

West London Mental Health NHS 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)
RKL14	Lakeside Mental Health unit and Hounslow community services	Hounslow CAMHS	TW3 3EL
RKL79	Hammersmith and Fulham mental health unit and community services	Hammersmith and Fulham CAMHS	W6 0LS
RKL53	St Bernard's and Ealing community services	Ealing CAMHS	UB2 4SA

This report describes our judgement of the quality of care provided within this core service by West London Mental Health 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 West London Mental Health Trust and these are brought together to inform our overall judgement of West London Mental Health Trust.

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

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 gave an overall rating for the specialist community mental health services for children and young people of **good** because:

- Incident reporting took place and the learning from these was shared across the teams.
- Risk assessments were comprehensive and regularly updated.
- Staff knew how to raise a safeguarding children referral and there was good support from managers with this role.
- Assessments were completed in a timely manner with multi-disciplinary input.
- Care plans were detailed, personalised and enabled holistic evidence based care. New care plan templates had been developed in conjunction with young people and their families to increase involvement in care.
- The services were using the latest guidance to support their work.
- There was effective multi-disciplinary and multi-agency working.
- Staff showed compassion and understood the needs of young people and their families.
- The service recognised gaps in service user involvement and implemented projects to include younger people who had less of a voice in service development.

- There were a number of ways for young people to be engaged in their care and the service.
- All teams had access to meeting rooms where young people and their families could meet with staff in private. The rooms were well-maintained, light and airy.
- Staff worked to ensure young people attended their appointments. Numbers of patients who did not attend were closely monitored.
- People who used the service and staff were aware of the complaints process and using it appropriately.
- Staff were very committed and reflected the values of the trust.
- There were team meetings in place and access to other information to support the management of the teams.

However the team bases need to be reviewed to ensure staff can call for assistance where needed and rooms are sufficiently soundproofed to avoid confidential conversations being overheard. There is also a need for some ongoing work on staff engagement to ensure staff feel supported and able to raise issues with the confidence that they will be listened to and addressed.

Summary of findings

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

Are services safe?

We rated safe as **good** because:

- Incident reporting took place and the learning from these was shared across the teams.
- Risk assessments were comprehensive and regularly updated.
- Staff knew how to raise a safeguarding children referral and there was good support from managers with this role.

However, the security and access to alarms especially in the Hammersmith & Fulham team base needs to be addressed. Staffing levels need to be kept under review including administrative staff.

Good



Are services effective?

We rated effective as **good** because:

- Assessments were completed in a timely manner with multi-disciplinary input.
- Care plans were detailed, personalised and enabled holistic evidence based care. New care plan templates had been developed in conjunction with young people and their families to increase involvement in care.
- The services were using the latest guidance to support their work.
- There was effective multi-disciplinary and multi-agency working.

Good



Are services caring?

We rated caring as **good** because:

- Staff showed compassion and understood the needs of young people and their families.
- The service recognised gaps in service user involvement and implemented projects to include younger people who had less of a voice in service development.
- There were a number of ways for young people to be engaged in their care and the service.

Good



Are services responsive to people's needs?

We rated responsive as **good** because:

- All teams had access to meeting rooms where young people and their families could meet with staff in private. The rooms were well-maintained, light and airy.

Good



Summary of findings

- Staff worked to ensure young people attended their appointments. Numbers of patients who did not attend were closely monitored.
- People who used the service and staff were aware of the complaints process and using it appropriately.

However there was a possible lack of confidentiality as rooms were not sound proofed. Staff felt more could be done to meet the needs of hard to reach families particularly in some communities.

Are services well-led?

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

- Staff were very committed and reflected the values of the trust.
- There were team meetings in place and access to other information to support the management of the teams.

However some staff were clearly anxious about the changes taking place and the pressures they were facing. Some staff did not feel fully engaged. More work is needed to address this going forward to ensure staff feel well supported.

Good



Summary of findings

Information about the service

West London Mental Health Trust provide four specialist child and adolescent mental health services (CAMHS) community teams for young people up to the age of 18 across the boroughs of Hounslow, Hammersmith and Fulham, Ealing and Brent:

- Hounslow CAMHS specialist services – multi-disciplinary outpatient CAMHS teams
- Hammersmith and Fulham specialist services – multi-disciplinary outpatient CAMHS teams

- Ealing specialist services – multi-disciplinary outpatient CAMHS teams

We inspected these three teams. We did not inspect the specialist team provided by the trust in Brent.

In addition there are 19 targeted CAMHS teams that the trust provides some professional input into but these are led by the local authority. We did not inspect these services.

Our inspection team

The team that inspected the CAMHS community teams included two CQC inspectors, two clinical psychologists, a CAMHS nurse and a Mental Health Act reviewer.

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.

During the inspection visit, the inspection team:

- Visited the three CAMHS tier 3 services providing community services across the London boroughs of

Hounslow, Hammersmith and Fulham and Ealing and looked at the quality of the environment and observed how staff were caring for young people using the service

- Spoke with 13 young people who were using the service and/or their families
- Spoke with the managers for each of the teams
- Interviewed the service manager with responsibility for these services
- Interviewed the clinical director with responsibility for these services
- Spoke with 27 other staff members; including doctors, nurses, social workers, therapists, psychologists, and administration staff
- Looked at 16 care records of young people
- Looked at a range of policies, procedures and other documents relating to the running of the service
- Viewed the DVD prepared by the young people in Hounslow

Summary of findings

What people who use the provider's services say

Young people and their families felt that the support they received from clinicians was appropriate and well organised. They felt staff were caring, polite and interested in the well-being of young people. They said they felt well informed of the care they received and felt as if they could make their own choices.

The views of young people and families were gathered regularly by the service by use of surveys and groups held for them. Feedback had been utilised to inform changes to the service.

Good practice

The Hammersmith and Fulham team held a weekly safeguarding session for the whole team to consider potential referrals or review young people already known to social care. The meeting was attended by members of the multi-disciplinary team and discussed issues and agreed outcomes.

The trust wide CAMHS nurses forum brought nurses together from across sites to share information, give updates on business and share pieces of learning. Case studies were shared at the forum and used to develop good practice across the service.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that staff are appropriately supported in the light of increasing workloads and as a result of restructuring across the three boroughs.
- The trust should review the team bases to ensure staff can call for assistance where needed and rooms were sufficiently soundproofed to avoid confidential conversations being overheard.

West London Mental Health NHS 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
Hounslow CAMHS	Lakeside Mental Health unit and Hounslow community services
Hammersmith and Fulham CAMHS	Hammersmith and Fulham mental health unit and community services
Ealing CAMHS	St Bernard's and Ealing community services

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.

Mental Capacity Act and Deprivation of Liberty Safeguards

The majority of staff we spoke with demonstrated a working knowledge of the application of capacity and consent for children.

The records had clear evidence of Gillick competency and Mental Capacity Act (which applies to young people under the age of 16) assessments.

Information leaflets were provided to young persons and families that covered consent.

Staff felt that there was a need for Mental Capacity Act training and this had been commissioned with a request for CAMHS specific training.

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

We rated safe as **good** because:

- Incident reporting took place and the learning from these was shared across the teams.
- Risk assessments were comprehensive and regularly updated.
- Staff knew how to raise a safeguarding children referral and there was good support from managers with this role.

However, the security and access to alarms especially in the Hammersmith & Fulham team base needs to be addressed. Staffing levels need to be kept under review including administrative staff.

Our findings

Safe and clean environment

- There were alarms in interview rooms. However in the Ealing and Hammersmith & Fulham teams these were located away from the door. This meant that if an incident occurred that the staff member would be forced to move away from the exit to call for help. In the Hammersmith & Fulham team alarms were present, but not in use. A programme of works to update the equipment and provide staff training was in progress. This was being monitored in the service risk register as part of general building security issues.
- People who visited the Hammersmith & Fulham team base had to ring a bell and a receptionist would answer the door. However, once they were inside there was unrestricted access to the building which posed a potential risk of an incident. There was also a lack of space due to the restricted nature of the building but staff did not feel this was affecting the services being provided.

Safe staffing

- There were vacancies across the service. In December 2014 vacancies across CAMHS and Developmental services were 11.9%. Four new staff had been recruited within the Hammersmith & Fulham team but there is a nationwide challenge with recruiting CAMHS nurses.
- In Hounslow the team had recently submitted a business case for four additional posts which had been accepted. The Hounslow team faced challenges in filling the nurse prescriber post. A nursing development programme had been created to address this. The programme was successful and enabled the Hounslow service to recruit a band five nurse to a post that was traditionally a band seven post and provide them with appropriate training to gain the suitable skills.
- The Hammersmith and Fulham team told us the administrative team were short staffed due to the growth of the tier 2 clinical services which had added to their workload and increased the number of referrals. The team told us they felt supported by the local managers but were behind in updating the electronic documentation system due to the increased referrals, room bookings and general interface problems in sharing records due to using two patient record systems.
- The staff vacancies and the high numbers of referrals to the service were on the trust risk register.
- The service had an after-hours on call system provided by a specialist registrar and a consultant psychiatrist. An out of hours review was on-going with proposals to provide nursing staff to work at night.
- We were told there was a lead nurse for the service.

Assessing and managing risk to patients and staff

- Individual risk assessments were comprehensive and involved input from members of the team. The risk assessments were updated appropriately and within stated timescales after every session with informative summaries. The risk assessment was completed on the electronic recording system after the initial session.
- There was a single point of entry for referrals and a screening meeting identified risk from the outset.

Are services safe?

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

Appointments were undertaken at two levels – choice and partnership assessment appointments and urgent sessions. For urgent sessions, the electronic recording system was updated on the same day.

- When the lead clinician was on leave the young person and their parents were given a named person to contact for any urgent matters.
- The Ealing team conducted joint assessments with social services in relation to self-harm and overdoses to help keep children safe
- The formal lone working policy was supported by the administrative buddy system and had been reviewed and adapted for staff visiting young people at home. Each local area had a different protocol, but each included a risk assessment. Members of staff told a specific person where they were going and called that person to let them know they were safe at the conclusion of the appointment. There was a clear message not to stay alone beyond 5pm and if working out of hours does occur the policy states not to see patients who may be a risk or to see new families. The service was waiting for delivery of lone worker support devices at the time of the inspection.
- Staff had received training in safeguarding adults and children and knew how to raise a safeguarding children referral. There was a safeguarding lead for the trust as well as a local lead for each borough that was supported by the trust wide safeguarding procedures. The lead had responsibility for collating data regarding the number of referrals and outcomes. Staff identified that there had been a problem getting feedback from referrals made to the local authority. To address this, the local authority lead was regularly invited to the teams' business

meeting. Safeguarding was a standing item agenda on a weekly meeting. In the Ealing team the lead for safeguarding was also the director for safeguarding across the trust meaning easily accessible support. The safeguarding lead nurse liaised with the trust lead and leads from other agencies on a regular basis.

- Medicines could be prescribed but were not stored on-site.

Track record on safety

- There had been one serious incident in CAMHS community services since January 2014.

Reporting incidents and learning from when things go wrong

- Incidents without harm were reported to the manager who ensured the incident was recorded on the electronic documentation system and any actions were completed. Incidents involving harm were reported to the service manager to complete a 24 hour report. The incidents were then forwarded to the trust risk team and graded.
- When incidents had occurred they were reflected on quickly at weekly seminar meetings. Learning from incidents was reviewed by an incident review group. The lead for incident reporting attended the trust wide incident review group and produced a written report of the relevant incidents and learning relating to CAMHS. This was then taken to the clinical improvement group and disseminated through the teams and clinical leads.
- Staff identified the trusts intranet called the 'exchange' as a forum for sharing information about lessons learnt.

Are services effective?

Good 

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

Summary of findings

We rated effective as **good** because:

- Assessments were completed in a timely manner with multi-disciplinary input.
- Care plans were detailed, personalised and enabled holistic evidence based care. New care plan templates had been developed in conjunction with young people and their families to increase involvement in care.
- The services were using the latest guidance to support their work.
- There was effective multi-disciplinary and multi-agency working.

Our findings

Assessment of needs and planning of care

- Assessments were completed in a timely manner and the care plans were detailed, personalised and displayed holistic evidence based care. A range of needs were covered in assessments including education, social circumstances, mental health and family dynamics. Clinicians spoke to parents and young people individually.
- After the initial assessment the young person would be reviewed by the multi-disciplinary team and allocated to the appropriate clinician.
- Care plans were until recently stored in the notes section on the trusts electronic documentation system. At the time of our inspection a new care plan template had been developed in collaboration with the young person user group. Young people and their families were involved in the development of the care plan and were given copies.

Best practice in treatment and care

- National institute for health and social care guidance was used to inform treatment pathways, particularly the use of psychological therapies. NICE guidance was also followed for prescribing medication.
- At the time of our inspection the trust was moving towards particular specialist services being based

centrally. For example the eating disorder service was based in Ealing and was providing services for Ealing and Hammersmith and Fulham. There was feedback that this change happened without careful consideration of risk management or a discussion with users of the service.

- The clinical effectiveness group considered all new NICE publications which were then evaluated and implementation considered. An example of this was the recent audit of the latest recommendations from NICE about the treatment of depression in children and young people which was completed and feedback was shared.
- Outcome measures were used across teams to monitor a young person's progress in a systematic way. Clinicians used routine outcome measures including the health of the nation outcome scales for children and adolescents. The rate of completion of this measure was not yet meeting targets set by the clinical commissioning group but was improving.

Skilled staff to deliver care

- Staff working across the CAMHS teams, were made up of staff from a range of professional backgrounds including consultant psychiatrists, junior doctors, clinical psychologists, nurses, and therapists.
- Staff were skilled and development and training were seen as integral to the service. Leadership training was available and staff members from Hounslow had completed this.
- Permanent staff received appropriate training, individual and peer supervision, and professional development. Staff completed mandatory training in addition to other external training. Some staff reported challenges in recording the training they had completed externally onto the trust database.
- There were regular team and business meetings and staff we spoke with told us they felt well supported by other disciplines.
- There was an annual away morning for each team and a fortnightly academic programme for staff with internal and external people presenting.

Multi-disciplinary and inter-agency team work

Are services effective?

Good 

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

- The service had a variety of multi-disciplinary team meetings which included opportunities for reflective practice. Staff also attended the business meetings and the clinical improvement group which gave feedback to the senior management team.
- Staff valued the multi-disciplinary working.
- There were examples of effective working with other teams within the trust such as the paediatric liaison team and also of close working with other agencies such as social services or education. The ability to work jointly with social services did vary between boroughs and staff said this was harder in Hounslow.
- The CAMHS teams also worked closely with inpatient services when a young person was being admitted or discharged.

Good practice in applying the MCA

- The majority of staff we spoke with demonstrated a working knowledge of the application of capacity and consent for children.
- The records had clear evidence of Gillick competency and Mental Capacity Act (which applies to young people over the age of 16) assessments.
- Information leaflets were provided to young persons and families that covered consent.
- Staff felt that there was a need for Mental Capacity Act training and this had already been commissioned with a request for CAMHS specific training.

Are services caring?

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

Summary of findings

We rated caring as **good** because:

- Staff showed compassion and understood the needs of young people and their families.
- The service recognised gaps in service user involvement and implemented projects to include younger people who had less of a voice in service development.
- There were a number of ways for young people to be engaged in their care and the service.

Our findings

Kindness, dignity, respect and support

- Staff showed compassion with an understanding of the needs of young people and their families.
- Parents and young people we spoke with felt that staff were caring, supportive and polite. They felt that the staff were good listeners and gave appropriate support when working with other agencies.

The involvement of people in the care they receive

- The views of young people and families were gathered through the use of surveys, groups and interviews held by staff. The service recognised that whilst older patients had a voice in service development, younger patients did not. It was decided that regular involvement would be overwhelming so they were involved on a project driven basis.
- Young people identified that they wanted more group activities and the service had responded by providing groups for social skills, activities like art and lesbian gay bisexual transgender groups.
- There was a young person's panel which met monthly which was run by the young people and facilitated by Hounslow CAMHS. The young people set the agenda for the panel and the Hounslow team could request support with specific issues
- Young people had been included in interview panels during staff recruitment. The trust had also identified a service lead for service user involvement.

Are services responsive to people's needs?

Good 

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

Summary of findings

We rated responsive as **good** because:

- All teams had access to meeting rooms where young people and their families could meet with staff in private. The rooms were well-maintained, light and airy.
- Staff worked to ensure young people attended their appointments. Numbers of patients who did not attend were closely monitored.
- People who used the service and staff were aware of the complaints process and using it appropriately.

However there was a possible lack of confidentiality as rooms were not sound proofed. Staff felt more could be done to meet the needs of hard to reach families particularly in some communities.

Our findings

Access and discharge

- Young people could access the specialist CAMHS service through a referral from their GP, school or social services. All referrals were screened and triaged by the duty worker with urgent cases allocated to a team and the young person and their families informed.
- The trust-wide target from referral to initial assessment was 77 days (11 weeks) and CAMHS had an internal target across teams of five to six weeks. All teams were currently meeting the internal target with the exception of neurodevelopmental teams. There had been an increase in referrals to the Ealing and Hounslow team in the last few years of 35% which was believed to be due to a general awareness of young people's mental health needs.
- The teams were closely monitoring young people who did not attend (DNA) their appointments. Within the Hounslow team there was a period of three months when the target of 15% was being breached. An audit of DNAs was carried out to understand the differences between attendance at appointments between Hounslow, Ealing and Hammersmith and Fulham. The audit showed that DNAs were on average twice as high in the Hounslow team compared to the Ealing and

Hammersmith & Fulham teams and an action plan was developed and targets were now being met. Actions included offering more flexible appointments and appointments would only be considered confirmed if it had been offered by SMS, email or telephone.

- Staff said that finding a CAMHS inpatient bed for an unwell young person could be very problematic. Senior administrative staff spent a large part of their working week trying to find beds when they were needed and these could be anywhere across England. The response had been to work collaboratively to reduce the need for inpatient services. If a young person was admitted to an adult ward this was treated as a serious incident. The CAMHS teams worked closely with families to consider the options for when an inpatient bed was needed. The service had taken this issue up with commissioners over a long period of time as it was the commissioner's responsibility to ensure suitable inpatient services are available for young people. The lack of suitable inpatient facilities was on the trust risk registers and was revisited regularly.

The facilities promote recovery, comfort, dignity and confidentiality

- All teams had access to meeting rooms where young people and their families could meet with staff in private. The rooms we saw were well-maintained, light and airy. They were comfortably furnished and maintained at an appropriate temperature.
- The waiting rooms were welcoming and warm with young people involved in choosing the décor.
- Weighing scales and height measurement and physical health equipment were available to clinicians.
- Parents of young person's we spoke to noted how the physical environment was very accessible to families and that rooms are always available. They also commented that there was a possible lack of confidentiality due to rooms not being soundproofed.
- In the Ealing team there was a lack of public transport to get to the building and patients had to walk from Ealing Hospital. Some families told us that they did not feel safe doing this during the darker evenings and had declined to attend these sessions.

Are services responsive to people's needs?

Good 

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

- In the Hammersmith and Fulham team there was a lack of space in the building and access for disabled users is limited to the ground floor as there was no lift

Meeting the needs of all people who use the service

- 76% of staff had completed training in equality and diversity. This formed part of the trust's mandatory programme of training.
- We spoke with a parent who was partially sighted, they told us that the service had asked how they could work with her. For example all contact was by telephone and appointments were arranged at their child's school.
- Young people and their families told us that appointments could be flexible to suit individual commitments.
- Families of young people we spoke with felt that there were issues with accessing the service if you are not in the right post code. Young people can live in the borough but have a GP in another borough whilst attending school in another borough. They also felt that there were no parents groups in the evening for parents who work and attendance at the parents' groups were not always possible due to work commitments.

- Some staff felt that more could be done to meet the needs of hard to reach families especially in some cultural groups.

Listening to and learning from concerns and complaints

- Parents and young people we spoke with said they knew how to make a complaint and felt comfortable speaking to staff about any concerns they might have.
- Staff we spoke with were aware of the process for dealing with complaints. They told us that they aimed to resolve complaints quickly through informal processes, but would use formal complaints processes should this approach prove unsuccessful.
- Staff told us that written complaints were dealt with appropriately and that there was a formal process available which logged complaints received within the team and centrally in the trust.
- The service manager and clinical director had conducted a review of complaints. They advised that feedback and learning from complaints took place at local clinical improvement groups. Staff also told us that they found out about lessons learned across the trust by accessing the trust intranet.

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

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

- Staff were very committed and reflected the values of the trust.
- There were team meetings in place and access to other information to support the management of the teams.

However some staff were clearly anxious about the changes taking place and the pressures they were facing. Some staff did not feel fully engaged. More work is needed to address this going forward to ensure staff feel well supported.

Our findings

Vision and values

- Staff were aware of and reflected the trusts values in their work.

Good governance

- The CAMHS senior management team across the three boroughs met each month to discuss all aspects of delivering the service.
- Staff we spoke with felt the current chief executive was a positive addition to the trust and had helped implement a culture of positive change.
- Supervision records we examined indicated that strong working relationships had been established and that where challenges to practise occurred, these were thoughtful and constructive.
- Line managers had oversight of mandatory training through access to the trust database. The database does not automatically update when training has been completed, and relies upon staff to manually input this information.

- The clinical improvement groups ensured information about incidents, complaints, performance were discussed.

Leadership, morale and staff engagement

- The CAMHS services were part of the trust's local and specialist services clinical service unit. The service was led by a clinical director, clinical team leads and lead professionals for each discipline.
- There was strong leadership at a service and team level that promoted a positive nature within the teams wanting to improve services for young people. All the teams were represented on the senior management team. There were concerns that while different ideas were acknowledged by the senior management team they may not be taken forward.
- Some staff commented that the current climate of cost improvements was challenging and whilst they felt they delivered a quality service, they felt short staffed, often stayed late, had pressured workloads and did extra hours. Morale in Hammersmith and Fulham was variable as a result of restructuring and the loss of some posts.
- Some staff expressed concerns about the restructuring of some services, so that the specialist services would be centralised in one location and would be provided across all three boroughs. They felt this had not been effectively communicated to the teams and the impact on patients had not been fully considered.
- Staff were aware of the whistleblowing process and felt confident to use it if needed.

Commitment to quality improvement and innovation

- The CAMHS nurses forum brought together CAMHS nurses across the Trust. The forum was used to disseminate information with business items and nursing issues discussed. This was a positive means of promoting learning and development.