Tavistock and Portman NHS Foundation Trust

Specialist community mental health services for children and young people

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Requires Improvement**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Specialist community mental health services for children and young people

Inspected but not rated

We carried out this short notice announced, focused inspection in line with our inspection methodology.

At our last inspection visit in 2018 we rated specialist community mental health services for children and young people as good overall, and outstanding in effective.

During this focused inspection we looked at three domains. We looked at safe, responsive, and well led.

The Tavistock and Portman NHS Foundation Trust provides specialist mental health services for adults and children across several London boroughs, most are based in Camden.

We inspected the Camden north and south child and adolescent community teams and the Camden Adolescent Intensive Support Service (CAISS) team. The north and south teams offer assessment and treatment that include cognitive behavioural therapy, psychology, child psychotherapy, psychiatric input and family therapy. The CAISS team provides short term support to young people who are at risk of requiring admission to an inpatient service.

Five months before our inspection, the trust had experienced a malware attack effecting the trust's electronic patient record system. We took this into account during our inspection and assessed how the service had managed this. This issue had affected several NHS and independent health providers.

At this inspection there was not an overall rating for the service as we only inspected three domains. We rated safe as requires improvement; we did not rate responsive and well led.

We found the following:

- Staff knew patients and their risks well. Staff had good discussions around current clinical risks of young people, their progress and any challenges for both the young people and their families. Staff planned care for the young people well.
- Staff assessed and treated patients in crisis promptly. In 2 of the 12 months before the inspection, the CAISS team were able to support young people in the community and no young people had required an inpatient admission.
- Staff followed good practice in relation to safeguarding young people and their families.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. Clinical staff recognised and responded to the cultural diversity of the young people and their families.
- The website for the service had sections for young people and for children, and these were written in an age appropriate voice so they would be accessible to the young people and children.
- The criteria for referral to the service did not exclude children and young people who would have benefited from care.
- The service was well led, and the governance processes ensured that procedures relating to the work of the service ran smoothly.

Our findings

However:

- Staff were not always up to date with important training. Most staff had received and were up to date with appropriate training, however we found 5 out of 13 staff in the Camden CAMHS south team had not completed mandatory resuscitation training.
- The service did not provide alarms for staff or rooms where therapies with the patients took place in case there was an incident.
- Since our last inspection, the service was still working on making all information accessible for young children.
- There were vacancies for staff across the Camden CAMHS north and south team.
- The service did not record informal complaints, therefore staff could not learn from this feedback.
- Rooms where clinicians met with young people to have confidential discussions were not well soundproofed, which could compromise the young person's confidentiality. The premises where the Camden CAMHS south team was based still had issues with providing enough room for treatments.
- The care records systems would experience technical issues which made it difficult for staff to keep up to date with their notes.

How we carried out the inspection

During the inspection, the inspection team:

- conducted a review of the 2 environments where the teams were located
- observed 2 multi-disciplinary team meetings, a clinical review meeting, a referrals meeting and a quality improvement forum
- spoke to the general manager of the service and the 3 team leads of the Camden CAMHS north, Camden CAMHS south and CAISS team
- spoke with 23 other staff members including the speciality registrar, the lead psychologist, clinical psychologists, a nurse, 2 lead child psychotherapists, psychotherapists, lead family therapist, 2 consultant psychiatrists, cognitive behavioural therapy lead, senior child well-being practitioner 3 administrators, and 2 trainee psychotherapists
- spoke with 7 family members and carers
- spoke with 2 patients
- reviewed 19 patient records
- looked at a range of policies, procedures and other documents relating to the operation of the service.

What people who use the service say

We spoke with 2 young people who had been using the service and 4 carers and families. The feedback was positive. Families and carers told us they were very happy with the care the patients were receiving and could not speak more highly of the service.

The young person told us they felt the service had definitely helped them and that they felt safe when receiving care.

Our findings

Most families, carers and the young person told us they did not have to wait long to be seen.

Is the service safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement.

Safe and clean environments

All clinical premises where patients received care were clean, well equipped and well furnished. However, the service did not have robust systems in place to ensure staff safety when seeing patients.

All areas were visibly clean, uncluttered and the furniture was in good condition. There was artwork displayed in all communal areas and the environment was well maintained. Waiting areas for young people were bright and colourful.

At the last inspection in 2018, there was no cleaning schedule in place for toys at any of the services. This meant there was no process to ensure that toys that were available in reception and used in sessions with the children were cleaned regularly to reduce the risk of the spread of infection. At this inspection, staff had implemented a toy allocation, storage and cleaning policy. Additionally, following the pandemic, the service had removed communal toys and each child now had their own named box of toys. The toys were cleaned by a clinician following each use. We saw records that toys were being checked and cleaned.

At the last inspection in 2018, fire safety systems at both sites were not robust. At this inspection teams were completing fire drills; however, these were not regular. Camden CAMHS north had completed a fire drill in June 2022 and had another scheduled for November 2022, however a fire evacuation took place instead in November 2022 and an incident was recorded. Camden CAMHS south team completed a fire drill in September 2022. The action plan from this was for regular onsite staff to complete certified fire drill training. Fire alarms were tested once a fortnight.

At our last inspection in 2018, we said the trust should ensure the service had robust systems in place to ensure a timely and effective response should there be an incident on site during therapy sessions. At this inspection, rooms where patients were seen for therapy were still not fitted with alarms. The general manager told us the service had considered installing alarms buttons in rooms but concluded the children and young people would press these and cause false alarms. Therefore, this was not trialled or implemented. Desktop and laptop computers in reception had a ‘green button’ that staff could press and other nearby computers in the network would be notified. This alerted staff to the location of a colleague who needed assistance.

At our last inspection in 2018, the CAMHS teams and Camden Adolescent Intensive Support Service (CAISS) team were due to be issued with personal alarms and had to complete operational training of the alarms first. These alarms would be used when staff visited patients off site and in their homes. However, staff did not find these effective and teams were not using them. In order to mitigate risk, staff in the CAISS team conducted a risk assessment before an appointment. Staff across the teams said the risk profile for the patients was low and patients were more likely to present a risk to themselves rather than the staff. If risks were identified, a visit would always be conducted in pairs. The CAISS team always completed a first visit in pairs. Staff told us that they followed the lone-working policy and that they reported their location to the team through a group chat and would notify the group chat when leaving. Some staff at the Camden CAMHS south team thought re-introducing alarms would be an additional benefit for home visits.

Our findings

The Camden CAMHS north and CAISS teams had access to a small medical room on site, however the general manager told us this was not used by these teams as the consultants had weighing scales and blood pressure monitors in their office. The blood pressure monitor at the Camden CAMHS south team had been calibrated. GP's mainly managed patients' physical health.

Safe staffing

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. The Camden CAMHS north and Camden CAMHS south teams used temporary staff to fill vacant posts.

At the time of inspection there was a high vacancy rate for the community CAMHS teams. The Camden CAMHS north team had 3.2 whole time equivalent vacancy against 12.55 staff at full capacity, and the Camden CAMHS south team had 3.4 whole time equivalent vacancy against 13.5 staff at full capacity. The teams used temporary staff to fill these vacancies, and permanent staff would also work additional bank shifts. For example the clinical intake team would also work in the community teams as clinicians, in addition to their clinical intake role. The CAISS team was fully staffed.

Staff told us they thought the high vacancy rate had an effect on the waiting times. This was a result of both the vacancy rates, and the strategic review. The Trust had undergone a strategic review of the service and teams and this had been enacted in November 2022. The result of this was that new team manager roles were created and 5 teams in the service had a vacancy for a permanent manager, including the Camden CAMHS north team. At the time of inspection these roles had been filled or awaiting the post holder to start. The managers of the teams and the general manager told us that the strategic review had had a negative effect on staff morale.

However, caseloads for the Camden CAMHS south and CAISS teams had decreased. Between July 2021 and July 2022 the caseload for Camden CAMHS south went from 243 to 211 and for CAISS 55 to 38. For Camden CAMHS north team this had increased slightly from 304 to 312.

12 months before the inspection, the recruitment process for new staff had changed to a centralised service as part of the North London Partnership. This had resulted in delays and challenges in speaking to the central recruitment team. This has been fed back and staff had reported some improvement, but the impact had not been felt yet. Team managers reviewed clinicians' caseloads regularly through supervisions and business meetings.

In the CAISS team, there were cover arrangements in place for sickness and leave. Each young person was allocated two clinicians, which ensured continuity of care when one of the clinicians was on leave.

The turnover rate for the Camden CAMHS north team was 34% and for the Camden CAMHS south team was 42%. The CAISS team had not had any staff leave in the 12 months before the inspection. The sickness rate for both short- and long-term sickness was less than 1%.

Medical staffing

Teams had rapid access to a consultant psychiatrist from Monday to Friday when the service was open. The CAMHS consultant psychiatrists worked on an on-call rota. This rota provided rapid access to a psychiatrist for a patient at a time of crisis. The service used the north central London integrated care system crisis service helpline which was a

phone service available 24 hours a day 7 days a week. Access to a psychiatrist out of hours was through a rota of junior doctors and consultants from the north and south hubs. Hubs were set up during the pandemic to take pressure off accident and emergency attendance, and these were ongoing. There is an out of hours liaison that assessed the patients. All psychiatrists were aware of the arrangement and took part in the rota system.

Mandatory training

Staff had received and were up to date with appropriate training, however for the resus training for the Camden CAMHS south team 5 out of 13 staff had not completed this which meant this had a compliance rate of 62%. The mandatory and statutory training rates were 98% for the Camden CAMHS north team, 92% for the Camden CAMHS south team, and 99% for the CAISS team.

Assessing and managing risk to patients

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans.

At the last inspection in 2018, we found that records did not always include an up-to-date risk assessment. During this inspection we found this was improved. We reviewed 19 care records across the Camden CAMHS north, Camden CAMHS south and CAISS teams and saw staff had completed risk assessments on admission to the service for all patients, and these were updated regularly. Risk management plans were in place for all patients. Staff used a recognised risk assessment tool, which was part of the electronic records system.

Staff created care plans with patients that were personalised, holistic and recovery orientated. Staff developed care plans with the patients, and care plans stated who they should be shared with. Families and carers, we spoke to told us care plans had been shared with them. However, we found even when developed with the patient care plans were not always child friendly or in in the child's voice.

At the last inspection in 2018, we found staff were not always clear how they should share crisis plans with young people and their parent or carer. Some young people and parents were not aware who they should contact in a crisis. At this inspection we found improvement. Care records showed that a crisis plan was in place for all patients who required one, and all patients had clear safety planning. Staff created crisis plans for patients based on clinical need. Parents we spoke with said they were given contact numbers to contact in a crisis and some had received a crisis plan. Parents who had not received a crisis plan told us there had been no need as their child had not experienced a crisis. We found a good example of a crisis plan that had been written and signed by the young person to reflect their views.

Management of patient risk

Staff discussed patients' risks regularly during team meetings and we saw evidence of this in the minutes. Staff had a good understanding of each individual patient and what their risks were. We observed a clinical team meeting, where staff demonstrated excellent knowledge of young peoples' risks and discussed plans to manage the risk.

Staff ensured that young people were risk assessed and monitored whilst on the waiting list for an appointment. Staff sent letters out to young people and their families informing them that their referral had been accepted. Staff discussed new referrals in a weekly intake meeting and allocated referrals to the appropriate clinician.

Our findings

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The teams had a safeguarding lead and staff knew who this was.

Staff were trained in safeguarding and knew how to make a safeguarding alert and did so when it was appropriate. Training rates across the teams in level 3 safeguarding were 90% for the Camden CAMHS north team, 92% for the Camden CAMHS south team and 80% for the CAISS team.

Staff kept records of safeguarding referrals to the local authority safeguarding team. Staff put protection plans in place to keep patients safe. Records showed that staff knew how to recognise a safeguarding concern and take appropriate action.

Staff access to essential information

Staff were able to access clinical information and maintain high quality paper-based and electronic clinical records. However, staff had regular technical issues when accessing the electronic patient care record system.

At our last inspection in 2018, staff had told us that the electronic patient care record system sometimes stopped working, which meant they were unable to document patient notes promptly. Staff also told us that they could not access electronic patient records on trust laptops when visiting patients at premises such as school. During this inspection staff told us that the electronic patient care record system would still freeze and crash often which made it time consuming to record notes.

At this inspection the service had been a victim of a malware attack on their care records system in summer of 2022. This meant the service did not have access to the patient's care records for several months. During this time, the service created a version of the electronic care record system so the staff could continue recording patient notes. The service had their electronic patient care record system restored prior to the inspection, and the service was using system where administration staff were uploading the records made on the temporary system, and this would be checked by a clinician before it was confirmed.

Medicines management

The service used systems and processes to prescribe medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

None of the teams administered medicines on site or in patients' homes and medicines were not kept on site at the services. Psychiatrists used prescription pads that were secured according to the trust pharmacy guidance. The consultant psychiatrist would give a prescription to the patient or their family in person. Local arrangements were in place for children and young peoples' GPs to manage their physical health.

Patient allergies to medications were recorded in the care records as part of the clinical history.

Track record on safety

The service had a good track record on safety. In the 12 months prior to our inspection the teams did not report any serious incidents.

Our findings

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

At our previous inspection in 2018 staff knew how to report incidents, but not all staff where clear on what to report as an incident. At this inspection staff were able to explain to us what to report as an incident. Staff and managers told us that they followed an approach where they would report an incident were the behaviour went 'above and beyond' what was considered the usual behaviour for the patient.

In the 12 months prior to the inspection the service reported 38 incidents, most of these were information governance incidents. This means that confidential information was shared without permission.

Team managers attended a monthly clinical governance meeting and incidents was a standing agenda item, to enable managers to learn about incidents that occurred in other CAMHS teams and other services provided by the trust. Managers said they shared this information with their staff at team meetings and meeting minutes confirmed this. At the January 2023 clinical governance meeting incidents discussed included a theft of a mobile phone form a patient just outside the grounds of Tavistock, and a malware attack on the video conferencing system used by the trust. The clinical governance manager created a training presentation on incidents and how to report them, that could be used at supervision and in team meetings.

Staff reported incidents by logging them onto the quality portal. The manager would then review this, and the incident would be escalated to the incident panel. The monthly incident panel involved senior staff discussing the incidents and any themes. The service also provided learning from incident events every 6 months for staff to attend.

Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Staff were aware of the need to be open and transparent when things went wrong.

Is the service responsive?

Inspected but not rated

Access and waiting times

The service was easy to access. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments in line with the Trust policy.

Teams were responsive and saw young people and their families in a timely manner. Young people were rated according the RAG (red, amber, green) rating system, and young people that were rated red, and had either attended accident and emergency or had harmed themselves were seen within 7 days. The CAISS team saw 100% of their referrals from acute hospitals or in the community within 24 hours. Managers collated and monitored information on waiting times with the exception of their care records outage.

Our findings

Waiting times from referral to assessment was 3 weeks on average. This was within the Trust target of 4 weeks. The average waiting time between assessment to treatment was 4 weeks for Camden CAMHS north team and 6 weeks for the Camden CAMHS south team. The teams shared staff if they had a shorter waiting time to assist the other teams.

The service accepted referrals from a variety of sources, including schools, GPs, health visitors and midwives. Young people and their families could self-refer to the service and a clinician would carry out a telephone screening to see if they were suitable for the service.

The teams had clear criteria for which patients would be offered a service. The teams were nonrestrictive in how they assessed young people. They worked hard to offer an appropriate service to children, young adults and families who suffered with wide ranging mental health and/or emotional needs. For example, the CAISS team worked with eleven to 18-year olds and their families who were experiencing a significant deterioration in their mental health and if left unmanaged could lead to a tier 4 psychiatric admission. The referral route to the CAISS crisis pathway was a young person presenting to A&E or in the community. The young person must be registered with a Camden GP.

Service managers screened referrals to ensure urgent referrals were seen quickly. All new referrals were discussed at a weekly meeting, following an initial screening by a clinician. The leads of each discipline held the waiting lists for that discipline. For example, the lead psychotherapist of the Camden CAMHS north team held the waiting list for that team. For the Camden CAMHS north team there were 11 people waiting for family therapy, 39 waiting for psychology and 18 waiting for child psychotherapy. For the Camden CAMHS south team there were 8 people waiting for family therapy, 15 waiting for psychology and 17 waiting for child psychotherapy.

The service had created an application called the waiting room that the young people could use while waiting for treatment. This contained sections such as goals, check-in, clinician review and urgent help. Since implementation the application had had 11,572 page views. The service did not provide groups for young people to attend in the time they were waiting for treatment.

There were crisis hubs in the north central London clinical commissioning group in south Camden where patients could go instead of accessing the crisis line to avoid attending accident and emergency.

Staff could explain the steps outlined in the trust's 'Did not attend' (DNA) policy. When a young person did not attend an appointment, staff told us how they actively contacted the person and contacted other services if they were unable to get hold of them. The service had introduced a text messaging service, patients and/or their parent or carer were sent a text message reminder at two intervals, at one week and one day prior to their appointment.

Appointments were arranged between the hours of 9am with the last appointment at 5pm. At the previous inspection in 2018 the service was exploring ways to enable longer opening hours. At this inspection we were told the service could not support longer hours 7 days a week service as it would be difficult to supply consistent clinicians. Staff from all teams also saw children and their families at schools if this was their preferred option. This meant that the services were more accessible for those who were less likely to engage in services.

Staff demonstrated an in-depth knowledge of the individual needs and circumstances of the young people they supported. This was particularly evident in the case discussions we observed. Staff spoke about young people in a professional, dignified and respectful way. Staff also made appointments at a location which was most suitable for the patient and their family to meet. This may be at their school, a children's centre, community CAMHS centre or their home if they preferred.

Our findings

The service ensured that patients transitioning to adult mental health services took place without any disruption to the patient's care. One family member told us there were plans and dates in place to meet the adult services team for their child using the service and that they were happy with how information was being shared and the transition process.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, and dignity. However, the rooms patients were seen in for treatment were not soundproof.

The waiting rooms at Camden CAMHS north and Camden CAMHS south were bright, colourful and spacious. There were welcome messages on the waiting room wall from young people, such as 'I have a lot of fun here.' There was an art exhibition with messages and drawings from young people using the service.

There were communal toys and colouring available for younger children in the waiting areas. Each child also had their own named box of toys and games, which could be used during therapy sessions.

There was furniture for children, but the chairs in reception appeared worn, and some of the furniture, for example an armchair, in the consultation rooms could do with replacement. We were told new chairs were on order at the time of inspection.

There were 6 therapy rooms for patients at Camden CAMHS south. We were informed by staff that there were not always enough rooms available to hold sessions with patients, which meant some appointments dates were later than needed due to availability of rooms. However, the Camden CAMHS south team worked together to schedule appointments and maintained a low waiting times.

During the inspection we noted that at times, it was possible to hear conversations in therapy rooms when in an adjoining room or walking past the rooms. These were the rooms young people were seen in for treatment, and this raised the risk their privacy and confidentiality being compromised.

There were information leaflets available in reception, for families and carers and young people. They were not all written in a format suitable for younger children and were directed at families and carers even when this was regarding the young person. For example, a leaflet about how personal information was used was about the young person's information but directed at their family or carer. However, staff showed us a child friendly bespoke medicines leaflet as an example of leaflets accessible for young people.

The trust communications team was able to translate written information sheets, and staff in the teams could also speak a number of languages. The current common languages were Bengali, Somali, Romanian and Polish.

Staff in the Camden CAMHS south team also told us they were not provided with mobile phones to communicate with the young people as part of their care and were expected to use their own phones and hide their personal number. This method raised the risk of staff accidentally sharing their personal numbers.

At the Camden CAMHS south team there were photos of the staff that were in the team, however they needed to be updated to reflect lots of new staff. The water cooler machine in reception at the Camden CAMHS south team had not been working for months which we fed back on the day of inspection.

Our findings

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Staff considered the format of letters so they would not have too many words for young people, and letters were tailored to be age appropriate. Staff used emails to send letters to young people as they preferred this.

The premises were accessible for people of family members with physical disabilities. Camden CAMHS south was based on the ground floor and Camden CAMHS north had a lift if people needed to use therapy rooms that were not on the ground floor. There were toilets with disabled access.

The trust used a local service to provide interpreters for people who required them. Staff told us they were able to translate letters for young people, families and carers.

Staff told us that they could always access an interpreter when required. Staff had access to leaflets in different languages. Staff acknowledged that the initial form for young people, families and carers was in English, but this form asked for all accessibility needs including the need for leaflets in other languages.

Staff were aware of the impact of cultural diversity on care. Staff discussed the cultural diversity between the clinical staff and families during clinical discussions.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. However, the service was not recording and learning from informal feedback.

Staff knew how to handle complaints appropriately. Staff dealt with informal complaints immediately if a patient, family member or carer informed them. If necessary, staff escalated the complaint to the manager. However, the service did not currently record informal complaints and therefore learning from these could not be identified shared with the wider staff group. If a formal complaint was received, staff said they would follow the Trust policy to record and escalate this to a manager.

There were 2 formal complaints in the 12 months prior to inspection. Both complaints were acknowledged within 3 days.

There were leaflets displayed in the waiting room at Camden CAMHS north and Camden CAMHS south that informed patients' and their families on how to make a complaint about the service.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and knowledge to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Our findings

Leaders had the skills and knowledge to perform their roles. As a result of the strategic review there had been structural changes to leadership. As a result, team managers had clinical roles as well.

Managers could explain clearly how the teams worked to provide high quality care. Managers attended a range of meetings, including a weekly clinical services leadership meeting, fortnightly senior operations leadership meetings and senior clinical leadership meetings. The managers understood how their service was performing in terms of quality outcomes for patients as well as staffing arrangements and the condition of the environments.

Leaders were visible in the service and approachable for patients and staff. Staff found the managers to be approachable and provided good direction. Staff knew who the senior management team were for their service and said they found them supportive. The senior management team had set up an online drop-in service for staff, staff told us they found this helpful.

Vision and strategy

Staff knew of and demonstrated the provider's vision and values and how they were applied to the work of their team.

Staff were enthusiastic about the service and the work they did. Staff told us they were aware of the Trust's vision and values and where to find them, however they were not able to provide detail about these.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us morale had been lower since the strategic review, however now that this has been implemented morale was improving. Staff said they felt positive and proud about working for their team and the trust.

The Camden CAMHS north team had recently implemented a monthly equality, inclusion and diversity meeting. We reviewed minutes from meetings in July and December 2022, and January and February 2023. Topics discussed included power dynamics amongst clinicians and how to make these meetings more useful for staff. The service had an online half-day away day for equality, inclusion and diversity in July 2022.

Teams worked well together. They were multidisciplinary with each profession's contribution valued. We found they worked in a non-hierarchical way in which each person's view was welcomed.

Staff told us they felt comfortable to raise concerns with their manager and that they would be listened to and that any concerns they raised would be actioned on.

Staff knew how to use the whistle blowing process and a copy of this was available on the trust intranet. Staff knew about the role of the freedom to speak up guardian, and how to find information about them.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Our findings

The service had a framework for the discussion of important information such as learning from incidents and complaints. Managers attended a clinical governance meeting where these were standard agenda items, and this was then cascaded down to team meetings. Senior staff attended incident discussion panels and staff attended team meetings, clinical meetings and learning from incident events.

The service completed audits to evaluate how the service was running. This included audits of care records, transitioning to adult services, and trainee audits. The audit of carer records was prior to the outage, 101 patients' records were audited in the 12 months prior to inspection.

Management of risk, issues and performance

There were systems in place to manage risk and issues to the service.

There was a risk register in place for the service. Service and team managers identified the main risks to the service from the risk register as being the shared human resources recruitment issues, the gaps in management for the Camden CAMHS north team and the information governance breaches**.**

A permanent team manager for the Camden CAMHS north team was starting in March 2023. There were plans to reissue the guidance around sharing information to staff. The risk register did not have an action plan for addressing the shared human resources issues, however we were told the service had fed back their concerns and there had been some recent improvement to this.

Managers also identified the impact of the strategic review as well as the care record system outage and the slow recovery from this on staff morale.

The service had an updated business continuity plan from December 2022.

Information management

Following the electronic records outage, the service created a temporary system to store care records. The interim process was effective, and the staff continued to maintain good quality patient care records. The service had their electronic carer records system restored just before the inspection and at the time of inspection administrative staff were moving the information from the temporary system to the usual system.

Engagement

Managers engaged actively other local health and social care providers through the north central London partnership to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Managers worked closely with other local healthcare services and organisations, schools and local authorities to ensure that there was an integrated local system that met the needs of children and young people living in the area.

The service used staff satisfaction surveys to learn from staff perspectives, to fully evaluate the service and make improvements. The 2021 staff survey results were below average in all 9 themes, and this was used to inform the strategic review and 2022-2027 people plan

Staff used feedback from patients, families and carers to bring about improvements to the service. However, the service was not recording informal feedback, which was a missed opportunity to learn from this and use this feedback to make improvements to the service.

Our findings

Learning, continuous improvement and innovation

The service engaged in quality improvement projects to improve the service.

The service held monthly quality improvement forums at both sites to support, encourage and develop quality improvement projects. The forum at the location for the Camden CAMHS south team was the first in the Trust.

The service had at least 10 active quality improvement projects at the time of inspection. One project was run by the psychiatry team to increase confidence and support in handling risk and improving access to psychiatry support. The Camden CAMHS south team trialled a fortnightly discussion space chaired by a member of the psychiatry team, and the service created clearer multidisciplinary structures to hold risk as a team rather than individually. The project them created a survey to assess current access to psychiatry support which was re-administered following these interventions.

There were several projects around equality, diversity and inclusion. This included a project in Camden CAMHS south team aimed at increasing the use of race, ethnicity and culture conversions in case work through developing a visual tool to refer to during supervision.

The CAISS team had been implemented to reduce admission to inpatient services, and there were 2 months in the 12 months prior to inspection were there were 0 admissions.

The service held a quality improvement introductory session in April 2022 which was attended by 24 staff. The service planned to further roll out this training in spring of 2023.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that staff complete the mandatory resuscitation training (Regulation 18(2)(a))

Action the trust Should take to improve:

- The trust should consider the use of room and personal alarms for those staff who wish to use them when working on site or visiting patients off site.
- The trust should ensure that all emergency equipment on site is suitable for the patient groups seen at that site.
- The trust should continue their work to make the written information on site more accessible to young children
- The trust should review whether rooms for confidential assessments and treatments are adequately soundproofed to maintain confidentiality
- The trust should consider creating more space for clinicians to see patients.
- The trust should ensure IT infrastructure and systems to support staff to carry out their roles is effective. The trust should ensure that all staff who require equipment for their work, such as phones, are provided with it.

Our inspection team

The inspection team consisted of a lead inspector, another inspector, 2 specialist advisers and an expert by experience. An expert by experience is someone who has experience of care and treatment in a mental health service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-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
	Regulation 18 HSCA (RA) Regulations 2014 Staffing