

North East London NHS Foundation Trust

# Specialist community mental health services for children and young people

## Quality Report

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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RATX8	Trust Headquarters	EWMHS Colchester	CO4 9YQ
RATX8	Trust Headquarters	EWMHS Chelmsford	CM1 1QH
RATX8	Trust Headquarters	EWMHS Harlow	CM20 1DG

This report describes our judgement of the quality of care provided within this core service by North East London 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 North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East London 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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

#### **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 found the following areas of good practice:

- At the April 2016 inspection, systems to monitor changes in risk for children and young people waiting for assessment and treatment were not robust and not all patients had a care plan. At this inspection, we found that this had improved. Patients who had been assessed or had commenced treatment had risk assessment and management plans in place. All patients had a care plan. However, further improvement was needed as half of the care plans we looked at did not include goals for recovery.
- Safe staffing levels were maintained, vacant posts were being recruited to and agency staff covered the majority of unfilled posts. Whilst caseloads were increasing, they were manageable and were kept under regular review. Teams were made up of a wide range of professionals. Staff were skilled and experienced. Eighty percent of staff had completed mandatory training.
- Staff made comprehensive assessments of the children and young people referred to the service. They identified the patients' physical health needs and addressed them. They delivered treatment and therapies in accordance with NICE guidance.
- Staff were compassionate, demonstrated an in-depth knowledge of the young person's circumstances and were respectful towards them. Young people felt listened to and said that their views were valued. The majority of carers were positive about the service they had received. They said that staff appeared to understand their child and their needs. Young people were involved in the development of the service and in recruitment of staff.
- Managers had put robust governance systems in place to monitor the effectiveness and safety of the service. Systems to identify themes from incidents across the directorate were in place.

- Team managers were experienced and led staff teams effectively. Service wide changes were being made as a result of learning from a recent cluster of serious incidents. Robust systems were in place to safeguard patients.

However, we found that following areas the trust needs to improve:

- The trust were not meeting their target times for referral to assessment of 12 weeks. Increasing referral rates meant that it was unlikely this would improve. Teams knew how they were performing against targets and were working hard to ensure patients were seen as quickly as possible. The trust were also not meeting their referral to treatment target time of 18 weeks, however compliance against this target was better and 92% of children and young people were being seen within 18 weeks.
- Alarm systems to ensure the safety of staff and patients were not in use.
- Whilst the majority of physical health tests were carried out by GPs, some checks were carried out by staff. Not all equipment used in in these checks was regularly calibrated. At some sites children and young people's privacy and dignity were compromised as height and weight measurements were taken in a corridor.
- Staff did not clean toys at the Chelmsford site regularly. This could present an infection control risk.
- Whilst staff were receiving regular supervision, at Harlow there was no system to monitor the content and frequency of supervision.
- Staff demonstrated a sound understanding of the Mental Capacity Act and Gillick competency. However, where decision specific capacity assessments were made these were not recorded in patients' records and there was no system to monitor the appropriate use of the Mental Capacity Act.

# Summary of findings

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

### Are services safe?

We found the following areas the trust needs to improve:

- Alarm systems to ensure the safety of staff and patients were not in place in at Chelmsford and Harlow. Whilst personal alarms were available at Colchester, these were not widely used.
- Whilst the majority of physical health tests were carried out by GPs, some checks were carried out by staff. Not all equipment used in in these checks was regularly calibrated.
- Toys at the Chelmsford site were not regularly cleaned, which could present an infection control risk.

However, we found the following areas of good practice:

- At the April 2016 inspection systems to monitor changes in risk for children and young people waiting for assessment and treatment were not robust. At this inspection patients who had been assessed or had commenced treatment had risk assessment and management plans in place.
- Safe staffing levels were maintained, vacant posts were being recruited to and the majority of vacant posts were covered by agency staff in the interim.
- Whilst caseloads were increasing, they were manageable and were kept under regular review.
- Staff followed safe lone-working processes.
- Eighty percent of staff had completed mandatory training. Staff had received safeguarding training and robust systems were in place to protect and safeguard children.
- Incidents were reported and regularly reviewed. Systems to learn from incidents, including serious incidents were in place and changes were implemented as a result of this learning.

### Are services effective?

We found the following areas of good practice:

- At the inspection in April 2016, not all children and young people had a care and treatment plan in place. At this inspection, all patients had a care plan. However, further improvement was needed as half of the care plans did not include goals for recovery.
- Children and young people were comprehensively assessed. Their physical health needs were assessed and addressed. The service measured outcomes, to see how children and young people benefitted from their treatment.

# Summary of findings

- Staff were skilled and experienced and undertook additional training.
- Psychological therapies were delivered in line with NICE guidance. The service worked closely with partner organisations, for example “in reach” work with schools.
- The teams were made up of a wide range of professionals including psychiatrists, psychotherapists, family therapists, nurses, psychologists and social workers. All staff including agency staff received a local and corporate induction.

However, we found the following areas the trust needs to improve:

- Whilst staff were receiving regular supervision, at Harlow there was no system to monitor the content and frequency of supervision.
- Staff demonstrated a sound understanding of the Mental Capacity Act and Gillick competency. However, where decision specific capacity assessments were made these were not recorded in patients’ records and there was no system to monitor the appropriate use of the Mental Capacity Act.

## Are services caring?

We found the following areas of good practice:

- Staff were compassionate, demonstrated an in-depth knowledge of the young person’s circumstances and were respectful towards them. Children and young people were treated in age appropriate way and were involved in their treatment.
- Young people felt listened to and that their views were valued. Young people were positive about the service they received and praised the staff for their caring approach.
- The majority of carers were positive about the service they had received. They said that staff appeared to understand their child and their needs.

## Are services responsive to people's needs?

We found the following areas of good practice:

- Referrals into EWMHS were screened daily and young people could gain quick access into the service with urgent referrals being seen within 14 days. Children and young people could be easily referred to specialist crisis services that supported patients at home and operated out of hours.

# Summary of findings

- The service could access rooms in GP surgeries and other locations to allow children, young people and families, to attend appointments nearer to where they lived. There were interpreter services for young people and families who needed them.
- Young people were involved in the development of the service and in recruitment of staff.

However, we found the following areas the trust needs to improve:

- The trust were not meeting their target times for referral to assessment of 12 weeks. Increasing referral rates meant that it was unlikely this would improve. Teams knew how they were performing against targets and were working hard to ensure that children and young people were seen as quickly as possible.
- The trust was also not meeting their referral to treatment target time of 18 weeks. However compliance against this target was monitored by the trust and 92% of children and young people were being seen within 18 weeks.
- At some sites, children and young people's privacy and dignity were compromised as height and weight measurements were taken in a corridor.

## Are services well-led?

We found the following areas of good practice:

- Managers ensured there were thorough and effective checks on the quality of the service.
- Team managers were experienced and led staff teams effectively.
- Robust governance systems were in place that monitored the effectiveness and safety of the service.
- Systems to identify incident themes across the directorate were in place. Service wide changes were being made as a result of learning from a recent cluster of serious incidents.
- Staff had the opportunity to develop their leadership and clinical skills.

# Summary of findings

## Information about the service

North East London NHS Foundation Trust provides specialist tier 3, community mental health services for children and young people in the county of Essex and four London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest.

Within Essex, North East London NHS Foundation trust also provides primary mental health services for children and young people. Within Essex, these integrated primary mental health services and specialist mental health services for children and young people are called Emotional Wellbeing and Mental Health Services (EWMHS).

EWMHS provide care, treatment and support to children, young people and their families who present with a range of mental health and emotional well-being issues including anxiety, depression, trauma, psychosis and self-harming behaviour. The service also had specialist teams to support children and young people with eating disorders and those children and young people with a learning disability.

Seven EWMHS teams provide support to children, young people and their families or carers. In addition there are three crisis teams. During our inspection we visited EWMHS teams based at Colchester, Harlow and Chelmsford.

## Our inspection team

The team that inspected this core service consisted of one inspector, one specialist advisor who was a nurse with a background working in child and adolescent mental health services, an occupational therapist specialist advisor with a background working in child and

adolescent mental health services and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, mental health services.

## Why we carried out this inspection

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We undertook this short notice announced, focused inspection in August 2017 in response to information of concern regarding the unrelated deaths of three young people who were all known to the service. We also followed up the regulatory action from the previous comprehensive inspection at the three teams we inspected.

At our last comprehensive inspection of the trust, in April 2016, we rated specialist community mental health services for children and young people as good overall. We rated specialist community mental health services for children and young people good for safe, requires improvement for effective, good for caring, good for responsive and good for well-led.

Following the April 2016 inspection we told the trust that it must take the following actions to improve specialist community mental health services for children and young people;

- The trust must ensure all children and young people have a care and/or treatment plan.
- The trust should ensure that all risks to the health and safety of young people receiving care and treatment is assessed to manage any such risks. There should be a more pro-active system in place to assess the risks to children and young people while they were waiting for assessment or treatment.

We issued the trust with a requirement notice in relation to regulation 9 (person-centred care) of the Health and Social Care Act, (RA) Regulations 2014.



# Summary of findings

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- visited three community child and adolescent mental health teams in Essex and looked at the quality of the environment and observed how staff were caring for patients
- spoke with seven young people who were using the service

- spoke with 33 carers or parents
- received 11 comments cards completed by patients and carers
- spoke with two area managers and four team managers
- spoke with 14 other staff members; including psychiatrists, nurses, psychotherapists, psychologists and social workers
- attended and observed an initial assessment for a young person, a consultation session with the learning disabilities team, a senior leadership team meeting, a complex case pathway discussion group and a clinical discussion group
- looked at 19 patient care records
- looked at a range of policies, procedures and other documents relating to the running of the service

## What people who use the provider's services say

We spoke to seven young people and 33 family members or carers. Most spoke highly of and were positive about the service and its staff. They said staff were compassionate, caring and offered interventions that had made a difference to them.

Some carers said the wait for assessment and treatment was too long and that they were not fully involved with the care plans for their child. Most carers and young people told us the environment in which they had their clinical appointments was clean and comfortable.

The majority of comments cards received from young people and their carers were positive about the service. All of them said they felt listened to and supported by staff.

## Areas for improvement

### Action the provider **MUST** take to improve

- The trust must ensure that appropriate alarm systems are in place at all sites.

### Action the provider **SHOULD** take to improve

- The trust should ensure that children and young people are assessed and commence their treatment within target times.
- The trust should ensure that all care plans include the patient voice and are recovery orientated.

# Summary of findings

- The trust should ensure that team environments are appropriately maintained.
- The trust should ensure that staff are trained in the use of fire evacuation chairs, where these are available.
- The trust should all ensure that all equipment used to monitor physical health is regularly calibrated.
- The trust should ensure that where decision specific capacity assessments are undertaken, these are appropriately recorded in patient care and treatment records.
- The trust should ensure that suitable arrangements are in place to promote the privacy and dignity of patients when physical health observations are taken.
- The trust should ensure that toys at all sites are regularly cleaned, and that records to support this are maintained.
- The trust should ensure that systems to monitor the content and frequency of supervision are in place at all sites.

## North East 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
EWMHS Chelmsford	Phoenix House
EWMHS Colchester	Phoenix House
EWMHS Harlow	Phoenix 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.

All staff had received training in the Mental Health Act. Staff understood the requirements of the Mental Health Act, the code of practice and its guiding principles, in relation to children and young people. However, this was rarely used in the service. At the time of inspection no children or young people were subject to a community treatment order (CTO).

Consultant psychiatrists across the service were Section 12 approved doctors who had completed additional training in the Mental Health Act and could assess young people under the Act.

Staff had access to administrative support and advice on the implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were. The provider had relevant policies and procedures in place and staff knew how to access these.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

Ninety five per cent of staff had completed training in the Mental Capacity Act 2005 which met the trust's target. This course was mandatory for all staff.

The Mental Capacity Act only applies to young people who are 16 years or older. Gillick competency (a test in medical law) is used to decide whether a child younger than 16 years competent to consent to medical examination or treatment without the need for parental permission or knowledge. Staff had a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles and Gillick competency. There were no recent examples of

children and young people having had their capacity assessed for specific decisions. No children or young people were subject to best interests decisions at the time of our inspection.

Staff knew where to get advice regarding capacity issues and the provider had a policy relating to capacity. However, staff and managers told us that if a decision specific capacity assessment did take place, this would not be formally recorded. Staff were unclear what trust policy was in relation to this. No audits or other arrangements to monitor adherence to the Mental Capacity Act were in place.

# 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

- During the course of our inspection, the provider completed a ligature risk assessment at each site we visited. We saw the draft ligature risk assessment for the Colchester site during our inspection. This identified potential ligature risks within the building and the measures that should be put in place to manage or mitigate them.
- Interview rooms at all three sites were not fitted with alarms. At the Colchester site personal alarms were available to staff but we saw that these were not widely used. At Harlow the alarm system had been deactivated. Staff said they had requested the provision of an alternative alarm system, but were not aware of the progress of this. At Chelmsford staff told us they would raise the alarm by using their mobile phone or shouting. At some sites, for example Chelmsford, interview rooms were situated several floors down from staff work areas, which meant that staff were isolated when using interview rooms which increased risk that colleagues would not be aware of and respond to staff requiring assistance.
- None of the sites we visited had designated clinic rooms. Medical and nursing staff did have access to equipment to take physical healthcare observations such as blood pressure, pulse, weight and height. We found that equipment for taking physical observations such as height, weight and blood pressure was not always calibrated. This meant that the measurements may not be accurate. At Colchester we did not find any paediatric blood pressure cuffs on site. More complex physical healthcare observations, for example blood tests were undertaken by the child or young person's GP.
- First aid kits were available and in date.
- Electrical equipment had been tested for safety and equipment was visibly clean.
- All three sites were visibly clean and had comfortable furnishings. Team sites at Harlow and Chelmsford were well maintained. However, at Colchester the premises

were not well maintained. We saw that some areas of the building were badly affected by damp. This had been escalated within the trust, however, responsibility for maintenance works sat with a private landlord. Electrical equipment testing was in date in all locations.

- Staff adhered to infection control principles, including handwashing. Information about infection control was displayed at each of the sites we visited. However, there were no cleaning rotas in place for toys at the Chelmsford site, which could pose an infection control risk.
- All three locations had an identified fire warden, fire extinguishers and fire exit signage visible. An evacuation chair was available at Harlow. However, staff had not received training in how to use it in case of an emergency.

### Safe staffing

- Staffing levels were sufficient to meet the needs of patients. At the time of inspection each team we visited had vacancies. Across the whole service the vacancy rate was 26.5% for July 2017. All vacancies were being actively recruited to, some posts had been appointed to, with staff due to start. Managers were able to use locum agency staff to cover the majority of unfilled posts.
- Staffing establishments had been calculated using guidance from the Royal College of Psychiatrists.
- Caseloads averaged between 35-45 cases for clinicians and between 70-100 for doctors, which was in line with trust targets. Team managers and service directors reviewed clinicians' caseloads regularly through supervision and business meetings. Across the services each full time clinician would offer 16 face to face appointments with children and young people each week as a minimum. Team managers and staff told us that caseloads were increasing as the number of referrals to the service rose.
- Managers and psychiatrists told us that there was rapid access to a psychiatrist from Monday to Friday between 9 am and 5 pm and there was an on-call rota to provide emergency medical cover out of hours.

# Are services safe?

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- Sickness rates were low for psychiatrists at 0.95%. Sickness for Chelmsford was the highest across the service at 5% the lowest sickness was at 0.42% at Colchester. Recently the service had changed from paper records to an electronic record therefore the figures for sickness provided were from May 2017.
- Overall there was a high average turnover rate of 23% for substantive staff across all three locations including psychiatry. Managers told us that this was due to staff retiring or moving to different areas. Staff turnover and recruitment was reviewed at monthly business meetings.
- Eighty per cent of staff had completed mandatory training courses.

## Assessing and managing risk to patients and staff

### Assessment of patient risk

- We reviewed 19 care records across the three sites. Whilst all patients had a risk assessment in place, two care records did not have a risk assessment in place that reflected the current risks for the young person.
- All assessments were completed at the time of the initial assessment and in conjunction with the young person. The service used a flagging tool to ensure that risk assessments were updated at least every six weeks. For the majority of patients risk assessments had been updated more frequently when there had been a change that affected their risk presentation. For two patients risk assessments had not been updated to reflect recent events.
- At the time of this inspection, services were using a generic risk assessment tool that had not been developed for use within CAMHS. However, managers told us that they were introducing a new risk tool with staff due to have training followed by implementation by the end of September 2017. The new risk tool had been developed by the service director and senior managers and addressed risk issues relevant to children and young people.
- When needed, staff created and made good use of crisis plans which were shared with patients and their carers'.

### Management of risk

- At the April 2016 inspection we had found that systems to monitor changes in risk for children and young

people waiting for assessment and treatment were not robust. During this inspection we found that this had improved. Systems were in place to identify and respond to changes in risk for patients waiting for assessment. Young people were monitored whilst waiting for treatment. Following initial assessment families were made aware of how to contact EWMHS if there was a change in the young persons' presentation. Their first point of contact was the clinician who had assessed them, which ensured consistency of care. Staff responded appropriately if contacted by patients or carers who were waiting for their treatment to start. At Harlow children and young people were given a hand written care plan to take with them following their appointment. This was a trial project that was being audited by the manager and we saw that these plans included information on what to do if the young persons' health or presentation deteriorated.

- There was a safe lone worker policy in place that staff followed. Appointments were logged and the addresses registered at each service location. Practitioners would 'buddy up' with a colleague who would call them if they had not made contact following the community visit. Where possible staff would meet with children and young people in schools or satellite offices. Where the patient was not known to the service a home visit would be undertaken by two members of staff. Managers told us that no clinician would see children and families outside of office hours unless it was in a hospital or place of safety.

### Safeguarding

- Staff were trained in safeguarding. All staff had attended level four safeguarding children training which covered different themes such as neglect, female genital mutilation, physical and psychological abuse. In addition, 92.5% of staff had completed level three safeguarding training.
- Staff knew how to raise a safeguarding concern and did so when appropriate. Each team had a lead safeguarding clinician within their team. Staff received monthly safeguarding supervision from safeguarding leads within the trust.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm. That included working in

# Are services safe?

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

partnership with other agencies. Across the teams 92% of staff had received safeguarding adults recognition and referral training to help them identify adults that were at risk or suffering significant harm.

## Staff access to essential information

- Staff had access to an electronic records system. This was linked with both GP and hospital electronic records. All staff including agency workers received training in using these notes, and had individual logins and secure smartcards in order to access these systems. Information needed to deliver patient care was available to all relevant staff when they needed it and in an accessible form. That included when patients moved between teams.
- Staff were expected to record the routine outcome measures such as the health of the nation outcome scales and the strengths and difficulties questionnaires on a separate computer system which caused them to spend more time recording this information. The trust told us that they were reviewing the system and looking at other alternatives.

## Medicines Management

- None of the EWMHS sites administered medicines on site or in patient homes. Psychiatrists used prescription pads that were audited and secured according to the trust pharmacy guidance.
- Local arrangements were in place for children and young people's general practitioners to undertake blood tests and other physical health investigations such as electrocardiograms. These results were accessible via the electronic records system.
- A pharmacist told us that they were currently undertaking an audit of the use of psychotropic medicines including the use of antipsychotics. The audit findings would be fed back through business meetings when completed.

## Track record on safety

- Across the EWMHS service there were 187 incidents from July 2016 to July 2017 of which three were serious incidents involving the death of a young person. Two of these deaths were young people who had been accessing care and treatment at Chelmsford. The service had conducted a thematic review into the three deaths and learning points had been implemented by the trust. Other incidents recorded included abuse against staff and safeguarding incidents.
- There were comprehensive investigations following serious incidents.
- There was appropriate support in place for staff for example de-briefings and additional supervision.

## Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them.
- Staff we spoke with knew about the duty of candour requirement and what this meant in relation to being open and transparent with young people and their carers when things went wrong. We found evidence of a complaint raised by a family at Harlow being discussed in the team's business meeting in relation to the duty of candour requirement.
- Team managers discussed incidents across the service at weekly business meetings. Staff were able to explain how information regarding incidents was shared through team meetings.
- There was evidence of change having been made as a result of incidents. For example, as a result of a recent cluster of unexpected deaths, an investigation had been carried out. As a result of preliminary findings changes were being made to how the service assessed and managed risk and to the process for supporting young people when they transitioned to adult services.



# Are services 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.

## Our findings

### Assessment of needs and planning of care

- Comprehensive mental health assessments were completed for 18 of the 19 care records we looked at. Assessments were completed in a timely manner following the initial appointment with the clinician and then updated when circumstances changed. The patient without an assessment was waiting to be seen for their initial appointment. Care plans were reviewed and updated regularly.
- Seven of the patients whose records we examined required physical health checks related to their treatment. We saw that these had been obtained for six patients. However, we did find one young person who was prescribed medicines for attention deficit hyperactivity disorder who had no record of having their weight or height measured in line with NICE guidance. This was raised with managers and we were told that these measurements were monitored by the community paediatricians. The results of these checks were not readily accessible on the patients electronic record.
- At the previous inspection in April 2016, we found that not all children and young people had a plan that outlined their care and treatment. During this inspection, we saw that this had improved. Staff developed care plans that met the needs of patients identified during assessment. The majority of care plans had been developed and shared with the young person and their carer.
- Half of the care plans we saw were not personalised, holistic, recovery-oriented and based on the young persons' strengths or goals. For example, plans did not use child-friendly language and did not identify goals.

### Best practice in treatment and care

- Psychological therapies in line with NICE guidance were provided including children and young people's improving access to psychological therapies, art therapy, family therapy and psychotherapy. Clinicians across the three locations we inspected were qualified to deliver recommended psychological therapies and more staff were due to undertake this training.
- Services followed NICE guidance in relation to the treatment of mood disorders including anxiety and

depression, psychosis, eating disorders and self-harming behaviours. This best practice approach was reflected into four care pathways provided by services, which helped to identify the model of treatment a young person should expect. The specified care pathways were for mood and anxiety, complex mental health, neurodevelopmental and behaviour and conduct.

- A young person accessing the mood and anxiety pathway would be offered a psycho-education workshop on a rolling programme every two to three weeks. Parents and carers would also be offered a psycho-education group as well. The service offered more specific groups to support young people who had depression, anxiety or obsessional compulsive disorder. Clinicians were able to offer, where appropriate, between six and eight individual sessions and/or family work on this pathway.
- Children and young people were prescribed medicines in accordance with NICE guidelines.
- Staff ensured that patients' physical healthcare needs were being met, including their need for an annual health check. Children and young people were referred to their GP for physical health tests. As the service used shared electronic records, staff could easily access results for physical health checks.
- Staff supported patients to live healthier lives. For example, young people could be referred to specialist substance misuse services.
- The service used four routine outcome measures to monitor the child or young person's progress during treatment. These included the Health of the Nation Outcome Scale for children and adolescents (HoNOSCA), strength and difficulties questionnaires (SDQ) and the revised child anxiety and depression scale (RCADS). All staff we spoke with were aware of these measures and routinely used them.
- Staff used technology to support patients effectively. The service offered support via a digital support service called the "big white wall" for 16-18 year olds. This online website had safe and secure anonymous 24 hour access. The website stated it had self-management materials and online guided support courses.



# Are services 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.

- Staff participated in clinical audit. Waiting times, care plans, risk assessments and outcome measures were regularly audited. The outcome of these audits, along with actions, were discussed in team business meetings.

## Skilled staff to deliver care

- The multidisciplinary teams had a broad range of clinicians who had various skills and training in mental health.
- Staff were experienced and qualified, and had the right skills and knowledge to meet the needs of the patient group. The service employed clinicians who had a mental health qualification or professional qualification such as psychology, mental health nursing, art therapy, play therapy, social work or psychiatry. There was an art therapy student placement at Harlow. Some staff were also trained in the "triple p" parenting course which was used as a treatment approach in the behaviour and conduct pathway to help support parents and carers and their children.
- Managers provided new staff and agency staff with an appropriate induction. Staff were matched with a buddy to support them when they joined the service.
- Staff received regular supervision, either individually or in a group. Supervision included elements of both management and clinical discussion, in accordance with trust policy. Staff we spoke with said that they could request extra supervision when required.
- The trust had recently implemented a new electronic system for recording and documenting supervision. However not all data regarding supervision had been transferred to this system. At Harlow, supervision records for the three months from May 2017 to July 2017 were not available for 22 out of 32 staff.
- Staff had access to regular team meetings. Staff told us they were able to speak freely at these meetings and they were used effectively to improve the work of the team.
- Staff received appraisals annually. Seventy three percent of staff across EWMHS in Essex had received an appraisal. The remaining 46 staff members had a confirmed appraisal booked before early October 2017.
- Staff told us that they could access training relevant to their role to enhance their knowledge. Staff received

support to meet their training needs and this was demonstrated by the service investing in recommended psychological therapy training for clinicians across the service.

- Managers dealt with poor staff performance promptly and effectively. We saw examples at two of the sites we visited where managers were appropriately addressing performance issues.

## Multi-disciplinary and inter-agency team work

- Staff attended weekly multidisciplinary meetings where there was clinical case discussion. We observed one of these meetings and found that staff worked effectively and shared information and formulations regarding the child or young persons' mental health needs.
- Staff shared information about patients at effective handover meetings within the team. When staff went away on holiday arrangements were made to cover their caseload.
- Teams had effective working relationships, including good handovers, with other teams within the organisation. This included the four access teams who triaged referrals to the EWMH service and two children and young persons' crisis teams.
- Teams had good working links, including effective handovers, with primary care, social services, and other teams external to the organisation for children and young people they were working with. The service provided "in-reach" to schools including appointments, delivering training for teachers and allied professionals and the provision of specialist consultations in complex cases. In addition, the four access teams were able to provide advice and support to external stakeholders, including schools and GPs.

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

- All staff had received training in the Mental Health Act. Staff understood the requirements of the Mental Health Act, the Code of Practice and its guiding principles, in relation to children and young people. However, this was rarely used in the service. At the time of inspection no children or young people were subject to a community treatment order.

# Are services 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.

- Consultant psychiatrists across the service were Section 12 approved doctors who had completed additional training in the Mental Health Act and could assess young people under the Act.
- Staff had access to administrative support and advice on the implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were. The provider had relevant policies and procedures in place and staff knew how to access these.

## Good practice in applying the Mental Capacity Act

- Ninety five per cent of staff had completed training in the Mental Capacity Act 2005 which met the trust's target. This course was mandatory for all staff.
- The Mental Capacity Act only applies to young people who are 16 years or older. Gillick competency (a test in medical law) is used to decide whether a child younger

than 16 years is competent to consent to medical examination or treatment without the need for parental permission or knowledge. Staff had a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles and Gillick competency. There were no recent examples of children and young people having had their capacity assessed for specific decisions. No children or young people were subject to best interests decisions at the time of our inspection.

- Staff knew where to get advice regarding capacity issues and the provider had a policy relating to capacity. However, staff and managers told us that if a decision specific capacity assessment did take place, this would not be formally recorded. Staff were unclear what trust policy was in relation to this. No audits or other arrangements to monitor appropriate use of the Mental Capacity Act were in place.

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

- Staff interactions with patients demonstrated that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Staff supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services when appropriate.
- We observed assessments and meetings where staff spoke in a respectful way with the young people and their carers'. Staff spoke with young people in a way that engaged them and was dignified, caring and supportive.
- Young people were very positive about the service and praised the staff for their caring approach. All young people said they felt listened to and their views were valued. Young people said they were treated in an age appropriate way.
- Young people had access to the "My Mind app" which provided interactive, confidential advice and support for those who were receiving care and treatment. The app also gave access to on-line resources, appointments and care plans. This app had won an NHS digital pioneer award.
- Most of the carers were positive about the service they had received. They said that staff appeared to understand their child and their needs.
- Staff demonstrated an in-depth knowledge of their young peoples' individual needs and circumstances. This was particularly evident in the case discussions we observed. Staff spoke about young people in a respectful and professional way.
- Staff told us they felt able to report abusive or discriminatory behaviour towards them by patients and incidents of abuse had been recorded using the trust incident reporting procedure.
- Confidentiality was understood by the staff. Workstations were locked and records stored securely on an electronic records system. Young people were

asked if they would like their carers present during assessments and therapy appointments. Staff explained to young people and their carers when they needed to share information with other parties, discussed this with them in advance and where needed sought their permission.

### Involvement in care

#### The involvement of patients

- Staff involved patients in care planning and risk assessment. We saw evidence of this in care plans and risk assessments which showed that staff communicated with children and young people in ways they could understand.
- The service sought feedback from young people and carers and involved them in decisions about the service. For example, the Harlow team were trialling a written care plan of actions and goals which was developed in partnership with the child, young person and family during their initial appointment. This approach had been implemented based on feedback from young people and their families. Young people had been approached by the patient involvement representative from the trust, who was previously a service user, to get involved in the recruitment of new staff.
- Information was available to children and young people and their carers about local advocacy services.

#### Involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed. Twenty six carers said that they had contributed to the young person's care plan and received a copy of this. Seven carers said they had not been involved.
- Staff enabled families and carers to give feedback on the service they received. In August 2017 results from a parent and carer questionnaire for the mid Essex hub found that 100% of respondents were extremely likely to recommend the service to family and friends.
- Carers were provided with information about how to access a carer's assessment.

# Are services responsive to people's needs?

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

## Our findings

### Access and discharge

- The service had clear criteria for which patients would be offered a service. The criteria did not exclude patients who needed treatment and would benefit from it. Referrals into the service were initially screened by an access team. A suitably qualified clinician screened and triaged all referrals. Between April 2016 and June 2017, 30% of referrals received by access teams were signposted to other services.
- Where access teams triaged a referral as requiring an urgent appointment with EWMHS, these were seen within 14 days, by the most appropriate clinician. EWMHS teams and the point of access teams were able to refer children and young people directly to specialist children and young people crisis teams, commissioned as part of the wider EWMH service, which operated 24 hours a day, 365 days a year.
- The service had clear target times for waiting time from referral to assessment and from referral to treatment. These were 12 and 18 weeks respectively. The trust aimed to see 95% of referrals within these timescales, but was not meeting this target at the time of this inspection.
- Looked after children and children referred from the youth offending teams were assessed within seven days of referral, in line with local commissioning requirements.
- Between April 2016 and June 2017, the service received 13,066 referrals. The service had seen an increase in referrals and was working hard to try and meet targets.
- Between 1 January 2017 and 31 July 2017, the trust had not achieved its 12 week referral to assessment target at the sites we visited. During this period 62% of patients in Harlow, 78% of patients in Chelmsford and 93% of patients in Colchester had been assessed within 12 weeks of referral. Across the three locations a total of 298 children and young people waited longer than 12 weeks to be assessed in the same time period.
- Where children and young people did not attend their initial appointment it could take up to six weeks for non-urgent appointments to be rearranged, this caused delays in an initial assessment being completed and impacted upon targets.
- Ninety two percent of children were being seen with the 18 week referral to treatment target. Managers told us the breaches of referral to treatment targets were due to groups waiting to start or because young people would not attend groups and asked for individual appointments.
- Services remained under pressure as there were 788 children and young people who had been assessed by EWMHS and were waiting to commence their treatment. The highest number was in Chelmsford, where 343 children were waiting. At Colchester 244 children were waiting and in Harlow 201 children were waiting to commence treatment.
- Sixty four children and young people were not seen within the trust target time of 18 weeks from referral to treatment. In July 2017, the longest wait times for treatment for individual patients were 30 weeks at Colchester, 27 weeks at Chelmsford and 26 weeks at Harlow.
- Overall, teams responded promptly and adequately when patients contacted the service. Emergency appointments were available seven days a week with a consultant psychiatrist. The service also had a "clinician of the day" who was an experienced who would offer advice and support for young people and families awaiting assessment and provide cover for staff away from the office. Most of the young people and their carers told us that they could access a clinician or consultant psychiatrist urgently when required. However, two carers told us that they did not find it helpful to be told by staff to take their child to the local accident and emergency department in response to their telephone call. A small proportion of carers said that a clinician could not be accessed quickly if required, they commented that the phone lines were busy or that they did not always get a response from the clinician following a message being left.
- The team tried to make follow-up contact with people who did not attend appointments. Between 1 January and 31 July 2017 "did not attend" (DNA) was between

# Are services responsive to people's needs?

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3% and 4% for all three locations visited. The service routinely offered a second appointment for young people who did not attend their initial assessment, however, staff told us that it could be up to six weeks before another date was arranged.

- Managers told us they aimed to reduce DNA rates. Strategies to do this included phoning families and young people to arrange a mutually convenient time and changing the location for the assessment to a school or satellite office. Administration staff told us they would routinely telephone parents/carers and young people who did not attend their appointments.
- Where possible, staff offered patients flexibility in the times of appointments. Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to access treatment as soon as possible. Appointments usually ran on time and patients were kept informed when they did not.
- Where young people were approaching 18 years of age and needed transfer into adult mental health services, there was a system in place where clinicians and managers could discuss cases with the adult community mental health team to facilitate the transition.

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

- The service had a range of rooms and equipment to support treatment and care. Waiting areas included adequate seating. Interview and therapy rooms were available. There were toys and child-friendly furnishings at all three locations. Interview rooms were appropriately sound proofed.
- None of the sites we visited had designated clinic rooms. At Chelmsford and Harlow the height and weight equipment was located in a corridor which compromised patient privacy and dignity.

## **Patients engagement with the wider community**

- Patients were encouraged to develop and maintain relationships with people and services that mattered to them. We saw that children and young people were supported to engage with wider family networks and encouraged to engage with education. This was supported by the schools "in reach" programme.

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

- Services at Harlow and Colchester were wheelchair accessible. In Chelmsford, interview rooms could be booked at an adjacent local authority building as the office space was not wheelchair accessible. For those children and young people who found accessing the service difficult because of mobility or other issues, the service could conduct home visits or school visits.
- The waiting area displayed a range of information including leaflets for mental health conditions such as anxiety and depression and local support groups. There were also leaflets available on how to complain. However, these were not age specific for younger children.
- Staff were able to access interpretation services centrally from the trust. One carer we spoke with had used the interpretation service for sessions and found this helpful. Letters could be translated into different languages and into braille. Leaflets in other languages were not displayed. Staff told us they were able to print these when needed. We did not find leaflets in easy-read format for those young people with a learning disability.
- The patient representative attended trust equality and diversity and dyslexia networks and contributed to discussions on how services could be developed.

## **Listening to and learning from concerns and complaints**

- The three locations we inspected received 12 complaints between 16 August 2016 and 16 August 2017. Two of the complaints were partially upheld. None of the complaints were referred to the Ombudsman. Chelmsford received the highest number of complaints at six and Colchester and Harlow received three each. Complaints related to delays in patient care, communication issues and attitudes of staff.
- Complaints were responded to in accordance to trust policies with the exception of one complaint that was not acknowledged within 72 hours.
- Most of the young people and carers we spoke with knew how to complain and the ones that did not felt able to raise concerns freely. When patients or carers

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complained or raised concerns, they received feedback. We spoke to two carers who had complained and they told us that their concerns had been addressed thoroughly and promptly.

- Staff demonstrated an understanding of the complaints process and gave examples of how they would invite parents or carers in for a face to face meeting or telephone them in order to try and resolve the complaint.
- Staff received feedback on the outcome of investigation of complaints and acted on the findings.



# Are services 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.

## Our findings

### Leadership

- Leaders had the skills, knowledge and experience to perform their roles. Managers were from health and social care backgrounds. Some managers had recently moved to teams to ensure a balance of skills and expertise.
- Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Managers were able to tell us about the transformation of the service over the last 18 months and the challenges this had brought.
- Leaders were visible in the service and approachable for patients and staff. All of the staff we spoke with told us they felt their managers were approachable and understanding. Staff reported that senior managers were visible in the service and there were opportunities to feedback about the service. Some staff said that the managers were very busy and were not always available.
- Leadership development opportunities were available. Managers were able to attend courses to develop their leadership skills. One manager had been promoted from a clinical role and they said they had been supported during this transition.

### Vision and strategy

- Staff were passionate about helping young people with emotional well-being and mental health difficulties. This was in line with the trust's visions which focussed on the five "P"s, prioritising people and quality, being professional and honest, improving the lives of people who used the service and promoting recovery and quality of life. Some staff we spoke with knew these values. All staff demonstrated the trust values in their behaviour and attitude.
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff told us that the service was starting to become more stable following the transformation and the trust taking over the service.

### Culture

- Staff felt respected, supported and valued. Overall staff reported that morale had improved. Staff we spoke with said that morale had improved during the course of the transformation process, but that this could still fluctuate, mainly as a result of work pressures. Staff said there was an open and transparent culture within teams.
- Staff we spoke with felt able to raise concerns with their managers without fear of reprisal. They knew how to whistle-blow if needed. However, there was little awareness of the freedom to speak up guardian and their role.
- Teams worked well together, they were multidisciplinary with each professions contribution welcomed and valued.
- Staff appraisals included conversations about career development and how it could be supported. The appraisal encouraged staff to set their own individual goals in relation to their professional development.
- Staff had access to support for their own physical and emotional health needs through an occupational health service.

### Governance

- Overall, there were systems and procedures to ensure that the premises were safe and clean; there were enough staff; staff were trained and supervised; patients were assessed and treated well; incidents were reported, investigated and learned from.
- At each site there were regular clinical meetings, leadership meetings and business meetings. These used standardised agendas that ensured incidents and concerns, waiting lists, safeguarding, and complex cases were all discussed.
- Staff had implemented recommendations from reviews of deaths. For example, as a result of the recent thematic review a new risk tool specific to CAMHS had been developed and was being implemented.
- We saw that clinical audits were undertaken in relation to the use of prescription charts, risk assessments and care plans and that actions identified as a result of these were followed through.

### Management of risk issues and performance

# Are services 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.

- Staff maintained and had access to a local risk register which could feed into a directorate and trust wide risk register. Team managers had identified recruitment challenges and staff shortages as local risks. These had been escalated to the trust risk register and the trust human resources department was working to address these.
- We saw that a locality team commitment to learn from a recent cluster of unexpected deaths was mirrored within the senior leadership who had commissioned a thematic review. Potential risks identified through the thematic review were recorded on the local risk register, pulled through into the trust risk register and these corresponded with concerns raised by staff.

## Information management

- The service used systems to collect data from teams that were not over-burdensome for frontline staff. Staff had access to the equipment and information technology needed to do their work.
- Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, and was timely, accurate and identified areas for improvement. Staff made notifications to external bodies such as NHS England and the local authority as needed.

## Engagement

- Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. We saw examples of how patient and

carer feedback had been used to improve services and make changes. There were comments boxes visible at each location and managers were aware of feedback and issues raised by children and their families. There was evidence that this feedback was discussed and had influenced planning for service development.

- The trust had employed a patient representative. They were engaging with young people to promote training opportunities that would lead to their involvement in staff recruitment. The patient representative had recently helped to organise a positive mental health day-participation group at the Thundersley hub.
- At Harlow the team had worked in partnership with Epping Forest Youth council and had been involved in local events to highlight mental health issues.
- Directors of the service engaged with external stakeholders, for example the seven different clinical commissioning groups who commissioned the service.

## Learning, continuous improvement and innovation

- Staff across the service were given time and support to access specialist training in NICE recommended therapies such as children and young people improving access to psychological therapies (CYP-IAPT). The service provided placements for art therapy students and psychotherapy trainees. One psychiatrist was able to continue their role as a lecturer one day per week at a nearby university.
- The service was not participating in accreditation schemes, for example, the quality network for CAMHS at the time of this inspection.



This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 (1) (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</p> <p>The trust did not ensure that staff had a call system or alarms in place that would enable them to call for assistance in an emergency.</p> <p>This was a breach of Regulation 12(1)(b)</p>