South London and Maudsley NHS Foundation Trust

Specialist community mental health services for children and young people

Trust Headquarters
1st Floor Admin Building
London
SE5 8AZ
Tel: 02032286000
www.slam.nhs.uk

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Ratings

Overall rating for this service	Good
Are services safe?	
Are services effective?	
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Good**

Summary of findings

Specialist community mental health services for children and young people

Good ➔➔

Summary of this 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 primarily focussed on the specialist community teams supporting children, young people and their families from the four local boroughs, crisis services, and National and Specialist services for people with complex autism associated neurodevelopmental disorders (SCAAND).

Following the last CQC inspection of this core service in January 2016, this core service was rated Goodacross all domains. However, SCAAND and centralised crisis services were not included. The current responsive focussed inspection, only includes ratings for Caring, Responsive, and Well-Led for this core service, as we did not inspect all areas of the other two domains. We used CQC's interim methodology for monitoring services during the COVID -19 pandemic.

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?

As part of this inspection, we:

• Visited one CAMHS service office in the London borough of Lewisham, to look at 34 care records of young people currently using, or recently discharged from CAMHS services (including seven from SCAAND services, six from crisis services, and 21 from the four local borough teams).

• Had telephone conversations with 12 young people who were currently or had recently been using the local borough services.

• Had telephone conversations with 47 parents/carers of young people who were currently or had recently been using the services (38 from local borough services, and nine from SCAAND services).

• Had telephone/video conversations with 75 multidisciplinary staff (25 from local borough teams, 21 from crisis services, and 29 from SCAAND teams). These included doctors, nurses, psychologists, therapists (including psychotherapists, family, behavioural, occupational and speech and language therapists), trainees, and administrators.

• Had video conversations with 13 senior managers/directors with responsibility for

Summary of findings

these services.

• Had telephone/video conversations with seven Special Education Needs Coordinators (SENCO workers) working in schools in the local boroughs.

The Service for Complex Autism & Associated Neurodevelopmental Disorders (SCAAND) is a national service. It is commissioned by NHS England with some Clinical Commissioning Group (CCG) contracts. Patients tend to have multiple co-morbidities. There are four clinical service 'streams' and a senior leadership team. Referrals are jointly screened and allocated to one of four streams. These are Neuropsychiatry, Intellectual Disabilities (IDT), Autism and Related Disorders (ARD) and the Autism and Intellectual Disabilities Intensive Intervention Team (AID-IIT).

The SLAM CAMHS Crisis Hub, a centralised team in place for approximately 18 months, includes four services. These are a Response team, Enhanced Treatment Service, Crisis Line, and CAMHS Bed Management team. They are in place to enhance the quality of crisis intervention within the boroughs of Southwark, Lambeth, Lewisham and Croydon. They provide a range of short-term community-based assessment and treatment options for up to two weeks and advice and support to parents/carers in partnership with various internal and external agencies.

We did not re-rate Safe and Effective for this core service as this was a focussed inspection which did not look at all sections within those domains. The rating of **Good** from the previous inspection across those two domains still applies.

- The service provided safe care. The number of children and young people on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each young person the time they needed. For young people who required urgent care, staff managed access well to ensure they were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved children, young people, families and carers in care decisions. Children, young people and parents/carers were involved in the design and delivery of the service.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the children and young people. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of children and young people under their care. Staff from different disciplines worked together as a team to benefit children and young people. Managers ensured that these staff received training, supervision and appraisal. The teams had effective working relationships with other relevant teams within and outside of the trust.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people and managed and recorded decisions relating to these well.
- The enhanced treatment service had developed an alternative model to young people being admitted to hospital, published in various professional publications. It demonstrated creative ways of working with young people, involving them in the service, and in training CAMHS staff.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The service was well-led and the governance processes ensured that procedures relating to the work of the service ran smoothly.
- Leaders had the skills, knowledge and experience to perform their roles. Most staff said they felt respected, supported and valued, and that they had received appropriate support in adapting to new ways of working during the COVID-19 pandemic.

Summary of findings

However:

- Some children and young people had significant waits for assessment and treatment. There were long waits for treatment of trauma, obsessive compulsive disorder, attention deficit hyperactivity disorder and for autism assessments (which had been exacerbated by COVID-19 restrictions).
- Many parents/carers told us that they had not received communication or support whilst waiting for assessment or treatment. Staff were aware of this and had taken steps to contact people on the waiting list in recent months.
- Parents/carers told us that they were not always given enough support or signposted to support available to them outside of working hours.
- There was a lack of consistency in where staff recorded information about children and young people's care and treatment in care records. This could lead to delay in locating the most up-to-date information by a team member if needed promptly.
- Although young people said staff discussed care with them, we did not find evidence of the child or young person's views documented in the care records.
- Some teams were struggling with ongoing staff recruitment and retention issues and insufficient funding to meet the needs of children and young people living in their area. Croydon teams in particular had experienced recent disinvestment. Some staff spoke of their frustration in having limited resources to focus on prevention and early identification of mental health issues in children and young people.

Is the service safe?

- Staff knew the children and young people on their caseload well and received 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 children and young people the time they needed.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a child or young person's health. When necessary, staff worked with young people and their families and carers to develop crisis plans and shared these with them.
- Staff understood how to protect children and young people 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 provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.
- The teams had a good track record on safety. 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. When things went wrong, staff apologised and gave young people and families/carers honest information and suitable support.

However:

- Some teams continued to struggle with a high number of staff vacancies and turnover which impacted on continuity of care for children and young people and their relatives/carers.
- Staff were not consistently updating the bespoke risk assessment documents, which meant there was a risk that staff might not be able to access the most up to date information swiftly when needed.

Is the service effective?

Summary of findings

- Staff assessed the mental health needs of children and young people. They worked with children, young people and families/carers to develop individual care plans and updated them when needed.
- Staff provided a range of treatment and care for children and young people based on national guidance and best practice. Where physical health issues were identified, staff ensured that children and young people had good access to physical healthcare.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of children and young people under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit children and young people. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff supported young people to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for young people who might have impaired mental capacity or competence.
- The enhanced treatment service had developed an alternative model to young people being admitted to hospital. The model was published in various professional publications and demonstrated creative ways of working with young people, involving them in the service, and in training CAMHS staff.
- In one Lambeth team some staff had undertaken training in Eye Movement Desensitisation Reprogramming (EMDR), and compassion focussed training, in order to provide swifter support for children and young people waiting for treatment for trauma.

However:

- Staff did not record information about children and young people's care and treatment in a consistent place on the electronic record system. This could lead to delay in locating the most up-to-date information. This was identified in the last inspection, and although improvements had been made, more work was needed to ensure a consistent approach.
- Staff in the local community teams spoke of their frustration in having limited resources to focus on prevention and early identification of mental health issues in children and young people.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated children and young people and their families/carers with compassion and kindness. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Summary of findings

- Young people told us that they were consulted about and involved in making decisions about their care and treatment.
- When appropriate, staff involved families and carers in assessment, treatment and care planning.
- Children, young people and parents/carers were involved in the design and delivery of the service.

However:

- Although feedback from young people was that they were involved in verbal discussion and decisions about care, we did not find consistent evidence that staff recorded their views in their care records.
- Parents/carers told us that there was not always sufficient communication and support provided for those waiting for assessment or treatment, or information about sources of support for parents/carers outside of working hours.

Is the service responsive?

Requires improvement  

Our rating of responsive went down. We rated it as requires improvement because:

- Some children and young people not assessed as needing urgent care, had significant waits for assessment and treatment. There were long waits for treatment of trauma, obsessive compulsive disorder, attention deficit hyperactivity disorder and for autism assessments (which had been exacerbated by COVID-19 restrictions).
- Many parents/carers and education staff told us that they thought the thresholds for acceptance to services were sometimes too high, and that they had not received communication or support whilst waiting for assessment or treatment. Staff in each team were aware of this issue and had recently taken steps to contact those on the waiting list.
- Six parents/carers of children and young people did not feel there was sufficient support or signposting for parents, particularly outside of working hours.

However

- Staff assessed and treated children and young people who required urgent care promptly. Staff followed up children and young people who missed appointments.
- The service ensured that children and young people, who would benefit from care from another agency, made a smooth transition. This included working to achieve a smooth transition to adult mental health service.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for children, young people, parents/carers, and staff.

Summary of findings

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff said that the leadership had encouraged consideration of the Black Lives Matter movement, including looking at ways to talk to children about racism.
- Most staff said they felt respected, supported and valued, and that they had received appropriate support in adapting to new ways of working during the COVID-19 pandemic. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers worked closely with other local healthcare services and organisations (schools, and voluntary sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

However:

- Some teams were struggling with ongoing staff recruitment and retention issues and insufficient funding to meet the needs of children and young people living in their area. Croydon teams in particular had experienced recent disinvestment.

Detailed findings from this inspection

Is the service safe?

Safe staffing

The service had enough experienced staff, who had training to keep children and young people 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 patients the time they needed. Maintaining safe staffing levels and filling vacancies continued to be a challenge in the local borough teams. However ongoing recruitment was taking place. Where possible young people who used the service took part in the recruitment process.

Some parents reported a high turnover of staff including psychiatrists (if on rotation) which could result in a lack of continuity of care. As at 30 September 2020 the vacancy rate for the local borough CAMHS services we looked at was 17% and the turnover rate was 13.6%. The highest turnover rate at this time was 47% in Lambeth CLAMHS (looked after children).

Where there were vacancies in particular teams, there had been recent recruitment, with many of the positions appointed to. Some teams said that recruitment and retention of staff was a particular challenge. Newly recruited staff completed the corporate and local inductions.

Mandatory training rates in August 2020 were 90% for Croydon, 88% for Lewisham, 87% for Lambeth and Southwark. They were 90% for national and specialist CAMHS services, and 95% for central crisis services (all above the trust target of 85%). Staff told us that some face to face training sessions had been delayed due to the COVID-19 pandemic (for example in first aid and disengagement techniques), but there were plans in place for these to be completed.

The sickness rates for the local borough CAMHS services we looked at was recorded at 1.3% on 30 September 2020 and low sickness rates were evident across the teams.

Staff told us that medical staff across the services were accessible and responsive. There was a named consultant on duty every day. Young people and relatives/carers who used the service said they could contact staff including doctors easily.

Caseloads were managed and reassessed regularly, and staff we spoke with said that their caseloads were manageable at the time of the inspection.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff assessed and managed risks to children and young people and themselves. They responded promptly to sudden deterioration in a child or young person's health. When necessary, staff worked with children and young people and their families/carers to develop crisis plans.

Risk assessments were comprehensive and had detailed risk formulations and safety plans. Staff ensured that risks around a young person's or child's family life and home environment were part of the risk assessments. Practitioners updated risks in a letter addressed to the GP and/or in the progress notes. We saw evidence where appropriate that risk assessments were updated after there had been a specific risk incident. Young people who were at risk were presented with a safety plan, which detailed strategies and details of who to contact in a crisis. Any identified risks were highlighted on the child or young person's care record. Young people that we spoke with told us that they were given a safety plan including a crisis contact number.

Detailed findings from this inspection

Most parents/carers were clear about who to contact in the event of a crisis. However, some parents/carers reported significant deterioration in their child's mental health during the initial wait for an assessment/treatment. Staff were particularly aware about long waits for assessment/treatment and each teamhad introduced improved monitoring of children/young people on waiting lists in recent monthsto detect and respond to increases in the level of risk.

Management of patient risk

Following the initial assessment, staff sent a summary letter to the GP, copied to the young person and their relatives/ carers where appropriate. Most of the records we looked at had a COVID-19 response letter. This gave information to parents/carers, young people and children as to what to do during a crisis and that appointments were to be held virtually where possible.

Staff discussed risk assessments at multi-disciplinary team meetings and during managerial and clinical supervision. This supported them to respond appropriately to changing risks to young people. Managers were able to access reports giving them an oversight of the completion of risk assessments and risk management plans. There was an expectation that risk assessment should be updated at least every six months, and this was happening as appropriate.

CAMHS teams had a duty system to manage referrals and waiting lists on a daily basis. Staff discussed waiting lists and high-risk cases at weekly team meetings. They recorded referral discussions, including clear actions, and rated each case for urgency. Allocation of referrals was based on clinical need and urgent referrals could be seen immediately.

The local CAMHS teams worked closely with the child and adolescent paediatric liaison service to follow up children and young people who were at risk. 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 aimed to visit young people discharged from an inpatient service within seven days.

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 followed good personal safety protocols. There were clear lone working protocols and staff described how they kept themselves safe. Staff worked in pairs where risks were identified and were mindful of their colleagues' whereabouts.

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 trust had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

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.

There were good links with the local authorities, and evidence of multi-agency working and information sharing to ensure that young people were protected from abuse and avoidable harm.

Safeguarding concerns were clearly followed up within the recordswe examined and appropriate multi-disciplinary meetings were documented outlining any concerns. Records for children and young people who were looked after, included reference to current or past child protection plans in place. Staff detailed any associated risks in their risk assessments.

Detailed findings from this inspection

Staff in one local borough team described a significant rise in safeguarding concerns during the COVID-19 pandemic. Staff across the teams were aware that safeguarding issues were harder to pick up when working remotely, and that there were also issues of confidentiality if children or young people did not have a private space for sessions. They made efforts to check on who else was in the room when talking to young people, and discussed any concerns they might have with the wider staff team.

Staff access to essential information

Staff kept detailed records of children and young people's care and treatment. Records were written clearly and up-to-date. However, staff did not always update risk assessments in the bespoke risk assessment record in the electronic patient record system. As noted at the previous inspection in 2015, this meant there was a risk that staff might not be able to access the most up to date information swiftly when needed.

Track record on safety

The teams had a good track record on safety. 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. When things went wrong, staff apologised and gave patients honest information and suitable support.

There were six serious incidents reported in the year between October 2019 and September 2020 concerning CAMHS community services. Staff were able to describe the process following a serious 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 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.

Staff described learning from a near-miss incident when a referral had been missed, which resulted in improvements made to the duty system. In one team, learning from a serious incident had resulted in a much clearer chronology being maintained for each child/young person, when they had contacts with multiple services. Staff described lots of learning about how to work with young people who came under the youth offending service, in terms of managing the risks they faced from gang activity.

Incidents were discussed in a range of forums including clinical governance days, senior management team and local team meetings. Staff received information about adverse events within the trust by way of blue light and purple light bulletins.

Is the service effective?

Assessment of needs and planning of care

Staff assessed the mental health needs of children and young people. They worked with children, young people and families/carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs and recovery-oriented.

We looked at 34 records across the SCAAND services, crisis services and the CAMHS teams across the four boroughs. Most of the care records showed that a comprehensive and timely assessment was completed for each person after the initial assessment. Appropriate seven day follow up was given to young people and children under the crisis teams.

Detailed findings from this inspection

Assessments were holistic and personalised. All the records showed a detailed CAMHS assessment, with background, mental health concerns, family dynamics, risk factors and the next plan of action. Children or young people who were subject to a looked after child plan had a joint CAMHS assessment with the local authority. Children of school age had input from their school. For example, one assessment included a written report provided by the child's school. All identified needs were acted upon, for example one young person required their school to complete an Education Health and Care (EHC) assessment and this was followed up. Any identified assessments were acted upon, such as ensuring that an ASD (Autistic Spectrum Disorder) and ADHD (Attention Deficit Hyperactivity Disorder) assessment was completed for a young person or child with suspected ASD and ADHD. One letter detailed how a parent had finally received a diagnosis for their child after a long period of time.

Staff discussed general or specific physical health needs with young people and recorded any needs in their notes**.** We saw that some records documented weight, height and blood test results. Where physical health problems were identified, staff made sure that patients had a full physical health assessment and knew about any physical health problems. For example, children and young people under the SCAAND service has a full physical health assessment completed.

Care plans were recovery-orientated and outlined individual goals, although we could not see evidence of the patient's voice documented in the care plans. However, young people and parents told us that they were involved in agreeing the plan of care and treatment.

At the previous inspection in 2015, we found that there was not a consistent approach to where staff documented information on patient care and treatment, including risk assessments, care plans and consent. During the current inspection, we found there was still variation in where care plans and risk assessments were documented. Although current information was present, it meant it could take staff some time to locate the most up-to-date care and treatment plan if the key worker was not present to direct them to it. Some practitioners chose to outline the plan of care and review risk assessments in a letter to the GP, copying in the young person and/or their parents. Other practitioners chose to use the care plan and risk assessment tabs and others chose to update the care plan or risk assessment using the progress notes tab. Staff regularly reviewed and updated care plans when patients' needs changed or at least monthly.

Records showed that contact was made withparents whilst the child or young person was on the waiting list. A letter was sent out to parents explaining that they had been placed on a waiting list and how long the wait would be. It also detailed who to contact if their child's mental health deteriorated, such as details of the duty line or the SLAM crisis line. However, several parents/carers who we spoke with said that they had not received this information. Staff told us that they had been working to improve contact with people on the waiting lists, and had made improvements over the COVID-19 pandemic period.

All records we examined showed that staff worked in partnership with schools/colleges, children's services, primary care primary services and other relevant services to ensure people using the service with particular needs (such as autistic spectrum disorders / sensory impairments) receive coordinated care and intervention. For example, we saw that appropriate liaison was made with the young offender's service for one young person.

Best practice in treatment and care

Staff provided a range of treatment and care for children and young people based on national guidance and best practice.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. Staff used the Revised Child Anxiety and Depression Scale. (RCADS) and the Children's Global Assessment Scale (CGAS) to record outcomes measures in the records. We saw outcome measures specifically mentioned in correspondence in three records to show how the young person's mental health had

improved. For example, the practitioner had recorded the RCAD score at the beginning of the intervention and at the end of the intervention to show how the young person's mood had improved since accessing the service. We did see that some practitioners were completing initial outcome measures, but these were not repeated before a child or young person was discharged from the service.

Staff ensured that outcome measures were completed in conjunction with external agencies and schools where appropriate. The progress notes and correspondence tabs showed lots of commentary and reports and outcome measures in conjunction with the child's school or with the child's designated social worker or if they were under another service, such as paediatrics. Southwark staff were also funded to provide specialist support for under five-year olds. They provided joint training with social care and education.

Medication reviews were taking place and documented in correspondence and in the progress notes. Records showed that a letter was sent to the GP and the young person or parent was copied in after each medical review to update them on any changes to medication. Young people also had access to a range of psychological therapies and groups as part of their treatment.

In the centralised crisis service, the enhanced treatment service had developed alternatives to young people being admitted to hospital. In 2020 they were shortlisted for the third time for a British Medical Journal award for this innovative work. The model the team used was published in various professional publications including in the Lancet journal in 2018, comparing the effectiveness of an intensive community care service, to inpatient treatment as usual for adolescents with severe psychiatric disorders. The team demonstrated creative ways of working with young people, involving them in the service, and in training CAMHS staff.

Staff across the teams were working hard to address long waiting times for treatment. In one Lambeth team some staff had undertaken training in Eye Movement Desensitisation Reprogramming (EMDR), and compassion focussed training, in order to provide swifter support for children and young people waiting for treatment for trauma. They were also looking at ways to adapt attention deficit hyperactivity disorder (ADHD) assessments using personal protective equipment. The Lambeth team also told us about quality improvement projects to look at ways of better virtual working and providing better resources to local schools including teaching in sleep issues, attention deficit hyperactivity disorders, and cognitive behavioural therapy.

The crisis teams, having been commissioned differently, joined into a centralised team in 2018. Staff told us that they were working on a quality improvement project to improve the model of crisis care, with input from teams across the country, and feedback from all stakeholders. Two particular areas being focussed on were the assessment processes in accident and emergency departments and providing a daytime telephone service for urgent response.

Most staff and special educational needs coordinators (SENCO workers) spoke of their frustration that there were not more resources for prevention and early identification of mental health issues in children and young people. Staff told us that, although the current focus of most services was on risk management, they had plans to increase their offer of psychoeducation, parenting support, and support provided whilst people waited for assessments/treatment.

Skilled staff to deliver care

Staff from different disciplines worked together as a team to benefit children and young people. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

The teams included or had access to the full range of specialists required to meet the needs of children and young people under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Detailed findings from this inspection

Teams included a range of relevant mental health disciplines including psychiatrists, nurses, social workers, occupational therapists, psychologists and a range of therapists. There were specialist roles within the teams such as safeguarding leads. Staff told us they received a range of opportunities for supervision and support including regular team meetings, individual and group clinical supervision, managerial supervision, and team away days.

Due to the COVID-19 pandemic, some staff were struggling with new ways of working, with little or no face to face contact with colleagues. Depending on individual personal situations, some staff had to deal with complex, and sometimes distressing contacts from home, without differentiation from their personal spaces. This had resulted in some staff feeling deskilled, in terms of having to work in very new ways. However, they spoke positively about the support their line managers and team members had provided during the pandemic, including resilience training, and regular reflective practice sessions. They told us that they had opportunities for specialist training in relevant areas. They spoke highly of the dedicated staff working in their teams, and work with other sectors including social care, GPs and schools.

Multidisciplinary and interagency team work

We saw good evidence in the SCAAND records that multi-disciplinary discussions took place. This was less evident in the other records we examined. However, discussion with staff indicated that effective multidisciplinary work was taking place. Where necessary staff shared information about young people including safeguarding concerns and physical health issues.

Staff told us of a range of meetings they attended to discuss and share information with their teams including daily breakfast meetings, weekly bed management meetings (crisis services), and monthly team meetings, as well as referrals meetings and reflective practice sessions.

There was a trust policy for young people in transition to adult mental health services. 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 including appropriate communication with youth offending services and schools. They noted that an unexpected result of the COVID-19 pandemic was increased multiagency working, as it was easier for different professionals to attend virtual meetings than it had been to attend in person.

Staff were able to provide a range of different therapies to children and young people on their caseloads, including family therapy, interpersonal therapy for adolescents, eye movement desensitisation reprogramming and cognitive analytical therapy. Staff in the Southwark team supporting looked after children told us that they provided weekly foster parent support, parent child therapy, and early interventions to build up strong attachments. They also provided help with transition to kinship carers or guardians. They had further plans for group work, including photography workshops, mindfulness groups and non-violent resistance.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

However, where a young person was over 16 and assumed competent to make decisions about their own care and the involvement of parents/carers, we saw that letters were usually still addressed to the parent/guardian, instead of directly to the young person/child.

The Mental Capacity Act (MCA) 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.

Detailed findings from this inspection

Staff told us that they had completed MCA training as part of their mandatory training. We saw some discussion of mental capacity as part of a multi-disciplinary assessment in at least two of the records.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition. Staff spoke with respect and consideration about the children and young people they worked with and were mindful of confidentiality. Staff demonstrated sensitivity in forming positive relationships with young people and their families.

Young people and their families said they had been given emotional support to cope with their care and treatment. Most young people and parents/carers described staff as welcoming, respectful, supportive, and flexible in their approach. There main concerns they raised related to waiting times, and a small number of examples of poor communication about what to expect in terms of treatment.

Young people and parents told us that the staff really cared, listened to them, and wanted to help. They said staff had provided invaluable support and/or therapy when they were struggling. Young people told us that staff were non-judgemental, talked to them on an equal level, and had helped them to look after their health and wellbeing. Several mentioned being quite frightened of the process when initially seen, but then finding it easier after a few sessions. Some young people told us that there should be more support provided after therapy, as when this was complete, they had felt left on their own.

Parents described staff as generous with their time and interacting very well with their children. One parent said that the psychologist had adapted their style to match that of their child, walking around and engaging rather than sitting opposite one another. One parent/carer told us that the services had saved their child's life. All said that staff gave them helpful information about local support groups, resources and educational videos about relevant conditions such as sleep, and attachment disorders, which they found empowering. Parents found support in addressing challenging behaviours from their children invaluable. A small number were pleasantly surprised at how quickly their child was seen, having expected long waits.

However, parents spoke about significant delays and anxiety in accessing services for their children. They talked of hoops to jump through before meeting the criteria for the services,and having to fight for support. Some told us that their child's mental health had deteriorated whilst they were waiting to be seen, and they had ended up using crisis services. Several parents who had been on the waiting list for some time complained about a lack of contact whilst they were waiting for treatment or assessment for their child and no clear expectations about how long the wait was likely to be. The recent work done by staff to improve this for people new to the waiting list had not reached this group of parents.

Detailed findings from this inspection

Some parents mentioned a lack of continuity for their child due to a high turnover of staff (there was a high turnover in 4 teams of 14 inspected in total). Some parents did not feel they were sufficiently involved in making decisions. Some foster parents said that they understood the need for confidentiality for their child, but that this could make it difficult for them to provide the best support.

Most young people and parents said that services had flexible times, so that they did not need to miss school. They said that staff had been incredibly flexible in enabling remote working since the COVID-19 pandemic, and this worked particularly well for some children and young people. One parent mentioned that their child had been given the option of communicating by typing during an appointment, and found this particularly helpful. However, some young people found it difficult to have video or phone appointments, particularly when working with trauma.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had access to advocates when needed. Patients were involved in the design and delivery of the service.

Young people's agreement was sought and where appropriate information was shared with others about their care and treatment. Young people told us that they had been involved in their care plans and had received copies.

Feedback received from young people was collected and used to make improvements to the services. The friends and family test (survey) results from October 2019 to September 2020 indicated a 92.63% positive rating (and 1.75% negative rating) with patient and family/carer involvement rated as 91% positive. We saw evidence of involving young people in the design of services, via various groups including youth advisory groups, the children's, and teenagers, and the Alchemy project for coproduction activity, which included a summer school (based on the recovery college model) produced by and for young people. The Alchemy project in Lewisham co-ran groups and training for CAMHS staff in culture awareness delivered by young people.

In Southwark there was a children's CAMHS council for under 12-year olds, as well as a teenage group and parent group monthly. Changes made as a result of these groups included providing better support to young people transferred to local CAMHS teams from an emergency department, as there was often a gap in between services. Young people and parents had produced a letter to be given to young people in this position, with information about the CAMHS team services. The groups had also ensured CAMHS outreach team now contacted people straight away after leaving an emergency department, so that they were not left without support.

Croydon had been involved in the initial trial of the i-THRIVE initiative, a national programme of innovation and improvement in child and adolescent mental health. Young people in Croydon were involved in codesigning crisis plans for the service.

We saw numerous examples of children and young people's consultation and involvement in quality assurance of each service in creative ways. These included a Manga themed workshop held in Croydon to design the youth advisory group T-shirt, Southwark secret shopper calls to the counselling service, a 'building bridges' patient and public involvement day planning a wellbeing festival, and creating a short film about the invisibility of mental health.

SCAAND teams arranged for young people's consultations about new treatments. They adjusted the autistic spectrum disorders group for girls to include more group discussion, going over homework set, and more interactive tasks, in response to young people's feedback.

Detailed findings from this inspection

The patient and public involvement committee in August 2020 looked at activities across the teams including a coproduced newsletter and a mindful photography group in Southwark, developing a booklet and a podcast regarding LGBT+ issues in Croydon, and providing a DBT group for parents in the SCAAND teams.

The Crisis team held an event for young people to look at the crisis pathway, with a cartoonist employed to create a summary of people's feedback. They were involved in a one-year consultation about the pathway, including codesigned workshops and presenting stories, to improve young people's experience. Staff told us that for some young people having a written crisis plan was not helpful, and they benefitted far more from practicing interventions for when they were in crisis.

Young people were involved in developing questions and taking part in interview panels when recruiting new staff in the trust.

Involvement of families and carers

When appropriate, staff involved families and carers in assessment and treatment. Parents and carers were also encouraged to be involved in the design and delivery of the service by involvement in parent groups.

Staff involved relatives/carers as partners in children and young people's care, and in making decisions although this was not always recorded in detail. Families were involved as appropriate and according to the young person's wishes. Most relatives/carers that we spoke with told us that they felt listened to and were kept informed and were given copies of letters. However, several indicated that whilst waiting to be seen initially, there was not enough information provided about likely waiting times, or other forms of support available. Six parents felt that they had not received enough support, and that this was particularly a problem for working parents.

The crisis team ran parent groups and was in the process of producing a mental health wellbeing directory, and toolkit about different triggers to poor mental health.

Parents and carers spoke very highly about the support received from the SCAAND service but described poor relationships with their local CAMHS teams (based across the country as this service receives referrals nationally), often feeling blamed by them. Staff in the SCAAND team were aware of this issue and said that they worked to repair relationships with young people's local CAMHS teams, looking at the variability of what the local teams could offer young people waiting to be seen by SCAAND.

Is the service responsive?

Access and waiting times

Staff assessed and treated children and young people who required urgent care promptly. However, there were long waiting times for some non-urgent care and treatment. Waiting times varied but were described as particularly long for treatment of trauma, obsessive compulsive disorder, attention deficit hyperactivity disorder, and for autism assessments (which had been exacerbated by COVID-19 restrictions). There were also some long waits for therapies including cognitive behavioural therapy.

Looking at data up to June 2020, for waits in local borough teams from referral to a second contact (treatment) of any nature (face to face, phone or video) we found that average waits were highest in Lambeth in June 2019 at 38.79 weeks, in Lewisham in October 2019 at 31.38 weeks, in Croydon in February 2020 at 31.27 weeks, and in Southwark in August 2019 at 19.93 weeks.

Looking at times between first and second contacts, waits were increasing in Croydon from March 2020, with a high of 12.38 weeks in June 2020, in Lewisham they had reached 8.96 weeks in June 2020, in Southwark 5.89 weeks, and in Lambeth 4.7 weeks.

Detailed findings from this inspection

Most parents/carers and young people told us about long waits to be seen by services following referral. However, the teams were working hard to address waiting times, with various initiatives put in place These included ensuring equitable waits across different services, and looking at what could be offered to young people whilst waiting, such as psychoeducation and mindfulness techniques. In Lambeth staff had undertaken neurodevelopment skills training, to support young people waiting for specialist appointments. In Lewisham, a small clinical team reviewed all referrals, and they had recruited referral coordinators to ensure better throughput in the service. Croydon teams in particular were struggling to meet their waiting times targets, due to long term underfunding and some additional recent disinvestment. They had escalated their concerns and were looking at moving to a needs-led rather than a diagnostic model.

Overall the number of young people waiting more than 52 weeks had decreased since the peak in October 2019. The trust advised that for community 52-week waits, most patients had been offered appointments and had not attended or cancelled, in many cases multiple times. In some cases, patients had refused remote appointments and had elected to wait until a face to face one became possible. Service managers were monitoring each individual 52-week wait to ensure that there was a clear plan for all, and the next focus was to do this for all waits over 26 weeks. They noted that the Croydon figures were inflated as the borough commissions CAMHS to provide autistic spectrum disorder assessments, and elsewhere this function would be led by paediatric services. SCAAND services were closed to non-urgent referrals, from April to June 2020.

The number of patients who had not attended a face to face, phone or video contact in the last 12 months was 147 patients in Lewisham, 78 in Southwark, 42 in Lambeth, 36 in Croydon, and 66 in the national and specialist teams.

Young people and parents/carers were happy with the way that staff had adapted their practice swiftly during the COVID-19 pandemic and were supporting them effectively primarily through virtual appointments by phone or video call. However, for some young people, particularly when dealing with trauma, phone or video callscould be difficult. Where they had been seen face to face, they were satisfied with the precautions put in place.

The CAMHS teams accepted referrals from general practitioners and a range of professionals and other agencies. Young people could also refer themselves to some services. Team managers monitored the referrals and allocations to clinicians, enabling services to prioritise care and treatment for young people with the most urgent need. The SCAAND service records showed that children and young people had a timely and comprehensive assessment under the SCAAND team. Children and young people could access this service through a variety of different sources.

We saw evidence that services supported children or young people who were on a waiting list for another service, whether this was a SLaM service, or one provided by another organisation. For example, one child was held by their local CAMHS team whilst on the waiting list for the Gender Identity Development (GID) Service at another NHS trust as this had a waiting list for over a year. Plans were in place to discharge the young person once they had started to engage with the GID service.

We saw that staff made at least weekly contact with the young person or their parent/guardian, once they were open to the service. Staff sent follow up letters to summarise the first assessment appointment and the treatment plan. Staff worked hard to avoid cancelling appointments and when they had to do so, they gave people clear explanations and offered new appointments.

Detailed findings from this inspection

Staff attempted to ensure that young people who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care. Most of the records showed that discharge planning was considered before the child reached the age of 18. Where the young person was a looked after child, we saw evidence that discussions were held with social services around discharge planning. We saw one record where discharge planning was not discussed with the young person and a letter of discharge was sent to their GP explaining that they had reached the age of 18 and were being discharged back to their service. Staff reported that transitions to adult services could be difficult, with long waits for Improving access to Psychological Therapies (IAPT) services. Where appropriate, staff provided young people and parents/carers with information and resources to access in their local area, such as a wellbeing centre for people who were aged 18 years and older.

Patients' engagement with the wider community

We spoke with seven Special Educational Needs Coordinators (SENCO) working in primary or secondary schools in the local boroughs covered by the trust. They were very positive about the integration of mental health teams with children's wellbeing practitioners in some schools. This provided support for pupils with low mood and anxiety, helped to screen for ASD and ADHD, and helped prioritise those requiring a CAMHS assessment. They said the single point of access for referrals at Croydon and Lambeth was helpful. Single points of access were also being introduced in Lewisham and Southwark.

SENCO staff said that the incorporation of mental health services in schools had helped to take away the perceived stigma some young people and families had about attending CAMHS services. One SENCO suggested that CAMHS staff should spend time in schools as part of their training, to understand children's experience better. In general SENCOs said that the threshold for CAMHS referrals was too high. They noted that younger children were less prioritised, as they generally presented a lower risk, and this might mean missing out on preventative support, and early identification on mental health issues. They described a group of children whose needs were too high for the children's wellbeing practitioners in the schools (for example having anger management issues), as often having the least support whilst waiting for a CAMHS assessment. They felt that there was room for improvement in communication between CAMHS teams and the schools (with the permission of young people and parents/carers) about why referrals were not accepted, and any treatment plan and coping strategies agreed (which they could support children with).

Meeting the needs of all people who use the service

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

Staff ensured that communication needs were assessed for each child and young person by using an accessible communications standard assessment form. This identified if a person had any communication needs and what additional support they would require. For example, one record considered what language staff should use when breaking bad news to a young person with learning difficulties. Another record showed that a young person had additional communication needs and required an easy read format.

We saw a copy of a leaflet sent to parents/carers in the Croydon team explaining the background to the Black Lives Matter movement with colourful and detailed guidance on how parents can talk about this movement with their children, and reference to relevant films and literature.

We saw evidence in the records that staff used an interpreter when required. For example, an interpreter was booked for face to face meetings for one parent who had limited understanding of English. We saw evidence in one record that a young person had been given information about their local LGBTQ group to support their needs.

Detailed findings from this inspection

We saw that staff considered how to meet the parent/carer's needs in addition to their child's needs. For example, we saw evidence that staff had considered a parent's psychoeducational needs by offering access to an ADHD awareness course offered by the CAMHS team.

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 all staff. The trust had a complaints procedure that was summarised in leaflets and on the trust website.

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. Most young people or family members/carers told us they knew how to complain, or would find out if they needed to. The main complaint expressed to us by young people and parents/carers was about waiting times, particularly if there had been an escalation in the young person's symptoms whilst waiting.

The services had received 20 formal complaints between 1 October 2019 to 30 September 2020, of which six were upheld, eight were partially upheld, four were not upheld and two remained open. Learning included improvements needed in communication with families/carers of children or young people on the waiting list, and other agencies involved, better communication regarding care and treatment plans.

There were clear communication structures in place to feedback lessons from complaints, and staff were able to tell us about improvements that had been put in place following complaints. For example, they described improving the way they kept in touch with children and young people on the waiting lists, although they acknowledged that there was more work to do to address this issue.

Is the service well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable to children, young people and staff.

At the last CQC inspection published in January 2016 this core service was rated Goodacross all domains, with five areas of recommendation for improvement. The trust produced an action plan to address these areas. They reported improvements in making the environment safe in the Lambeth community teams, regular infection control audits across all CAMHS services, improvements in technology for accessing patient records and in the consistency of children and young people's risk assessments and care plans. Although they had made significant efforts, they reported ongoing issues with waiting times for children and young people to access services. Since the previous inspection they reported particular difficulties in recruitment and retention of qualified staff to some teams and were looking at strategies to address this.

Staff reported 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.

Staff described strong team support by managers and colleagues enabling them to maintain their morale despite significant challenges during the COVID-19 pandemic. Staff particularly praised the leadership team in Southwark. Staff felt able to raise concerns without fear of victimisation or bullying, and were aware of the whistleblowing policy and the freedom to speak up guardians. Some staff found that remote working had a significant impact on their morale, and some felt that there should be better communication from senior managers in their areas.

Detailed findings from this inspection

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Trust values and behaviours had been developed, collaboratively and were embedded in the staff appraisal process.

Senior managers regularly visited the services or attended video meetings, and most staff were able to identify and meet them. However, a significant number of staff and SENCO workers spoke at their frustration that CAMHS were not able to be more involved in more prevention and early identification work with children and young people, and the rising thresholds for CAMHS services.

Culture

Staff said they felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Morale in the services varied, but most staff told us they were happy in their job and that supportive relationships amongst staff were encouraged. Staff told us that the leadership encouraged them to practice self-care, resilience, and wellbeing techniques. They had encouraged engagement and maintaining social contacts, including arranging evening events such as quizzes, yoga and crafts nights.

Staff noted that the leadership had encouraged consideration of the Black Lives Matter movement, including looking at ways to talk to children about racism. In one team we saw a copy of a leaflet sent to families 'A Parent's Guide to Black Lives Matter,' with colourful and detailed guidance on how parents can communicate about this movement with their children, and reference to films and literature that they could show 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. 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 away days, including learning across different boroughs. There was opportunity for staff to submit items to their risk registers.

Services had begun implementing 'Perfect Ward' a quality assurance system for monitoring performance across teams. CAMHS presented its performance and quality data monthly at a Performance and Quality meeting with the trust, and we had the opportunity to attend one of these meetings.The meeting included data about a wide range of areas of team performance, from staffing to caseloads, to waiting times and review of policies. It provided an opportunity to challenge the service about areas that required improvement in addition to acknowledging areas of achievement. Issues discussed included addressing waiting times and various strategies put in place including individual tracking of long waits, improved referral management, and ensuring contact with all young people on the waiting list. A decrease in referrals during the pandemic had resulted in some reduction in waiting times for some services. However, services reported a dramatic increase in referrals following schools reopening, with some already almost working at full capacity, and staff expressed concerns that demand may outstrip capacity.

In addition to Perfect Ward, staff carried out a number of routine audits across all CAMHS community services. These included fire safety, health and safety and safeguarding audits. The most recent care plan and risk assessment deep dive in July 2020 indicated improvements in the timeliness of staff recording risk assessments. There were also deep dives into patient experience, including 11 CAMHS patients, and staff experience including 52 staff members.

Management of risk, issues and performance

Detailed findings from this inspection

Staff and managers in each team were very aware of the challenges faced by their service. These were recorded on their service risk registers, and they had looked at ways of mitigating these as far as possible. In most cases waiting times for assessment and treatment were the chief concern. All teams were working hard to address waiting times for children and young people.

In Lambeth, staff had arranged for one waiting list on referral, in order to ensure equitable waits. They had also undertaken training in neurodevelopmental skills, to ensure that they could provide appropriate support for children and young people whilst awaiting a specialist assessment. Managers had recently recruited to a number of vacancies, and said that they were working on developing a new pathway to provide support for young people falling between tiers three and four.

In Lewisham they were undertaking quality improvement work looking at the detail of flow across the team, to better understand waits for complex and more generic cases.

Croydon teams in particular were struggling to meet their waiting times targets, due to long term underfunding and some additional recent disinvestment. This had resulted in low morale amongst the staff team, recent staff turnover and difficulties in recruiting to posts, which further impacted on waiting times for children and young people. Team leads had escalated their concerns to the chief executive, and were working on a needs-based, rather than a diagnosis-led approach to supporting children and young people and improve throughput.

The SCAAND team were generally meeting their commissioned targets, with most children and young people seen within eight to nine months. However, due to an unsustainable funding model, they were not funded to achieve above the target despite there being considerable demand. Managers said that they continued to exceed targets, although this was in effect unpaid activity, and therefore not sustainable.

Several services also had to look at issues of accommodation and space for their teams, due to recent or forthcoming changes, and the impact of the pandemic on space requirements. In Lambeth there was limited clinical space which had limited the number of appointments that could be offered, and three teams had recently lost their accommodation, so that they were now rootless, working as a virtual team. In Southwark, the teams would be losing one of the buildings housing the CAMHS teams, and needed to seek alternative accommodation. In Lewisham, staff advised that there were building issues, including a need for refurbishment and IT upgrades, as well as installing COVID-19 screens. Work was planned to address these issues.

Information management

Staff had access to the information they needed to provide safe and effective care and used that information to good effect. Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff mentioned some initial technical issues during the move to distance working following the outbreak of the COVID-19 pandemic. However, they noted that overall the trust had been remarkably responsive and supported them during the technical changes with minimal disruption.

Staff recorded information about care but did not store this in a consistent location in the notes we looked at. For example, staff were not always using or updating the bespoke risk formulation tools and care plans but did include relevant information in the progress notes and letters. This could make it time consuming to find the most up-to-date information on each young person and demonstrated inconsistency across staff and teams.

Engagement

Detailed findings from this inspection

Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

Children, young people and parents/carers had the opportunity to feedback about the service, and help shape the future of services, via service user advisory groups held every six months.

We saw evidence of involving young people and their carers in the design of services, via various groups including youth advisory groups, the children's, teenagers, and parents groups, and the Alchemy project for coproduction activity, which includes a summer school (based on the recovery college model) produced by and for young people.

Learning, continuous improvement and innovation

Staff were highly committed to continuous improvement of the services. Senior managers were committed to quality improvement and innovation using evidence-based practice and service development and improvement plans were in place.

The crisis team had been shortlisted for the third time for a British Medical Journal award for its innovative work in providing intensive support to young people who would otherwise have been admitted to hospital. They were working on a quality improvement project to create agreed standards for crisis care, with input from teams across the country. They were particularly looking at children and young people's experience in accident and emergency departments when in a mental health crisis, and provision of a daytime telephone contact for an urgent responder.

The SCAAND teams were working on a quality improvement project to look at what could be provided to children and young people whilst waiting for an assessment or treatment. They were also planning to move to electronic health records for children and young people so that they could input their views directly into their care and treatment plans.

In the Lambeth service, some staff had undertaken training in Eye Movement Desensitisation Reprogramming (EMDR), and compassion focussed training, in order to provide a swifter support for patients waiting for treatment for trauma. They were also looking at ways to adapt attention deficit hyperactivity disorder (ADHD) assessments using personal protective equipment.

Outstanding practice

The enhanced treatment service had developed an alternative model to young people being admitted to hospital. The model was published in various professional publications, comparing the effectiveness of an intensive community care service, to inpatient treatment as usual. The team demonstrated creative ways of working with young people, involving them in the service, and in training CAMHS staff.

In the Lambeth service, some staff had undertaken training in Eye Movement Desensitisation Reprogramming (EMDR), and compassion focussed training, in order to provide swifter support for children and young people waiting for treatment for trauma.

Areas for improvement

The service must continue to take action to address the waiting times for non-urgent patients.

The trust should continue to work to address issues of staff recruitment and retention, and work with commissioners toprovide support for teams that have insufficient funding.

Detailed findings from this inspection

The trust should ensure all staff use a consistent approach in where to store risk assessments and care plans, so that information can be accessed quickly by the wider team if and when needed.

The trust should ensure that there is evidence of the child or young person's views on the care and treatment documented in the care records.

The trust should continue recent work to ensure that there is regular communication and support provided for those waiting for assessment or treatment.

Our inspection team

The inspection team that conducted the review of care records consisted of one CQC inspector and one specialist advisor who was a community CAMHS specialist nurse.

Telephone and video calls were made to young people, relatives/carers and staff by seven inspectors, two inspection managers, an inspection planner, and two experts by experience (people who have experience of using or caring for someone using similar services).

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment