

Good 

Oxleas NHS Foundation Trust

# Specialist community mental health services for children and young people

## Quality Report

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Date of inspection visit: 26 - 28 April 2016  
Date of publication: 13/09/2016

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RPGAG	Memorial Hospital	Bromley CAMHS	BR1 1RJ
RPGAG	Memorial Hospital	Greenwich Adolescent CAMHS	SE18 1BH
RPGDV	Highpoint House	Bexley CAMHS	SE18 3RZ

This report describes our judgement of the quality of care provided within this core service by Oxleas 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 Oxleas NHS Foundation Trust and these are brought together to inform our overall judgement of Oxleas 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 service as good because:

- Patients told us they generally felt safe in the service. Staff effectively mitigated individual clinical risks.
- Staff were positive about working for the trust. Mandatory training rates were high; staff felt supported and accessed regular supervision. The teams consisted of enthusiastic people with patient care as their priority. Services included a range of staff able to deliver psychological therapies recommended by NICE.
- Parents, carers and young people felt services were welcoming, clean and comfortable and gave very positive feedback about how staff treated them. The trust employed a participation worker who supported engagement with young people and families to support their involvement in service development.
- Staff regularly assessed and discussed elevated risks. This meant that young people and parents/carers had crisis plans in place if needed.
- Service waiting times were within the trust maximum target of 13 weeks. Services could offer rapid response in an emergency between 9am and 5pm. Bromley CAMHS was a pilot site for an out-of-hours service and was able to offer an emergency response between 9am and 9pm on weekdays and 8am and 10pm on weekends.
- Services had developed several helpful resources, such as a physical healthcare clinic and a self-help and referral website called 'headscape'. This was created with the input of young people and provided information about mental health issues and self-help.

However:

- Staff did not carry out regular environmental ligature risk assessments. There were several areas where ligature risks were present. For example, in bathrooms where staff were unable to fully mitigate risks.
- There were several vacancies across teams so there was pressure to meet the demands on the service. A large number of vacant posts had been recruited to and staff were waiting to start. In the interim, agency staff filled a large amount of the vacant posts.
- Leaflets that were available, for example about the complaints procedure, were only available in English. Information about advocacy services was not displayed clearly across all services.
- The trust had designated a CAMHS inpatient bed on an adult acute ward for use when an inpatient CAMHS bed was not available. There was a protocol on the use of this bed, which was a shared responsibility between this team and the acute ward concerned; however, we found several examples where CAMHS and other trust staff had not followed procedures appropriately. CAMHS staff had not worked together with other trust staff to ensure that the environment on this ward was appropriate and safe for a young person.
- We found evidence that feedback and learning from incidents was effective within a borough, but not as effective across services in the three different boroughs.

# Summary of findings

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

### Are services safe?

We rated safe as good for community child and adolescent mental health services because:

- Staff assessed individual risks for young people and discussed this regularly at team meetings. Staff created crisis plans with young people and parents/carers who needed them. Young people were able to access a psychiatrist quickly in a crisis.
- Staff were trained in safeguarding children levels one, two and three. Staff understood safeguarding procedures and followed personal safety protocols when working alone.
- Mandatory training rates were high.
- Staff showed a clear understanding of their responsibilities under the duty of candour. That is, to provide service users support and information in the event that a reportable patient safety incident occurred.
- Greenwich adolescent service had a dedicated clinic room which was visibly clean and organised with an infection control checklist that staff had completed.
- Staff were able to describe changes in their services following learning from incidents that had taken place.

However:

- There were several vacancies across services in the three boroughs. A large number of vacant posts had been recruited to and staff were waiting to start. In the interim, agency staff filled a number of the vacant posts. We found evidence that agency staff did not document case records as thoroughly as permanent staff.
- Staff did not carry out regular environmental ligature risk assessments. There were several areas where unnecessary ligature risks were present.

Good



### Are services effective?

We rated effective as good for community child and adolescent mental health services because:

- Services were made up of a range of staff able to deliver psychological therapies recommended by NICE. The trust developed care pathways to other trusts where they were not able to offer therapies recommended by NICE.
- Services implemented several initiatives and models of care designed to improve services. For example THRIVE and Children and Young People Improving Access to Psychological Therapies

Good



# Summary of findings

(CYP IAPT). These were involved in assessing the needs of a service user rather than planning care based on a diagnosis and using outcome measures to improve involvement of young people in their care.

- Senior nursing staff developed a pilot for a nurse led, physical healthcare clinic, which was set up in September 2015 and piloted in Greenwich adolescent CAMHS.
- Staff were supervised, appraised, and accessed regular team meetings. Staff felt supported with learning and development needs by the trust.

However:

- Care plans did not all contain recorded up-to-date information or evidence of review. Not all care plans contained information that was holistic and focussed on achieving goals.
- There were examples of poor liaison between CAMHS crisis services and A&E. At times, CAMHS were not made aware of a young person's presentation to A&E in a timely way. This meant they could not provide specific support and advice to the young person and the staff at A&E.

## Are services caring?

We rated caring as good for community child and adolescent mental health services because:

- Young people and parents/carers gave very positive feedback about staff. They told us that staff were welcoming, kind and supportive. Young people and parents and carers felt involved in decisions about care and several parents and carers said staff gave appropriate support to the whole family.
- Young people and parents/carers said staff discussed confidentiality with them.
- The trust employed a participation worker for the children's services directorate. They supported engagement with young people and families to gather their feedback about services and supported involvement in service development. Parents and carers said they felt they had the opportunity to raise issues if needed and felt staff encouraged feedback.
- Parents, carers and young people felt services were welcoming, clean and comfortable. Staff had sought feedback from service users about how they would like to make improvements to the environment, for example the waiting rooms.

However:

Good



# Summary of findings

- Information about independent advocacy services were not clearly displayed across all services. Some parents and staff were not aware of how to access this service if required.

## Are services responsive to people's needs?

We rated responsive as good for community child and adolescent mental health services because:

- Waiting times did not go over the trust maximum target of a 13 week wait.
- In April 2016, senior staff at Bromley CAMHS carried out an activity analysis in response to growing demand on the service and the limited capacity it had. They were aware of the challenges facing the services.
- Services could offer rapid response in an emergency during working hours of 9am to 5pm. Bromley CAMHS was a pilot site for an out of hour's service. Outside of this, the trust's crisis duty team was accessible.
- The trust had a self-help and referral website for young people to access.
- Clear criteria for acceptance to the service were outlined on the service website. Referral information also included contact details for the teams if a referrer had a question or wanted to make an emergency referral.
- Young people and parents/carers said they could choose their appointment times and felt this was easy to do.
- Waiting areas had a number of leaflets signposting people to external agencies and general information about what CAMHS was. There was information about how to complain and the trust patient advice and liaison service. In the Greenwich adolescent service waiting room, there were a range of leaflets that were relevant to adolescents.

However:

- Throughout the services there were no leaflets available in a language other than English. Staff said these could be requested, but this was not made clear.
- The services did not have written information leaflets about all specific treatments offered. Staff said this was an area they could improve upon. Young people and parent/carers said that following their assessment, staff shared information about treatment with them verbally, but not always in writing.
- Each service had a board in or near reception that had pictures of staff and their names. At Bromley CAMHS, staff had not updated the board to include all new staff members.

Good



# Summary of findings

## Are services well-led?

We rated well-led as good for community child and adolescent mental health services because:

- Staff were very positive about working for the trust and said they really valued working there, as it was a supportive employer. The trust supported leadership development and staff said there were opportunities for internal promotion. Staff felt the trust wanted them to stay.
- Mandatory training rates were high and staff said they felt supported and accessed regular supervision.
- Management staff were considering ways in which to recruit a wider pool of applicants to posts that were hard to fill, such as nursing posts, and decrease the number of vacant positions.
- Team and operational managers had introduced several initiatives to improve efficiencies and effectiveness of teams. One example was in Bexley CAMHS, from February 2016, the manager introduced a referrals meeting every day rather than once a week. Another was the piloting of the physical health clinic in Greenwich adolescent CAMHS.
- Most teams described morale as positive or improving after facing challenges during service restructure.
- Staff were very positive about their colleagues and said that the teams had a friendly atmosphere. Staff told us that the teams were supportive and made up of enthusiastic people with patient care as a priority.
- Across all boroughs, clinical staff accessed both individual and peer supervision on a fortnightly or monthly basis.

However:

- The trust had designated a CAMHS inpatient bed on an adult acute ward for use when an inpatient CAMHS bed was not available elsewhere in adjoining London trusts. There was a protocol on the use of this bed; however, we found several examples that not all these procedures were followed appropriately. Trust staff had not ensured that the environment on this ward was appropriate and safe for a young person. The trust had recognised this issue at the time of the inspection and was reviewing their policy.
- Not all medical equipment was calibrated to ensure their readings were accurate. There was no system in place across the services to remind staff when calibration was due.
- We found evidence that feedback and learning from incidents took place effectively within a borough, but not as effectively across services in the three different boroughs.

Good





# Summary of findings

- Staff did not regularly participate in clinical audits, although there were a small number that took place.

# Summary of findings

## Information about the service

The trust provided services in the London boroughs of Bromley, Bexley and Greenwich. Child and adolescent mental health services in each borough delivered care to young people and children that were experiencing mental health problems.

Each borough was divided into sub teams. Generic teams provided care and treatment to young people with moderate to severe mental health difficulties. The looked after children team provided assessment and treatment for adopted children and those looked after by social services. Crisis teams, called adolescent services, provided in-reach to young people that attended accident and emergency departments. They also provided intensive support at home with the idea to stop admission to hospitals. Each borough also had a team supporting young people with learning disabilities and neurodevelopmental disorders.

A wellbeing service was in development in the borough of Bexley, which planned to offer consultations and training to staff in schools, children's centres and GP surgeries to support young people with mild to moderate needs. In Greenwich CAMHS, an early intervention team delivered in-reach services to schools and GPs.

Each borough had been involved in redesigning their services in the two years leading up to the trust inspection and had received transformation funding from NHS England and the Department of Health under Future in Mind.

The trust had introduced a number of new initiatives, such as a single point of access in Bromley CAMHS. However, a number of changes were being embedded at the time of inspection.

## Our inspection team

The comprehensive inspection was led by:

**Chair:** Joe Rafferty, Chief Executive, Mersey Care NHS Trust

**Head of Inspection:** Pauline Carpenter, Care Quality Commission

**Inspection managers:** Peter Johnson and Shaun Marten  
Care Quality Commission

The team that inspected Oxleas NHS Foundation trust's community child and adolescent mental health services comprised of one CQC inspector and three specialist advisors with experience of working in child and adolescent mental health services. One assistant inspector joined the team for a day.

## 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?

# Summary of findings

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 three focus groups.

During the inspection visit, the inspection team:

- visited three services and looked at the quality of the environment and observed how staff were interacting with young people and parents/carers
- met with 22 young people and parents/carers who were using the services;
- observed one group supervision session for clinicians
- interviewed the operational managers for each of the services
- spoke with 22 other clinical staff members; including nurses, clinical psychologists, psychiatrists, family therapists and child psychotherapists
- met with four non-clinical staff members including administrative staff and a participation worker
- interviewed the service director with responsibility for these services
- attended and observed three clinical team meetings, one referral meeting, one business meeting and a physical healthcare clinic meeting
- reviewed in detail 26 care and treatment records of patients
- examined 34 anonymous feedback comment cards
- reviewed 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 and families gave very positive feedback about the staff in all services. They said both clinical and administrative staff were extremely kind and respectful, had welcomed them to the service and had put them at ease. They felt staff created a relaxed and calm environment. One parent said they could not speak highly enough of staff and one young person said they could not recommend the service enough.

Young people and parents/carers were positive about the care and treatment they received. They found the service

helpful and were grateful for the impact it had made on their lives. They confirmed that families were provided with the support and input they needed and that staff were flexible and approachable.

Staff were accessible when needed and would be available to speak on the phone or would return calls within the day. Young people and parents/carers felt involved in decisions and discussions about their care and felt able to give feedback on the experience of care they received.

## Good practice

The website 'headscape', developed by the trust in 2015 and created with the input of young people, provided detailed information about sources of self-help and different mental health issues. It was young person friendly and straightforward to use. The website allowed young people in Greenwich to self-refer. Young people living outside of Greenwich could still access the information, but would not be able to self-refer.

The development of a physical health clinic in Greenwich adolescent CAMHS enabled staff to provide a more holistic treatment package. It meant young people could

access necessary physical health checks, for example those related to medicines, on site rather than having to wait for a referral to a GP. This was a nurse led initiative and three members of nursing staff had been recruited through a specifically designed interview process.

The trust employed a participation worker for the children's services directorate who worked full time to support engagement with young people and families in service development. The participation worker was embedded well into CAMHS.

# Summary of findings

## Areas for improvement

### Action the provider SHOULD take to improve

- The trust should ensure that the care provided on the adult ward with a CAMHS designated bed is appropriate, as outlined in the trust protocol.
- The trust should ensure that all medical equipment is appropriately calibrated.
- The trust should ensure the environments are assessed for ligature risks and staff are aware of plans to mitigate risks.
- The trust should ensure that feedback and learning from incidents is shared across the three boroughs as well as within teams.
- The trust should ensure that all risk assessments are up to date, case records contain plans for care and have evidence of regular review.
- The trust should ensure information about advocacy services, including what they offer and how to contact them, are available to service users.
- The trust should ensure service users know how to access information in languages other than English and have access to written information about treatments available to them.
- The trust should ensure all staff are aware of the complaints procedure and are able to advise service users how to do this.
- The trust should ensure that all staff, including locum staff, are aware of the trust whistleblowing policy.

## Oxleas 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
Bromley CAMHS	Memorial Hospital
Greenwich Adolescent CAMHS	Memorial Hospital
Bexley CAMHS	Highpoint House

### Mental Health Act responsibilities

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

Training in the Mental Health Act 1983 (MHA) and the MHA Code of Practice was not mandatory for all staff and was

available as an e-learning module. Not all staff had a thorough understanding of the MHA and the MHA Code of Practice. There were no children on a community treatment order.

### Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act 2005 (MCA) was not mandatory and staff said they would seek advice from a psychiatrist within their team if needed. There was no specific training for the application of the MCA with young people aged 16 and over, which is covered in chapter 12 of the MCA Code of Practice.

The trust did not provide any specific training about Gillick competence; staff said that the trust relied on staff prior knowledge in this area. Gillick competence is concerned with determining whether a child or young person is able to

# Detailed findings

consent to their own medical treatment, without the need for parental permission or knowledge. Staff were able to describe when an assessment of Gillick competence would be applied and showed a clear understanding.

For people who may have impaired capacity to consent, we found evidence in four records that staff assessed and

recorded this appropriately. Staff at Bexley CAMHS said they were developing a preformat for capacity assessments as they felt the current documentation about capacity and consent was unclear.

# 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

- There were alarms fitted in therapy rooms throughout the buildings where Bexley and Greenwich CAMHS teams were based. The alarm system alerted staff in the administration office to where the incident was. There had been no incidents requiring the use of an alarm in the 12 months leading up to the inspection. There was no alarm system at Bromley CAMHS. At Bromley CAMHS, staff said each young person was assessed for risk before their first appointment, and would be seen in a room nearby to offices, so the staff member could raise an alarm themselves if needed.
- Greenwich adolescent service had a dedicated clinical room for physical examination. The clinic room was visibly clean and organised. There was a cleaning checklist that staff completed. This was completed and available from the two weeks before the inspection. There was also an infection control checklist, outlining when and how to clean equipment after use. Signed records for this were available from January 2016 onwards. In other services, staff kept equipment to measure height, weight and blood pressure in individual clinician's offices.
- Greenwich adolescent service had a medical device list which outlined when equipment was due for a routine service. This included weighing scales, heart monitoring (ECG) machines and blood pressure monitors. There were 10 devices listed and all were out of date for their calibration.
- All services had first aid boxes available for staff to access. At Bromley there were three first aid boxes, however, two of the first aid boxes contained out of date contents and there was no contents list available. This was identified to the service on the day and immediately addressed by senior staff. At Greenwich adolescent service and Bromley CAMHS, first aid boxes contained in date equipment.
- Clinical areas appeared visibly clean. Staff requested and logged building repairs that were needed and maintenance staff carried these out. Entrances to services were monitored by CCTV and/or reception staff.
- Bexley CAMHS and several sub teams of Greenwich CAMHS were temporarily based in a building at Memorial Hospital during refurbishment of their building. This relocation was scheduled to last around 12 months. Staff described the temporary building as originally unfit for purpose. However, staff had escalated concerns about the environment and the maintenance team responded quickly to resolve any issues. The new design of the building was intended to address these concerns.
- Staff encouraged young people and parents to be involved in improving the environment of the waiting room. There was a large mural on the wall at the entrance to the service created by professional artists with the help of young people. This detailed a young person's journey through CAMHS and was visible as soon as you entered the service. Parents and young people's felt the waiting area had been improved following the changes. One parent felt the therapy rooms remained unwelcoming. The environment of the Bromley CAMHS and Greenwich adolescent CAMHS was well maintained. The waiting area had comfortable seating and a selection of toys for younger children. There were no particular adjustments for adolescents.
- Parents, carers and young people gave positive feedback about the environment of services. They felt it was clean, comfortable and welcoming.
- Access to staff offices at Bromley and Bexley CAMHS was through locked doors requiring an access code or pass. These doors were appropriately locked throughout the inspection.
- Each service had a toy-cleaning schedule. This outlined who was responsible for using disinfectant wipes with toys and how often this should take place. Each service had records for the week of inspection, although these were not available for dates previous to the inspection.
- Cleaning records for communal areas were kept with cleaning equipment securely stored on site. The

# Are services safe?

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external cleaning company had access to these records and trust staff did not. At Bexley CAMHS, each bathroom had cleaning records on the back of the door. Cleaning staff signed these as completed for all weekdays in April 2016.

- There were hand-washing signs in all bathrooms and in the staff kitchen.
- Staff assessed the environment for risks using trust standard assessment forms. Staff carried out the last assessments in October 2014 and trust policy outlined they were due to be redone in October 2016.
- Staff did not carry out regular assessment of the environment for ligature risks. There were several areas where ligature risks were present unnecessarily, for example in bathrooms. There were no management plans in place for young people who may access these bathrooms or other areas in a distressed state. However, they had been no incidents of patients attempting to self-ligate whilst using this service.
- Fire extinguishers were located appropriately throughout the services and were serviced in the last 12 months. Fire alarm test records were available for 2015 and 2016 and showed there was weekly site attendance from external staff to carry out checks at all sites. Records for emergency lighting tests showed these had taken place in 2016.

## Safe staffing

- Managers used an electronic system to review team and individual caseloads. One staff member in Greenwich CAMHS said that the caseload reduced after the new configuration, which they found helpful.
- All services had vacancy rates that varied from 14% to 49% across a range of positions. Agency staff covered the majority of these vacant positions and at the time of inspection, a number of staff had been recently appointed but had not yet started. The turnover rate for staff across the three boroughs was 26% in the 12 months before the inspection. The sickness rate was 2% in the 12 months leading up to the inspection. Permanent staff noted that the high vacancy rates meant there was a high turnover of agency staff, which had created difficulties in creating a culture of therapeutic work and reflection. However, senior staff told us that positions were being recruited to and this was improving all the time.
- At Bromley CAMHS, staff said vacancy rates were higher than the team had experienced previously. The established staffing level across teams was 37.5 staff with just over five posts vacant. Of these, agency staff covered 2.1 posts and two members of staff had been recently appointed but not started. Management staff said they could not find suitable applicants to fill the positions and there was difficulty in filling nursing posts in particular.
- At Greenwich adolescent CAMHS, there were vacancies for five staff positions. Agency staff filled three of these vacancies. One member of staff said the process to join the trust bank was lengthy and had delayed them joining the team. At the time of the inspection, a team manager had been appointed but had not yet commenced in post. They would manage the Greenwich adolescent service and looked after children team.
- In the generic Greenwich team, there were seven vacancies in a team for 15 staff. Agency staff filled the majority of these vacancies, leaving 0.7 positions vacant. Management staff said there were a number of positions recently recruited to with staff due to start. Through the Greenwich reconfiguration there was some long term sickness in the staff group.
- In Bexley CAMHS there were several vacancies across the sub teams. In the adolescent service there was a vacancy of two staff, one bank staff were filling one vacancy and one member of staff was due to return from maternity leave. A small substance misuse team was vacant 0.5 staff. The generic team had just over two vacancies although a new staff member had been recruited. The looked after children team had one vacancy. The learning disability and neurodevelopment team used two agency staff. Staff said there were difficulties around recruitment of permanent staff but also around appropriate agency staff with sufficient training. Management staff felt the human resources department in the trust had been supportive and helpful through the recruitment and appointment processes.



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- In Bexley CAMHS, a community health and wellbeing team was being developed. The planned establishment for this team was 6.4 staff. There were currently 1.8 recruited to posts.
- Staff from all three boroughs said there had been difficulties in recruiting nursing staff to advertised posts. These posts were in place in order to increase the capacity and range of skills in the teams and through-flow of referrals. Senior staff were thinking creatively about how to create posts that would attract a wider pool of applicants.
- Adolescent services in each borough provided in-reach emergency assessments of young people who presented hospital Accident and Emergency (A&E) in their borough. This was provided during working hours.
- Provision of an out-of-hours service was being introduced across all boroughs, but was in place in Bromley CAMHS at the time of inspection. Between Monday and Friday, staff provided in-reach CAMHS emergency assessments to Princess Royal University Hospital A&E department from 5pm to 9pm. Telephone advice was available between 9pm and 10pm. On weekends, this in-reach service was provided from 8am to 10pm. The rota for the in-reach services was not yet fully staffed, so the general out-of-hours duty system in place across the trust was used when this CAMHS specific service was not available. The rota was not fully staffed due to some staff not wanting to join the rota and others not joining until they had shadowed experienced staff and completed a competency checklist. The introduction of the in-reach service at Bromley CAMHS caused dissatisfaction with some of the staff team and had led to several members of staff leaving. Staff at Bromley CAMHS said they were uncertain as to how much difference the out-of-hours service had made to the care delivered to young people. The Trust had undertaken reviews of the service and shared these with staff.
- The trust provided 11 mandatory training courses. Average mandatory training rates for all staff across the three boroughs was 94%. In Greenwich services the training average was 91%, in Bexley, it was 90% and in Bromley, it was 97%. Locum staff also received the trust

mandatory training. Management staff received monthly reports about compliance with mandatory training from the central trust and could access training rates for teams on an electronic system.

- Staff said the trust were very supportive of training. Management staff said that as referrals increased over time, it was more difficult to free staff up for training, but they were managing it.

## Assessing and managing risk to patients and staff

- Of 26 records across services in the three boroughs, 24 contained a risk assessment. The services where a risk assessment was not present in the notes were Bexley generic and Greenwich generic CAMHS. For the young person accessing Greenwich generic CAMHS without a risk assessment present in their notes, they had joined the service six months previously. For the young person accessing Bexley CAMHS, there were no notes in their care records at all. However, they had joined the service within the last month and had received an appointment. This was highlighted to the service on the day for immediate review. Within the 24 case notes with risk assessments present, 15 contained evidence that these had been reviewed and updated at the last contact with the young person. However, incidents were included in risk assessments where they had taken place. For two young people accessing Bromley CAMHS, staff had not updated their individual risk assessment since 2011 and 2014.
- We observed three team meetings and saw staff discussed risk for each young person. This was particularly the case in the Greenwich adolescent team, where staff discussed risks, crisis plans, advice to parents and carers about crisis plans and included discussion of
- Staff created crisis plans with young people and parents/carers who needed them. In Bexley adolescent service, staff had developed a colour coded red, amber and green safety plan which related level of risk involved in that young person's case. This was rolled out to other services. Parents and carers we spoke with were aware of the safety plans created for their child and had written copies of these. Parents and carers said they knew who to contact in a crisis and felt supported to manage this situation. The first letter that young people

# Are services safe?

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and/or parents/carers received when they were on the waiting list included contact information for a duty staff member they would be able to access during CAMHS opening times.

- Staff received training in safeguarding children levels one, two and three. Compliance with training was 100% for levels one and two, and 90% for level three across all services. Staff understood safeguarding procedures and knew who the safeguarding contacts were within the service and trust. Staff said that the safeguarding processes worked and that safeguarding was discussed at multidisciplinary team (MDT) meetings. The safeguarding lead for CAMHS provided safeguarding supervision. The safeguarding lead also updated the safeguarding supervision policy to state that staff were required to document that safeguarding supervision had taken place.
- Staff followed personal safety protocols. These included a lone working policy and first assessments being carried out on site at the service rather than in a community setting. Administrative staff across services were aware of the use of a code word if a clinician called through and needed assistance from emergency services. Staff at the Greenwich adolescent service gave an example in the last six months of clear and detailed management of a situation that required staff to attend an appointment in the community where there was potential risk involved from external sources and how the safety of these staff members was managed. In this instance, staff were required to increase the contact with the team, calling when they arrived at the appointment, when they had left the appointment and when they were in the car to return to the service.
- The trust had a monthly newsletter called Quality Street that went out to all staff. This was a one page information sheet which highlighted key policies. The April 2016 addition was the 17th addition and highlighted the lone working policy and incident management policy.

## Track record on safety

- These services had not been involved in any serious incidents in the last 12 months.

## Reporting incidents and learning from when things go wrong

- The trust had a document that outlined and classified incidents. Staff at Bexley CAMHS said they added items to this document that were specifically CAMHS related. The additions were reviewed in 2015 and agreed with the young person patient safety group and CAMHS leadership group. Management staff said admission to an inpatient service was a reportable incident, as was a delay in finding a bed in an appropriate inpatient service. Staff also reported self-harm as an incident where this was an unusual action for a person and was outside of the information already recorded on their care management plan. Management staff said they were encouraging staff to report verbal aggression as an incident as previously, staff had not been reporting this each time.
- Staff were aware of the trust incident policy, were able to describe what an incident was and how it should be reported. Staff used the trust's internal reporting system to report and classify incidents and managers would receive this information for review. Across the three boroughs between January and March 2016, staff reported 38 incidents. Incident reports were brought to quality meetings that managers attended.
- The majority of staff showed a clear understanding of their responsibilities under duty of candour,, and referenced this in discussion. At Greenwich adolescent service there was information about the duty of candour on the information board in the staff kitchen.
- Staff said that incidents from their own service were discussed at team level in business and clinical meetings and at a patient safety group across trust directorates. Staff identified incidents that had taken place within their own boroughs in the last six months. Staff were less able to identify incidents that had taken place in other boroughs, indicating that feedback and learning from incidents took place within a borough, but not across boroughs.
- Staff from across all three boroughs gave examples of changes that had been made following incidents within their own service.

# 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

- For routine referrals, staff completed comprehensive assessments over one to three sessions with a young person and family. Staff said a plan for care would be developed with the young person and family during the assessment.
- Of the 26 care records we looked at across generic and adolescent services within the three boroughs, 21 contained information that outlined the plan for care. All records in the adolescent teams in Greenwich and Bexley contained information about the plan for care. The trust carried out a care plan audit in October 2015 and results from CAMHS reflected the findings from this inspection. The trust audited 86 care plans from CAMHS and found care plans were present in 83% of records.
- In the care plans we looked at, there was no clear evidence of whether the plans for care were being regularly updated with new information after the initial assessment. Care plans contained up-to-date information or evidence of review in seven of 21 records. For one person, the care plan had not been updated since 2014. For another, there was evidence of care planning in their progress notes kept by their clinician, but this was not stored in an accessible way in the location required.
- In the adolescent services in Greenwich and Bexley, nine of 10 care plans had information that was holistic and focussed on outcomes. This was less evident in the care plans within the generic services.
- In the 26 records we saw, 16 contained documented evidence of informed consent for a treatment being obtained from a young person or parent/carer where appropriate. A further three records contained information about consent, but it was not recorded clearly. Young people and parents/carers said that staff has asked them for consent prior to providing treatment.
- Case notes at Greenwich adolescent service showed that staff routinely assessed and supported the physical healthcare needs of young people. In other services, there was no evidence that staff asked about physical healthcare needs in the assessment. At Bromley CAMHS, in one of six care records, there was information about the physical healthcare needs of the young person, although this was brought to the attention of staff by the young person. The Royal College of Psychiatrists quality standards for community CAMHS recommends that staff ask young people about aspects of their physical health as part of the assessment process.
- Senior nursing staff working across the teams had developed a pilot for a nurse led, physical healthcare clinic which was set up in September 2015 in Greenwich adolescent CAMHS. The clinic was developed in order to offer young people services such as initial screening for medicines, blood tests, heart monitoring checks (ECGs) and wound care for self-harm. This meant young people would not have to be referred to a GP or hospital to have this carried out. This included recording a health improvement profile with information such as current physical health problems and symptoms, vaccinations and past medical history, contact with opticians and dentists, dietary intake and alcohol intake, sexual health and allergies. Staff collected this information using evidence-based tools. This was a pilot project for six months and was due for review two weeks after the inspection. Staff were working through the waiting list to offer this service to all young people within Greenwich adolescent service. Staff sent young people written information about the service and how to book an appointment. Staff felt the pilot had been a positive experience, with particular benefits in identifying and managing side effects of anti-psychotic medicines. The staff also said this was a useful way to engage with some young people.
- The operational manager and the nurse consultant for all three boroughs designed an interview process and recruited staff to work in this physical health clinic from September 2015. They also developed a standard operating procedure for the health clinic, which was issued in April 2016. This outlined that the clinic appointments would be available between the hours of 9am and 5pm. However, this could be flexible if needed. It also outlined seven evidence-based tools to be used during the assessments. It stated that staff would seek patient feedback following all appointments using an adapted feedback questionnaire. This was not yet

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developed and staff used a standard template to get feedback in the meantime. Feedback questionnaires were available for one young person who had responded positively to four questions.

- At Greenwich adolescent service in eight records, four young people had received a physical health examination and one was on the waiting list for this. There was evidence in all eight records that staff had addressed the ongoing physical health care of young people, either through the healthcare clinic or through liaison with a GP.
- Information and records about care was stored securely and was available to staff in an accessible format using an electronic system. We spoke with one member of staff from Bromley CAMHS who also kept some paper records, although these were not recorded on the central electronic system.

## Best practice in treatment and care

- Services were made up of a range of staff that were able to deliver psychological therapies recommended by NICE. Where staff were unable to offer therapies recommended by NICE, for example dialectical behavioural therapy (DBT), the trust had developed care pathways where staff referred young people to a DBT team at the South London and Maudsley NHS Foundation Trust. Young people with eating disorders also followed care pathways to appropriate services in other trusts. Staff said the care pathways they were able to offer were based on NICE guidelines and several staff referred to NICE guidelines in their work.
- Services implemented a model of care called THRIVE which was developed by The Anna Freud Centre and The Tavistock and Portman NHS Foundation Trust. The model was based on identifying a young person's needs regardless of their diagnosis or the severity of the illness. For example, some young people may benefit from support in self-management of their illness and others may benefit from extensive support and treatment. The services did not use the tiered model of care, which was commonly used in CAMHS to identify a young person's care pathway.
- Staff from the Greenwich adolescent service said they were working toward improving accessibility to psychological therapies, as this had been difficult to provide as effectively as they would like due to vacancies. Staff felt this had improved, although there was still some way to go until vacancies were filled. One staff member had been appointed to be the therapies lead and embed these in the service. This person, however, was acting as team leader whilst this position was vacant. The team leader post had been recruited to at the time of inspection meaning the therapies lead would then be able to focus on this work.
- The services were part of an initiative called Children and Young People Improving Access to Psychological Therapies (CYP IAPT). This is a service transformation project for CAMHS aiming for improved collaboration with therapists and young people. This initiative provides specialist CAMHS training to staff. CYP IAPT requires staff to use session by session outcome measures with young people, as well as at assessment, review and discharge stage. Care pathways within CYP IAPT are agreed, time-limited and evidence-based. Examples of the outcome measures staff used were goal based outcomes and a strengths and difficulties questionnaires (SDQ). Between April 2014 and March 2015, 2015 referrals were accepted across the three boroughs and seen at least once. From 1623 goals set in this year, 236 were from closed cases. Of these, 202 young people (86%) showed an improvement in their goal based outcome score. In addition, of the 1070 cases closed in the year, 1410 SDQ's (either young person, parent/carer versions) were completed on one occasion and 295 at review (132 by young people, 163 by parents/carers). Of these, 65% young people and 63% parent/carer scores improved between first and last ratings.
- Across the services, assistant psychologists collected and collated data from outcome measures for internal reporting and submission to CYP IAPT. They requested that staff used at least one outcome measure at two time points in order to be able to make a comparison. Clinical staff used session-by-session measures in their clinical work. Greenwich was the leading site for outcomes within the London CYP IAPT collaborative.
- Information from the trust showed that across boroughs, over 80% of young people had a goal-based outcome recorded in their notes as part of their care, meeting the trust requirement. The trust had a target of a minimum of 60% of young people receiving a review of

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their goals at their third appointment. This was not being met each month by services as records demonstrated, the average review rates for January and February 2016 were 55%.

- Staff participated in some clinical audits. For example, care plan audits and an audit of prescribing of medicines for attention deficit hyperactivity disorder (ADHD) in children and adolescents. Audit of prescribing of medicines for ADHD in children, adolescent and adults, staff submitted data to a quality improvement programme at the Royal College of Psychiatrists 2013 and again in 2015. Results showed that before treatment, in a sample of eight records, staff recorded blood pressure, height and weight in all eight. Staff recorded cardiovascular risk in six of eight records and heart rate in seven of eight records. Three months after treatment, staff recorded heart rate, blood pressure, height and weight in all eight records.

## Skilled staff to deliver care

- Teams were made up of a range of professionals including nurses, psychiatrists, child psychotherapists, clinical psychologists, social workers and family therapists. Staff from the different disciplines felt their skills were valued as part of the multidisciplinary approach to care. This range of professionals meant services were able to deliver a range of interventions, including CBT, interpersonal psychotherapy, EMDR and systemic family therapy.
- Staff were supervised and appraised and accessed regular team meetings. There was a supervision matrix in place across all teams. Management staff received monthly reports which highlighted numbers of staff who had or had not received supervision. They said this had helped to identify the need for staff to record their supervision as taking place.
- Across all boroughs, clinical staff said they accessed both individual and peer supervision on a fortnightly or monthly basis and were supported with external CPD needs by the trust. Peer supervision took place within discipline. For example family therapists, nurses, psychotherapists and psychiatrists met monthly for peer supervision. The trust were to hold a nursing conference in May 2016 focussing on advances in practice. Administrative staff received supervision every six weeks.

- At Bexley CAMHS we observed the adolescent team mentalisation supervision group. This was a very reflective and functional meeting and we saw that time was used in a disciplined and useful way. The group helped staff to understand principles of mentalisation as well as practising them in the room. The mentalisation model was well embedded in the team's thinking and reflective practice was valued.
- All teams within the CAMHS services had weekly team meetings. We observed three team meetings for generic and adolescent teams within the boroughs. At the meetings we saw staff discuss new and/or complex cases and the risks in each case. At Greenwich adolescent CAMHS staff also discussed input from other agencies such as supported accommodation services. In Bexley CAMHS, we saw that staff considered and discussed goals and there was a person-centred approach to the discussions of the meetings we observed. Staff kept minutes from team meetings and these were available on a shared drive for staff to access. At Bromley CAMHS, one of the team managers introduced a template for the meeting in August 2015. Staff said this made the meetings structured and well organised. In addition, staff added information from clinical discussion onto the record system as the meeting went on, therefore eliminating the need for this to be done outside of meeting times.
- Forty-five clinical staff and an additional 12 supervisors and nine service leads from the three boroughs had received or were receiving training in line with the CYP-IAPT service transformation programme delivered by NHS England. Within the Greenwich adolescent service, staff also said there were plans for mentalisation training at The Anna Freud Centre.

## Multi-disciplinary and inter-agency team work

- Management staff from across boroughs met regularly. Clinical staff from different disciplines across the boroughs had several opportunities to meet regularly. A small number said links between the teams could be improved. Staff felt opportunities for joint working between the teams would be welcomed.
- Staff said that pharmacy support from colleagues within the trust was positive and there was a pharmacy

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information line for patients and families. The operational manager at Bexley CAMHS said they attended the community paediatric referral meeting most weeks.

- The trust were aware of a small number of incidents of young people who presented at A&E not being referred to CAMHS in a timely manner. These were reported as incidents, investigated and actions followed up with the staff or team concerned. Staff in the crisis services said they received referrals from A&E when a young person had turned up in a crisis situation. Staff at Greenwich Adolescent said there had been two occasions in the last 12 months when referrals had not been received that a young person was at A&E at the Queen Elizabeth Hospital. During the inspection we found one further example that staff at Bromley CAMHS had not been notified through their duty team that a young person had presented at an A&E on a Friday. Information was sent to a member of staff who did not access the information until the following Monday. This meant staff at A&E were unable to receive input or support from a CAMHS member of staff until the Monday. One parent said that liaison between CAMHS and A&E was not good as CAMHS had not been aware of their child being in A&E.
- Where a young person required inpatient care, there were nationally commissioned facilities based within local trusts. In addition, if no inpatient CAMHS beds were available, a bed on an adult ward had been allocated for emergency admissions. The trust had a protocol on the use of this bed in an emergency, which was under review at the time of inspection. There were 22 young people admitted to this bed in 2015, and six admitted in 2016 between January and April 2016.
- In Bromley CAMHS, a single point of access was established in December 2014. This was commissioned by the local authority and provided by a local charity. Originally, referrals from the single point of access were shared in writing, but the manager at Bromley CAMHS had changed this to weekly face-to-face meetings. This was to increase the effectiveness of information sharing and reduce time spent discussion referrals on the telephone. They made this change soon after the introduction of the single point of access after recognising this would make the system more efficient. Where services worked with other external agencies, there were no written interagency agreements in place outlining the roles and responsibilities allocated to each organisation. Having these agreements in place would be in line with recommendations made by the Quality Network for Community CAMHS based at The Royal College of Psychiatrists for interagency working.
- At Greenwich and Bexley CAMHS, parents felt there had been good link working between CAMHS and the local authority and felt staff handled transition into and out of other services well. Staff at Bexley staff said transition work started six months before a young person's 18 birthday, which is in line with recommended national standards. Staff said that if a referral came in and the young person was within three months of turning 18, the referral would be sent to adult services. Parent/carers at Bexley CAMHS said staff attended meetings at school and liaised very well with the school staff and felt there were good links with the youth offending service. Several parents said staff attended meetings with other teams and agencies about their child and there was evidence of this in the team meeting diary for Greenwich adolescent service. A drug and alcohol worker attended team meetings at Greenwich adolescent service and had utilised the therapy rooms at the service to meet a young person who did not want to attend the drug and alcohol service building.
- The operational manager at Bromley CAMHS said they were working on improving relationships with other agencies outside the trust. They gave an example of work with school nurses, following feedback that school nurses wanted more information from CAMHS, where it was appropriate CAMHS share this. They had attended a meeting with school nurses who fed back they were unhappy with young people not being seen sooner and not getting much feedback about care plans. At Bexley CAMHS, the learning disability and neurodevelopmental team was co-located with services such as speech and language, children's community nursing team and paediatrics.
- Where staff had seen they could offer advice to colleagues, they had done this. One example was that CAMHS staff created a list of key tasks and responsibilities for the nurses in the local A&E department in the instance a young person presented their in crisis. This was in response to concerns raised by

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the nurses in A&E and included information on observation levels, training in physical intervention, handovers, confidentiality, reference to diversity and what documentation is necessary for them to keep.

- CAMHS provided group supervision every three months for school nurses bands five through seven. One school nurse in Bexley was seconded two days a week with CAMHS. This was to pilot a link with schools and CAMHS. The trust employed a youth participation based within CAMHS who went into schools to ask for volunteers to set up a trust youth forum. Once established, this would feed into the trust patient experience group.

## **Adherence to the MHA and the MHA Code of Practice**

- Training in the Mental Health Act 1983 (MHA) and the MHA Code of Practice was not mandatory for all staff and was available as an e-learning module. Not all staff had a thorough understanding of the MHA and the MHA Code of Practice. There were no young people being treated under a community treatment order.

## **Good practice in applying the MCA**

- Training in the Mental Capacity Act 2005 (MCA) was not mandatory and staff said they would seek advice from a

psychiatrist within their team if needed. There was no specific training for the application of the MCA with young people aged 16 and over, which is covered in chapter 12 of the MCA Code of Practice.

- At Greenwich Adolescent service, information about the MCA was displayed in the staff kitchen.
- For people who may have impaired capacity to consent, we found evidence in four records that staff assessed and recorded this appropriately. Staff at Bexley CAMHS were developing a capacity assessment form as they felt the current documentation about capacity and consent was unclear.
- The trust provided training about Gillick competence within safeguarding level 3 training. Across services, 90% of staff had completed this. The training included a definition of Gillick competence, but did not outline how to assess this. Gillick competence is concerned with determining whether a child or young person is able to consent to their own medical treatment, without the need for parental permission or knowledge. Staff described when this would be applied and gave examples of recent Gillick competence assessments.

# 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

- All young people and parents/carers we spoke with were very positive about the staff and the care they received. Parents/carers said they had received a good service and their family was provided with the support and input they needed. Several parents and young people said they were grateful for the service and the impact it had made on their lives.
- Parents/carers and young people said that both clinical and administrative staff were extremely kind and respectful when they first met them. They felt staff really listened to them and one person said the quality of listening was much better than that they had had in other services. Another said they could not speak highly enough of staff. One young person said they could not recommend the service enough and that it had led to their remission and still being alive.
- Parent/carers and young people said staff were friendly and caring and also very flexible and approachable. One parent/carer gave an example of the staff maintaining consistency although the team was changing, they did not transfer care between clinicians. They said staff were accessible when needed and would be available to speak on the phone or would return calls within the day. One young person said they were nervous before their first appointment but nothing intimidated them once they arrived, the waiting area and the staff were nice. Parents/carers and young people felt staff created a relaxed and calm environment.
- One parent/carer felt they had to wait a long time to access the service, although once they were receiving care, they felt staff listened to them and provided very helpful support.
- Young people and parents/carers said staff discussed confidentiality with them and explained what this was and that the young person could make a choice about this where appropriate. One parent/carer was able to give a clear description of confidentiality and how this was relevant to the care their child was receiving. There was clear evidence in the care records of one person that staff had considered the young person's wishes in the context of sharing information.

- One parent said that staff initially discussed confidentiality with them, but had not repeated the information over a number of years.
- We received 34 anonymous comments cards during the inspection and 29 of these contained positive comments about how staff treated service users and communicated well with them. The negative comments were about waiting times to access the service. One comment from Bexley CAMHS was that the service was busy and you did not always see the same doctors.

### The involvement of people in the care they receive

- Parents/carers and young people across the services within the three boroughs said they felt involved in decisions and discussions about their care. They said that staff gave them information about the types of treatments available and spoke with them about which one they wanted. Parents/carers said they felt staff tailored treatment to their child and family's particular needs.
- The services had developed a care plan template document for use across services which staff felt was more young person friendly than the template available on the electronic system. This was completed with the young person during the assessment period and sent out as a letter. Parents/carers and young people said they had copies of these letters and were aware of the plans for their care. Two parents/carers were not aware that this letter was the plan for care. For one family, both the young person and the parent/carer had their own copy of the information. In Greenwich adolescent service, three parents/carers said they had regular meetings or feedback from staff. Parents/carers said they received copies of care plans when they were updated. Staff from a residential home said CAMHS staff
- Across all services, several parents and carers said staff gave appropriate support to the whole family. One young person gave an example of their family being supportive of them after the whole family was offered support from CAMHS. One parent said that staff had identified the needs of other children in the family and suggested appropriate support for them.
- There were several family support groups available for parents. In Bromley CAMHS, there was a parenting group for those with children with ADHD. In Bexley CAMHS, there were three sessions of a mood and mind group



# Are services caring?

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open to parents, who met at the same time as a young people's group, but in a separate room. One parent in Bexley CAMHS said they found the group they attended very useful and felt more parents would benefit from attending as staff had put a lot of effort in.

- Information about advocacy services was not displayed clearly across all services. Advocacy services are where a person independent of a trust to support a service user to defend or promote their rights, speak out about issues that matter to them, access information about a service and/or explore choices and options about care.
- At Bromley CAMHS, details about advocacy services were not displayed in the waiting room. This was highlighted to staff and leaflets were ordered on the day of inspection. Two staff we spoke with were unclear about who provided advocacy services. Three parents had not been told by staff who provided advocacy services and what this was. One young person was aware of the advocacy service.
- At Greenwich adolescent service, details of how to contact advocacy services were displayed on the wall, although there were no information leaflets about what an advocate offers. Three parents were not aware of the advocacy service they could access. One member of staff was also not aware of the advocacy services.
- At Bexley CAMHS, where Greenwich generic CAMHS were also based, there were leaflets about advocacy services from the organisation Mind available in the waiting room. One member of staff, five parents/carers and young people were unaware of the advocacy service and how these were accessed.
- The trust employed a participation worker for the children's services directorate who worked across the three boroughs. They supported engagement with young people and families in order to gather their feedback about services and support involvement in service development. A participation group ran each week and was open for people aged 12 to 20. The participation worker was able to work out of the 9am to 5pm hours in order to run groups for young people to attend after school. Five or six young people attended this group regularly, and others attended on an ad hoc basis. The participation worker had adapted training for interview panels for young people who had been involved in interviewing new staff. There was information on how to get in touch with the participation worker in the waiting room and clinicians could refer young people directly to them. The participation worker gave examples of group work as well as individual work they had done with young people, for example with those who did not wish to attend groups, but were interested in having their artwork displayed at the service.
- The participation worker met regularly with participation workers in other organisations for peer support and sharing good practice. The participation worker was clear on how to handle risk and gave examples of when they had engaged clinical staff when they had concerns about a young person. They developed a terms of reference for actions if they had concerns which they got young people's feedback on before it was signed off by management staff. This terms of reference included informing the young person of the action they would take if they felt it necessary to speak to a clinician due to concerns about the individual.
- There was also a patient experience group attended by staff and young people that met every six weeks. Staff read written comments from patient experience questionnaires at this meeting.
- Young people and parents/carers were able to give feedback on the experience of care they received. Staff collected the Commission for Health Improvement Experience of Service Questionnaire (CHI-ESQ). Between October 2015 and September 2015, services received 270 responses from young people and 327 from parents/carers. Parent/carer satisfaction was greater overall.
- Staff collected CHI-ESQ responses for Bromley CAMHS between April 2014 to March 2015 from 61 young people and 82 parents. At Greenwich adolescent CAMHS, CHI ESQ results collected between October and December 2015 were displayed in the waiting room. The results showed that between 91% and 99% of young people and parents said they felt listened to, felt it was easy to talk to a CAMHS professional and they had received good help. Additional feedback questionnaires from 30 service users across the Greenwich CAMHS sub teams showed that over 90% of parents/carers felt they were treated with dignity and respect. They felt they were involved in decisions and staff gave them enough information. Also, 67% said they felt their quality of life

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had improved. For young people, 100% felt involved in their care to some extent and 97% felt staff had given them enough information. 79% felt their family had been supported and 48% felt their quality of life had improved.

- Staff uploaded written comments from CHI-ESQ to a spreadsheet that managers could access. The comments were analysed by managers and the patient experience group.
- Parents and carers said they felt they had the opportunity to raise issues if needed and felt staff encouraged feedback. Two parents/carers whose child accessed Bexley CAMHS were not aware of how they could give feedback on the service.
- Each service had a suggestions box in the waiting room. At Bromley CAMHS the suggestions box was located behind the water dispenser, making it harder to see. Each service also had a 'you said, we did' board on display. These outlined changes staff had made to the service or the environment following feedback.
- Each year services carried out a systematic friends and family test. For one month, staff ask everyone to complete the form. Six months before the inspection there was a patient experience half day. Young people presented to clinicians within the trust about their experience of using services.
- Across the services, there were several thank you cards on display in offices and in staff kitchens. Managers said they encouraged people to talk about compliments.

# 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

- Average waiting times did not go over the trust maximum target of a 13 week wait. Waiting times were longest for the generic teams and learning disability and neurodevelopment teams. The operational manager at Bexley CAMHS had dedicated two members of staff to carry out assessments from April 2016 onwards in order to maintain a through flow of assessments.
- In April 2016, senior staff at Bromley CAMHS carried out an activity analysis in response to growing demand on the service and its limited capacity. This showed that from December 2014, there was a loss of 19% clinical staff due to restructuring. There was also an increase in referrals over time, including an increase in the acuity of referrals. Average waiting times increased between February 2015 and February 2016 from four weeks to seven weeks. The analysis had six areas of risk outlined because of pressures from the demand and capacity of the service.
- Each borough had a team that offered immediate response in a crisis. Staff would see a young person the same day if necessary. Otherwise, staff carried out assessments in five working to 15 working days. Staff carried out an analysis of self-harm amongst children and young people in Greenwich and reported the results in April 2016. This identified the needs of the population and demonstrated the type of work the crisis teams were involved in. The report stated that over the past three years, the number of young people presenting to the adolescent team with self-harm, suicidal ideation and/or behaviour increased by 43%.
- Staff that processed referrals were aware of the classification of urgent and non-urgent referrals and would escalate these appropriately. Eight young people and parents/carers who had accessed these crisis services said they were seen quickly.
- At Greenwich adolescent service we observed a daily referral meeting. Staff discussed safeguarding issues and joint working with the police to respond rapidly to information. At Bexley CAMHS the manager introduced a daily referrals meeting, rather than weekly, to assess risks faster. This meeting was attended by the operational manager and a senior clinician and was still in a pilot phase to assess its effectiveness. Once the team was fully recruited to, the manager planned for staff to call young people and families on the same day to update them on their referral time. At the time of inspection, a duty worker called only very risky cases on the day.
- At Bromley CAMHS, the out-of-hours duty rota was in place offering telephone consultation and assessment at A&E at certain times. Some staff felt that the out-of-hours service was helpful but lack of resourcing to support it. They said there were gaps in the rota. Where there were gaps, the general trust out-of-hours service were available.
- Parents/carers said staff were always available when they contacted them or would call back within the hour.
- The trust had an age appropriate bed designated on an adult acute ward for young people who were unable to access a CAMHS inpatient bed. Senior management staff were updating the policy on the use of this bed at the time of inspection. It was last updated in January 2013. Senior management staff said they had met in April 2016 to discuss how to implement data recording for the use of the bed as this was not in place.
- Clear criteria for acceptance to the service were outlined on the service website. Information also included contact details for the teams if a referrer had a question or wanted to make an emergency referral. The operational manager at Greenwich CAMHS said they planned to develop a set of information sheets to let people who do not meet the acceptance criteria know where they could find help and support. The first one had been developed and would be passed to the young person participation group for their feedback.
- Staff took proactive steps to re-engage with people who did not attend (DNA) appointments. Between January and March 2016, average DNA rates were between 11% and 13.5% across the boroughs. The trust target for DNA rates was 11% or below.
- Young people and parents/carers we spoke with said they could choose their appointment times and felt this was easy to do, as staff were flexible.

### The facilities promote recovery, comfort, dignity and confidentiality

# Are services responsive to people's needs?

Good 

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

- At each service there were a range of clinical therapy rooms available which were booked using an electronic system. Staff said room bookings were well managed and rooms were available when needed.
- Therapy rooms were clean, light, and comfortable and contained several toys and resources. The temporary building for Bexley CAMHS and several sub teams of Greenwich CAMHS was in need of redecoration, but services were relocating to a refurbished building within 12 months. Rooms had adequate sound proofing to allow confidential conversations to take place. There was a lot of young peoples' artwork on the walls. Staff had asked young people for feedback about how to improve the waiting room and had put things in place, such as a radio.
- At Greenwich adolescent service the waiting room was age appropriate, it had books for adolescents and a small number of activities and toys available for younger children. There were also leaflets relevant to adolescents. For example, information leaflets about (LGBT) groups, drug and alcohol services and smoking cessation services. There were also posters from the LGBT organisation Stonewall throughout the service, including a poster about LGBT history month 2016.
- Eleven young people and parents/carers said they received clear information about CAMHS before their first appointment. This was through verbal and written explanation with staff and also from a service DVD sent to them. Three young people and parents/carers said they received limited information before their first appointment, however at the first appointment staff explained things to them and put them at ease.
- Young people and parent/carers said that after their assessment, staff gave them information about treatment verbally. Parents at Greenwich adolescent service said that a locum psychiatrist was not able to give as much information about medicines as permanent members of staff had. The services did not have a range of written information leaflets about treatments that staff provided to young people and parents regularly. Staff said this was an area they could improve on.
- Each service had a board in or near reception that had pictures of staff and their names. At Bromley CAMHS staff had not updated the board to include staff that had started working in the team two months earlier.
- Waiting areas had a number of leaflets signposting people to external agencies and information about CAMHS. Waiting rooms had information about who the first aiders were and when fire alarm tests would take place.
- In 2015, the trust launched a self-help and referral website called 'headscape'. This website was created with the input of young people and provided detailed information about sources of self-help and different mental health issues. There was information throughout communal areas in the Greenwich adolescent services about the website. This website also had information and contact details for services to contact in an emergency, including Child Line and the Samaritans.

## Meeting the needs of all people who use the service

- All services had a bathroom allowing access with a wheelchair and therapy room facilities available on ground floors. At Bromley CAMHS, which also had therapy rooms on other floors, a lift was accessible between 9am and 5pm.
- Throughout the services and waiting rooms there were no leaflets available in a language other than English. At Bromley CAMHS there was a poster about how to access information in other languages. There was no information on how to access information in easy read or braille format. At Bexley CAMHS there was a welcome sign at the entrance in several different languages.
- Staff said they could access interpreters through the trust and we saw evidence of this in care records.
- Young people and parent/carers said staff did not routinely ask about any cultural or religious needs in relation to their care.

## Listening to and learning from concerns and complaints

- Most young people and parent/carers were aware of how to make a complaint, however some were not. One

# Are services responsive to people's needs?

Good 

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

parent in Bromley CAMHS had not been given advice by staff to follow the trust complaints procedure when they wanted to make a complaint. This was fed back to management staff on the day who acted upon this.

- Complaints received by the services were presented at manager meetings. Operational managers investigated formal complaints. If complaints were upheld, staff developed an action plan to address them.

- Staff received information about the outcome of complaint investigations. Staff were able to describe changes that had taken place within their services following complaints.

# Are services well-led?

Good 

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

## Our findings

### Vision and values

- The trust values of having a user focus, excellence, learning, being responsive and partnership and safety were displayed in staff offices and in communal areas.
- Staff were aware of who the most senior managers in the organisation were. They were also aware of the direct management structure within their teams. Staff said there was a very connected leadership group and a helpful and supportive management team.

### Good governance

- Not all-medical equipment was calibrated to ensure their readings were accurate. There was no trust wide system in place across the services to remind staff when calibration was due.
- We found evidence that feedback and learning from incidents took place effectively within a borough, but not as effectively across services in the three different boroughs.
- Staff did not regularly participate in clinical audits.
- Managers could access information about the team, such as training rates and supervision rates, on simple and accessible databases. Information could be broken down by team and by individual clinician. Mandatory training rates were high and staff said they felt supported and accessed regular supervision. Compliance with annual appraisals for staff was high.
- Operational managers attended monthly CAMHS leadership meetings. Managers discussed risks in this meetings as well as incidents and complaints.
- Each service had an operational policy. Staff could access all policies on the trust intranet. The operational manager at Bromley CAMHS said they were trying to bring together local policies and procedures to ensure boroughs reflective of one another. Teams discussed incidents and complaints within their own services, however we could not find evidence that learning from incidents took place effectively across boroughs.

- Management staff had introduced several initiatives through pilot and review systems to improve efficiencies and effectiveness of teams. One example was the physical health clinic in Greenwich CAMHS.
- Staff accessed regular business meetings. The operational manager from Bromley CAMHS said they presented the information that they send to commissioners to the staff team in one meeting, which helped staff to see why consistent information recording was essential.
- Information from the trust showed that the percentage of non-medical staff that had an appraisal in the 12 months before the inspection was 88% in Greenwich, 82% in Bromley and 75% in Bexley. Of medical staff, 100% of were revalidated. Operational managers received monthly reports showing appraisal rates and who was due to have one.
- Administrative staff were part of the teams in each borough and one administrative manager worked across all three boroughs. The administrator manager was on the trust's training panel for new administrative staff across the trust.
- The trust had designated a bed on an adult acute ward for use when an inpatient CAMHS bed was not available. The trust had a protocol on the use of this bed. This policy outlined that consultant responsibility lay with the staff in the adult service, however, CAMHS staff should be closely involved with care planning and support of the young person. We found several examples where staff had not followed the procedures outlined in the trust protocol. One example was that for the most recent admission, an attempt to find an inpatient CAMHS bed following a mental health act assessment had not taken place. Secondly, records showed a care plan with input from CAMHS staff was not created until 18 days after admission. In addition, staff on the adult ward did not receive regular training relating to working with people under 18.

### Leadership, morale and staff engagement

- Most staff we spoke with were aware of the whistleblowing policy. Locum staff had less understanding of this policy. At Bromley CAMHS, we saw that whistleblowing was a standard item on the management meeting agenda. Staff said they felt able to raise concerns without fear of victimisation.

# 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.

- At Greenwich adolescent service, several staff said the restructure of CAMHS was managed well. However, the restructure had caused more difficulties in continuous service provision at the generic Greenwich team. Some staff in this team felt morale was good and others felt it was still improving following the restructure. Managers were aware of the difficulties the team had experienced and the impact this had on morale.
- In Bexley CAMHS, staff described team morale as good.
- In Bromley CAMHS, staff said the changes during the restructuring and the introduction of the out-of-hours duty work affected heavily on staff. Staff said morale had been low however, it was improving. An external facilitator attended meetings between staff and senior managers to address staff concerns and feelings. This was introduced at the request of staff.
- Staff were very positive about their colleagues and said they work well together. Teams had supportive and friendly atmospheres and consisted of responsive, enthusiastic people. They said patient care at the forefront of everyone's minds. Staff across teams were positive about team leaders. They gave examples of the positive impact of team leaders, such as being very visible and a positive influence. Managers were very positive about their teams, describing them as fantastic and going above what was expected in their work. Managers collected positive comments from experience of service questionnaires and regularly shared these with staff.
- The trust supported staff in leadership development. Several managers had developed their management roles within the trust. Staff from across the three boroughs had attended internal leadership courses. Staff said the trust encouraged internal promotion and felt that they wanted staff to come and to stay.

## **Commitment to quality improvement and innovation**

- Services had adopted and implemented several initiatives to improve service provision. This included the THRIVE model of care and the use of CYP IAPT.