Good

Hertfordshire Partnership University NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Trust Headquarters
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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)
RWR99	Trust Headquarters	CAMHS eating disorders, Kingsley Green	AL3 5TL
RWR99	Trust Headquarters	Rosanne House child and family clinic	AL8 6JE
RWR99	Trust Headquarters	Borehamwood child and family clinic	WD6 1WA
RWR99	Trust Headquarters	Adolescent drug & alcohol service	AL10 8HR

Summary of findings

RWR99	Trust Headquarters	CAMHS Crisis, assessment & treatment team, Kingsley Green	AL3 5TL

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	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 rated the community child & adolescent mental health services as good overall because:

- Due to the shortages in staff, the services relied heavily on bank and agency staff. As such, recruitment of substantive staff was active at the time of the inspection. This was having a knock on effect on key areas of the service such as appointment waiting times, completion of risk assessments and staff morale. Psychiatrists were also found to be carrying higher than normal caseloads. This was in part due to a large number of patients with ADHD who required ongoing medication reviews.
- Staff reported IT problems within the services; most notably at the adolescent drug & alcohol service where they had limited access to the electronic patient record system (BOMIC) for over 6 months. This issue was being escalated through the county council at the time of the inspection as the solution rests wit the IT provider.
- The team did however find that reporting and learning from incidents was being achieved. We saw evidence of the dissemination of lessons learned throughout the services inspected.
- The services were effective overall. The inspection team viewed evidence of robust risk assessments, ongoing assessments and outcomes being achieved. Regular audits were carried out in order to monitor effectiveness in key areas such as waiting times, infection control and safeguarding and the outcomes of these discussed within the directorate governance meetings. In order to provide safe and cohesive pathways, inter-agency working with local authorities and internal Trust partners was also in evidence.
- Caring throughout the services was of a good standard. We saw evidence of staff showing compassion and empathy towards the young people in their care. Young people and their families were involved in decisions regarding their care.
- Responsiveness within the services was evident and of a good standard. Referrals were received via the single point of access and also internally through the various child and adolescent mental health teams. We saw good examples of the services meeting assessment targets; 88% of young people were being assessed within 28 days of referral and assessments within four hours for those presenting in the emergency department of the local general hospitals.
- The inspection team rated the well-led element of the child and adolescent mental health services as good. This was due to the notable alignment of the services with the trust's vision and values. The managers that we spoke with provided evidence that they and staff are offered development. We also noted governance systems that robustly monitored performance, risk and quality. Senior management and team leaders provided visible leadership.

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:

- Staff knew how to report incidents and safeguarding concerns. Lessons learned from a serious untoward incident in 2013 were being effectively cascaded to staff. Some teams had recently moved to refurbished premises which were clean.
- The 2014 PLACE score results for CAMHS at the trust were cleanliness 98% and for condition, appearance and maintenance 96%.

However:

- The risk register identified staffing as an issue and as such there was a recruitment campaign in place. There was reliance upon agency staff in the child and family clinic teams. The impact of staffing affected staff morale.
- The risk register identified that across all CAMHS there were 452 risk assessments out of a total caseload of 3,204 (amounting to 14%) that had not been completed on the electronic PARIS system. The inspection team were assured however that risk assessments were written in the narrative of the young people's notes. A specific data report is run each week showing the number of outstanding risk assessments. This report is reviewed in the weekly CAMHS manager conference call.
- The risk register identified that some psychiatrists carried caseloads of up to 200. These were due to young people with attention deficit hyperactivity disorder (ADHD) requiring ongoing medication reviews, although there was a voluntary shared pathway across the county not all paediatricians or GPs participated in it.
- There were IT failures occurring on the week of our visit affecting different teams. There were particular problems of the substance misuse team in accessing the trust IT system due to a lack of broadband facilities. Both the Trust and the county council IT departments were working on a solution and the urgency of this escalated within the county council.

Are services effective?

Good

We rated effective as good because:-

- All young people received care plans and there was evidence that care pathways were in place. Physical health needs were assessed and monitored.

Summary of findings

- The child and family clinics, eating disorder teams and substance misuse team used NICE guidance for the treatment/ use of eating disorders, anxiety and depression, obsessive compulsive disorder (OCD), depression and self-harm.
- There was a range of outcome tools used to measure progress. There were clinical audits being undertaken in order to monitor waiting times, infection control, safeguarding children, implementing the actions from serious untoward incidents, care co-ordinators in CAMHS and the use of antipsychotic medication in CAMHS. Results were discussed at the trust governance and CAMHS governance committees and cascaded to staff.
- There was good inter-agency and multi-agency working. Staff carefully considered issues related to information sharing, confidentiality, capacity and consent.

However:

- Data showed that there were 160 young people without a care co-ordinator on the 28 April 2015.

Are services caring?

Good

We rated caring as good because:-

- Staff provided respectful, compassionate care. Young people and their families were involved in their care and family therapy. Text messaging was used to communicate with young people. Young people were given choice of times and locations of their appointments.
- There was an active youth council who provided peer support and participated in staff employment issues. The council was involved in a range of projects.
- The 2014 PLACE score results showed that for privacy, dignity and wellbeing the CAMHS scored 82%.

Are services responsive to people's needs?

Good

We rated responsive as good because:-

- Referrals came in through the single point of access and internally through the various CAMHS teams. Young people were assessed by the crisis team within four hours in the emergency department. Choice and partnership appointments were offered to young people. Clinical meetings took place to monitor the referrals and waiting lists. A transition process was in place to support young people going into adult services. There was suitable information provided to young people in the waiting rooms.

Summary of findings

- 90% of referrals were seen within the seven day target. There were waiting times for partnership appointments of between 6 -10 weeks.

However:

- There was voluntary shared pathway for young people with ADHD across Hertfordshire that GPs and paediatricians could participate in. However the arrangements for paediatricians were different across Hertfordshire as they were employed by different trusts. GPs and paediatricians were reluctant to undertake follow up care. This meant that the psychiatrists in the CAMHS teams found it difficult to discharge young people with ADHD. The review of children's services and CAMHS services intended in the future to address this issue.

Are services well-led?

Good

We rated well led as good because:-

- There was a good alignment of the service and trust vision and values. Senior management and team leaders provided visible leadership. Leadership development was available. There were governance systems in place in the CAMHS services with a risk register in place and monitoring of the performance and trends in the service with action plans in place.
- There was a commitment to improvement, the substance misuse team and the eating disorders team had earned internal recognition for the services they provided.

However:

- Morale had been affected by the transition changes in the service and this was also reflected in the 2014 staff survey results.
- The quality of the collection of data was not always timely or accurate which affected the accuracy of performance monitoring reports.

Summary of findings

Information about the service

- The CAMHS community crisis team assesses young people in the emergency departments, paediatric wards and at home. Out of hours cover is provided by the single point of access team.
- A choice and partnership appointment system was in place. This meant that young people could book their preferred appointment times and locations to be seen for in the child and family clinics. Once assessed they were referred to the most appropriate professional for a partnership appointment for their treatment.
- There were 14 child and family clinics providing services from 9 am to 5 pm during weekdays throughout Hertfordshire. The services provided young people with support for mental health, psychological, behavioural and emotional problems. Referrals were made by GP, health visitors, social workers, school teams through the single point of access (SPA) and by the internal CAMHS teams.
- The CAMHS adolescent drug and alcohol service (A-DAS) for Hertfordshire provided services for under 18 years. The service provided advice, treatment and support. Referrals were made by GPs, children's services, youth connections, youth justice, and youth support teams. Self-referrals by young people were also made. The service was inspected as it was an integral part of the CAMHS service.
- A community CAMHS eating disorder service was provided for young people.
- There are around 220,000 young people in Hertfordshire. The expenditure for child and adolescent mental health services (CAMHS) for April 2014 to March 2015 was £9.1 million against a budget of £ 8.3million.
- The over expenditure was incurred to provide additional staffing to meet the demands of bed pressures and increased severity of illness of young people being admitted into Forest House. Additional community staffing was funded to respond to the increase in demand and meet the requirements of the local health system to radically improve the tier three CAMHS access times. Additional funding was also used as part of the transformation programme leading to new staffing structure. This resulted in some roles needing to be recruited to, leading to agency spend in the interim.
- CQC undertook an integrated Inspection of safeguarding and looked after children's Services in Hertfordshire in 2010 and found arrangements to be adequate. We did not inspect the youth offending team or looked after children team on this inspection as they are subject to separate CQC inspection programmes. The community CAMHS service has not been inspected before by the CQC or via Mental Health Act monitoring visits.
- The sites visited included
  - The child and family clinics at Borehamwood Civic Centre, Roseanne House and 99 Waverley Road
  - The CAMHS crisis assessment and treatment team at Kingsley Green Forest House annex
  - The CAMHS eating disorders team at Kingsley Green
  - The adolescent drug and alcohol team at Downs Farm Centre

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett Consultant psychiatrist

Head of Inspection: James Mullins, Head of Hospital Inspection (mental health) CQC

Team Leader: Peter Johnson, Inspection Manager (mental health) CQC.

The team that inspected the child and adolescent community mental health services comprised of CQC inspection manager, a Mental Health Act reviewer, specialist professional advisors consisting of CAMHS consultant psychiatrist, CAMHS psychologist, CAMHS nurse and social worker.

Summary of findings

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?

During the inspection visit, the inspection team:

- Toured the clinic areas and community team offices
- Spoke with seven young people and four members of the youth council
- Spoke with ten parents of young people
- Spoke with five managers or acting managers for CAMHS community teams
- Spoke with 30 other staff members; including doctors, nurses and social workers
- Attended and observed one multi-disciplinary meeting, one team meetings, and one transition group meeting.
- Looked at 23 care 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

- Young people we spoke with were positive about the services they received. They and their parents spoke highly about the eating disorder services.
- Friends and family questionnaires provided overall positive feedback about the services.
- The youth council members we spoke with said they felt involved in collaborative interviews for staff recruitment, policy making and service audits. The council had provided their views on the proposed uniform policy and felt listened to. The council members also provided peer to peer support.
- The youth council told us that improvements needed to be made in the transition from CAMHS to adult services. Waiting lists were perceived to be too long, and there was a perception that young people were signposted to the accident and emergency service in order to gain access to tier 3 services sooner.
- The youth council were involved in reviewing the complaints policy.

Good practice

- The CAMHS eating disorder and substance misuse teams provided effective services to which enabled many young people to be treated in the community who would otherwise have been admitted to hospital.
- The trust had a range of awards to recognise good practice. The eating disorder team had received an award for "valuing our customers" in 2014.
- A number of staff in the trust were trained to carry out "Warner" interviews on all new CAMHS staff (Warner 'Choosing with care' report 1992). This was to check that staff had the right attitude, values and attributes to work with young people.
- We saw the trust "spot the signs and save a live" campaign leaflets around clinic areas. These encouraged people to talk openly about suicide in

order to reduce suicide rates. The campaign was in collaboration with the Hertfordshire MIND network. It aimed to alert everyone to the signs of suicidal thoughts and feelings and to challenge the stigma surroundings suicide. It asked local people to make a pledge to take positive action to prevent suicide.

- A CAMHS practitioner was part of the police HALO operational team, providing support to victims of sexual exploitation.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should continue to recruit staff into vacant posts.
- The provider should make improvements in its partnership appointment waiting times.
- The trust should ensure that the electronic system has up to date risk assessments in place to meet its own policy requirements.
- The trust should review the caseload of clinicians to ensure they are manageable.
- The substance misuse team should have access to trust IT systems
- There should be increased compliance with the uptake of mandatory training and clinical supervision. The training in relation to the Mental Health Act and Mental Capacity Act and the interface of the Children's act should be in a format that meets the needs of CAMHS staff.

Hertfordshire Partnership University NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Crisis, assessment & treatment team	Trust Headquarters
Adolescent drug & alcohol service	Trust Headquarters
Community CAMH eating disorders team	Trust Headquarters
Rosanne House child and family clinic	Trust Headquarters
Borehamwood child and family clinic	Trust Headquarters
Waverley Road child and family clinic	Trust Headquarters

Mental Health Act responsibilities

- Staff had received Mental Health Act training as part of their induction and mandatory training.
- No specific training sessions on the new Mental Health Act Code of Practice had been attended by staff. The trust had asked CAMHS to produce a summary of the Code's application within the service.
- Staff told us that Mental Health Act e-learning modules were adult orientated and did not meet their needs.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training was delivered as part of the trust induction. Staff knew that it would apply to people over the age of 16 years. The substance misuse team reported that they did not access mandatory training related to the Mental Capacity Act. Some staff in the child and family clinic teams had not updated their mandatory training.
- There was access to the Trust Mental Capacity Act policy & code of conduct on the intranet
- Staff stated that Mental Capacity Act e-learning modules were adult services orientated and did not meet their needs.

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

- The 2014 PLACE score for the CAMHS were cleanliness 98% and for condition, appearance and maintenance 96%.
- The community CAMHS crisis team premises were being decorated and builders were carrying out work. Therefore, it was not possible to make judgements about the environment. The rooms were spacious and soundproofed. A disabled toilet and disabled access was present. Suitable toys of young children were available.
- The community CAMHS crisis team had access to a specific room in the emergency departments and to trust records in the emergency department.
- Rosanne House child and family clinic was accessible and equipped with a play room, with a bright reception area and clinic rooms. All areas were clean.
- The child and family clinic had just moved to Waverley road following a refurbishment. Facilities were shared with adult and older people community services. There were separate waiting facilities for young people with access to drinking water. The children's area was clean and had play materials. There were disabled toilet facilities and baby changing facilities. Observation of the children's play area in reception area was not good and mirrors had been ordered to improve this. One room was being converted into a therapeutic reflecting room and equipment was on order. The room had child friendly decor.
- The community CAMHS eating disorders team had also just moved in to a new adequate office and were still in the process of unpacking.
- The community substance misuse team had an open plan shared office which was cramped. They did not have additional space for meetings. There was a lack of meeting rooms were hard to access due to other agencies using them. Whilst there were advantages in the team being co-located with local authority criminal justice teams, the building was not meeting the needs of the staff.
- Some family and child clinic staff were observed to be carrying personal alcohol gels. In teams such as the crisis team, that had just moved we found the alcohol dispenser by the entrance was not working, however personal alcohol gels were available in the office.
- We observed fire certificates had been completed and were visibly displayed.

Safe staffing

- There were 14.37 whole time equivalent (WTE) nursing vacancies across community CAHMS teams. There were two consultant vacancies. The turnover of staff across CAMHS services saw 26 leave out of an establishment of 130 due to the transformation programme, retirement, promotion and work life balance. The trust's response to reduce the amount of vacancies was via a recruitment and retention Group. The strategy included recruiting agency staff to substantive posts. They had also planned a 'People's Week' which include a targeted recruitment drive for CAMHS staff.
- The human resources department was responsible for ensuring that staff undergo a disclosure and barring service (DBS) and checking the protection of children act (POCA) register before staff are appointed.
- A number of staff in the trust were trained to carry out "Warner" interviews on all new CAMHS staff (Warner 'Choosing with care' report 1992). This was to check that staff had the right attitude, values and attributes to work with young people.
- Across all the CAMHS services in the previous 12 months, 6271 shifts were filled by agency/bank staff. Overall, 222 shifts were not filled in that time period. In the community teams 1225 shifts were covered by bank or agency staff to cover sickness, absence or vacancies.
- The crisis team had one permanent consultant Psychiatrist, a locum consultant psychiatrist, one staff grade and a further middle grade doctor, a social worker and two community psychiatric nurses (CPN). The current case load for the team was 80 and the staff reported struggling to discharge cases which no longer met with the new remit of the team. The crisis team routinely used agency staff over long periods as there

Good

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were difficulties in recruiting staff to permanent positions. The internal bank system was unable to provide cover for all shifts. There was good access to medical staff out of hours.

- In the child and family clinics there were difficulties in recruiting staff. In the CAMHS West area there was a fulltime consultant psychotherapist, two full time consultant psychiatrists, a psychological therapist, and a consultant social worker and three social workers. There were vacancies for a social worker and two psychologists. The team were experiencing difficulties in recruiting people with the right skills. Two social work agency staff and an agency psychologist were being employed on a regular basis. The sickness rates were 4% due to long term sickness.
- Caseloads were disproportionate across child and family clinic teams. Each practitioner had approximately 45 cases, although we found one practitioner at Rosanne House had a caseload of 60. Consultant psychiatrist caseloads varied. Five consultants had caseloads between 118 to 211; eight consultants had caseloads between 10 and 95, whilst seven consultants had case loads of between one and eight. Managers did monitor caseloads on a regular basis in order to provide support. Administrative support was available to the child and family clinics.
- The eating disorders team had three advanced practitioners who covered the county. A fourth was being recruited. The designated caseload for each practitioner was 15 each. However current caseloads were between 17 to 19. Some of these required a minimum of two visits a week. 27% of practitioner time was spent on travel
- The substance misuse team had a minimum of two clinical staff on duty which was reflected in the staff rotas seen and during the core hours of service 9.30 am to 3.30 pm. When no administrator was available then a member of staff would respond to incoming calls. Full time members of staff carried a case load of 15 and part time member 12. Caseloads were monitored by the team leader.
- The substance misuse team consisted of staff that had been in post a long time. There was a whole time equivalent (wte) team leader who was a qualified mental health nurse, a 0.5 wte consultant, two 0.8wte young person drugs workers, one of whom held a substance misuse qualification, a full time youth worker with counselling qualifications and dual diagnosis course, a full time drugs worker experienced in substance misuse and a full time administrator.
- The eating disorder and substance misuse teams did not use agency staff and only used their own staff for bank. Sickness rates for the substance misuse team was low at 0.3%
- There was access to a CAMHS consultant by all the teams including out of hours.
- The overall compliance with mandatory training across the whole CAMHS service was 76%.
- Mandatory training in the crisis and child and family clinics was not up to date in the staff logs we reviewed.

Assessing and managing risk to patients and staff

- A risk assessment form on the electronic BOMIC system had been introduced by the trust in 2014. This meant that every risk assessment needed to be updated on the system. CAMHS risk assessments were identified as an area of concern in February 2015 on the risk register. We were informed that across CAMHS there were 452 risk assessments out of a total caseload of 3,204 (14%) that had not been completed on the BOMIC system. There were over 800 assessments that had either not been completed or updated in the past 12 months. The majority of out of date risk assessments were on the psychiatrists' caseloads, hence each consultant psychiatrist was expected to update a specific number of risk assessments each week. The bulk of the risk assessments related to the child and family clinics. Therefore some psychiatrists were waiting to see the young person and their family before putting an up to date risk assessment on the system. Many of these related to young people with attention deficit hyperactivity disorder (ADHD). All other clinicians were expected to update risk assessments on their caseload, and managers were reviewing progress in monthly supervision. The trust informed us that there were data quality issues with the reports on the number of outstanding risk assessments. This was being addressed as part of the actions being undertaken. The trust informed us they were assured that the clinical risk was identified within the narrative of the young person's case record rather than directly in the risk assessment section of the BOMIC record. However there was a potential clinical risk in relation to agency staff to accessing risk assessments quickly from the narrative.

Good

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The CAMHS medical lead in conjunction with the service line lead was leading the actions to ensure that all risk assessments or patients seen by CAMHS were up to date. The CAMHS quality oversight board received a monthly report. The issue was also being monitored through the CAMHS quality and best practice meeting and the service business unit quality and risk group. A specific data report was run each week, showing the number of outstanding risk assessments and this report is reviewed in the weekly CAMHS manager's conference call.

- Assessments were completed on first appointment and staff told us that it was sometimes difficult to keep them regularly up to date due to their work load. The clinical team held daily meetings to discuss cases and risks.
- Risk assessments were completed at the admission stage and again in preparation for discharge. In handover meeting we observed good management of risk being discussed.
- The eating disorder team used Junior Marzipan as a risk assessment tool. This assessed physical health & changes associated with eating disorders.
- We saw and the crisis team confirmed that crisis plans were made with young people at the point of assessment and was a collaborative process.
- The substance misuse team had developed their own broad risk assessment tool to suit their client group. Risk assessments were made relating to self, others, sexual and financial. There was also a specific risk assessment form for young people who were very high risk. The risk plans were developed and reviewed by the whole team until the risks were mitigated.
- The substance misuse risk register dated February 2015 showed that IT was a risk. The premises did not have access to the trust IT services as the landlord of the premises would not allow the appropriate broadband to be fitted. This meant the team would have to go to other trust premises to access the trust intranet for policies and training. It also prevented national treatment agency statistics from be submitted and assessment records being completed in time. Staff had limited access to electronic records held on the BOMIC system. This issue was being escalated through the county council as the solution rests with the IT provider. This situation had existed for 18 months and created a lot of stress for staff. Paper light records were kept of risk plans and care plans so that continuity of care could occur.
- Each community CAMHS team had a risk register. This informed the overall CAMHS risk register and in turn the trust risk registers. The key areas of risk identified related to recruitment to vacant posts due to lack of suitable applicant, and reliance on agency staff.
- Key performance indicator reports were produced showing the numbers of people waiting to be seen and these were rated in terms of level of urgency. 89% of young people were seen within 28 days. 92% of urgent cases were seen within seven days. The SPA recorded their decisions about how referrals were managed.
- A CAMHS consultant was the medical safeguarding lead for the trust and there was also an overall trust safeguarding team for the trust. Safeguarding meetings were held internally in the trust. Multi agency safe guarding meetings were held at strategic and operational level.
- The crisis team were observed to be discussing safeguarding concerns. The team also checked that the safeguarding alerts they had sent had been acknowledged by the local authority.
- Safeguarding was a challenge in the substance misuse team due to the complex issues related to substance misuse. They had seven young people subject to safeguarding proceedings. The paperwork related to this was placed in a locked drawer. The team were not able to scan the information onto the trust IT system due to the systemic IT issues. The manager agreed that the medical records department could assist in archiving the safeguarding records. The team participated in multi-agency strategy meetings. Safeguarding was discussed in team meetings and planned supervision meetings. The team were supported by the trust safeguarding leads.
- We observed a discussion between manager and staff member following a multi-agency safeguarding meeting. The member of staff had returned from the meeting concerned about a young person vulnerable to sexual exploitation, whose views were not being taken into account and that that the young person was not being adequately safeguarded by the options discussed. The member of staff demonstrated good knowledge of the family, behaviours and trigger factors and clearly understood the safeguarding issues. The manger and staff member agreed that the issue was so serious that it needed to be escalated urgently to the deputy chief executive who sat on the strategic multi agency safeguarding group.

Good

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- There was a lone worker policy in place. There was a code word used by staff in an emergency when telephoning through to the office. The whereabouts of staff was monitored by the shift co coordinator and marked on white boards. Two staff visited for first time appointments or thereafter when there were potential risks identified.
- The substance misuse team had recently requested a lone working device following threats made to staff. The crisis team also confirmed that they required lone working devices.
- The Albany bungalow was a separate building away from the main Waverley road child and family clinic. Young people were given a choice of going there. On the day of our visit there was single practitioner operating in the building which was locked, the main clinic were aware of this. We spoke with a female young person visiting there who told us that she would have preferred to see a female practitioner but did not want to say this to the male practitioner who was very professional. We observed that there could be a potential vulnerability for both staff member and a young person in an isolated setting.
- Most young people were seen in the child and family clinics. The psychiatrist also attended visits with the nurse if required.
- The crisis team did not store medications on site and told us that medication was a second line intervention; they promoted talking and behaviour management therapies.
- The substance misuse team did not store medications. It used a local pharmacy to supervise medication administration and supply for young people. If the pharmacy was not open on a Sunday an agreement was made with the parents to administrate the medication and they were given a lockable container to store the medicines in. When a young person did not attend the pharmacy for two days the prescription was stopped and the care plan was reviewed with the young person.
- An audit of drug and alcohol substance standards was carried out on the 14/4/15. It identified that a local medication management standard operating procedure should be in place. It recommended that staff should delete any scanned prescriptions once printed from blackberries. Their audit recommended that staff should familiarise themselves with relevant sections of the medicines policy affecting their practices and attend the medicines management education program. An action plan was in place to implement the recommendations.
- The child and family clinics did not store medication. However they did facilitate repeat prescriptions for young people with ADHD.

Track record on safety

- There were 85 incidents reported across the inpatient and community CAMHS March 2014 to April 2015. There was one CAMHS Community serious incident in December 2013 and one in February 2015. There was one serious case review for community CAMHS and one pending from 2014.
- The trust carried out an investigation following a death of a young person in 2013. The findings were presented to the serious case review panel in 2014. Lessons learnt from the review were shared in a series of events for staff and cascaded through governance and team meetings. We found all teams referred to the lessons learnt from this event and the changes in practice as a consequence. One of the changes was the appointment of a specialist nurse in the child and family clinic team to deal with high risk urgent cases and respond to sudden deterioration in a young person's health.
- There were 62 incidents of self-harm in the trust's CAHMS services between 01/04/14 and 31/03/15. These were rated as either no harm or low harm incidents.

Reporting incidents and learning from when things go wrong

- The trust published a sharing good practice newsletter dated spring 2015 in which the recommendations from all the serious incident reports done in 2014 were analysed to identify key themes and actions staff should undertake.
- Staff we spoke with told us how they would report incidents and explained what types of incidents they would report. Incidents were reported electronically on the Datix system. A report went to the manager and was analysed by a risk team and prioritised in terms of level of risk. Lessons learnt were presented at team meetings. Young people and parents were debriefed. Duty of candour existed in explaining to young people and parents of mistakes that had occurred.
- We tracked through an incident relating to a young person being admitted to an adult ward. The young

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person had been seen in the child and family clinic, conveyed by ambulance to the emergency department with police assistance. Once in the emergency department the young person was put on a section 2 of the Mental Health Act whilst a bed was being found. When a detention is made under the Mental Health Act a hospital/ward must be specified. Whilst the lessons learnt showed that staff needed further training in relation to s136 health based place of safety and placing a young person on an adult ward. No consideration had been given to other matters such as the legality of conveyancing, when and how a Mental Health Act section 2 should be applied. We raised this with the service manager.

- The substance misuse team held practice governance meetings. Minutes showed that the team discussed risk and child protection, quality, workforce, service development issues as well as having presentations about learning from adverse events. The CAMHS wide quality and risk meeting minutes showed that there was learning from serious incidents in the trust and from other hospitals.

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

- We looked at two crisis team records; the initial risk assessment record was completed two days after the assessment in both cases. Staff reported that they did not always have time to complete records on the day of the visit and often had to complete records in their own time. We found that the care plans were written as part of the narrative of the assessment and were not stand alone documents. There were good assessments of physical health care on initial assessment and ongoing.
- We saw two case records that showed good risk assessments and physical health monitoring undertaken by the eating disorders team. Rapid contact within 48 hours was made for young people assessed as red (urgent) referrals.
- Education and support was given by the eating disorders team to the inpatient unit and other CAMHS community teams. This occurred when young people with eating disorders were not responding to treatment.
- Care co-ordinators were expected by the trust to be in place for all young people. This was monitored. Data we looked at showed referrals open for more than 28 days without a care co coordinator on the April 13 totalled 129, on the 20/4/15 it was 155 and on the 28/4/15 it had arisen to 160. Staff stated that there were some data errors in the reports which did not show the data they had submitted making the reports inaccurate. All teams had a combination of PARIS records printed out in the form of the referral, care and risk plan in paper form and how to get in touch with patient if IT systems went down. To ensure continuity of care.
- Young people were asked for their consent over what information they wished to be shared; this was prompted by the risk assessment tool. The substance misuse records reviewed showed that there was detailed individualised consent to share information discussed with young people. Staff were able to give examples where young people had not given their consent in the past that it was checked at regular intervals.

Best practice in treatment and care

- There was a range of clinical pathways in place for example ADHD, autistic spectrum disorder, emotional difficulties, eating disorders, self-harm. The CAMHS teams used the NICE guidance to inform the treatment/use of eating disorders, anxiety and depression, obsessive compulsive disorder (OCD), depression, self-harm to underpin the pathways.
- The child and family clinics had access to two trained clinicians in interpersonal therapy, and 12 prescriptive sessions were offered for anxiety and depression.
- The substance misuse team used the NICE guidance for alcohol, dual diagnosis and treatment of depression in young people. The Royal College of Psychiatrist standards for young people with substance misuse problems were followed. The majority of the work the team did was based on harm reduction principles or abstinence model depending on the young persons preferred model. The team were delayed in providing data to the National Treatment Agency (NTA) monitoring system due to the IT problems; the information received back from the NTA would in the future provide information on outcomes in comparison to the national picture. Outcome tools were used to set the baseline picture with young people and repeated at three months to review progress. Staff were able to provide examples where really good outcomes had been achieved as a result of their interventions and working with multi agencies in the short and long term.
- Outcomes were monitored; the child and family clinics were part of the London and south east collaborative for IAPT. The CAMHS teams had a range of outcome measures. Strengths and difficulties questionnaire were completed on first appointments and reassessed after 6 months to measure progress. A revised children's anxiety and depression scale (RCADS) was done at the first appointment and following each therapy session. A children's global assessment scale was also used to assess functioning of young people under 18 years of age for depression. Goal setting and achievement was monitored. A further questionnaire was used at six months and prior to discharge to measure the young person's experience.
- Health of the nation outcome scores (HoNOS) were used. Data produced from HoNOS in graph and report format was discussed by the senior management team every four months and by the clinical teams. The results of the HoNOS outcome measures were positive. .
- Physical health needs were considered in holistic assessments. There was general monitoring of height and weight in the child and family clinics. Through physical investigations and monitoring were undertaken

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for those suffering from an eating disorder. The eating disorders teams work involved providing advice on physical safety and the importance of GP checks regarding feeding and motivational support.

- Crisis staff were not able to access the physical health recording data base of the emergency department and relied on emergency department clinicians to access the information for them.
- Three out of three records reviewed in the substance misuse team showed that physical healthcare needs were assessed during the initial assessment. For example we found that a patient with early urinary symptoms was picked up quickly and a specialist referral made to urology. The team also focused on sexual health and blood borne viruses. There were links with the sexual health clinic and the team carried chlamydia screening kits to use for testing.
- The substance misuse team had carried out a range of audits for example the availability of service user care records was carried out from the 7-10 April 2015 and found all electronic records were available for visits. A health and safety audit had been carried out in July 2014. An infection control audit had last been completed in October 2013.The team had also received a quality visit in July 2014 from managers. The results of the audits were positive.
- All CAMHS teams undertook audits relating to the uptake and cancellation of appointments. With the choice and partnership model there were few cancellations made by young people. Texting was used by some teams to send reminders.

Skilled staff to deliver care

- Teams had a range of professionals to provide multi-disciplinary care although this was hampered by recruitment difficulties.
- The amount of specialist training and take up of training was spread thinly across the whole CAMHS service. There was a dependency on in house specialist training sessions provided by the clinical team. The substance misuse team records reviewed showed that staff were up to date with their mandatory training and staff received supervision regularly. Appraisals were up to date.
- Staff across the whole of the CAMHS had accessed children and young people's improving access to psychological therapies (IAPT) training. The numbers who had undertaken this across the whole CAMHS service were; -cognitive behavioural therapy (8), interpersonal psychotherapy for adolescents (5), systemic therapy (2), systemic therapy supervision (1), cognitive behavioural therapy supervision (3), Supervisor training (7).
- Senior social workers working across the whole of the CAMHS teams were highly qualified holding a range of qualifications related to young people such as degrees in child and adolescent mental health, systemic family psychotherapy, psychology, eating disorders and counselling. Diplomas such as systemic psychotherapy, DBT, specialist practice with children and families.
- Eight healthcare assistants across the whole CAMHS had undertaken NVQ training related to healthcare/ childcare.
- All three staff from the eating disorder team were being supported to undertake a diploma in eating disorders. We saw information showing that the team educated other community teams in eating disorders.
- The substance misuse team were provided with specialist training by the team leader and the consultant. There was also access to external conferences.
- The overall compliance in relation to personal development plans across all the CAMHS services was 61%. The overall compliance in relation to mandatory training across CAMHS was 76%. The substance misuse team had achieved 100% of their mandatory training. However we looked at the register for the Waverley child and family clinic teams and found that seven out of nine people had not achieved 100 %. However staff we spoke with also said that the performance information they received back had data quality issues and were not always accurate. Mandatory training was also accessible by agency staff. New starters also had a week's shadowing experience before commencing substantively.
- Managerial supervision was provided by managers. Clinical supervision arrangements related to professional groups seeking internal or external clinical supervision. For example the eating disorders team received external supervision from a specialist in eating disorders. In the substance misuse team clinical meetings provided peer supervision. Appraisals were done jointly with the substance misuse consultant and took into account the business objectives of the team.

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Multi-disciplinary and inter-agency team work

- The crisis team held daily effective multi-disciplinary meetings. We observed discussion taking place about risk, confidentiality, capacity, consent .social services support, school and social transition support. The planning of two CPA meetings was taking place during our visit. Some cases were complex requiring liaison with families and services out of area. The crisis team also attended inpatient CPA meetings. Young people admitted to inpatients had access to the crisis team following discharge. All the clinical team spoke compassionately and with great understanding about the young people and their careers. It was evident that the staff team had good liaison with the safeguarding team, police, education and the criminal justice system. Social inclusion was discussed in all CAMHS teams.
- The crisis team held monthly joint meetings with emergency department staff. There were effective relationships built with the paediatric wards.
- The eating disorder team provided education and training to CAMHS inpatient and community teams, paediatric services and accident and emergency departments.
- The substance misuse team had been part of the looked after children's inspection in November 2013; they had an action plan in place to promote the service and pathway in response to the recommendations. The team was also visited by Ofsted as a partnership agency.
- The substance misuse team had close links with the youth justice team in providing early interventions and assessments.
- The single point access (SPA) had initial contact with GPs. Correspondence was sent following assessment and a copy of their care plan also given upon discharge. This was monitored on the PARIS system. GPs give informal feedback on how this was working. Staff we spoke with told us that they were also supposed to send a review every 6 months to the GPs; however they informed us this did not happen regularly.
- Young people were asked for their consent over what information they wished to be shared; this was prompted by the risk assessment tool. The substance misuse records reviewed showed that there was detailed individualised consent to share information discussed with young people. Staff were able to give examples where young people had not given their consent in the past that it was checked at regular intervals and recorded in the case notes.

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

- Mental Health Act training was provided on induction and part of mandatory training. Not all staff had undertaken mandatory training.
- The crisis team staff had a good understanding of the Mental Health Act. They were not confident about the team's knowledge of the new Mental Health Act code of practice and had not attended any sessions related to this. Staff knew who the trust Mental Health Act lead was.
- Community treatment orders were not used by the teams.

Good practice in applying the Mental Capacity Act

- The policies related to the Mental Capacity Act were accessible from the trust intranet. Staff knew it applied to young people aged 16 years and over. The substance misuse team reported that they did not access mandatory training related to the Mental Capacity Act.
- The crisis team staff we spoke with understood the Mental Capacity Act. They were experienced in assessment of capacity and Gillick competence.

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

- We observed a crisis team member acting as a duty worker facilitating appointments and dealing with referrals. The staff member discussed young people in a respectful and thoughtful manner, with a good understanding of individual needs.
- We observed a CAMHS practitioner in a child and family clinic speaking over the telephone. The staff member was discussing and checking the parent's involvement in the young person's appointment. There was a good discussion about the young person's general needs and planning on how to go forward with their care plan. The staff member spoke respectfully and was clearly supportive of the young person and their parents.
- We observed a young person being assessed and treated in a in a professional dignified manner by staff.
- One young person we spoke with told us that the medical staff were caring and interested in their wellbeing. They felt involved in their care and medication changes. They were asked if they gave their consent for information to be shared with their family. They said advocacy was not available in the community setting. A direct contact number was given to the young person to call 24/7, however when the parent tried this there was no answer and the parent contacted the police instead. The young person experienced seeing several different staff which did not give consistency of care.
- Six young people we spoke with were generally positive about the care they received. The youth council we spoke with gave mixed views of the CAMHS services ranging from being good to it being a service they would not recommend to friends and family.
- A parent we spoke with told us that monthly family therapy sessions were offered which were helpful. There was a team focused approach and the sessions provided reflective space. This worked well as the same clinician involved in the young person's care led the sessions. The parent commented positively about the new clinic facilities to see young people in. The parent told us that they would tell staff if they were concerned about something, however may not complain in case it impacted on their child's care. Other parents we spoke made generally positive comments about the CAMHS services.
- We observed a clinical team meeting and in which confidentiality issues related to young people were carefully considered.

The involvement of people in the care that they receive

- Substance misuse records reviewed showed that young people were asked if they wanted a copy of their care plans.
- Text messaging was used to communicate with young people by the various community CAMHS teams.
- There was access to general advocacy for young people however not all were aware of this in the community.
- Feedback from families about the eating disorder team described them as empowering and supporting parents to form positive therapeutic relationships with young people. The eating disorders team used text messaging to keep them connected with young people.
- Parents we spoke with gave positive feedback about the eating disorders team. The team were described as extraordinary. Parents told us their child had gained weight and had it not been for the work of the team the young people would have person may have not survived or engaged with the family or therapy treatment.
- We observed booklets giving information to young people with eating disorders.
- All the CAMHS teams had implemented the friends and family test. The results for the eating disorders team was 100% positive.
- The friends and family test results for the substance misuse team for one quarter showed that 6 young people and three parents were extremely likely to recommend the service, with only one young person unlikely to recommend the service.
- We met with members of the youth council and looked at minutes of meetings. The trust had an active youth council who were involved in staff recruitment, activity programmes, and advising on décor. Members of the council made presentations at team away days. Projects that the youth council were involved in included the good governance institute (GGI) CAMHS review. Changing the name on the young people charter to " our Promise" so that it could be sent out in correspondence to young people and getting involved in the complaints procedure and participation leaflet. The youth council meetings were also attended by the NHS England commissioners.

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- One youth council member described being involved in the audit of adult mental health services which had provided a negative view of the services and caused concern about transition to adult services for young people. The council had provided their views on the proposed uniform policy and felt listened to. The council members also provided peer to peer support.

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 youth council said that improvements needed to be made in the transition from CAMHS to adult services. Waiting lists were perceived to be too long and there was a perception that young people were signposted to the accident and emergency service in order to gain access to tier 3 services sooner.
- There was a single point of access which received referrals from young people, family and professionals. A four hours response time target was in place and young people were offered appointments giving choice over the location for the assessment. The team did not offer assessments to young people in custody settings.
- Referrals were made to the eating disorders team by GPs and through the single point of access (SPA).
- All urgent referrals to CAMHS had to be seen within a seven day target. This target was achieved in 90% of cases.
- The CAMHS crisis team attended two emergency departments and were contactable by via a pager system. There was out of hours contact available to a CAMHS consultant. The crisis team had a four hour response time in the emergency department and achieved this in 90% of cases.
- We observed a duty worker in the crisis team dealing with referrals proactively. For example an appointment was brought forward following concerns raised by a GP for a young person. When young people did not attend appointments these were followed up proactively.
- We observed a crisis clinical team meeting being held, these took place daily lasting two hours. Three referrals and risk assessments were discussed in. One of the referrals was checked on the electronic PARIS system for details following a referral from the single point of access however the young person was unknown to the service. Depending on the urgency, cases were colour coded for follow up. A young person was seen by the crisis team in the emergency department (ED) and a follow-up appointment made to see the young person that day. Decisions were made for follow up within seven days depending on urgency. Child and family clinics were used for follow up and monitoring.
- There were difficulties in discharging young people with attention deficit hyperactivity disorder (ADHD). There was an inconsistent approach as GPs or paediatricians were often reluctant to manage young people with ADHD and instead Psychiatrists had high caseloads as a consequence.
- Referrals to the child and family clinics were made by the SPA. The trust used the choice and partnership approach model (CAPA). It was devised by one of its own consultants and was a model used internationally. It was a clinical system that brought together the active involvement of young people and their families, demand and capacity ideas and an approach to clinic skills and job planning.
- Young people were able to choose their appointment through the choice system. 88% of appointments were met within 28 days. Once the choice appointment was booked there would be a full clinical team discussion. The risk assessment would be carried out at the initial appointment and the appropriate CAMHS pathway was identified. The young person then would be placed on a partnership waiting list in order to progress along a pathway. The clinician making the initial assessment at the choice assessment remained the co-ordinator until the partnership clinician was identified. Partnership appointments were offered within six weeks, however the staff told us that the average wait was 10-12 weeks across the western quadrant of community CAMHS services. The crisis team, eating disorders team and the CAMHS targeted team for looked after children also made internal referrals which did not come through the SPA and this created a 'bottle neck' in appointments. Waiting lists were monitored by the consultants for risk and as such sometimes the choice care co-ordinator would see the young person again whilst waiting for the partnership appointment.
- A colour coding system was used to denote the urgency of the referral. Red for the most urgent, Amber for urgent and green or blue for the less urgent. The eating disorder team saw young people who were assessed as red within 48 hours. The aim initially was to stabilise weight loss and ensure physical safety. Young people who were rated as amber were also added to the team's caseload. Those that were assessed as green or blue were referred to the generic community CAMHs services. There was close working with community CAMHS teams and the inpatient unit. The eating disorders team educated and supported these teams to managing young people with eating disorders.

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- Young people were given choices over the location of their appointments. It was not always possible to give them the choice of gender of staff.
- The eating disorder team and substance misuse team did not provide an on call service, however some practitioners did keep their telephones on out of hours in case of emergency
- There was good transition planning by the eating disorders team. For example a young person aged 18 years going to university and was maintained on the team and they were supported in registering with a GP in the university town. This ensured that the young person could have a smooth transition to adult ED services.
- There were no waiting lists for the substance misuse team from referral to assessment. The average length of treatment was 14 weeks which was shorter than the national average. Over a 12 month period the team had on average 240 active cases.
- There were 22 sources of referral to the substance misuse team. Young people could refer themselves by phone, email or text. Referrals from other CAMHS teams were taken if the young person consented. The team advertised their services on "FRANK" a national drug newsletter, a young person's Hertfordshire website called MOJO and on a police websites. Telephone referrals were noted and placed in the young person's file.
- The Adolescent drug and alcohol team received 242 referrals in 2014/15. Young people were seen within five days of referral and attendance rates were monitored. For 2014/15 72% of young people kept their appointments, 16% were DNA and 11% were cancelled by young people for initial assessments. For follow up the attendance was 76%, 13% DNA, 13% cancelled by young people. Ongoing engagement figures were that 88 % kept appointments, 3% missed, 1% was cancelled by young people. When young people did not attend appointments follow up texts, calls and letters were sent. Other Community CAMHS teams also monitored their figures and found that the choice and partnership booking system had resulted in fewer missed appointments by young people.
- Young people could request to be seen at school or a place of their choice and were also able to request appointments before 9am or up until 6.30 pm.
- The substance misuse team raised an incident in 2014 when a young person was admitted to an adult ward for substance detox. The team visited the facility in advance and again with the young person and the parents. This was to enable an informed choice about admission to be made. Records reviewed showed that appropriate questions had been asked of the adult ward.
- Between March 2014 to April 2015 there were 714 young people transitioned into adult services after turning 18. There was a transition protocol in place with adult service relating to young people with substance misuse which included the substance misuse team introducing the young person to adult services in person. However staff told us that not all staff in adult services was aware of the transition arrangements. Only a small proportion of young people went on to adult services. Young people were given information about the adult services.
- There was a transition pathway in place which recommended that the process began six months prior to a young person's 18th birthday. The process involved the CAMHS consultant having a verbal conversation with the adult services consultant. This was followed up with a formal letter and a transfer meeting organised. Staff confirmed that this generally occurred with good attendance. Once a young person was aged 18 years the CAMHS teams still had ongoing involvement until the transition process was completed. For example, young people and their families were supported in understanding the changes in the models of care provided. The crisis team provided face to face handovers and this was supported by the case notes.
- Staff carried mobile phones in order to be contacted. The crisis team had a used a pager system in order to be contacted by staff in the emergency departments. Young people had emergency access via the A&E to care and out of hours there was also access to a CAMHS consultant.
- The ADHD pathways within Hertfordshire were different within each of the two clinical commission groups (CCG's) in the county. There was also a shared care protocol in place with primary care which was optional and therefore if a GP did not wish to engage with shared care the duty of care remained with the trust. This meant that for many young people the psychiatrist in the CAMHS clinics had to maintain the appropriate oversight to support the safe prescribing of medication and it affected their ability to discharge young people who had ongoing needs. The trust had developed a business case that was being discussed with commissioners to introduce nurse prescribers as an

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adjunct to the psychiatric led clinics within CAMHS. The trust informed us that they were putting in measures to support psychiatrists to manage their ADHD related caseloads.

The facilities promote recovery, comfort, dignity and confidentiality

- Information was provided in waiting rooms on how to access the PALs service and how to complain or give feedback.
- We saw "Spot the signs and save a live" campaign leaflets around clinic areas. These encouraged people to talk openly about suicide in order to reduce mortality rates. The campaign was in collaboration with the Hertfordshire MIND network. It aimed to alert everyone to the signs of suicidal thoughts and feelings and to challenge the stigma surroundings suicide. It asked local people to make a pledge to take positive action to prevent suicide.

Meeting the needs of all people who use the service

- The composition of the current teams meant that it was not always possible to give young people a choice in the gender of the practitioner providing treatment.
- We saw an excellent carer handbook with detailed information sharing strategies, stories of hope relating to eating disorders.
- Child and family clinics provided information in the waiting rooms on parent line, local parent partnership services and LGBT. Information was not available in easy read or in other languages. Waiting rooms also had images of the trust board and its values. Magazines suitable for young people were provided and toys for younger children.
- There was a CAMHS website for the public to access for information.
- There was access to interpreters and signers if required.

Listening to and learning from concerns and complaints

- Complaints in the CAMHS services were very low. The whole of the CAMHS received 102 compliments in the period 1 April 2014 to 31 March 2015. We also a highly complementary letter praising the substance misuse service.
- The number of formal complaints the western community CAMHS teams had received in 2014 was one and it was upheld.
- There were two CAMHS complaints that were not upheld in 2014 by the parliamentary health service ombudsman.
- Practice was changed as a result of complaints. For example in response to learning from a complaint, the crisis team had introduced a duty clinician and administrative support to undertake telephone duties.
- Complaints had been received for example about a room that was not sound proofed. This room subsequently was not used. There was a complaint about a member of staff cancelling an appointment. An apology was given and this was discussed with the person concerned.
- The substance misuse service had never received a formal complaint. It had received two informal complaints that had been resolved locally. A log of the informal complaints was made. We saw that staff had offered apologies to parents and wider members of the service who had raised issues. Informal complaints were discussed at the teams practice governance meetings.

Are services well-led?

Good

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Our findings

Vision and values

- A number of CAMHS teams reported that they lived the trust values and vision through the delivery of the services and this was monitored through supervision with reinforcement during training. Not all teams had team objectives; however they did use the performance management information to evaluate any gaps.
- Managers worked with teams to establish business plans. For example, there was recognition that the eating disorders team were not able to undertake preventative work and as such a business plan was submitted in order to expand the service. A business plan was also in place for a nurse prescriber to support ADHD patients.
- The executive team and senior managers were visible and visited teams. Staff we spoke with said team leaders were visible and valued by the clinical teams.
- The trust was undertaking transformation of the CAMHS services and had introduced new staffing roles and structures as part of the change programme.

Good governance

- There was a CAMHS quality and safety dashboard in development. However, staff that we spoke with said the information was not always accurate and the information provided was not timely. The dashboard gave information about staffing, agency use, incidents, referrals, waiting times, complaints, safeguarding, and medication incidents and staff appraisals. The performance reports gave information about assessments recorded, care coordinators. A weekly conference call with operational service and governance leads was held to discuss and take action in relation to the information provided.
- Each team had a risk register which was discussed in team meetings. This fed into the overall CAMHs risk register and then to the overall trust version. The risk register identified issues such as service disruption due to the restructure of teams, longer partnership appointment waits leading to potentially increased clinical risk, budget overspend, lack of continuity of care due to high use of bank and agency staff and failure to meet targets set by clinical commissioning bodies for access to services. Mitigating actions were occurring. The trust governance structures monitored the register.
- Each CAMHS quadrant in the county had a lead for clinical governance to make sure that processes were clinically safe and responsive. Clinical governance meetings were held monthly to discuss patient safety, incidents and learning. The output of these governance meetings fed into the trust wide governance structures.
- Following learning from a serious untoward incident in 2013 a high risk pathway was established and young people who had been put on the pathway were discussed weekly by the clinical team.

Leadership, morale and staff engagement

- The results of the 2014 staff survey for the whole of CAMHS showed that there was scope for improvement in a number of areas; 54% of staff agreed they would feel safe reporting unsafe clinical practice, 46% staff reported suffering work related stress. Scores for work pressure felt by staff and for extra hours worked put the trust in the bottom 20% of trusts nationally. Scores for effective team working and support from managers put the trust in the bottom 20% of trusts.
- Staff we spoke with said that morale had started to improve with the appointment of some new staff in the child and family clinics.
- The staff survey provided results for CAMHS services overall showing that 93% of staff had appraisals , 46% of which were well-structured appraisals, 36% said there was good communication with managers,47% agreed that they received job relevant training, 100% of staff agreed their role made a difference to patients, 86% said they were able to contribute to improvements at work.
- The general medical council (GMC) 2014 survey found that medical staff in CAMHS was in the middle quartile (average) in terms of receiving access to educational resources, adequate clinical experience, clinical and educational supervision, induction, local and regional teaching, study leave and overall satisfaction. For handovers and workload they scored below average.
- Staff we spoke with knew about bullying and harassment, grievance and whistleblowing policies and stated that they would feel comfortable using them if necessary.
- Morale had been effected by the transition and services changes and staffing in the crisis team.
- There were opportunities for leadership development via the trust academy which team leaders told us they had access to.

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Commitment to quality improvement and innovation

- The trust had a range of internal awards to recognise good practice. The eating disorder team had received an award for "valuing our customers" in 2014.
- The substance misuse team were the first service in Hertfordshire receiving accreditation for the DOH "Your welcome scheme" in 2012 and the team were going for renewal this year. The team also won an award for community safety from the Hertfordshire county council trading standards and police for the work undertaken in relation to "legal highs". The team were also identified as a model practice example by the National Treatment Agency in 2007.