The London Psychiatry Centre

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	**Good**
Are services effective?	**Outstanding**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This service is rated as Good **overall.** (Previous inspection June 2017. We did not rate Independent doctors services were not rated at that time).

The key questions are rated as:

Are services safe? - Good

Are services effective? - Outstanding

Are services caring? - Good

Are services responsive? - Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at The London Psychiatry Centre.

CQC inspected the service on 13 June 2017. At that time we did not rate independent doctor services. Following the June 2017 inspection we asked the provider to make improvements regarding the mandatory training of staff and recruitment checks on staff. We checked these areas as part of this comprehensive inspection and found these had been resolved.

The London Psychiatry Centre operates a consultant led out-patient service to assess and treat people with mental health needs. Patients of the service include children and young people, older adults and people with substance misuse problems.

The practice manager at the service is also the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We received 13 comment cards completed by patients. All of the comments were very positive, describing caring, kind and professional staff. Patients said they had effective treatment in a clean and organised service.

Our key findings were :

- Patients described staff as sensitive, supportive and caring. They felt fully involved in decisions about their care and treatment.
- Staff assessed patients' treatment needs holistically. Patients at risk of physical health problems linked to their mental health problems or treatment had investigations or were referred to specialists.
- The service had clear systems to manage risk. There were effective systems to safeguard children and vulnerable adults from abuse and to prevent avoidable harm to patients.
- The service developed and made changes to address the specific needs of patients. These included assessment tools in different languages and a specific complaints form designed for children and young people.

We saw the following outstanding practice:

- Patients in the service had an extensive, holistic assessment when they first attended the service. Patients routinely had appropriate physical health investigations before treatment and the service used a wide range of validated assessment tools to inform patients' future treatment.
- Patients with treatment-resistant mood disorders were treated in a stepped way, following published guidance. Patients were told about their treatment options and treatment decisions were made jointly between patients and clinicians in an open, fully informed, way.

Overall summary

- Clinicians in the service were continuously reviewing research findings and identifying possible treatment options which could benefit patients.
- Clinicians in the service had published in journals and designed poster presentations for professional conferences, including international conferences. The service had also been visited by national and international healthcare organisations.

The areas where the provider **should** make improvements are:

The provider should improve clinical governance meetings to further focus on quality and performance in the service.

The provider should seek formal feedback from patients more frequently to inform service development.

Our inspection team

Our inspection team was led by a CQC lead inspector with another CQC inspector completing the inspection team. The inspection was led by a CQC inspector who had access to advice from a specialist advisor.

Background to The London Psychiatry Centre

The service provides outpatient mental health assessment and treatment for patients of all ages. The service includes a multidisciplinary assessment of children and young people, psychological therapies and neuromodulation therapy. The provider contracts with six consultant psychiatrists (two of whom were child and adolescent psychiatrists), four clinical psychologists, four psychotherapists, a psychodynamic therapist, a clinical nurse specialist and a nutritionist. The service has a medical director, practice manager, registered nurses and administrative staff. The service is open 9am to 6pm Monday to Friday. The service has additional opening times by appointment only. These are 6pm to 8pm Monday to Thursday and 10am to 1pm on Saturday.

In 2019 the service assessed and treated approximately 1200 patients. Fifty-six percent of patients had a mood disorder, such as depression or bipolar affective disorder. Twenty-one percent had post-traumatic stress disorder, 13% had attention deficit hyperactivity disorder and 10% had addiction problems. Assessment and treatment in the service could be face to face or internet-based.

How we inspected this service

During the inspection visit to the service, the inspection team:

- checked the safety, maintenance and cleanliness of the premises
- spoke with the practice manager, the medical director, two consultant psychiatrists, a clinical psychologist, a registered nurse and a clinical nurse specialist
- reviewed five patient care and treatment records
- reviewed 13 comment cards from patients using the service
- reviewed five staff records
- reviewed information and documents relating to the operation and management of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

We rated safe as Good because:

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their refresher training. The service had systems to safeguard children and vulnerable adults from abuse.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. There were clear and detailed policies for safeguarding children and adults. A clinician in the service was a trainer in safeguarding children and was a resource for advice to staff. Staff in the service made referrals to local authority safeguarding services when this was appropriate.
- At the inspection in June 2017, we found that a clinician did not have a completed Disclosure and Barring Service (DBS) criminal records check. At this inspection, the provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. DBS checks were undertaken where required.
- At the inspection in June 2017 we found that some staff had not completed some mandatory training, including safeguarding training. At this inspection, we found that all staff had undertaken all mandatory training. This included all clinicians undertaking safeguarding adults training and level 3 safeguarding children training. All staff knew how to identify and report concerns. Staff who acted as chaperones had received a DBS check and training for this role.
- There was an effective system to manage infection prevention and control. This included regular legionella water checks being undertaken.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- The building was leased by the provider. The provider's landlord undertook appropriate environmental risk assessments and acted on the findings. Asbestos and legionella risk assessments had been completed. Electrical checks were completed and staff participated in fire drills.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- Patients and clinicians completed a risk assessment when patients were first seen at the service. A new risk assessment form had been developed since the last inspection. Corroboration of patients' past risk incidents and behaviour was received from GPs and healthcare providers who had previously treated patients. Clinicians developed risk management plans with patients. Patients were also given a crisis card which included contact details of services they could use in a crisis, such as the Samaritans.
- Staff responded appropriately to changing risks. They took action to address emerging risks. Clinicians discussed patients with colleagues and other clinicians frequently. Registered nurses communicated with consultants when patients attended for repetitive transcranial magnetic stimulation (rTMS) treatment. There was always a consultant psychiatrist in the service or in the local area. If a consultant psychiatrist was required urgently, one could attend within two hours. Clinicians in the service referred patients to local area crisis teams when this was indicated. The service also worked with another provider who offered crisis care and home treatment.
- There were arrangements for planning and monitoring the number of staff needed. Two registered nurses worked in the service administering rTMS. The service had arrangements for planned and short notice cover arrangements by registered mental health nurses who had been trained to administer rTMS. All of these nurses had worked in the service and were experienced in delivering rTMS.
- The service had emergency equipment and emergency medicines, in line with national guidance.
- There were appropriate indemnity arrangements in place to cover all potential liabilities. All clinicians had individual professional indemnity and this was checked by the provider regularly.

Information to deliver safe care and treatment

Are services safe?

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Care records were stored securely. The provider was in the process of transferring all patient care records onto an electronic system. Electronic information regarding patients was stored on two servers in separate locations and staff were always able to access the information.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines minimised risks. The service kept prescription stationery securely. Following internet appointments, clinicians would not directly prescribe medicines to patients. They would write to a local clinician who knew the patient, with their recommendations. The service did not operate a system of repeat prescriptions. A patient needed to see a clinician for a prescription. Emergency medicines were checked regularly and included naloxone for opiate overdoses. The service had a system to receive medicines alerts.
- Staff prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. When patients were prescribed 'off licence' medicines, there was a clear record that patients had been informed what this meant and the reason for this. Patients also signed their consent to take such medicines.
- Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety. For example, patients prescribed levothyroxine had bone density scans. Patients were also informed of the research evidence for the efficacy of 'off licence' medicines.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- There had been no serious untoward incidents in the service in the previous year.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, following a complaint, all clinicians were reminded of the need to maintain clear boundaries regarding communicating with patients.
- The provider was aware of the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents. The service gave affected people reasonable support, truthful information and a verbal and written apology.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional staff.

Are services effective?

We rated effective as Outstanding because:

- Patients in the service had an extensive, holistic assessment when they first attended the service. Patients routinely had appropriate physical health investigations before treatment and the service used a wide range of validated assessment tools to inform patients' future treatment.
- Patients with treatment-resistant mood disorders were treated in a stepped way, following published guidance. Patients were told about their treatment options and treatment decisions were made jointly between patients and clinicians in an open, fully informed, way.
- Clinicians in the service were continuously reviewing research findings and identifying possible treatment options which could benefit patients.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- The service provided innovative treatment for patients when conventional treatment approaches had not been successful. Repetitive transcranial magnetic stimulation (rTMS) was used for the treatment of patients' chronic depression. This treatment is approved by the National Institute for Health and Clinical Excellence (Repetitive transcranial magnetic stimulation for depression, 2015). However, rTMS was also used for patients with specific depressive symptoms in the context of bipolar affective disorder. This was underpinned by emerging international research in this area.
- Patients having eye movement desensitisation and reprocessing (EMDR) treatment for post traumatic stress disorder (PTSD) had exposure treatment for a longer time period per episode than usual. Some patients with complex PTSD had a rapid reduction, or absence, of symptoms within a few weeks. EMDR treatment is usually required for eight to 12 weeks (Post-traumatic stress disorder, National Institute for Health and Care Excellence, 2018). Trauma-based cognitive behavioural therapy was also available for patients with PTSD, as recommended by the National Institute for Health and Care Excellence.
- Patients' immediate needs were continuously assessed. For patients having rTMS, registered mental health nurses assessed patients when they attended for treatment. If there were concerns about a patient, a consultant psychiatrist would review this new information within two hours. This could also mean the consultant saw the patient. Patients ongoing needs were also assessed. Patients having rTMS and levothyroxine treatment had bone density scans, due to potential side effects of thyroxine treatment. The service worked with a specific endocrinologist to assess these patients' health. Clinicians also worked closely with a cardiologist as research has highlighted the clear link between heart disease and certain mental health problems. Patients had an electrocardiogram either in the service or at the cardiology service. Other investigations, such as blood tests, were also undertaken to assess patients' health.
- Patients with addictions were mainly treated with psychological approaches, such as motivational interviewing and cognitive behavioural therapy. Patients with problematic alcohol misuse were offered medicines to assist them with abstinence. This followed best practice guidance.
- The service had a system in place to alert clinicians when new guidance was published by the National Institute for Health and Care Excellence.
- Clinicians had enough information to make or confirm a diagnosis. They contacted patients' general practitioners or previous healthcare providers for details of patients' medical history. Clinicians assessed patients' needs holistically. A range of validated assessment tools were used to support clinical assessments of patients. These included Beck's Depression Inventory, Beck's Anxiety Inventory, the Sheehan Disability Scale, the Pittsburgh Sleep Quality Index, the modified hypomania checklist (HCL 32), the Impact of Events Scale and the Alcohol Use Disorders Identification Test (AUDIT). For younger patients with suspected autism or attention deficit hyperactivity disorder, a multidisciplinary assessment was undertaken by the child and adolescent mental health (CAMHs) team. Clinicians in the CAMHs team undertook school, play and parenting assessments.
- Clinicians considered patients' specific needs. For example, some assessment tools were written in Russian and Arabic, and the second rTMS room was located in a building which had an elevator.

Are services effective?

- Clinicians were able to offer internet appointments, for patients in the UK and internationally. These appointments enabled clinicians to see patients when assessing and communicating with them and were more convenient for some patients. There were safeguards concerning internet appointments and clinicians did not directly prescribe medicines for these patients.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements. The service made improvements through the use of completed audits and protocols. Clinical audits and protocols had a positive impact on the quality of care and outcomes for patients.
- Clinicians in the service reviewed research on treatment developments for possible development in the service. These included rTMS treatment for adolescents and the Barcelona model of psychoeducation. The service had developed an antidepressant discontinuation symptoms questionnaire to better manage potential antidepressant withdrawal syndrome when patients were stopping antidepressants. The use of Omega 3 polyunsaturated fatty acids as an adjunctive treatment for depression was also reviewed and available to patients. Clinicians also maintained communication with an international network of academics and experts.
- There were clear protocols for carrying out innovative treatment interventions with patients. For example, the high dose levothyroxine protocol included blood tests to measure efficacy and bone density scans.
- The service conducted a routine audit of clinical outcomes for patients to measure the effectiveness of treatment. There was an ongoing audit of patients receiving rTMS. Patients received this treatment together with levothyroxine, rather than the standard antidepressant medicines. The rate of full remission of patients' symptoms was 62%, compared to 28% when it is used with antidepressant medicines. Clinicians in the service had also collated the outcomes of 20 patients with bipolar affective disorder who had received rTMS treatment and levothyroxine.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. Relevant professionals were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and Healthcare Professions Council and were up to date with revalidation.
- Clinicians had extensive experience in their speciality or sub-speciality, including international experience. The Medical Director had introduced rTMS to the UK, and clinicians from the service had been specialist advisors to the National Institute of Health and Care Excellence.
- The provider understood the learning needs of staff and provided training to meet them. Where appropriate, clinicians provided training to each other, including on rTMS and safeguarding children. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with other services when appropriate, such as the cardiologist, endocrinologist, or crisis teams.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP.
- The provider had risk assessed the treatments they offered. Clinicians did not prescribe medicines if the patient did not give their consent to share information with their GP. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance. In some cases, the service obtained patients' medical history from overseas healthcare services and doctors.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

Are services effective?

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care, such as nutritional advice.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs. This included patients' own GP, crisis teams and inpatient services.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance .

- Staff understood the requirements of legislation and guidance when considering consent and decision making. When clinicians prescribed 'off licence' medicines, patients were provided with clear information. Patients' consent for treatment was recorded before each episode of treatment with rTMS. Patients were routinely copied into correspondence from the provider to patients' GPs.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. For young people, staff used the Gillick competency where appropriate.

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from 13 comment cards completed by patients was extremely positive about the way staff treat people. Staff were universally described as sensitive, supportive and caring. Two comments cards described staff as the best mental health staff they had ever met.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Interpretation services were available for patients who did not have English as a first language. Patients were told about multi-lingual staff who might be able to support them. Some documents were in large print, or written in Russian and Arabic.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patients were very positive about the level of involvement they had in making decisions about their care and treatment.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. Staff asked patients for their consent in relation to information sharing.

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patients' needs and preferences.

- Patients could choose male or female clinicians for their assessment and treatment. Staff in the clinic spoke a range of languages. If required, the practice manager contacted the patient's embassy or consulate for a list of approved translators.
- The provider understood the needs of their patients and improved services in response to those needs. Russian and Arabic versions of the Beck's Depression Inventory and Beck's Anxiety Inventory were available. Large print assessment documents were available for patients with poor eyesight. Staff asked patients if they required assistance with assessment documents when they first attended the service. A hearing induction loop was available for patients with hearing difficulties and specific complaints forms had also been developed for children and young people.
- The facilities and premises were appropriate for the services delivered. The waiting area for the service was separate from other tenants in the building. It was discreet and comfortable. The new rTMS room was located in a separate building that had an elevator, so that patients with mobility needs could more easily access treatment.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment. There was no waiting list for assessment or treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately. The service had expanded in 2019 to include a second rTMS room. This was in response to a waiting list developing to access rTMS treatment.
- Referrals and transfers to other services were undertaken in a timely way. For example, consultant psychiatrists could easily refer patients to a nearby private mental health hospital if necessary. Referrals were also made to crisis teams and to a private home treatment service.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately, reassuring them that their treatment would be unaffected by their complaint. A specific complaints form had been developed for young people to use.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint. There was a clear process for patients to be able to appeal against the outcome of the complaint with an independent body.
- The service had a complaints policy and procedures in place. The service learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care. For example, one complaint led to a clinician having their practising privileges withdrawn as they had not met standards regarding communicating with patients.

Are services well-led?

We rated well-led as Good because:

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- The service had a clear vision to provide world class quality care for patients. The service was committed to an integrated multidisciplinary approach to care and viewed health in the same terms as the World Health Organisation; as a state of complete wellbeing and not just the absence of illness.
- The service strategy was to be at the forefront of effective treatment for mental health problems. New and innovative approaches were developed based on research. They were safely implemented and clinicians in the service were specialist advisors to the National Institute for Health and Care Excellence. Clinicians also maintained productive professional relationships with international experts.
- Staff were aware of and understood the vision of the service and their role in achieving this. Clinicians in the service were involved with research, service development, conference presentations and clinical governance.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values. There was evidence that action was taken when staff did not meet the standards expected in the service. This included a clinician having their practising privileges removed.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, a complaint response we reviewed included an explicit and unequivocal apology to the complainant. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. Staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. Staff had received equality and diversity training.
- There were positive relationships between staff.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out and understood. However, clinical governance meetings focused primarily on future developments. There was no standard agenda for clinical governance meetings. This meant safeguarding referrals, incidents and complaints were not always on the agenda. Information from ongoing operational audits was not routinely discussed.
- Staff were clear on their roles and accountabilities**.**
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Are services well-led?

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The service had processes to manage current and future performance. Leaders had oversight of safety alerts, incidents, and complaints. However, there were no audits of clinicians and therapists' consultations, prescribing and referral decisions. This impacted on the ability of leaders to monitor clinicians' and therapists' performance.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. However, the most recent survey of patients' views was two years previously. At the time of the inspection, a survey of patients and their families using the CAMHs service was in progress.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients and staff. Leaders acted on them to shape services and culture. For example, the rTMS service expanded to prevent waiting lists. Staff were also reminded to be clear about the fees charged at the service.
- Staff could describe to us the systems in place to give feedback. We saw evidence of feedback opportunities for staff, such as a planned lunch for CAMHs staff.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints.
- There were systems to support improvement and innovation work. For example, the Barcelona model of psychoeducation for patients with bipolar affective disorder was discussed at the clinical governance meeting for possible development in the service. There were also plans to conduct a review of the evidence for rTMS treatment for adolescents.
- The service had developed safe and comprehensive systems to provide innovative and pioneering treatments for patients. Clinicians in the service communicated with other specialists, international academics and experts in these areas.
- Clinicians in the service had published in journals and designed poster presentations for professional conferences, including international conferences. The service had also been visited by national and international healthcare organisations.