Good

Central and North West London 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)
RV3EE	Stephenson House	Westminster CAMHS	NW8 0PJ
RV3EE	Stephenson House	Violet Melchett Clinic	SW3 5RR
RV3EE	Stephenson House	Paediatric Liaison	SW10 9NH
RV3EE	Stephenson House	Kensington and Chelsea Behaviour Family Support Team	W8 7NX
RV3EE	Stephenson House	Hillingdon CAMHS	UB8 1SZ
RV3EE	Stephenson House	Brent CAMHS	NW10 1DD

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Central North West London 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 Central North West London Foundation Trust and these are brought together to inform our overall judgement of Central North West London 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 gave an overall rating for the specialist community mental health services for children and young people of **good** because:

- Incident reporting and learning from incidents was apparent across teams. Staff had been trained and knew how to make safeguarding alerts. Staff managed medicines well.
- Young people referred to teams were seen by a service that enabled the delivery of effective, accessible and holistic evidence-based care.
- Staff demonstrated their commitment to ensuring young people received robust care by being proactive and committed to people using the service, despite the challenges they faced at times with limited resources.
- There was strong leadership at a local level and service level across most of CAMHS that promoted a positive culture within teams.
- There was a commitment to continual improvement across the services.

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:

Incident reporting and learning from incidents was apparent across teams. There was a culture of openness and transparency. Staff had been trained and knew how to make safeguarding alerts. Safeguarding was discussed as part of supervisions. Staff managed medicines well. Whilst recruitment was a challenge this was being actively addressed.

However, some improvements were needed:

- There was a difference in how the panic alarm system and lone working system was operating across the teams. This meant that, in some teams, that if there was an incident other staff in the team would not be alerted to this, and be able to offer effective support or take steps to ensure staff safety in a timely manner.
- CNWL co-ordinated the current CAMHS out of hours service using on call specialist trainee doctors on weekends, public holidays and between the hours of 5pm and 9am Monday to Friday. It was found that the current system was not adequately meeting the needs of children and young people and their families having not been reviewed since it was introduced approximately 20 years ago. Due to these concerns, the service was recently reviewed by commissioners, internally reviewed by the trust, and was currently being reviewed by an independent agency to look at how the current system was working and ways to improve it.

Are services effective?

Good

We rated effective as **good** because:

Young people referred to teams were admitted to a service that enabled the delivery of effective, accessible and holistic evidence-based care.

Assessments across the teams were multidisciplinary in approach. Care plans were detailed and personalised and assessments were timely.

NICE guidance was followed when prescribing medication. The CAMHS teams had good links with other relevant services to ensure the particular needs of young people were met.

The majority of staff we spoke with demonstrated a working knowledge of the application of the Mental Capacity Act (MCA) 2005

Summary of findings

legislation and their responsibilities within this for young people over the age of 16. Staff understanding of Gillick / Fraser competencies was good, in deciding whether a young person under the age of 16, was able to consent to treatment without the need for parental permission or knowledge.

Are services caring?

Good

We rated caring as **good** because**:**

Staff we spoke with showed they knew people who use services well. They demonstrated compassion and genuine feeling about the people they supported. The views of young people and families were gathered through the use of surveys and groups held for young people and families. Feedback had been used to inform changes where possible. Young people had also been used on interview panels for new staff in the trust and had been involved in developing questions for candidates.

People could contact the trust for out of hours crisis care line and this information was available on the trust website. However, the advice around what people could access outside of hours varied

Are services responsive to people's needs?

Good

We rated responsive as **good** because**:**

Staff demonstrated their commitment to ensuring people received robust care by being proactive and committed to people using the service, despite the challenges they faced at times with limited resources. Some waiting lists and times for treatment were long. Measures had been put in place to help address these issues.

All teams had access to meeting rooms where people could meet with staff in private. Most rooms were well-maintained and appropriately furnished. Staff across teams demonstrated sensitivity and understanding of the cultural and religious needs of the population they served. Staff would try to resolve issues raised locally where possible.

However, some improvements were needed:

- In Hillingdon there were two waiting lists for treatment. At the time of the Hillingdon inspection there were over 100 people on the treatment waiting list and some had been waiting for 12 months or more.
- Some young people and their families needed clearer guidance on who to contact in an out of hours emergency.

Summary of findings

Are services well-led?

Good

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

There was strong leadership at a local level and service level across most of CAMHS that promoted a positive culture within teams. We saw a number of changes had taken place and that the changes within CAMHS were heading in a positive direction. Regular care quality and team meetings were taking place. Most staff across teams said they felt well supported by management and enjoyed working in the trust. There was a commitment to continual improvement across the service line.

However, some improvements were needed:

- Morale amongst staff was varied in the Westminster CAMHS team due to a number of changes in the service. Not all staff felt listened to or involved in the changes.

Summary of findings

Information about the service

Central North West London Foundation Trust (CNWL) has seven Child and Adolescent Mental Health Services (CAMHS) community teams for young people up to the age of 18. These are located across several London Borough and Milton Keynes. We inspected six of these teams.

The trust does not provide CAMHS tier 4 beds for its own population; specialist in-patient care to children. Admissions to inpatient services are provided by neighbouring independent mental health providers. However some beds can be accessed at CNWL's Collingham Children and Family Centre for pre-adolescents dependent on admission criteria.

CNWL provide a number of services across the local authorities in London and Milton Keynes:

- CAMHS tier 3 services – specialist multi-disciplinary outpatient CAMHS teams.
- CAMHS tier 2 services – mental health practitioners who tend to be CAMHS specialists working in teams in community and primary care settings.
- CAMHS for Looked After Children
- CAMHS for children/young people with learning disabilities
- CAMHS workers based in youth offending teams
- CAMHS Out of Hours - the on call service provides emergency CAMHS services on weekends, public holidays and between the hours of 5pm and 9am Monday to Friday.
- Collingham Gardens Children & Family Centre - Inpatient Regional Resource for pre-adolescents. See separate report on this inspection.

CNWL co-ordinates the current CAMHS out of hours service, consisting of 'on call' doctors.

The Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) had been brought into a number of the CAMHS teams.

Our inspection team

The team that inspected the CAMHS community teams included two CQC inspectors, a consultant child psychologist, a social worker, a trainee psychiatrist, a CAMHS team manager and the CQC national advisor for CAMHS.

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 get to the heart of 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 focus groups for people of all ages.

Summary of findings

During the inspection visit, the inspection team:

- visited six of the seven CAMHS teams providing community services across various sites in London and looked at the quality of the environment and observed how staff were caring for young people using the service
- spoke with seven young people who were using the service and their families
- spoke with the managers or acting managers for each of the teams
- spoke with 20 other staff members; including doctors, nurses and social workers, therapists, psychologists and administration staff.
- interviewed the service director with responsibility for these services
- attended and observed some multi-disciplinary meetings.

We also:

- Looked at 10 care records of young people

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

Overall young people and their families described good support from the teams and feeling involved in the development of care plans and decision-making. They said they were always asked for consent to share information with external bodies including with GPs and schools.

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

Good practice

- The Brent CAMHS service ran the targeted mental health in schools (TaMHS) programme. They worked to support school staff to recognise young people with emotional wellbeing and mental health needs. They provided access to advice and consultation from a professional in mental health.
- Young people had been used on interview panels for new staff in the trust and had been involved in developing questions for candidates.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that the lone working policy and use of panic alarms are embedded across the service. There was a difference in how the panic alarm system and lone working system was operating across the teams. This meant that if there was an incident other staff in the team would not be alerted to this, and be able to offer effective support or take steps to ensure staff safety in a timely manner.
- The trust should ensure that all staff know how to report incidents and understand the duty of candour regulation. The duty of candour was introduced for providers to ensure they are open and honest with people when something goes wrong with their care and treatment.
- The trust should ensure that staff are appropriately supported about changes that affect them during the ongoing reconfiguration of the CAMHS community services.
- The trust should ensure young people and their families are clear on who to contact in a crisis out of hours.

Central and North West London NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Westminster CAMHS	Stephenson House
Violet Melchett Clinic	Stephenson House
Paediatric Liaison	Stephenson House
Kensington and Chelsea Behaviour Family Support Team (BFST)	Stephenson House
Hillingdon CAMHS	Stephenson House
Brent CAMHS	Stephenson House

Mental Health Act responsibilities

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.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The majority of staff we spoke with demonstrated a working knowledge of the Mental Capacity Act 2005 and their responsibilities within this for young people over the age of 16 years.

Staff understanding of Gillick competencies / Fraser guidelines was good when deciding whether a young person under the age of 16 was able to consent to treatment without the need for parental permission or knowledge.

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

Summary of findings

We rated safe as **good** because:

Incident reporting and learning from incidents was apparent across teams. There was a culture of openness and transparency. Staff had been trained and knew how to make safeguarding alerts. Safeguarding was discussed as part of supervisions. Staff managed medicines well. Whilst recruitment was a challenge this was being actively addressed.

However, some improvements were needed:

- There was a difference in how the panic alarm system and lone working system was operating across the teams. This meant that, in some teams, that if there was an incident other staff in the team would not be alerted to this, and be able to offer effective support or take steps to ensure staff safety in a timely manner.
- CNWL co-ordinated the current CAMHS out of hours service using on call specialist trainee doctors on weekends, public holidays and between the hours of 5pm and 9am Monday to Friday. It was found that the current system was not adequately meeting the needs of children and young people and their families having not been reviewed since it was introduced approximately 20 years ago. Due to these concerns, the service was recently reviewed by commissioners, internally reviewed by the trust, and was currently being reviewed by an independent agency to look at how the current system was working and ways to improve it.

Our findings

Are Specialist community mental health services for children and young

people safe?

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Specialist community health services for children and young people

Safe environment

- There was a difference in how the panic alarm system was operating across the teams. In some teams, for example, where rooms were being used for meeting with people, these were not fitted with panic alarms and staff were not routinely wearing or provided with personal alarms. Some staff did not know that personal alarms were available in the service. This meant there was a risk that if there was an incident other staff within the building would not be alerted and therefore not be able to respond in an appropriate / timely manner.
- Following an electrical fire in December 2014 in a building where the Westminster CAMHS team were based, some electrical appliances had been removed including portable heaters and some kettles. We reviewed the service's workplace risk assessment and were informed that all staff had been trained in the use of a fire extinguisher and that the fire brigade had reviewed the premises. However, no fire drills were carried out in the service. We were told fire doors were checked but this was not done as part of a regular fire safety check. One door was found to be non compliant with fire safety standards and we were informed that all staff were told not to use this door. However, there was no safety notice on the door to inform staff and people using the service that this was not a safe exit point. We also found that some of the fire extinguishers were labelled as out of date. Following the inspection the trust notified us that actions had been taken including a review of fire signage and fire extinguishers.
- Staff regularly checked the first aid kits in the service and these were kept in places where they were readily accessible. Emergency life support formed part of staff's mandatory training. New staff were expected to complete this as part of their induction and annually as a refresher.

Safe staffing

- There were some vacancies across some of the teams. In January 2015 vacancies across CAMHS and eating disorder services were 5%. In the Brent team, when they

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were made aware that staff were due to leave the service, they placed this on the local risk register to pre-empt the risk to continuity of staffing. This ensured seamless transition as they were able to begin the recruitment in advance of a staff member leaving the service.

- The Brent team told us the pressures of administrative work meant that the reception area was not always covered and we observed this on the day of the inspection. Whilst staff were usually available in this area there were occassions when young people and their families coming into the service may not always be able to always be able to access a staff member.
- In the Hillingdon team, there were pressures on staff due to staff shortages and long waiting lists for interventions. This was first entered on to the Hillingdon local risk register on 20 February 2015. It had been identified that additional staff were required to cover the demand for the service. Historically it had been difficult to recruit substantive staff in Hillingdon. An agency nurse specialist had been brought in recently to reduce the waiting lists. During our visit the staff member had been in post for three weeks. The waiting list was to be reviewed after the agency staff member had been in post for one month to assess the impact. An additional two fixed term posts had been agreed and another agency staff member had started in post. It was not clear what the longer term plan was. Additionally funding had recently been approved for recruitment of clinical staff to support young people with learning disabilities.
- The use of agency staff was very low. If agency staff were used it was from an approved agency. The trust expected agency staff to have fulfilled training in line with the trust's mandatory requirements before they were allowed to work in the service.
- In the Westminster CAMHS team the service manager reported staffing levels were adequate and there were no waiting lists. There were four vacancies in the team. We saw evidence of an on call rota system which ensured there were two clinical staff and a consultant psychiatrist available daily.
- The Kensington and Chelsea Behaviour Family Support Team (BFST) was fully staffed and there was no long term sickness. There were no vacancies and staff turnover was reported to be low.
- There were enough staff across most services to support young people. However, there had been higher rates of turnover across CAMHS overall (19% across CAMHS and eating disorder services in January 2015) as discussed with the CAMHS service director since the changes across CAMHS and eating disorders had taken place ie specifically Westminster new model and turnover from CYPIAPT training.

Assessing and managing risk to patients and staff

- There was a difference in how the panic alarm system and lone working system was operating across the teams. This meant that there were potential risks to staff safety. For example staff were not always checking in with each other following a visit in the community. This meant that if there was an incident other staff in the team would not be alerted to this, and be able to offer effective support or take steps to ensure staff safety in a timely manner.
- We looked at the medicines management systems. Medicines were prescribed only and were not stored on-site. For example in the Brent team prescribed medication was routinely reviewed monthly at the young person's care review or more often when needed. We reviewed the systems for prescription management. Prescriptions were scanned and uploaded to the trust's electronic system and a GP letter was then sent out. In Hillingdon and Brent for example, audits were completed for the storage of prescription pads.
- Individual risk assessments were carried out and generally updated across the teams. However, we noted examples from one care record we looked at in the Westminster team of limited detail recorded around identified risks following significant events, including identified safeguarding risks. There was a risk that other staff in the team would not have access to appropriate and accurate information about the care of the young people using the service. In Brent if a risk assessment was not completed, the managers told us they monitored which clinicians were responsible so this could be addressed.

Good

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- There was a red flag alert system in place on the trust's electronic system. For example if a person had an allergy or there was an open safeguarding concern, a red flag alert would pop up when the person's record was brought up. This ensured staff were aware of particular serious risks affecting young people.

CAMHS out of hours arrangements

- CNWL co-ordinated the current CAMHS out of hours service using on call specialist trainee doctors on weekends, public holidays and between the hours of 5pm and 9am Monday to Friday.
- It was found that the current system was not adequately meeting the needs of children and young people and their families having not been reviewed since it was introduced approximately 20 years ago. The delivery model seemed to be based on the capacity of the current service to deliver rather than what was most appropriate for the people using the service. It could take up to 4 hours for a CAMHS assessment in A&E . These were found to be contributing to increased hospital A&E 4hr breach targets, poor patient experience and admissions to already limited paediatric or adult inpatient beds. An out of hour's mental health liaison group was subsequently set up in the trust to review the current system.
- Due to these concerns, the service was recently reviewed by commissioners and internally reviewed by the trust to look at how the current system was working and ways to improve it. The concerns have been raised at corporate level in the trust. The findings for the report are due by the end of March 2015 and will shared be with the CQC in due course.

Track record on safety

- Staff had received training in safeguarding adults and children. Staff we spoke with knew how to raise a safeguarding alert and had a good understanding of safeguarding protocols and procedures. For example, in the Brent team procedures for reporting abuse and safeguarding were clear and linked to the local safeguarding children's board for each area and multi-agency safeguarding hub (MASH).
- There was a safeguarding lead in the trust and staff across teams we spoke with told us when they had and would access the lead for advice and support in complex safeguarding matters.
- Staff we spoke with said that safeguarding was discussed within general supervision but that there was no separate safeguarding supervision or safeguarding supervisor in teams.
- Care records showed that where there were safeguarding concerns, staff recorded when they had contacted social services. There was clear multi-disciplinary team working and sharing of safeguarding concerns between staff. There was evidence of collaborative working with child protection services and children and family services across the teams
- In the Westminster CAMHS team there was no overall list of children who were 'looked after' or who were subject to a child protection plan. Consultants who led each of the teams had oversight of these. However, there was no evidence of any central monitoring or review of the cases on the list from the operational manager. The service director agreed to look into this matter during the inspection.

Reporting incidents and learning from when things go wrong

- All staff were expected to take responsibility for reporting incidents. Staff told us that they reported incidents on the trust's electronic reporting system. However in one team two staff members were not aware of how to report an incident on the system.
- Incidents were investigated and discussed in a range of forums, such as in team, business, care quality, and senior management meetings.
- There were no reported serious untoward incidents in the last 12 months across the teams. Staff in the Brent team described the processes surrounding one incident going back a few years. There had been a debrief with individuals involved and the whole team. The final investigation report was shared with the whole team to ensure learning was shared.
- We asked a number of staff about the duty of candour. The duty of candour was introduced for providers to ensure they are open and honest with people when something goes wrong with their care and treatment.

Good

Are services safe?

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

Staff were not able to define what this meant or what impact this would have on their work. However, staff we met with demonstrated working within a culture of openness and transparency and discussed why it was important to be open with families and young people if something went wrong with their care delivery.

Are services effective?

Good

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

Summary of findings

We rated effective as **good** because:

Young people referred to teams were admitted to a service that enabled the delivery of effective, accessible and holistic evidence-based care.

Assessments across the teams were multidisciplinary in approach. Care plans were detailed and personalised and assessments were timely.

NICE guidance was followed when prescribing medication. The CAMHS teams had good links with other relevant services to ensure the particular needs of young people were met.

The majority of staff we spoke with demonstrated a working knowledge of the application of the Mental Capacity Act (MCA) 2005 legislation and their responsibilities within this for young people over the age of 16. Staff understanding of Gillick / Fraser competencies was good, in deciding whether a young person under the age of 16, was able to consent to treatment without the need for parental permission or knowledge.

Our findings

Are Specialist community mental health services for children and young

People effective?

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.

We rated the effective as **good** because:

Specialist community health services for children and young people

Assessment of needs and planning of care

- Young people referred to teams were seen by a service that enabled the delivery of effective, accessible and holistic evidence-based care. Young people with specific difficulties were able to access relevant expertise, for example, in attention deficit hyperactivity disorder (ADHD).
- Assessments were completed in a timely manner and the care plans were detailed, personalised and holistic. There was good detail about the presenting issues and how this was affecting a child / parent relationship.
- In Hillingdon there were two waiting lists for treatment. We looked at one person who was on the priority waiting list for treatment. This showed a clear plan outlining presenting issues and possible support whilst waiting to see a therapist.
- In several teams the design of care plans was discussed. In Brent care plan templates had recently been introduced to see what would work best for the young people.
- Records showed that risks to physical health were identified and managed effectively. Risks were identified on first assessment and updated as and when changes occurred. There were good links with GPs and we saw GP letters uploaded onto the electronic system.
- There were different electronic and paper based systems in use and staff within teams were not always working to the most up to date system. There was a risk that information about a person's care could be missed. This had been identified as a trust and local level risk. The electronic system was due to be updated in the trust and representatives' across teams had been able to feed into the tendering process to ensure the new system was fit for purpose and would meet the needs of young people.

Best practice in treatment and care

- CAMHS used a number of measures to monitor the effectiveness of the services provided. They conducted a range of audits on a regular basis. For example, in Hillingdon an audit in 2014 -15 was completed to look at the dissatisfaction of people using the service with medical student visits and the reasons for the differences. Feedback was used to inform changes.
- NICE guidance was followed for prescribing medication. Additionally staff could access local prescribing guidelines via the trust intranet. There were examples of this in people's records.

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.

- Young people could access psychological therapies as recommended by NICE guidelines which included cognitive behavioural therapy (CBT), systematic family therapy and psychodynamic psychotherapy.
- Outcome measures were used across teams to monitor a young person's progress in a systematic way. Clinicians used routine outcome measures including the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA), a Strengths and Difficulties Questionnaire (SDQ) and anxiety and depression scales (RCADS). These were used with young people and families to review progress.They told us families were interested in reviewing their progress. Teams reviewed their outcomes data in their annual audit. Brent submitted this data to their local clinical commissioning group. We saw for Brent that outcomes measures were recorded from HoNOSCA acceptance to HoNOSCA at discharge and they were above the 80% target for documenting this consistently.

Skilled staff to deliver care

- Staff working across the CAMHS teams were made up of staff from a range of professional backgrounds including, social work, nursing, psychology, therapy, and medicine. There were specialist roles within teams. For example in the Brent team, there was a learning disability nurse and a neuro-developmental nurse.
- Permanent staff received appropriate training, individual and peer supervision, and professional development. Across the CAMHS and eating disorder services in January 2015, 11% of staff did not have an up to date appraisal. This was being addressed by the manager and appraisals were being arranged.
- There were good opportunities for staff development. Where teams were part of children and young people's IAPT, staff were provided with specialist training to deliver this programme. One service manager has completed the CYP-IAPT leadership course last year.
- New staff received a trust and local induction to the service.
- There were regular team and business meetings and staff we spoke with said they felt well supported by managers and colleagues.

Multi-disciplinary and inter-agency team work

- Assessments across the teams were multidisciplinary in approach. Discussions which took place in multi-disciplinary team (MDT) meetings showed that there was effective MDT working taking place. These were effective in sharing information about young people and reviewing their progress. Safeguarding concerns or physical health issues were discussed. Different professionals worked together effectively to assess and plan young people's care and treatment. Specialist input was obtained outside of the teams when required.
- Care records included advice and input from different professionals. Young people and families we spoke with confirmed they were supported by a number of different professionals in the teams. There was good access to a range of therapies in the teams.
- There was a trust transition policy to support young people moving to adult services. CAMHS staff had good links with adult mental health services. Services worked together for a few months in advance of a person's 18th birthday to ensure their smooth transition to adult services.
- When young people were admitted to inpatient settings, the inpatient service would inform the CAMHS teams and make links in order to support ongoing care in the community upon discharge. A key worker from CAMHS was allocated immediately and made contact with the service.
- The CAMHS team had good links with other relevant services to ensure young people with particular needs had these met. These included links to alcohol and substance misuse teams, youth offending services, schools education departments, advocacy, and paediatric teams. Some teams had better links than others depending on the borough they were based in. For example, in Brent the team referred young people to the Royal Free Hospital when they required an eating disorder service.
- The Brent CAMHS service ran the targeted mental health in schools (TaMHS) programme. They worked to support school staff to recognise young people with emotional wellbeing and mental health needs, and provide access to advice and consultation from a professional in mental health.

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.

- Where there were challenges with inter-agency working, teams proactively engaged with agencies to improve relationships.

Good practice in applying the Mental Capacity Act (MCA)

- The majority of staff we spoke with demonstrated a working knowledge of the application of capacity and consent for children. We saw examples across the teams and had discussions with staff about complex scenarios.
- Staff understanding of Gillick competencies / Fraser guidelines was good, in deciding whether a young person under the age of 16, was able to consent to treatment without the need for parental permission or knowledge. In one team a manager said they checked whether young people would understand the pros and cons of treatment.
- The guidelines including the use of the MCA and Gillick / Fraser competency formed part of the mandatory mental health law training in the trust and that staff received annual updates. Supervision and consultation with senior clinicians were also available to help with issues of Gillick / Fraser competence.
- We did not always see formal capacity assessment forms but we saw examples of discussion of details and agreement across teams. In Hillingdon and Brent, we found some limited detail recorded relating to capacity and Gillick / Fraser competence in young people's records. The service manager acknowledged this needed improvement.
- Consent to treatment was starting to be monitored. For example, in Hillingdon an audit was completed on the standards of record keeping in relation to obtaining informed consent for treatment with psychotropic medication in 2013. A re-audit was carried out in December 2014. Findings indicated improved recording of reasons for treatment options and more improvement was required around the recording of capacity to consent. We heard that discussions had started in the care quality meetings about auditing the use of capacity assessments and Gillick / Fraser competency.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** because**:**

Staff we spoke with showed they knew people who use services well. They demonstrated compassion and genuine feeling about the people they supported. The views of young people and families were gathered through the use of surveys and groups held for young people and families. Feedback had been used to inform changes where possible. Young people had also been used on interview panels for new staff in the trust and had been involved in developing questions for candidates.

People could contact the trust for out of hours crisis care line and this information was available on the trust website. However, the advice around what people could access outside of hours varied.

Our findings

Are Specialist community mental health services for children and young

people caring?

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

We rated caring as **good** because**:**

Kindness, dignity, respect and compassion

- Staff we spoke with showed they knew young people who used services well. They demonstrated compassion and genuine feeling about the people they supported.
- When staff spoke to us about young people and their families, they showed a good understanding of their individual needs. We observed MDT meetings and found that across teams staff reflected the wishes and views of the people they were discussing.
- Young people and their families told us about the good support they received from the teams and feeling involved in the development of care plans and decision-making. They said they were always asked for consent to share information with external links including with GPs and schools.

The involvement of people in the care they receive

- The views of young people and families were gathered through the use of surveys and groups held for young people and families. Feedback from CAMHS service user groups had been used to inform changes and service developments.
- In Brent feedback from young people had informed the design of information leaflets and the trust's CAMHS and Me website. Information via the website was available in different languages to reflect the diversity of the population and there was a section for young people with age-appropriate images.
- Young people had also been used on the interview panels for new staff in the trust and had been involved in developing questions for candidates.
- Across CAMHS clinicians took steps to involve people in their care by offering different treatment options. The treatment plan was amended or alternatives given to engage a family / young person if appropriate. This was discussed in sessions with a young person and their families. They were then sent a copy of the letter outlining the appointment including discussion points and details of their individual plan.
- People could contact the trust for out of hours crisis care and this information was available on the trust website. However, the advice around what people could access outside of hours varied.

Are services responsive to people's needs?

Good

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

Summary of findings

We rated responsive as **good** because**:**

Staff demonstrated their commitment to ensuring people received robust care by being proactive and committed to people using the service, despite the challenges they faced at times with limited resources. Some waiting lists and times for treatment were long. Measures had been put in place to help address these issues.

All teams had access to meeting rooms where people could meet with staff in private. Most rooms were well-maintained and appropriately furnished. Staff across teams demonstrated sensitivity and understanding of the cultural and religious needs of the population they served. Staff would try to resolve issues raised locally where possible.

However, some improvements were needed:

- In Hillingdon there were two waiting lists for treatment. At the time of the Hillingdon inspection there were over 100 people on the treatment waiting list and some had been waiting for 12 months or more.
- Some young people and their families needed clearer guidance on who to contact in an out of hours emergency.

Our findings

Are Specialist community mental health services for children and young

people responsive to people's needs?

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

We rated responsive as **good** because**:**

Access, discharge and transfer

- Across the teams we were told that they tried assess young people within agreed timeframes. Emergency admissions to A&E were seen by staff on the same day, urgent referrals within 24 hours and routine referrals within four weeks. Waiting times from referral to assessment and assessment to treatment were monitored and the senior management team (SMT) in the trust had oversight of this.
- Referrals were received from a variety of sources across teams including from GPs, health and social care and schools. The quality of referrals received varied at times. Referrals were usually screened by senior clinicians and sent on to the appropriate pathway. Waiting times for young people varied depending on the pathway they were allocated to.
- There were a high number of referrals in Brent and Hillingdon teams and these continued to increase. The number of referrals accepted into teams had outstripped capacity which had had an impact on waiting lists and times for treatment.
- Waiting times had been identified on the overall CAMHS risk register as a high concern given the increasing number of referrals and complexity of cases. In Hillingdon there had been an increase in deliberate self-harm cases presenting to A&E who were not previously known to CAMHS or previously identified by other agencies.
- At the time of the Hillingdon inspection there were over 100 people on the treatment waiting list and some had been waiting for 12 months or more for treatment. A clinically driven protocol was in place to manage and reduce the list. This was done through a multi-disciplinary process oversenn by a consultant and team manager.
- A clinical nurse specialist had been brought in to help reduce the waiting list and following the inspection we were informed that further funding had been awarded to the Hillingdon team by the local commissioning group for a further two, fixed term, posts to help reduce the waiting list further. However, a longer tem sustainable plan was not in place.
- In Brent waiting lists were discussed in team meetings. Risk was monitored and urgent cases were prioritised. For instance if people self-harmed or exhibited psychotic behaviours. The biggest waiting lists were for people with attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD).

Are services responsive to people's needs?

Good

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

- One of the biggest challenges in Brent had been to get staff trained in the autism diagnostic observation schedule ADOS. Staff who were trained in this had left the service. The team had been proactive in accessing links in the community to for instance, the Brent autism outreach team.
- There was a trust 'Did Not Attend' (DNA) policy. Staff took a proactive approach to re-engaging with people who did not attend scheduled appointments. Staff described the protocol to follow if people did not attend appointments and we saw examples in records where people had not attended appointments and subsequent action taken.
- DNA rates were monitored across teams and rates were found to be low for most teams in line with their 15 % target. In the Behaviour Family Support team, for example, the last rating was minimal with a rate of 0.7% DNAs. In the Violet Melchett clinic the rate of DNAs was slightly above the target in January 2015 but they had yet looked into why this was the case.
- The trust told us that from April 2015 early and late appointments will be available across all the services to help young people and their familieis with access.
- The Tier 4 inpatient provision for CAMHS beds locally would include the CNWL Collingham Gardens service for preadolescents and independent health provision. If a bed was unavailable locally, staff would widen the search to out of area locations. Senior site administrators across the CAMHS teams followed the 'CAMHS trust-wide in-hours bed management protocol' when trying to find a bed for a young person. There were clear procedures in place to escalate concerns if staff were unable to find a bed. At times when beds were unavailable this resulted in under 18 admissions to adult inpatient wards. Inpatient activity was monitored carefully in the trust and reported to CAMHS senior management and local commissioners on a weekly basis.
- In the Westminster team the safe discharge protocol covered discharge planning, signposting to other services and informing the young person's GP.
- Young people and their families would where appropriate be given a crisis card saying who to contact in an emergency. The trust also provided a phone line for out of hours advice. This could however be confusing with some people directed to go to A&E and others to contact social services duty teams.

The facilities promote recovery, dignity and confidentiality

- All teams had access to meeting rooms where people could meet with staff in private. Most rooms were well-maintained and appropriately furnished. We saw that rooms were equipped with age-appropriate toys, books and coloured pencils for young children.
- The waiting rooms were bright and warm and furniture appeared to be in good order.
- In the Brent team, we spoke to staff who worked with adolescents. When they moved to the Brent CAMHs site they found that the building was not age-appropriate for adolescents. In response a room was identified on the ground floor and converted into a waiting room for adolescents. This was furnished this with age appropriate materials based on feedback from young people using the service.
- Weighing scales and height measurement and physical health equipment were available to teams.
- The trust had identified that the building where Westminster CAMHS was based was not considered fit for purpose. Options were being considered in the trust for a new base. Similarly the building where Brent CAMHS was based was considered not fit for purpose. The estates team within the trust had been tasked with finding appropriate premises.
- Currently the Brent team were split across two sites. Bell House which was a short walk away from the main CAMHS team base was used as a satellite service. Children with learning disabilities were seen there as it was considered a more appropriate base.
- The Hillingdon team was located on the first floor with stairs and no lift. It was not possible for people with physical disabilitities to access the first floor but arrangements were made on an ad-hoc basis to use a local GP surgery or other NHS facilities if needed.

Meeting the needs of all people who use 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.

- Teams had completed training in equality and diversity This formed part of the trust's mandatory programme of training.
- Staff discussed with us the different communities they served and where it was challenging to engage certain groups at times. Staff worked with people from a wide range of backgrounds.
- The team used interpreters where needed to engage non-English speaking families. Interpreters were used to help assess young people's needs and explain their rights, as well as their care and treatment.
- We saw some information was available in different languages, for example,. Urdu, Bengali and Punjabi and on the trust's 'CAMHS and Me' website. However, not all teams had relevant information leaflets available in languages other than English.
- In the Behaviour Family Support team some of the clinical staff spoke foreign languages including Arabic which was widely spoken in the local community.
- There were good links in the community to specialist services, for exampe, school counselling and domestic violence services. There were high levels of deprivation in Brent. The Brent team had brought in links in the borough to raise team awareness in certain subject areas. For instance, around sexual exploitation, radicalisation and teenage pregnancy.
- Staff across teams demonstrated sensitivity and understanding of the cultural and religious needs of the population they served. Staff explored a family's background to gain understanding of their culture and diversity needs. An example of this was given where the gender of a clinician visiting a family at home would be considered and negotiated with the family. Females could request a female worker and staff would try to accommodate this where possible. Examples were given where people were offered a therapist from a culturally specific background.
- The Behaviour Family Support team monitored the age, gender and ethnicity of people using the service. They had compared their data with the Children in Need Census carried out in February 2005 which revealed that two-thirds of children with disabilities came from black or minority ethnic (BME) backgrounds. This data allowed them to provide a service that met cultural and individual needs in a meaningful way.

Listening to and learning from concerns and complaints

- We saw patient and liaison services (PALS) and complaints leaflets on how to raise a complaint in the reception areas of teams and suggestion post boxes for young people and families to leave comments. One parent we spoke with did not know how to raise a complaint but said they would feel comfortable raising this with staff.
- Staff tried to resolve issues raised locally where possible and examples were given of informal concerns that were raised and how they had been resolved.
- Some teams reported they had not received any formal complaints in the last 12 months. Despite the long waiting lists in some teams, formal complaints were low. In Hillingdon staff actively discussed issues with the waiting list with families. Staff tried to manage people's expectations by being open and transparent with them.
- Staff said complaints were discussed in MDT meetings. We saw an example where a formal complaint had been responded to within a short time frame of receiving the letter, in line with trust policy. Formal complaints were logged within the team and centrally in the trust.

Are services well-led?

Good

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

Summary of findings

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

There was strong leadership at a local level and service level across most of CAMHS that promoted a positive culture within teams. We saw a number of changes had taken place and that the changes within CAMHS were heading in a positive direction. Regular care quality and team meetings were taking place. Most staff across teams said they felt well supported by management and enjoyed working in the trust. There was a commitment to continual improvement across the service line.

However, some improvements were needed:

- Morale amongst staff was varied in the Westminster CAMHS team due to a number of changes in the service. Not all staff felt listened to or involved in the changes.

Our findings

Are Specialist community mental health services for children and young

people well-led?

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.

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

Vision and values

- CNWL had recently made a number of changes in the way services were organised to ensure that services were consistent across boroughs. These changes had filtered down to the CAMHS teams to ensure resources were used in the most effective way to meet the needs of young people using the service and their families.
- Staff we spoke with reflected the values of the trust. They were committed, innovative and produced alternative solutions to problems such as long waiting lists. Service delivery was patient focussed and delivered in line with NICE guidelines and recommendations.

Good governance

- As a result of changes in the trust, new quality assurance arrangements had been implemented to ensure there was a clearer structure for issues to be fed from teams up to board level and back down again. At a local level care quality meetings had been introduced and the senior management team kept informed of developments across the CAMHS teams.
- Where appropriate, concerns were placed on the team's local risk register. We saw items which had been entered on the local risk register and where appropriate raised on the overall CAMHS risk register. This included the issues of long waiting lists and cost improvement impacting on services. We visited the Westminster team twice. During our first visit no risks had been identified on the local risk register. During our second visit local risks had been identified and we were provided with a copy of this.
- Senior management team meeting minutesfor January and February 2015 showed a number of the issues on the services risk register were discussed. This included the fact that the numbers of young people who deliberately self-harmed were increasing in complexity and risk and staff were feeling that there did not appear to be a current strategy in place to support this.
- Staff across teams said they received regular updates in the trust. Examples included three minute read emails from the CEO, away days and team meetings.

Leadership, morale and staff engagement

- There was strong leadership at a local level and service level across most of CAMHS that promoted a positive culture within teams.
- There had been a lot of change across services. In Westminster CAMHS staff told us about the introduction of a number of changes to management, systems and team composition. Managers also acknowledged some staff had struggled to adjust to significant changes and some staff had left the service as a result. Weekly team meetings were enabling staff to discuss proposed changes and where possible make decisions together.

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.

One staff told us they felt involved in the change process. Another said they did not feel listened to or involved in the changes. Some challenges to the new structure from employees were being escalated to clinical and service directors. Management told us they were not concerned about stress levels although some staff told us that they were feeling stressed at work. Management were looking to develop the service to further accommodate cultural differences. There was also a lot of work in progress in the behaviour family support team, however, the morale in this team appeared to be high.

- In preparation for the CQC inspection all community teams received an internal inspection which identified areas of good practice and areas for improvement.
- In Hillingdon and Brent the findings indicated that all felt supported at a local level but there was not always a sense of feeling listened to within the wider trust. One team told us that the CAMHS senior management group had become more detached from clinical delivery. Some issues included the management of increased referrals, high risk cases, the lack of tier 4 inpatient CAMHS placements and delayed recruitment impacting of staff morale. We saw there had been some improvements since the internal review had taken place as highlighted in the report.
- Staff were aware of the whistleblowing process if they needed to use it.

Commitment to quality improvement and innovation

- There was a commitment to continual improvement across in all services.
- The Behaviour Family Support team had annual away days to review their service delivery. The team had produced a list of new developments in response to its annual audit. This included pilots in different approaches to treatment, and building and improving links with local services.
- A clinical audit was carried out in the Brent CAMHS team on self-harm referrals. It was identified that there were an increased number of young people presenting to CAMHS with self-harm. This project was identified to think about care pathways and care planning to support young people who self-harmed. This was submitted in January 2015 and was ongoing.
- In Brent a DNA audit was carried out to evaluate the current practices surrounding non attendance at appointments and to review the current management of DNAs in Brent. This was to help formulate a protocol that could help to achieve better attendance rates. Similar work had been carried out in the Violet Melchett team and had led to improved ways of working.