

**Good** 

# South London and Maudsley NHS Foundation Trust

# Specialist community mental health services for children and young people

## Quality Report

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Date of inspection visit: 21-25 September 2015  
Date of publication: 08/01/2016

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RV504	Maudsley Hospital	Lambeth CAMHS	SE11 6JJ
RV504	Maudsley Hospital	Croydon CAMHS	CR0 1QG
RV504	Maudsley Hospital	Lewisham CAMHS	SE6 4JF
RV504	Maudsley Hospital	Southwark CAMHS	SE5 8AZ

This report describes our judgement of the quality of care provided within this core service by South London and Maudsley NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

# Summary of findings

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 South London and Maudsley NHS Foundation Trust and these are brought together to inform our overall judgement of South London and Maudsley NHS Foundation Trust.

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

### Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

### **Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

# Summary of findings

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# Summary of findings

## Overall summary

We gave an overall rating for the specialist community mental health services for children and young people of **good** because:

- Young people and their families were treated as partners in their care and staff treated young people and their families with kindness, dignity and respect.
- Managers supported staff to deliver effective care and treatment. Staff adopted a multi-disciplinary and collaborative approach to care and treatment.
- There was clear processes in place to safeguard young people and staff knew about these. Incident reporting and shared learning from incidents was apparent across the services.
- Most young people, children and families could access services promptly. There were robust systems in place to manage referrals and waiting lists. However in some areas waiting lists for assessment and treatment were not meeting national targets.
- There was strong leadership at both local team and service level which promoted a positive culture. There was a commitment to continual improvement across the services.

# Summary of findings

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

### Are services safe?

We rated safe as **good** because:

- There were sufficient staff with the appropriate skills and training to meet the needs of the young people accessing the teams. Caseloads were managed and reassessed regularly.
- Staff assessed, monitored, and managed risks to young people on a day-to-day basis.
- Clear processes were in place to safeguard young people and staff knew about these. There was an identified safeguarding lead. Safeguarding was discussed at team meetings and as part of individual supervision.
- Clear protocols were in place for lone working practice and staff were using them.
- Staff knew how to report incidents. Incident reporting and shared learning from incidents was apparent across all teams.

However, some improvements were needed to ensure all the buildings where staff saw patients were safe and the equipment was maintained. Risk assessments need to be completed and stored more consistently in the electronic records so they can be located when needed. Recruitment needs to continue to provide permanent stable teams of staff.

Good



### Are services effective?

We rated effective as **good** because:

- Young people had a comprehensive and timely assessment of their needs. Care records were personalised, holistic and recovery focused.
- Guidance was followed when prescribing medication and meeting the physical health care needs of the children and young people to ensure this was in line with current best practice. Outcome measures were used to measure and support children and young people make progress.
- Staff received good support from their managers with regular team meetings, clinical and management supervision.
- Staff adopted a multi-disciplinary and collaborative approach to care and treatment.
- Staff understood issues of capacity and consent and the use of the Gillick competencies was good in deciding whether a young person under the age of 16, was able to consent to treatment without the need for parental permission or knowledge.

Good



# Summary of findings

## Are services caring?

We rated caring as **good** because:

- Young people and their families were very complimentary about the service and the staff who supported them.
- Young people and their families were treated as partners in their care.
- Young people were given opportunities to be involved in how the service was provided.

Good



## Are services responsive to people's needs?

We rated responsive as **good** because:

- Referrals to the service were prioritized with young people who needed urgent support being seen immediately. Some children and young people with less urgent needs were experiencing long waits to access some of the services. They were monitored and if their needs changed they would be seen sooner.
- All teams had access to a full range of meeting and therapy rooms which were appropriately furnished, well maintained and suitable for purpose.
- All teams were sensitive to the needs of the young people and their families in terms of their diverse needs.
- Staff were transparent and honest where people who used the services had raised complaints or concerns.

Good



## Are services well-led?

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

- Managers and teams had effective meetings to ensure young people received appropriate and timely services to meet their individual needs.
- There was strong leadership at both local team and service level and staff felt supported by the trust and their line managers.
- Morale in the services had varied in response to a number of changes across the teams. However staff remained highly committed to continuous improvement of the services for young people.

Good



# Summary of findings

## Information about the service

South London and Maudsley NHS Foundation Trust provide specialist child and adolescent mental health services (CAMHS) community teams for children and young people up to the age of 18 across the boroughs of Southwark, Lewisham, Lambeth and Croydon.

The trust provides a diverse range of specialist outpatient services some of which are national specialist services

supporting children and young people with a wide range of disorders including autism, learning disabilities, eating disorders, self harm, substance abuse and emotional disorders.

This inspection focussed on the specialist community teams (called tier 3 services) supporting children, young people and their families from the four local boroughs. These services had not been previously inspected.

## Our inspection team

The team that inspected the CAMHS community teams included one CQC inspector; a social worker, two psychologists, a nurse specialist in CAMHS services and one expert by experience.

## Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups for people of all ages.

During the inspection visit, the inspection team:

- Visited the four CAMHS tier 3 services providing community services across the London boroughs of

Southwark, Lewisham, Lambeth and Croydon and looked at the quality of the environment and observed how staff were caring for young people using the service.

- Spoke with 12 young people who were using the service and their families, who shared their views and experiences of the services we visited.
- Spoke with the managers or acting managers for each of the teams.
- Spoke with 22 other staff members; including doctors, nurses and social workers, therapists, trainees and administration staff.
- Interviewed the service directors with responsibility for these services.
- Attended and observed seven clinical appointments, one group session and three multi-disciplinary meetings.
- Collected feedback from 28 people who use services using comment cards.



# Summary of findings

- Looked at 23 care records of young people.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

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

We spoke to 12 young people and their families during the inspection. We also received feedback from 28 people from comment cards. We met with a group of young people at a user group before the inspection.

All the young people and families we spoke with and the comments we reviewed were highly complementary about the service they received from the specialist community mental health services for children and young people.

All the children, young people and their families felt staff treated them with kindness, dignity and respect at all times. They felt listened to and involved as partners in their care.

The majority felt they could access services promptly although a few were critical of the length of time it took to be seen by services following their referral. We received one comment suggesting that it would be helpful to have an answering machine service at the Lambeth team base where messages could be left.

## Good practice

- There had been a shared learning event across Southwark and Lambeth CAMHS on the therapeutic assessment of self-harm and the teams were piloting their intervention approach.
- Staff from the CAMHS teams and parents with experience were delivering learning sessions to parents of young people to help them re-build relationships with their children whose behaviour of self-harm, violence and aggression had affected family relationships.
- Young people were involved in decision making about the teams, for example on interview panels for staff.

## Areas for improvement

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

- The trust should ensure that the environment at Lambeth is safe for those people who use or work in the service.
- The trust should ensure that infection control audits are carried out across all CAMHS services.
- The trust should continue to monitor and review the services to ensure that all children and young people can access the service in a timely manner.
- The trust should ensure that all staff have IT equipment and patient record systems that enable them to access the information they need in a timely manner.
- The trust should ensure that there is a consistent approach to the documentation of patient care and treatment, including risk assessments, care plans and consent.

# South London and Maudsley 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
Lambeth CAMHS	Maudsley Hospital
Croydon CAMHS	Maudsley Hospital
Lewisham CAMHS	Maudsley Hospital
Southwark CAMHS	Maudsley Hospital

#### 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

There were no young people subject to a community treatment order.

Staff were able to access training Mental Health Act 1983 and Code of Practice training. Staff were expected to complete this as part of their mandatory training. Completion of Mental Health Act training was below 75% in September 2015 across the teams and there was a training action plan in place to improve this.

Staff could access administrative support and legal advice about the Mental Health Act and the Code of Practice from a central team within the trust.

There were two Approved Mental Health Practitioners (AMHPS) who provided specialist CAMHS knowledge and experience to the teams about the Mental Health Act.

The trust information leaflets for young people being detained were displayed in public areas.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

The Care Quality Commission have made a public commitment to reviewing provider adherence to the Mental Capacity Act (MCA). The MCA applies to young people aged 16 and 17. Mental capacity assessments should be carried out to make sure the young person has the capacity to give consent.

The Mental Capacity Act does not apply to young people aged 16 and under. For children under the age of 16, staff applied the Gillick competency test. This recognised that some children may have a sufficient level of maturity to make some decisions themselves.

The patient record contained information that related to capacity and consent. Staff understanding of the Gillick competencies was good and they described how it would be applied when a young person had decided they did not want their family to be involved. This meant that consent for care and treatment was always sought from young people and their families where appropriate.

Staff were able to access MCA training. Staff were expected to complete this as part of their mandatory training. Staff training action plans were in place to ensure all staff received training.

# 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

- The design, layout and cleanliness of most of the clinic areas where young people met staff were safe and suitable. Alarms were available if staff needed support and the teams knew how to respond if the alarms were activated.
- However at the Lambeth team not all rooms were fitted with alarms or alarms within easy reach. There was no CCTV at the entrance and the buzzer system was not always clearly audible to staff. There was access to the street from the rear of the building. During the inspection the doors leading directly outside were left open. Although staff were always present, this meant there was a risk of people entering the building who were not using the service. The windows on the first floor rooms opened fully. This meant that when young people accessed those rooms there was a risk to their safety.
- At the Lambeth team the equipment to keep the environment safe had not all had updated checks. For example some electrical equipment required PAT testing to be completed. There had been a flood in the basement of the building which was being cleaned up. However areas requiring maintenance in other parts of the building were identified including damp and broken plaster and a broken door handle. Hot water was not available and there was a blocked sink. The inspection team brought these issues to the attention of the service at the time of the inspection and a plumber was in attendance before we left.
- Southwark CAMHS had a well-equipped clinic room, however the calibration of the equipment was out of date and supplies in the first aid kit and the bio hazard spillage kit.
- Across all four sites there was no evidence that staff carried out consistent infection control audits or toy cleaning schedules to prevent the spread of infection. This meant that there was a potential to put young people at risk of infection.

### Safe staffing

- Maintaining safe staffing levels and filling vacancies in the teams was an ongoing challenge. Recent recruitment had taken place with young people who used the service taking part in the recruitment process.
- The sickness rates for the CAMHS services was recorded at 3% at 31 July 2015 and low sickness rates were evident across the teams.
- There were vacancies in some of the teams with plans for these to be filled by the end of the year. To manage these staff shortages part time staff were asked to increase their hours and there were bank and agency staff in place who had previous CAMHS experience. Caseloads were managed and reassessed regularly.
- All newly recruited staff completed the corporate and local induction. Mandatory training rates for all services was 75% and above in the majority of areas.
- Medical staff across all four services were accessible and responsive. There was a named consultant on duty every day and the CAMHS crisis pathway included 24 hour availability to CAMHS specialists. Young people and relatives who used the service said staff could be contacted easily.

### Assessing and managing risk to patients and staff

- CAMHS teams had a duty system to manage referrals and waiting lists on a daily basis. Waiting lists were discussed at weekly team meetings. Referral discussions were recorded, actioned and rated for urgency. Allocation of referrals was based on clinical need and urgent referrals could be seen immediately. Young people were also signposted to other services and received an individualised letter with advice about what to do in an emergency. This included contacting the services directly in the event of a crisis to speak to the duty worker in normal working hours or to attend the accident and emergency department at the acute hospital.
- The CAMHS teams worked closely with the child and adolescent paediatric liaison service to follow up children and young people who were at risk. The teams were based at Kings College Hospital and St Thomas's

# Are services safe?

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

Hospital. This follow up would happen within seven days and would consist of a visit in some cases or a telephone call and follow up arrangements based on the risk. All the teams would visit young people discharged from an inpatient service within seven days.

- At the initial assessment an individual risk assessment and management plan was completed. This was updated following any change in circumstances. The risk assessment and plan was in the patients electronic record. Following the initial assessment a letter was generated which included the risk assessment and was also copied to the young person and their relatives where appropriate. Risk assessments were discussed at multi-disciplinary team (MDT) meetings and during managerial and clinical supervision with team leads. This meant all staff were able to respond appropriately to changing risks to young people who use services.
- Managers were able to access reports giving them an oversight of the completion of risk assessments. There was an expectation that risk assessment should be updated at least every six months. However when we reviewed the care records there was inconsistent recording of risk assessments, plans and updates within the patient record system. This meant there was a risk that staff would not be able to access the records when needed.
- Staff said the skills in completing risk assessments were variable in the teams. In Lambeth CAMHS they were trying to establish that initial assessments were done in collaboration with a senior clinician. Clinical risk training and risk management training were mandatory training requirements and there had been a reduction in compliance in some teams. This had been discussed by senior management and an action plan put in place.
- There was a red flag alert system on the young person's electronic record and any changes could be identified with smiling and non-smiling faces. This meant that staff were aware of particular risks affecting young people.
- There was a clear protocol when young people did not attend their appointments. Staff could clearly describe the actions to be taken which included always following up with contact from the team.
- Staff had received training in safeguarding adults and children. Staff knew how to raise a safeguarding alert and had a good understanding of the safeguarding

protocols and procedures. Safeguarding was clearly embedded across the teams. We observed MDT meetings where safeguarding was a key element of clinical discussion and action taken, including updating the patients record. We observed staff raising safeguarding issues at clinical appointments and agreeing plans with the young person to manage and reduce their risks. There was a safeguarding lead in every team. There were good links with the local authority, evidence of multi-agency working and information sharing. This meant that young people were protected from abuse and avoidable harm.

- There were clear lone working protocols and staff were able to describe how they kept themselves safe. Staff worked in pairs where risks were identified and were mindful of their colleague's whereabouts. In Lewisham CAMHS there was a staff movement board and an emergency contact file for staff. However staff were using their personal mobile phones if they needed to contact the team and the team manager had requested a team phone.
- Staff did not store or dispense medication at the services. Prescriptions were issued by medical staff directly to the young person or their relative. There was a shared care protocol in place with general practitioners.
- Some staff reported the electronic record system as slow which meant staff were not always able to access information they needed in a timely manner.

## Track record on safety

- In the six months prior to the inspection there had been 78 incidents reported with safeguarding concerns related to children. Incidents were graded and investigated.
- There were two serious incidents reported between April 2014 and August 2015 concerning CAMHS services. Staff were able to describe the process following the incident including the opportunity for de-briefing and how changes had been made to their work practices based on the lessons learnt.

## Reporting incidents and learning from when things go wrong

- Incident recording and reporting was effective and embedded across all services. All staff were aware of

# Are services safe?

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

how to report incidents using the electronic reporting system. All incidents were reviewed by the teams and staff were able to describe feedback they had received following incidents and changes which had been made.

- We asked a number of staff about the duty of candour which was introduced for providers to ensure they were open and honest with people when something goes wrong. Some staff were able to describe what this meant in their day to day work. Staff we met with demonstrated a culture of openness and transparency and the importance of being honest with those people who use the service.

- Incidents were investigated and discussed in a range of forums including clinical governance days, senior management team and local team meetings.
- Staff received information about adverse events from the trust using the blue light and purple light bulletins. We observed blue light information being cascaded to staff at team meetings. This meant there were reliable communication systems.

# Are services effective?

Good 

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

## Our findings

### Assessment of needs and planning of care

- The majority of care records were personalised, holistic and recovery focused. A comprehensive and timely assessment had been completed for each person at the initial assessment. Young people's plans of care were shared with the young person, their families and their general practitioner and school where appropriate. The care plan template within the electronic patient record system was not consistently used across teams. This meant there was a risk that staff may not be able to locate the information they need to deliver effective care and treatment.
- Young people mental health needs were thoroughly assessed by compassionate staff. The assessment was carried out at a pace to suit the young person and their family and could be conducted over a number of sessions. Staff planned for care and treatment during the assessment and agreed further actions with the young person and their family.

### Best practice in treatment and care

- The CAMHS teams were implementing evidence based clinical standards and adhered to National Institute for Health and Care Excellence guidelines. Examples of this were seen in the care that included management of self-harm, depression and ADHD.
- Young people had access to a range of psychological therapies and groups as part of their treatment and psychologists were part of the MDT. In Lewisham we observed a non-violent resistant (NVR) group session led by CAMHS practitioners and parents with experience. The session was delivered to parents of young people to help them re-build relationships with their children whose behaviour of self-harm, violence and aggression had affected family relationships. Parents said this group had given them their lives back. This meant that staff and services were working together to deliver effective care and treatment.
- Physical health care needs were addressed in clinical sessions and MDT meetings. Issues including side effects of medication, discontinuation syndrome and weight monitoring were discussed with young people and their

families. This meant that NICE guidance was followed when prescribing medication and the physical health care needs of the children and young people were considered.

- The use of a number of routine outcome measures (ROMS) were being collected in addition to condition specific outcomes. ROMS are questions that can be completed by the young person, the carer or the clinician, at the beginning and end or during interventions by staff. We heard evidence of outcome measures being discussed with young people to help inform future care planning and saw that young people were given copies of their outcome measures. Young people had presented their views on the use of ROMS to the trust board. This meant outcome measures were embedded and being used to monitor the effectiveness of the service.

### Skilled staff to deliver care

- Teams included a range of mental health disciplines required to care for children, young people and their families. Teams consisted of consultant psychiatrists, nurses, social workers, occupational therapists, psychologists and a range of therapists. There were specialist roles within the teams such as safeguarding leads.
- Staff had the qualifications and skills they needed to carry out their roles effectively. In Lambeth and Southwark all staff received the improving access to psychological therapies (IAPT) induction and support from a dedicated IAPT champion working with nine teams across seven sites. In Southwark all staff were trained in family partnership training and in Lambeth staff said they had recently received training in assessing self-harm assessment.
- All staff received a range of opportunities for supervision and support including regular team meetings, individual and group clinical supervision, and managerial supervision and team away days. Appraisals were up to date and we saw evidence of supervision records and appraisal documentation where staff were supported to develop.



# Are services effective?

Good 

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

## Multi-disciplinary and inter-agency team work

- Assessments were multidisciplinary in approach and discussions showed evidence of effective MDT working taking place. Staff shared information about young people including safeguarding concerns and physical health issues.
- There was a trust policy for young people in transition to adult mental health services. This is the planned movement of young people from child centred to adult orientated healthcare systems. Staff worked jointly with colleagues from adult mental health services during the transition to adult services.
- The CAMHS teams had good links with other relevant services to ensure the needs of young people were met. For example the teams in Lewisham were co-located with the paediatric clinicians and we saw good links with GPs with letters communicating outcomes of assessments and changing needs of the young people.

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

- There were no young people subject to a community treatment order.
- Staff were able to access training Mental Health Act 1983 and Code of Practice training. Staff were expected to complete this as part of their mandatory training. Completion of Mental Health Act training was below 75% in September 2015 across the teams and there was a training action plan in place to improve this.

- Staff could access administrative support and legal advice about the Mental Health Act and the Code of Practice from a central team within the trust.
- There were two Approved Mental Health Practitioners (AMHPS) who provided specialist CAMHS knowledge and experience to the teams about the Mental Health Act.
- The trust information leaflets for young people being detained were displayed in public areas.

## Good practice in applying the MCA

- The Mental Capacity Act does not apply to young people aged 16 and under. For children under the age of 16, staff applied the Gillick competency test. This recognised that some children may have a sufficient level of maturity to make some decisions themselves.
- The patient record contained information that related to capacity and consent. Staff understanding of the Gillick competencies was good and they described how it would be applied when a young person had decided they did not want their family to be involved. This meant that consent for care and treatment was always sought from young people and their families where appropriate.
- Staff were able to access MCA training. Staff were expected to complete this as part of their mandatory training. Staff training action plans were in place to ensure all staff received training.



# 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

- Young people and their families we spoke with and comments we received gave very positive feedback about the staff and the care and treatment that was provided. Young people said they were treated with kindness and respect by staff who were supportive of their needs. Families said staff were very helpful and accessible.
- We observed staff to be respectful, considerate and mindful of confidentiality. Staff demonstrated sensitivity and honesty and were engaged in positive relationships with young people and their families. Discussions at MDT meetings reflected care and compassion for the young people and their families.
- Young people and their families felt they had been given emotional support to cope with their care and treatment.

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

- Staff involved young people and their families as partners in their care and in making decisions. Families

were involved as appropriate and according to the young person's wishes. Young people's agreement was sought and where appropriate information was shared with others about their care and treatment.

- Young people commented they had been involved in their care plans and had received copies. We observed young people and their families fully involved in decisions about care and treatment at clinical appointments. Families commented they felt listened to and were kept informed and were given copies of letters.
- Staff considered the needs of young people and their families who required information to be provided in different accessible formats and the use of interpreting services.
- Young people had been involved in interview panels when recruiting new staff in the trust. They had been involved in developing questions and held an equal vote on the interview panel.
- Feedback received from young people was collected and used to make improvements to the services. We saw comments boxes and cards and "you said, we did" feedback displayed in public areas. In Lambeth staff told us the waiting area had been refurbished following feedback received from young people.

# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

- There was a duty system across the teams which reviewed and prioritised referrals using clear criteria on a daily basis. Urgent referrals could be seen immediately. Team managers monitored the referrals and allocations to clinicians. This meant that services were able to prioritise care and treatment for young people with the most urgent need.
- The trust did not have agreed target times for urgent and non-urgent referrals to be assessed and receive the treatment. They were working with commissioners to develop these targets. Lambeth CAMHS reported waiting times had improved from ten months to five months for non-urgent referrals with a plan to reduce to 18 weeks by the end of the year. In Southwark staff said there was a wait of up to five months for family therapy. In Croydon a standard letter was being sent to young people referred to the service advising the waiting list was over one year for non-urgent referrals. Semi-urgent referrals were seen within 25 weeks. There was a target of one year to reduce this to within the 18 week waiting time target. In Lewisham the neurodevelopmental team had 70 people who were identified as waiting since February 2015 and 100 children were waiting to be seen for ADHD medication. Whilst all these waiting times were of concern, the trust continuously monitored the referrals to prioritize the allocations to clinicians. They also worked closely with commissioners to identify how improvements to the service could be made.
- The CAMHS teams accepted referrals from general practitioners and a range of professionals and other agencies. Young people could refer themselves to the service.
- Services were mostly provided between the hours of nine to five during the week and most young people and their families were seen at the team sites. Staff told us there were some later clinics available and it was possible to conduct visits at alternative sites. Young people and their families said home visits had occurred. We observed flexibility around appointment times being offered by staff to suit the needs of the young person and their families. Staff told us that appointments are rarely cancelled however in the event of un-planned absence of staff, non-urgent appointments may be cancelled. This meant that as far as possible people could access care and treatment at a time to suit them.
- Young people could access specialist CAMHS help outside of normal opening times by going to accident and emergency departments at acute hospitals.
- Waiting lists for talking therapies across the service varied. There were historically long waiting lists for young people to be seen following referral. In Lambeth we were told 278 people were waiting up to ten months to be seen twelve months ago. This had reduced to 130 people waiting since April 2015. People told us about their long wait to be seen by services following referral. However there were clear plans to address the waiting lists, including recruitment of staff, changes in systems and the development of criteria for accessing services. The vision was to reduce the waiting time to 18 weeks. However all four services we inspected reported that they were able to provide a safe service because they had systems in place to ensure young people who were at risk were seen promptly.
- There was a trust policy for young people in transition to adult mental health services. This is the planned movement of young people from child centred to adult orientated healthcare systems. Staff described joint team working using the care programme approach. However staff reported it was often difficult to engage in joint working until the young person reached 18 years. This meant that it was difficult to plan, deliver and co-ordinate care for young people at times.
- Where young people were being discharged from the services, CAMHS teams ensured that identified services on discharge for the young people were in place.

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

- At all services we found the facilities promoted comfort, recovery, dignity and confidentiality of the young people. Waiting areas contained play equipment and suitable seating. There were adequate rooms available for individual consultations and therapies. In Croydon young people using the service had painted pictures which were displayed on the walls and in Lewisham, children from a local school provided pictures for display in the corridors.

# Are services responsive to people's needs?

Good 

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

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

- All services had considered the needs of those people accessing the service with a disability. However the building at Lambeth had limited accessibility for people with a disability.
- Information leaflets displayed across the services were mainly in English language. Staff said other languages were available to print from the trust intranet when needed. There was access to interpreting services when the young persons or families first language was not English.
- CAMHS had an identified equality and diversity lead. Staff reported they were able to access equality and diversity training. Staff were expected to complete this as part of their mandatory training and we saw that compliance was monitored by team managers. We observed young people's spiritual, ethnic and cultural needs were considered and their care and treatment was planned and delivered to reflect these needs.

## Listening to and learning from concerns and complaints

- The trust had a complaints procedure that was summarised in leaflets we saw displayed in public areas. The information displayed was in English and we were told easy read formats and other languages were available to print from the trust website. Staff told us they knew about the trust complaints policy. Staff

described a culture of honesty and openness when dealing with complaints and would try to resolve issues raised locally where possible. Staff gave examples of informal concerns that had been raised and how they had been resolved. Young people and their families told us they knew how to complain if they needed to.

- The trust recorded all formal complaints received about CAMHS services in the past 12 months. Croydon CAMHS had the highest number of complaints with 12 in total with four upheld following investigation. Staff told us that people who use the service and their families contact the service regularly to complain about waiting times. Staff said they try to deal sensitively with complaints and refer to the team manager and patient liaison service (PALS.) A relative commented that it "felt cruel to wait so long." This meant that people may not always access care and treatment in a timely way.
- There were clear communication structures in place to feedback lessons from complaints. The CAMHS staff survey action plan identified initiatives were in place to increase staffing and review the skill mix in teams. There was significant investment planned for CAMHS services supported by the "Future in Mind" strategy. This strategy recognised that more young people need support and they have to wait longer to get the right care and treatment. This meant that complaints and concerns were listened and responded to and used to improve the quality of care.

# Are services well-led?

Good 

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

## Our findings

### Vision and values

- Trust values and behaviours had been developed collaboratively and were embedded in the staff appraisal process. Trust values were displayed and staff were able to talk about how these were reflected when they carried out their work. We observed staff behave in ways that reflected the trust vision, purpose and commitments.
- Senior managers regularly visited the services and most staff were able to identify and meet them.

### Good governance

- The CAMHS service held regular senior management team meetings with evidence of applying robust governance systems. They identified any issues of risk or poor performance against key performance indicators as well as where improvements had been made. Issues were fed back at team meetings and there was opportunity for staff to submit items to their risk registers.
- In Lambeth a clinical governance day had taken place in June 2015 where learning from serious incidents took place. In Lewisham well organised and well led team meetings took place which allowed challenges being faced by the service to be discussed. Team away days were arranged.

### Leadership, morale and staff engagement

- There was strong leadership at both local team and service level which promoted good practice and most staff felt supported by the trust and their line managers.
- Some staff reported feeling under pressure because of staff vacancies and the pressure of increasing referrals and the complexities of the young people they were supporting.
- Morale in the services had varied in response to a number of changes across the teams. However most staff told us they were happy in their job. We observed staff using mindfulness strategies alongside opportunities to reflect on how they were feeling in team meetings. This meant that supportive relationships amongst staff was encouraged.

- Staff felt able to raise concerns without fear of victimisation or bullying with managers and were aware of the whistleblowing policy if they needed to use it.
- Staff had raised issues and concerns via the staff survey. In response the CAMHS clinical academic group was developing an action plan. This meant that staff were actively engaged so that their views were reflected in the planning and delivery of services.

### Commitment to quality improvement and innovation

- The trust had organised its services into clinical academic groups (CAGS). CAMHS service was one of seven CAGS, with the defined purpose of bringing together clinical and academic experts so that services could offer the very best care and treatment based upon reliable research evidence.
- Staff remained highly committed to continuous improvement of the services.
- The teams we inspected had not participated in the CAMHS Quality Network for community CAMHS accreditation scheme. However some teams had been involved in local audits of their service which was used to make changes to their practice. In Lewisham an audit of the quality of completion of assessments had resulted in a checking system at team meetings being implemented.
- Staff said they felt supported to access the training the required for their learning and development. There had been a shared learning event across Southwark and Lambeth CAMHS on the therapeutic assessment of self-harm and the teams were piloting their intervention approach.
- Improving access to psychological therapies for children and young people (IAPT) was embedded across the teams.
- Senior managers were committed to quality improvement and innovation using evidence based practice and service development and improvement plans were in place.