waiting times.

Leadership, morale and staff engagement

- Sickness rates were 4% in the London teams, (data was not yet available for the Essex teams). Managers said they had received advice and support from human resources.
- Literature on the Essex EWMHS community consultation was comprehensive and well consulted on. The clinical model and care pathways were well laid out. Given the size and significance of the community transformation, we found that teams were well organised and delivering an effective service. However, morale was very mixed with a sizable representation of staff feeling demoralised and unsupported in this new organisation. All staff commented that they had worked hard to see little disruption to children, young people and their families using services. A minority of senior doctors said they felt isolated, were not included and said there was a lack of medical leadership and support.
- Staff were aware of the whistleblowing process if they needed to use it. Some concerns had been raised about the EWMHS community consultation programme.
- We were assured that the local leadership within the service was aware of the issues and concerns that were raised by some staff, owing to the implementation of the community changes. We saw a robust risk register and action plan had been developed prior to our visit which set out a credible plan to address those concerns. Staff engagement plans were available and had been jointly developed.
- Children and young people were encouraged to give feedback on the services provided and were actively involved in the designing, planning, delivery and review of services.

Commitment to quality improvement and innovation

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.

- All teams joined the children and young people improving access to psychological therapies (CYP-IAPT) programme. This was a national service transformation programme delivered by NHS England that aimed to improve mental health services for children and young people. The programme involved the NHS and partners

from the local authority, voluntary and community sector who together formed local area partnerships. The programme also trained staff in evidence based cognitive behaviour therapy, the mentalisation model, dialectic behaviour therapy, parenting approaches and systemic family therapy.

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care.

The trust did not ensure all children and young people had a care and/ or treatment plan. In the Walthamstow CAMHS community service nine care records had no care plan developed or available.

This was a breach of Regulation 9(3)(b)