Good

South West London and St George's 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)
RQYXX	Trust HQ	Woodroffe FACT (Kingston CAMHS)	KT6 7QU
RQYXX	Trust HQ	Merton CAMHS	CR4 4LQ
RQYXX	Trust HQ	Richmond CAMHS	TW9 2TE
RQYXX	Trust HQ	Sutton CAMHS	SM6 0EX
RQYXX	Trust HQ	Wandsworth CAMHS	SW17 7DJ

Summary of findings

This report describes our judgement of the quality of care provided within this core service by South West London and St George's Mental Health NHS 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 South West London and St George's Mental Health NHS Trust and these are brought together to inform our overall judgement of South West London and St George's Mental Health NHS 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:

Young people and their families were treated as partners in their care. Staff treated young people and their families with kindness, dignity and respect.

Managers supported staff to deliver effective care and treatment. Staff adopted a multi-disciplinary and collaborative approach to care and treatment. There was strong leadership at both local team and service levels, which promoted a positive culture. There was a commitment to continual improvement across the services.

There were clear processes in place to safeguard young people and staff knew about these. Incident reporting and shared learning from incidents was apparent across the services.

Most young people, children and families could access services promptly. There were robust systems in place to manage referrals and waiting lists. However, in one area, there was a waiting list for treatment and this team was not meeting local targets. Staff worked to ensure young people attended their appointments. Numbers of patients who did not attend were closely monitored

However, the processes for assessing and managing the risk for young people identified as low risk were inconsistent across the teams. The local arrangements for lone working and for managing incidents of violence were being reviewed but this work needed to be fully implemented.

The interview rooms at the Kingston service were not sufficiently sound proofed to avoid confidential conversations being overheard. Support was needed for the administrative staff while they were going through changes in how their work was delivered.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- The office environment where the teams were located were safe for young people and their families when they came for appointments.
- Staff had a good understanding of safeguarding processes. Staff embedded these processes in all the work that was undertaken. CAMHS had strong relationships with the local safeguarding teams
- There was good use of crisis planning and young people used the 'what if plan...' to help them recognise and take appropriate steps when their mental health was deteriorating.
- All services used a zoning process to monitor the risk of patients identified as high and medium risk. Staff consulted with the virtual risk team and sought their support if they had difficulties with risk management.
- Staff were able to respond to emergencies. They could offer urgent appointments to young people who required them.

However:

- In three teams the arrangements for lone working and for seeing young people safely in the office were being reviewed. These revised arrangements need to be fully implemented.
- Staff need to ensure that young people who are waiting for an assessment are given clear instructions about what to do if their health is deteriorating.
- Staff need to review the decision for young people in some teams who are assessed as being low risk not having a risk assessment or management plan in place.
- Staff need to complete the outstanding mandatory training.

Are services effective?

Good

We rated effective as **good** because:

- There was good assessment of needs and planning of care with clear evidence of monitoring outcomes.
- Services offered young people and their families a range of evidence based therapies.
- Multi-agency working was strong with good links with statutory organisations and the third sector.
- The CAMHS service was supporting young people moving from CAMHS into adult mental health services.
- Staff had access to specialist training.

Summary of findings

- Staff participated in clinical audits which were leading to service improvements.
- Care records were up to date and comprehensive.

However:

- Information was not always easy to locate in the care records due to the lack of consistency in recording. This may have posed difficulties for staff that needed to access information in an emergency.

Are services caring?

Good

We rated caring as **good** because:

- Staff were caring and understood the needs of the young people and their families.
- Teams provided good support for looked after children who were placed out of borough.
- Reports from patients and families were very positive about the service
- There was good use of the 'what if plan…' which engaged young people in decisions about their care.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Teams worked in collaboration with young people and their families. In Sutton, they had a parent's forum and young person's council.
- Services used feedback from young people and their families to improve the service.
- There were clear criteria in respect of who could access the service.
- Services had specified time frames to assess and offer treatment to young people. The majority of teams were meeting their targets.
- Teams had a robust system to re-engage young people who missed appointments.

However:

- There were longer waits of up to 24 weeks for young people who had seen one professional but then needed psychology input. The trust needed to ensure that commissioners are aware of these waits so they can be addressed.
- The sound proofing of the interview rooms in the Kingston office was poor and conversations could be overheard.

Summary of findings

Are services well-led?

Good

We rated well-led as good because:

- Teams were supportive of each other. The team modelled the trusts' visions and values.
- All managers felt they had sufficient authority to undertake the tasks required to manage the service. One manager was in their first week and was clear about the role she was required to undertake and the processes.
- Teams had key performance indicators, which were monitored through monthly meetings.
- The majority of staff had high levels of morale. Colleagues were complimentary of each other.

However:

- There was low morale amongst the administration team as this team were undergoing a restructure.

Summary of findings

Information about the service

South West London and St George's Mental Health NHS Trust provide specialist community child and adolescent mental health services (CAMHS) for children and young people up to the age of 18 in the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth.

The trust divides CAMHS into Tier 2 and Tier 3 services. Tier 2 services provide support to children and young people with mild to moderate emotional wellbeing and mental health problems and provide a triage/single point of referral for young people who have been referred into tier 3 services. Tier 3 services provide a specialised service for children and young people with more severe, complex and persistent mental health problems. These services consist of multidisciplinary teams.

Within the Tier 3 service, there were a number of sub-teams available. This included an eating disorders team, a neuro-development team and generic CAMHS teams.

There were 2,196 young people receiving a service from tier 3 CAMHS at the point of inspection. Sutton CAMHS had the highest caseload of 574.

This inspection focussed on the generic CAMHS (Tier 3 services) provided by the trust.

These services had not been inspected before.

Our inspection team

The team was consisted of, three CQC inspectors, two specialist advisor social workers with experience of working in young people services, one specialist advisor nurse with experience of working in child and adolescent mental health services and two experts by experience. An expert by experience is someone who has used or cared for someone who has used mental health services.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at nine focus groups.

During the inspection visit, the inspection team:

- visited five CAMHS teams
- spoke with 17 young people or carers who shared their views and experiences of the services
- reviewed 22 comment cards, which provided feedback from people using the service
- spoke with the managers or acting managers for each of the teams
- spoke with 27 other staff members; including doctors, nurses and social workers
- interviewed the operations manager and psychology and psychotherapy lead with responsibility for these services

Summary of findings

- attended and observed three team meetings
- looked at 22 treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 17 young people and their families. They felt that the support they received from clinicians was appropriate and well organised. They felt that staff were caring, polite and interested in the well-being of young people. They said they felt well informed about the care they received and felt as if they could make their own choices. Teams gathered the views of young people and families using surveys and groups. Feedback had been used to inform changes to the service.

Good practice

The 'what if' plan had been co-produced by head teachers, school counsellors, a health commissioner and members of the Sutton child and adolescent mental health service (CAMHS) along with young people from a Sutton secondary school. Young people who were accessing Tier 3 CAMHS could use this as part of the crisis planning process. Young people included information on the plan that was personal to them. These included top tips on how to keep well and the people they would want to be contacted should they become unwell.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that the changes in local protocols and policies around managing incidents of violence and aggression and lone working are fully implemented and fit for purpose.
- The teams should ensure that they give young people who are waiting for an assessment clear instructions about what to do if their health deteriorates.
- The trust should ensure that staff have a consistent approach across all teams to assessing, managing and monitoring young people who are identified as low risk.
- The trust should ensure that there is a consistent approach to recording information in the patient's care and treatment records so that information can be located where needed.
- The teams should complete the outstanding mandatory training.
- The trust should ensure it keeps commissioners updated on the waiting times for psychology input so that this can be addressed.
- The trust should ensure that interview rooms at the Kingston team have adequate sound-proofing to ensure that confidential information cannot be overheard.
- The trust should ensure that the administrative staff receive ongoing support during the period of their roles being reviewed.

South West London and St George's 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
Woodroffe FACT (Kingston CAMHS)	Trust HQ
Merton CAMHS	Trust HQ
Richmond CAMHS	Trust HQ
Sutton CAMHS	Trust HQ
Wandsworth CAMHS	Trust HQ

Mental Health Act responsibilities

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

Staff received training on the MHA as part of their induction and as part of the mandatory training on consent. They could also get advice from the MHA administrators working for the trust.

There were no patients subject to the MHA receiving care or treatment from CAMHS.

Detailed findings

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. Training was provided as part of the mandatory training on consent and bespoke training for the teams.

The Mental Capacity Act does not apply to young people aged 16 and under. For children under the age of 16, staff applied the Gillick competency test. This recognised that some children might have a sufficient level of maturity to make some decisions for themselves.

The patients' records contained information that related to capacity and consent. The understanding of Gillick competencies amongst the staff group was good. Staff described how to apply the guidance when a young person had decided they did not want their family to be involved. This meant that staff always sought consent for care and treatment young people and their families where appropriate.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- At all the sites where CAMHS was located the teams were located separately from adult services.
- The Wandsworth team was in the process moving into newly decorated offices. All sites appeared clean and well maintained. There were cleaning audits for all the sites except Sutton. There were scores of 85% or above for cleanliness for the sites that had been audited. A number of the sites had children's toys in the waiting area. Administrative staff were responsible for cleaning toys in the waiting area. Staff had cleaned the toys two weeks before the inspection. The Wandsworth service was revising the toy cleaning schedule to once a week to minimise the likelihood of cross infection. Services displayed instructions on hand washing in toilets and in rooms where physical examinations took place.
- All the team bases had the facilities to carry out basic physical health checks on young people using the service. Staff had access to weighing scales, gender specific height charts and in some services there were examination couches and equipment to check the young persons blood pressure.

Safe staffing

- CAMHS teams had been part of a service transformation programme which had taken place approximately 12 months ago. The services had restructured and in some cases, the staff numbers had been reduced, for example, some of the psychotherapy roles were removed. The new team structure was aligned to the 'choice and partnership' (CAPA) model. The model focused on providing interventions that had a strong evidence base recommended by the national institute for health and care excellence (NICE).
- Six staff members had left across the five teams between November 2014 – October 2015. The average sickness rates for the CAMHS services was 3%. In Merton, there was a locum family therapist and an agency worker covered the management post in Sutton.
- The trust used the CAPA model to calculate the number of staff needed to deliver the service and the number of appointments that could be offered on a weekly basis. For example, in Richmond 11 initial assessments took take place each week; along with ongoing casework and in Kingston, they had a target of 10 initial assessments. There were no young people waiting to be allocated to a worker in any of the services.
- The caseload for consultant psychiatrists varied. One doctor was working with 98 patients, although many of these were on a 'shared care' basis. Under the 'shared care' arrangement, the young person's GP provided ongoing care and treatment and the consultant psychiatrist saw the patient once a year.
- All newly recruited staff completed the corporate and local induction. Mandatory training rates for all services was 75% and above in the majority of areas. However, Richmond CAMHS had low completion rate of 57% for safeguarding children and young people level 3 training and Wandsworth had a completion rate of 60%. However, there had been a number of staff changes and the CAMHS teams demonstrated a good working knowledge of safeguarding procedures.

Assessing and managing risk to patients and staff

- The triage/single point of referral team reviewed risks at the referral stage. The review process took different forms based on commissioning arrangements. For example, in Kingston CAMHS the triage process was a paper-based exercise and the triage worker reviewed the information supplied by the referrer and rated the risk based on the information. In Sutton and Wandsworth CAMHS, a specialist worker reviewed the referral. If the referral information identified that the young person was in urgent need, staff would prioritise their appointment. If it was unclear, workers made contact with the referrer, the young person and their parent or carers to gather information and to undertake an assessment. Based on the assessment the young person's risk was classified as either high (red), medium (amber) or low (green).
- Urgent referrals began treatment within seven days of assessment. The Kingston team were able to see young

Good

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people within 24 hours. During our visits, consultant psychiatrists responded immediately to urgent requests to see patients in the accident and emergency department of the local hospital.

- Young people who were classified as medium or low risk were placed on a waiting list for an appointment. All services reviewed young people waiting for appointments in zoning meetings. Staff scheduled appointments for treatment according to risk with those identified as low risk waiting up to 18 weeks for an appointment. Teams did not have a consistent approach for monitoring young people on the waiting list identified as being low risk. Some teams advised these young people to contact CAMHS if they were experiencing difficulties.
- Once young people had begun treatment, staff completed a risk assessment and management plan for young people identified as high or medium risk and updated this whenever there was a change in circumstances.
- The trust policy stated that individuals who were assessed as being low risk did not require a full risk assessment or management plan. It was unclear from the records what factors mitigated the risks for young people and what would trigger an increased risk. The CAMHS teams had identified that this was an issue. Wandsworth CAMHS had made a local decision in March 2016, to improve the risk assessment for those identified as low risk. The team had started to complete a risk assessment and management plan for these particular young people. Risk information would identify historical risk and the current assessment of risk. Managers from CAMHS teams were discussing providing staff with CAMHS specific risk assessment training and education.
- Young people receiving treatment were encouraged to create 'what if…' plans. These plans were prepared jointly with a clinician and included sections on how the young person would know when they were starting to feel unwell, what they could do when they felt unwell, what made things worse and 'top tips' on staying well.
- Staff in Sutton CAMHS had identified that they had high rates of self-harm amongst the young people who accessed the service. They had implemented protocols for managing the risks posed by these young people. The protocols included the young person being assessed by CAMHS within 24 hours, referrals being made to social care and if the young person received treatment from CAMHS that they would not be discharged until a team around the child meeting had been convened.
- The services had lone working protocols and safety procedures. However, these were not always robust and were being reviewed. In Wandsworth, the manager had noted that safety procedures needed updating after an incident had taken place. The manager had drafted a new policy, which was awaiting sign off by the trust. Interview rooms in Richmond were not fitted with alarms. A recent incident had led to the manager ordering personal alarms for staff working at the offices. In Merton, there were alarms buttons in the offices but staff had no system of identifying where an alarm had been activated. If an alarm was activated the administrator had to go round the building to find the incident. There were plans to upgrade this system. In Kingston, the teams occasionally offered appointments after 5pm. However the layout of the building meant that staff were some distance from the reception area and there would be delays in the reception responding if there was an emergency. The manager at Kingston was reviewing the protocol for out of hours appointments.
- Staff knew how to raise a safeguarding alert and had a good understanding of the safeguarding protocols and procedures. Safeguarding was clearly embedded across the teams. There was evidence of staff raising safeguarding issues at clinical appointments and agreed plans with the young person to manage and reduce their risks. The trust had trained staff to recognise child sexual exploitation and patient records showed that CAMHS staff had liaised with other agencies to protect the young person. Where there were concerns that a young person might be involved in a gang the staff liaised with the local gangs team. The trust had a safeguarding lead and a virtual risk team. There were good links with the local authority, evidence of multi-agency working and information sharing. This meant that young people were protected from abuse and avoidable harm.
- CAMHS maintained a risk register of looked after children who were placed in an out of area mental health provision. This was so they could follow up on their progress.

Good

Are services safe?

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Track record on safety

- There had been no serious incidents in CAMHS community services from October 2014 – October 2015.

Reporting incidents and learning from when things go wrong

- All staff we interviewed were aware of what incidents to report and how to report them. Staff told us that there was a positive culture around reporting incidents. They understood that they would not be blamed if things went wrong. Teams saw the reviewing of incidents as an opportunity for learning. Staff discussed incidents during monthly team meetings. Staff made good use of the trust's Oxford learning events, to learn about other incidents that had taken place in the trust. The Oxford learning events also allowed staff to review and reflect on learning around specific CAMHS incidents. Staff could also attend the adult services postgraduate learning events.
- In Richmond, there had been improvements to safety following an incident four weeks before the inspection. A young person had become distressed during an appointment and had damaged the interview room. As a result, this team had reviewed their local policy for managing incidents of violence and aggression. The policy stated that staff should attempt to de-escalate the situation in the first instance. The manager had provided staff with personal alarms.
- There had been a serious case review in December 2014 relating to a young person who had been a former CAMHS client. As a result of this review, there had been improvements in the support that CAMHS provided to looked after children (LAC) placed outside of the borough. The CAMHS team kept in contact with these young people. During zoning meetings, staff reviewed the risk classification for LAC. This allowed the teams to identify when risk was escalating.
- Every quarter there was a CAMHS learning event. The teams looked at incidents that had arisen and discussed the learning. The events were open to all staff and they were encouraged to attend.
- All staff had a good understanding of the duty of candour. This duty was introduced in April 2015. It required staff to provide people who use services with reasonable support, truthful information and an apology when things went wrong. There was evidence that staff had adhered to this duty in the work they undertook with young people and their families.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- After staff in the triage service or single point of referral had assessed the needs of the young person, the tier 3 CAMHS team reviewed the young person's referral and allocated them to the appropriate clinician for a more in-depth assessment.
- Staff assessed young people's mental health needs in a compassionate manner. They carried out the assessment at a pace to suit the young person and their family. Staff planned the care and treatment during the assessment and agreed further actions with the young person and their family.
- Care records were personalised, holistic, evidence based and recovery focused. A range of needs were covered in assessments including education, social circumstances, mental health and family dynamics. The assessment of needs was ongoing and if young people required an additional intervention, staff would offer this. For example, some young people required additional psychological input.
- Staff shared young people's plans of care with the young person, their families and their general practitioner and school where appropriate.
- CAMHS staff in all the teams did not use the care plan template within the electronic patient record system consistently. The lack of consistent methods of recording information meant that it might be difficult for staff to access information easily. This was concerning as staff working in A&E needed to access information quickly when young people accessing CAMHS presented to A&E in crisis.

Best practice in treatment and care

- Clinicians considered NICE guidance when prescribing medication and used it to inform treatment pathways, particularly the use of psychological therapies. During the appointments we attended we consistently saw evidence of staff following NICE guidance on 'psychosis and schizophrenia in children and young people' and 'depression in children and young people'. Doctors offered young people antipsychotic medication in conjunction with psychological interventions. We also saw that clinicians were skilled in explaining medication to young people in a way that was age appropriate and relevant to the person.
- The services offered psychological therapies recommended by NICE including cognitive behavioural therapy, interpersonal therapy, family therapy and psychodynamic psychotherapy.
- When families required support in relation to employment, housing and benefits, staff referred them to the children's services department within the local authority or to local voluntary sector organisations. The Sutton team had strong links with the Sutton Alliance who were able to refer young people to specialist services including children with complex medical needs.
- There was a shared care protocol between CAMHS and general practitioners (GPs). The GP dealt with the majority of the young person's physical healthcare needs. We saw that there was regular communication between the CAMHS and GPs. Clinicians monitored the weight and height of patients receiving medication for the treatment of attention deficit hyperactivity disorder (ADHD).
- Outcome measures were integral to clinical practice. A number of tools were used which included the monitoring of outcomes using the electronic database. Staff asked young people and their parents to complete 47 questions on the 'revised child anxiety and depression scale' to indicate the nature of the difficulties the young person was experiencing. The exercise enabled young people and families to classify their difficulties. Staff reviewed and discussed treatment outcomes with the young person and their families on a regular basis to measure the progress that the young person had made. They also used the treatment outcome measures to inform future care planning.
- Staff participated in clinical audits. There had been an audit in November 2015, regarding young people who presented to accident and emergency (A&E), who required a mental health assessment. The audit reviewed patterns of young people presenting to A&E and assessed whether this was most appropriate environment for staff to assess young people. The audit recommended improving communication and crisis planning between the young person, their family and primary care. The audit identified that CAMHS should provide training to other agencies, for example, hospital

Are services effective?

Good

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paediatric services and social work teams to improve their understanding of the assessment process and how best to support young people who presented to A&E. In the Sutton team, a psychiatrist had audited the prescribing of melatonin, which clinicians prescribed for young people with ADHD who had sleep disorders. The audit found that staff needed to improve procedures for prescribing melatonin and documenting it. There was information reminding staff to apply good practice for prescribing melatonin on display in the Sutton administration office. All teams had contributed to an audit on child sexual exploitation in collaboration with the local authority.

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. Sutton CAMHS had a substance misuse worker in their team, which meant that young people who had mental health problems and used drugs or alcohol received treatment for their substance misuse.
- Some staff including two of the managers were relatively new to the service but senior psychiatrists and psychologists had worked in CAMHS for many years.
- Staff had the qualifications and skills they needed to carry out their roles effectively. Some teams had received specialist training which was not mandatory. In Kingston, the team had received training from the Tavistock and Portman NHS Foundation Trust around supporting young people involved with CAMHS, who identified as being transgender. The Wandsworth team had worked with the local community to improve their understanding of female genital mutilation .
- All staff received a range of opportunities for supervision and support including regular team meetings, individual and group clinical supervision and managerial supervision. The staff in the Wandsworth and Kingston teams did not receive monthly managerial supervision due to the numbers of staff the manager had to supervise. The Wandsworth manager supervised 26 members of staff and the Kingston manager supervised 18 members of staff, they supervised their staff every two months but ensured that these members of staff had monthly clinical supervision.
- The majority of staff had received an annual appraisal. The average appraisal completion rate across the teams was 93%. Merton, Sutton and Kingston had appraised 100% of staff.
- There were regular team and business meetings and staff we spoke with told us they felt well supported by other disciplines.
- Staff who were performing poorly received prompt support. Managers assisted staff members to improve in their role. Managers used supervision sessions and action plans to address concerns about the staff performance.

Multi-disciplinary and inter-agency team work

- We saw that staff had a good understanding of patients' needs. In particular, we noted that multi-disciplinary team meetings discussed young people in considerable depth and that members of the team had a good understanding of both the difficulties each young person had and the dynamics with their families and schools.
- Multi-disciplinary team meetings took place regularly. In all teams, there was a weekly meeting to discuss current patients and review the waiting list. Business meetings for the whole team took place each month to discuss organisational and administrative matters. We attended one of the weekly meetings and read the minutes of business meetings. Attendance at all of these meetings was good.
- There was a trust policy for young people in transition to adult mental health services. This is the planned movement of young people from child centred to adult orientated healthcare systems. Staff worked jointly with colleagues from adult mental health services during the transition to adult services.
- There was frequent contact between the CAMHS teams and the local social services departments. This included the CAMHS team giving advice to social workers on strategies to support families. In Sutton, staff met with the social care team every six weeks to review cases. The single point of access for referrals co-ordinated a number of agencies that supported children and young people including schools, social services and voluntary organisations. We saw evidence of a clinician being part of a multi-agency 'child sexual exploitation' meeting following a concern about sexual exploitation of one of her patients.

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.

- CAMHS teams provided support to LAC placed in other boroughs. The local CAMHS team worked with the LAC social worker to provide support to the young person. This included the CAMHS worker visiting the young person in other parts of the country and supporting them to access services from the local CAMHS team.
- The CAMHS teams also worked closely with inpatient services when a young person was being admitted or discharged. There were examples of effective working with other teams within the trust such as the paediatric liaison team. The paediatric liaison nurses attended CAMHS team meetings and provided information about young people who had presented to A&E. The A&E nurses made referrals to CAMHS for this group of young people.

Adherence to the MHA and the MHA Code of Practice

- Staff received training on the MHA as part of their induction and as part of the mandatory training on consent. They could also get advice from the MHA administrators working for the trust.
- There were no patients subject to the MHA receiving care or treatment from CAMHS.

Good practice in applying the MCA

- The Mental Capacity Act does not apply to young people aged 16 and under. For children under the age of 16, staff applied the Gillick competency test. This recognised that some children might have a sufficient level of maturity to make some decisions themselves.
- Managers and staff said that initial assessments all included consideration of capacity, competency and consent.
- Staff understanding of the Gillick competencies was good and they described how it would be applied when a young person had decided they did not want their family to be involved. This meant that staff always sought consent for care and treatment from young people and their families where appropriate.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff showed compassion with an understanding of the diverse needs of young people and their families. There were good interactions between staff and young people. Staff acknowledged and praised the young person for the progress they had made. Where young people identified that progress was slow, the clinician provided the young person with appropriate and practical support. At all times staff spoke to young people in a considered and age appropriate manner. The staff had a very good understanding of the needs of young people and their carers. In all the meetings we attended, we saw clinicians speak to young people in a thoughtful and respectful manner. Staff explained both the illness and treatment in a way that the young person could understand.
- Feedback from the young people and parents that we spoke with was positive. Comments included ' the staff here are kind, caring and really nice'. One young person said they felt happy with the service and the fact that the staff allowed her parent to come to sessions. Patients commented that they felt listened to.
- During interviews, clinicians paid close attention to the boundaries of confidentiality and asked the patient's permission to include parents in the discussion.

The involvement of people in the care they receive

- Young people and their families commented they had been involved in their care plans and had received copies. Staff ensured that young people and their families were fully involved in decisions about care and treatment at clinical appointments. In sessions, there was a strong emphasis on collaborative strategies to resolve problems including the young person and their families. Young people were encouraged to write a 'what if plan' with their clinician, setting out the things that help them to manage their difficulties.
- Parents and carers were involved in the therapeutic process if appropriate. Clinicians worked in partnership with the young person and their families. Clinicians mediated between young people and their parents and helped individuals to have a better understanding of the other person's point of view.
- Teams tried to involve young people in decisions about the CAMHS services. The Kingston CAMHS had been renamed. The team was now known as Woodroffe Family Adolescent and Child team in response to feedback from individuals using the service who did not want references to mental health to be included in the name of the service.
- The trust had a participation officer who worked with young people to give them the best opportunity at engaging and participating.
- The participation worker was working with young people across the boroughs to involve them in recruitment. The worker provided training around the recruitment process including how to write a job description and the short listing process. The participation worker also supported young people to write interview questions for prospective interview candidates.
- Staff in the Sutton team used surveys and interviews with young people and their parents to improve the service provided. In Sutton, they had a parent's forum and young person's council, which met on a regular basis with staff from the local CAMHS service.
- The Merton CAMHS team sought feedback through completion of NHS 'friends and family' comment cards. Seven young people and parent carers had provided feedback. Four respondents said they were likely to recommend the service to a friend or family member and three respondents said they were extremely likely to do so.
- The Sutton team had also sought feedback and 15 people had responded. One hundred per cent of respondents had stated they felt listened to and all were satisfied with the service.

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

- The CAMHS teams received a large number of referrals. For example, the Wandsworth service received approximately 100 referrals per month and the Sutton service received 120 referrals per month. Staff from the triage team/single point of referral reviewed new referrals to assess whether they met the criteria for tier 3 CAMHS services. NHS England states that tier 3 services are for young people who present with moderate and severe mental health problems that are causing significant impairments in their day-to-day lives. This includes acute presentations. There was a trust policy that stated that the CAMHS tier 3 services were for young people with severe and enduring mental health problems. If young people did not meet the threshold for tier 3 services, the triage/single point of referral would signpost these young people to alternative sources of support. In Wandsworth, the single point of referral (tier 2 access team) could provide short-term psychological therapies for those young people who did meet the criteria for a tier 3 intervention.
- CAMHS based their model of care on the choice and partnership approach (CAPA). The CAPA model had set timeframes for young people to have an initial assessment and for treatment to commence (second appointment). Staff were expected to complete initial assessments on young people within four weeks and were expected to offer a second appointment and begin treatment within 18 weeks. For urgent referrals, for example, young people who presented to A&E, staff undertook an initial assessment within seven days and they were considered a priority to begin treatment. The services met the time frames for assessment and subsequent treatment.
- Staff responded appropriately to young people who were in crisis. For example, a young person who accessed CAMHS in Kingston had been admitted to an acute hospital with both physical and mental health difficulties. The team had visited the young person in hospital to support them around their mental health. They had worked in collaboration with colleagues to find a CAMHS inpatient bed. Once the young person had been admitted onto the CAMHS inpatient ward they had continued to support the young person and played an important part in planning for the young person being discharged from inpatient services into community CAMHS.
- There was a waiting list for psychological therapies in all services. The Sutton service had 49 young people waiting for a psychology appointment. These young people had been waiting for up to 24 weeks. Whilst these young people waited they were given ongoing psychiatric support.
- The majority of the services offered appointments between 9am – 5pm. However, Kingston and Wandsworth teams offered appointments outside of office hours. For example, the Kingston service was able to offer evening appointments and the Wandsworth service offered evening appointments two evenings per week and planned to open on Saturdays.
- Staff told us that appointments were rarely cancelled. However, in the event of un-planned absence of staff, non-urgent appointments were cancelled. This meant that as far as possible people received a service.
- Young people could access specialist help outside of normal opening times by going to accident and emergency departments at the local acute hospital.
- The services had identified that some young people might find it hard to engage with CAMHS. The participation worker was working with Wandsworth youth council to train young people to become mental health youth ambassadors. These ambassadors would work in schools to support young people who might have concerns about their mental health. The participation worker had also put forward a proposal to the trust to train young people as peer mentors. These peer mentors would be young people who had completed treatment in CAMHS and their role would be to support young people who might find it hard to engage with CAMHS services.
- Teams monitored young people who did not attend (DNA) their appointments. They would make efforts to contact the young person and offer them appointments. Before the young person's case was closed and they were discharged, they would review the risks and identify whether there were any safeguarding concerns and make appropriate referrals.

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- There was a trust policy for young people in transition to adult mental health services. This is the planned movement of young people from child centred to adult orientated healthcare systems. The policy emphasised the importance of services supporting young people and their families to exercise choice in the type of service in which they were involved. Staff described joint team working using the care programme approach. For example, staff had liaised with staff working at the Maudsley hospital about a young person with ADHD who was approaching 18 years of age and required transfer.
- For young people who did not meet the threshold for adult mental health services, CAMHS made robust plans for discharge. This included identifying other organisations that could support the young person. For example, in Sutton, young people could be referred to Sutton Uplift Wellbeing Support, which offered self-management courses led by the recovery college and psychological therapies.

The facilities promote recovery, comfort, dignity and confidentiality

- All teams were based in offices with therapy rooms. The Wandsworth, Sutton and Kingston teams had facilities on site to allow clinicians to undertake physical examinations. The lack of clinic rooms at the Richmond and Merton sites meant that it was difficult for clinicians to undertake physical examinations.
- All the teams had sufficient interview rooms, which meant that staff could meet with young people in private. The soundproofing of the interview rooms at the Kingston site was poor, which meant that other people could overhear conversations. Maintaining confidentiality during sessions was difficult because of this.
- All the CAMHS sites were child and young people friendly. The Wandsworth and Kingston site had artwork completed by young people who used the service displayed on the walls.
- Patients received a 'Welcome to CAMHS' booklet setting out what they could expect from the service. The information included what happens at appointments, information on goal setting and confidentiality. The services displayed information about local services and how to make a complaint on notice boards in the waiting areas.

Meeting the needs of all people who use the service

- Ninety-four per cent of staff had completed training in equality and diversity. This formed part of the trust's mandatory programme of training.
- CAMHS team bases had access for people with disabilities. Individuals with impaired mobility could use ramps and the lift to access the offices.
- Staff considered the needs of young people and their families and provided information in different accessible formats. For young people and parent carers whose first language was not English, staff used of interpreting services. Staff could organise interpreters quickly, which was beneficial to those who used the services.
- The 'Welcome to CAMHS' booklet included statements in community languages of how to request a translated copy of the information, along with details of how to request braille or easy-read copies.
- The teams ensured that they had an understanding of the needs of the diverse population they worked with. Staff undertook training to improve their knowledge. For example, the participation worker was working with transgender young people to develop a training course for staff around working with young people who were transgender. Young people would deliver this training. One team had consultation sessions from another specialist CAMHS team from another trust and used this learning to improve the service they offered to young people. The Wandsworth team had worked with the local team to get a better understanding of female genital mutilation.
- The Sutton team had an identified equality and diversity (ED) lead who led on these issues for the team. The ED lead had identified that a number of improvements that could be made in the Sutton service. This included celebrating different religious festivals. The ED lead ensured that staff from their team had access to conferences and about equalities and diversity and information about trans-cultural psychiatry.

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. There had been 29 complaints in the last 12 months.

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- The teams collated compliments. CAMHS had received 23 compliments from December 2014-November 2015. Wandsworth CAMHS had the highest number of compliments; they had received 16.
- All staff were committed to ensuring that young people and their parents and carers had a positive experience of using the services. Staff ensured that trust's complaints leaflets were available throughout the services.
- 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.
- Recent examples of complaints involved a patient who disagreed with his discharge from the CAMHS team to a less specialist service and parents who were unhappy with a treatment plan. The parents wanted their child to have weekly sessions with a psychologist. The team manager was responsible for investigating the complaint and sending a response to the complainant. In Kingston, a parent had complained informally about a decision made by the team. The manager had investigated that the complaint and had responded to the parent in a timely manner. The manger had also requested that despite the matter having been resolved informally that the parent should also raise the matter formally so that the trust's complaints team could review the issue.
- Team managers ensured that their contact details were available to young people and their families. Managers encouraged people to contact them if they have concerns about the service. The manager in Sutton attended the CAMHS parents' forum on a monthly basis, which provided the opportunity to meet with parents face to face to discuss any concerns they had about the service.
- Staff discussed the feedback and outcomes of investigations into complaints at monthly business meetings.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Staff demonstrated a very strong commitment to supporting the young people they were working with. Teams supported each other and had a culture of openness in which they could discuss challenges in their work with colleagues. Information for patients stated a commitment to have open and honest conversations with young people, listen to and respect their views and to give young people choices about their care and treatment.
- Trust values were on display in services and staff were able to talk about how these were reflected when they carried out their work. We observed staff behave in ways that reflected the trust vision, purpose and commitments.
- Staff knew who senior managers were. The CAMHS leadership team oversaw the service. This team held quarterly business meetings at each of the CAMHS locations.

Good governance

- There were systems and processes established to ensure that the quality and safety of the service was assessed, monitored and improved. The trust used a risk evaluation tool (dashboard) to identify teams that required support. There was good use of the dashboard reports, which enabled the trust to respond to issues of concern raised by the different CAMHS teams. The dashboard included information about sickness rates, vacancy rates, impact of incidents, complaints. The system also identified that the manager vacancy in Sutton was a potential risk. The Sutton team had recently recruited an agency worker to cover this management post.
- The operations manager had recently audited risk assessments completed by the Richmond CAMHS team and identified that improvements needed to be made regarding the timeliness of completion. The manager from Kingston team had identified that reduced staffing levels because staff leaving the team, might affect waiting times in the next quarter. Both these issues were being put on the risk register and this would ensure that the trust were aware of these emerging issues.
- The CAMHS service had robust governance systems. The service had a CAMHS triad management meeting. The operations manager, medical director and performance lead, attended this meeting. The triad meeting looked at data and ensured that services had the appropriate resources to run a safe service. In management team meetings, CAMHS managers discussed the activities that were taking place in the various team. Performance indicators, for example, waiting times were measured and discussed at monthly business meetings.
- There were regular performance scrutiny meetings. The managers used these meetings to review the waiting times for treatment, review young people who were known to the service and not attending school and to discuss the young people who were on the safeguarding list. Services also had weekly governance meetings, which focused on local governance for example treatment outcomes. Managers shared information from these governance meetings with staff in local teams.

Leadership, morale and staff engagement

- The trust undertook an annual staff survey. Ninety-six per cent of CAMHS staff agreed that their role made a difference to patients and 79% of CAMHS staff felt able to contribute to improvements at work.
- The operations manager visited the CAMHS teams and was highly visible. Members of the senior management team had visited the Kingston team to carry out a '15 steps challenge'. The helps organisations gain an understanding of how individuals feel about their care. It can also help them understand and identify the components of high quality care that are important to people who use services.
- The sickness rate for the team in Merton was high at 9.7% due to one member of staff being on a period of long-term sickness. The level for Richmond was low at 1.1%. There was one member of staff on long term sick leave who worked at the Sutton team.
- None of the staff we spoke to raised any concerns about bullying or harassment.
- Staff were aware of the whistleblowing process if they needed to use it, but thought this was through their line manager. Staff across all teams felt confident to raise concerns without fear of victimisation.
- The annual staff survey asked CAMHS staff to rate their satisfaction regarding the support they received from

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their managers. The survey used a scoring scale of one being poor to five being good. The respondents rated the support they received from their managers as 4 out of 5.

- Different disciplines spoke very highly of each other and understood the different roles staff had. Staff spoke positively about team working and mutual support.
- The managers were very complimentary about their teams. Levels of morale and job satisfaction were high amongst the majority of the teams. However, a number of administrators said that their morale was low due to restructuring of the admin teams, which meant that there might be a reduction in posts.
- The managers across all teams felt well supported by their managers. Managers told us that they had sufficient authority to carry out their work. They felt supported by the operations manager within the CAMHS leadership team. Experienced administrators supported managers.
- One team manager had been offered opportunities for leadership development, they spoke positively about this. He had recently completed a post-graduate diploma in leadership of children's mental health services at a local university with the support of his manager.
- Staff were open and transparent and apologised when things went wrong. For example, due to a staff error, a young person had experienced a delay in starting treatment. The manager had apologised to the young person and their parent. Additionally the Kingston service had reviewed processes and made improvements to work practices to minimise the likelihood of this happening again.
- Staff feedback had contributed to service development at the monthly business meetings. At the team meeting, we attended there were discussions about improving joint working with other agencies and improving the early planning of patients' discharge.

Commitment to quality improvement and innovation

- CAMHS services were participating but not yet accredited with the Royal College of Psychiatrists quality network for community CAMHS.