

## North East London NHS Foundation Trust

# Specialist community mental health services for children and young people

### Inspection report

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### Ratings

#### Overall rating for this service

Inspected but not rated ●

Are services safe?

Inspected but not rated ●

Are services effective?

Inspected but not rated ●

Are services caring?

Inspected but not rated ●

Are services responsive to people's needs?

Inspected but not rated ●

Are services well-led?

Inspected but not rated ●

# Our findings

## Specialist community mental health services for children and young people

### Inspected but not rated



This was a short notice announced focused inspection of community child and adolescent mental health services (CAMHS) in Kent. We carried out this inspection to see if improvements had been made since we last inspected the service in 2019.

During this inspection we looked at all five domains. We did not rate the service at this inspection as we only inspected services in Kent, we did not inspect community CAMHS services the trust provides in four north east London boroughs. We found that:

- The service was not always easy to access. Some young people who did not require urgent care waited too long to start treatment. There were long waiting times for assessment on the neurodevelopmental and learning disability needs pathway. Not all young people, parents and carers were updated on when they would be assessed or when treatment would start.
- The trust had moved to a new platform to collate and monitor a range of safety and performance data. Further work was needed to ensure that all staff knew how to access and use these systems, and that data was accurate.
- Whilst the work of the single point of access had been strengthened, changes needed further embedding to ensure that all referrals were triaged and signposted in a timely fashion.
- Staffing remained a challenge, consultant psychiatrist posts were particularly difficult to fill and most were covered by locum staff. Some teams, for example the crisis team, had 50% vacancies, although regular temporary staff were in place.
- In some teams not all staff had completed mandatory training.
- Staff demonstrated a good understanding of individual patient risk and the plans in place to manage these, however, these were not always consistently recorded in patient care and treatment records.

However:

- Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, was not too high to prevent staff from giving each patient the time they needed.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

### How we carried out the inspection

# Our findings

- we visited four team hubs, in the Dartford, Canterbury, Maidstone and Medway localities; we looked at the quality of the environment for patients and staff, and management of the clinic rooms
- spoke with 31 young people, parents and carers who were using the service
- reviewed 37 comment cards from young people, parents, carers and patients who were using the service
- spoke with a range of staff from Dartford, Canterbury, Maidstone and Thanet child and adolescent mental health services community teams, the single point of access service, the crisis response and enhanced support team, and the neurodevelopmental and learning disability team. This included one director, seven team managers and 13 other staff members comprising of mental health nurses and practitioners, psychotherapists, cognitive behaviour therapists, clinical psychologists and consultant psychiatrists
- observed a clinical multidisciplinary team business meeting, a team handover and safety huddle, and an anxiety group session
- reviewed 68 care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service, and the team management for the Dartford, Canterbury, Maidstone and Thanet teams.

You can find further information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

## What people who use the service say

We spoke with six young people and 25 parents and carers. They were positive about the staff and service they received once treatment started. They spoke highly of the staff saying they were caring and compassionate, focused on individual needs and the interventions offered had a positive impact. They also said that the service and individual staff were quick to respond in times for crisis. Some parents and carers said the wait for assessment and treatment was too long. However, once treatment started, the service that was provided made a difference to the children and young people, and their families.

The majority of the 37 comment cards from young people, parents and carers were positive. These stated that children, young people, parents and carers felt well respected and listened to. They reported staff were supportive and individual and family sessions were very helpful.

## Is the service safe?

Inspected but not rated



### Safe and clean environments

**All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.**

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Staff checked the environment and carried out weekly fire testing. Staff said that maintenance issues were escalated and addressed.

# Our findings

Interview rooms did not have alarms fitted. Staff carried personal alarms when they were seeing a young person and their family. Administration staff ensured the alarms were charged. Each site had staff available to respond.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. Each site had a clinic room where young people could have a physical examination. This included a blood pressure machine, and equipment for measuring height and weight.

All areas were visibly clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises and toys were clean. Young people, parents and carers reported finding the premises to be well maintained, safe and welcoming

Staff always followed infection control guidelines, including handwashing. Information about infection control was displayed at each of the sites. Hand gel, face masks and disinfectant wipes were readily available for staff and visitors. Young people, parents and carers found the rooms clean and hygienic.

## Safe staffing

**Whilst the service had enough staff, who knew the patients to keep them safe from avoidable harm, some teams and disciplines were difficult to recruit too. Consultant psychiatrist vacancies remained high, though these posts were covered by regular temporary staff.**

**The number of patients on the caseloads for individual members of staff were not too high to prevent staff from giving each patient the time they needed. However, not all teams had achieved trust targets for completing mandatory training.**

## Nursing and medical staff

Most of the community child and adolescent mental health service teams covering Kent had enough nursing, support and medical staff to keep patients safe, although some posts were filled with regular locums. Young people, parents and carers said staff were available when they needed them, and they felt supported. Team managers and senior leaders said staffing was one of the main service challenges.

The service's overall vacancy rates across the Kent region had improved since the last inspection. The single point of access service had no staff vacancies. The neurodevelopmental and learning disability service had two staff vacancies. The Canterbury, Dartford, Maidstone and Thanet locality teams had a total of 27 staff vacancies which meant their vacancy rates ranged from 14% to 18%. The crisis response and enhanced support service had the highest team vacancy rate at 51%.

Vacancies were spread across all staff groups. Consultant psychiatrist posts had the largest vacancies across the service with 68% of all vacant posts. Staff reported that these posts were significantly more challenging to fill. For example, the Canterbury team had a consultant psychiatrist post that had been vacant for over a year. Most vacant consultant posts were covered by locum consultant psychiatrists. Staff said that the cover for these posts provided suitable medical support and young people and parents and carers said they were still able to get support from a psychiatrist quickly when they needed to. Staff felt that the reliance on locum psychiatrists who were not fully integrated into the trust impacted the overall effectiveness of the teams.

Senior psychologist vacancies were also a challenge. The Canterbury team had a 0.5 full time equivalent post vacancy, and the Maidstone team had one full time vacancy. Whilst overall levels of sickness across the teams were low, the

# Our findings

Dartford and Canterbury teams each had one psychologist with long term sickness. Staff said that the absence of psychologists impacted on psychology input into multidisciplinary team discussions and case formulation. This also affected supervision for psychologists and assistant psychologists, with senior staff having to pick up additional supervisees to ensure supervision was provided.

Managers covered staff vacancies and sickness with bank, agency and locum staff who were familiar with the service. Young people and parents said that the staff they worked with were familiar to them and knew their support needs. Managers made sure all bank, agency and locum staff had a full induction and understood the service before starting their shift.

Managers and senior leaders were aware of the staffing challenges. Nursing, support and medical staffing was included on the Kent service risk register. A business contingency plan had been in place for the Canterbury team, but this had been stepped down as vacancies had been filled. The service had a rolling recruitment programme in place and posts that were not filled within three attempts, were considered for further incentivising through additional signing on bonuses.

The service was also building relationships with local universities and was proactive in ensuring that placements were filled. Over the last three years the service had developed enhanced training and development programmes to support retention. For example, two staff members in the Dartford locality team had been supported on postgraduate degree programmes in family therapy.

Since the last inspection the service had recruited a director of psychology and psychological therapies for Kent. Part of this role was focused on recruitment and retention of psychology staff. In addition, the service had a clinical and strategic psychology lead for Kent. This individual was working with national clinical psychology training providers to ensure all Kent placements for clinical psychology were filled. The training and development opportunities for psychologist, therapists and staff with an interest in psychology, had also been enhanced to aid staff retention and development. For example, training in dialectical behaviour therapy and family therapy was available for staff along with AMBIT training. AMBIT is a mentalisation based team approach for teams working with young people with severe and multiple needs, who do not tend to access mainstream services.

The number of patients on the caseload of most individual members of staff was manageable. The number of patients on staff caseloads varied significantly. Most staff's caseload was less than 30 patients. However, seven staff had caseloads between 30 and 87 and three staff had caseloads between 101 and 127. Staff said that although they felt they could manage their workload, at times they felt pressured and this impacted on activities such as updating and auditing patient care records. In all teams, managers had oversight of staff caseloads and were supporting those staff with larger caseloads.

## Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

However, there was more to do to ensure all staff were compliant with mandatory training. Whilst most teams had achieved at least 85% compliance with mandatory training, there were some exceptions. The Maidstone team had a compliance rate of 82%. This was due to lower completion rates in some courses including: advanced clinical risk assessments training at 66%, moving and handling for people level two at 57% and basic life support at 47%. The Canterbury team was also outside of the trust's training compliance rate for advanced clinical risk assessments training with a compliance rate of 71%.

# Our findings

## Assessing and managing risk to patients and staff

**Appropriate systems were in place to assess and manage risk across the service and staff spoke knowledgeably about individual patient risks and how these were managed. Improvements were needed to ensure risks and how they were managed were consistently recorded across all teams. Improvements were also needed to ensure that changes in risk were identified for young people who were waiting for assessment or treatment.**

**Staff responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop safety and crisis plans.**

## Assessment of patient risk

We reviewed 68 patient care and treatment records. All referrals first went through the single point of access (SPA). Since our last inspection the SPA had developed a clinical triage tool to screen for risk and identify the most appropriate clinical pathway. If more information was needed, the SPA worker would contact the referrer to obtain this. The referral was then passed to the appropriate team.

In geographical and specialist teams we saw that initial assessments and treatment plans included an assessment of risk. Improvements were needed to ensure consistency in how risk was recorded. For example, some of the patient care and treatment records we looked at did not include a rationale as to why risk levels had been assessed as increasing from medium to high.

## Management of patient risk

For some pathways there were waits to be assessed or to start treatment. Once the SPA had completed their triage and the referral allocated to the locality or specialist team, a letter was sent to the young person advising them of the outcome. This included information on community resources they may find useful whilst waiting for their assessment.

The trust had a system of clinical harm reviews that would be triggered at set intervals for each young person waiting to be assessed or start treatment. The aim of the clinical harm review was to establish whether there had been any change in risk that needed addressing whilst the young person waited. Improvements were needed to ensure that all teams were consistently following the trusts clinical harm review policy. Seven (10%) patient care and treatment records for young people waiting for the neurodevelopmental and learning disability assessment, did not include a clinical harm review. The risks associated with not carrying out a clinical harm review had been partially mitigated as the service was using technology to automatically generate text messages that were dispatched every six weeks, asking the young person to get in touch if there had been any changes in their circumstances.

Whilst improvements to how the SPA worked had been made since our last inspection, there was more to do. For example, one care and treatment record showed a delay in follow up contact from the SPA service for a young person whose referral indicated a potential risk of suicide. This was escalated at the time of our inspection.

Patient's care and treatment records showed that once children and young people started treatment most staff responded appropriately to any deterioration in a patient's health. Young people, parents and carers said that individual staff responded very quickly to concerns and crises, and they were able to access support quickly in an emergency.

We observed a clinical multidisciplinary team business meeting, a team handover meeting and safety huddle meetings, which all included comprehensive discussions of risk with full MDT input. In the crisis and enhanced support teams, appropriate use was made of crisis plans.

# Our findings

In some community team's improvement was needed in how risk assessments and management plans were updated following incidents. For example, for one young person after a serious incident the locality team did not ensure an appropriate safety plan was in place, and their care plan and risk assessment were not updated. This was escalated on the day of our inspection and was addressed immediately by the trust.

## 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.**

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. Trust data showed that individual teams were between 86% and 100% compliant for all required safeguarding training. Staff received alerts so they knew when to renew their training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff felt confident in reporting safeguarding alerts and knew how to make a safeguarding referral and who to inform if they had concerns. Staff regularly discussed safeguarding concerns within team business meetings and could raise concerns with the service safeguarding leads and team leaders if needed. Team business meeting minutes showed safeguarding as a standard agenda item.

## Staff access to essential information

**Staff working for the service kept detailed records of patients' care and treatment.**

Staff kept records of children's and young people's care and treatment. Records were stored securely. Staff had access to an electronic records system. All staff including agency workers received training in using these systems and had individual logins and secure smartcards in order to access them. Information needed to deliver patient care was available to all relevant staff.

## Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff used an electronic system to prescribe medicines. Medicines were not administered at any of the locations. Prescriptions would be given to the family/carers of the young person to be dispensed by a community pharmacy.

Medicines reviews were recorded in the patients care and treatment records. Medicines information was also shared appropriately with external healthcare providers, such as GPs.

The service followed the National Institute for Health and Care Excellence guidance when prescribing medicines for children and young people's mental health. This was always done alongside other forms of therapy where the benefit of the medicine outweighed any negatives. If a medicine was prescribed off-license (in a way different from the products licensing agreement) then the child or young person and their family were made aware of this before treatment was started.

Staff had access to emergency equipment, and this was checked daily. At the Dartford hub the defibrillator pads had expired at the end of the March 2022. Checks for the past seven days in April had failed to identify this. We informed the service at the time and they changed these immediately.



# Our findings

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. There was a weekly multidisciplinary team meeting at each of the teams where staff could bring cases to be discussed and reviewed. This included repeated follow ups of those children and young people deemed to be at the most risk. Medicines and treatment options could be reviewed and discussed at these meetings.

Children or young people and their families had a formal medicines and treatment review regularly depending on their needs. This could be anywhere from twice a week to monthly.

Children and young people and their families were always given time to go away and review treatment options before the decision to prescribe was made. They were given information to support them in their decisions and could accept or refuse the prescribing of a medicine at the following appointment.

There was access to a clinical pharmacist during the week either in person or remotely. Doctors would sometimes ask the pharmacist to join meetings to provide expert support around medicines.

Children, young people and their families had access to a website called 'choice and medication' which provided information and advice about any of their prescribed medicines.

Staff completed medicines records accurately and kept them up-to-date. Most people's medicine records were kept accurately and up to date. At Canterbury hub we identified one record where a formal medicine review had been scheduled to be conducted following side effects but no record of the outcome of this meeting was kept in the records reviewed.

Staff stored and managed all medicines and prescribing documents safely. Prescribing documents were stored safely and securely at each of the sites. Only administration team members had access to the areas where prescribing stationary was stored. Printers were locked so that the trays with prescribing stationary could not be accessed. There was a robust auditing and records system in place that could track and identify each prescription held at the various locations and those that had been used. There was a process to safely destroy unwanted prescriptions at each of the services. This was recorded and witnessed by two members of staff.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. When children and young people were accepted into the service the family would be sent a 'family information form'. This asked the family to provide details of other agencies involved in the care of the young person including their GP and other healthcare professionals.

When moving between or being discharged from services a formal discharge letter was sent to both the young person's family and their GP. This letter detailed any medicines that needed to be supplied.

If a GP was unwilling to prescribe specific medicines for a child or young person then the service would try to work alongside the GP to alleviate concerns or where necessary would continue to prescribe the medicine on a regular basis in place of the GP.

Staff learned from safety alerts and incidents to improve practice. Information from the Central Alerting System (a web-based cascading system for issuing patient safety alerts) was supplied to each of the locations by the pharmacy team. There was an electronic incident reporting system in place to log any errors or near misses. The pharmacy team discussed the outcomes of any medicines related incidents with the teams so that learning and improvements could be made.



# Our findings

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Medicines for the control of behaviour were prescribed infrequently and always for the minimum duration possible. Prescribers worked closely with the families of children and young people to ensure that these medicines were used appropriately. There were safeguards in place to ensure that these medicines were used as intended by the family. Psychiatrists were able to describe the tools they used to monitor and ensure the safety of young people when prescribing these types of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff were monitoring the effects of children and young people's medicines on their physical health. Blood tests and other tests such as echocardiograms were requested from a patient's GP or from local hospital where needed. We were told by staff at several sites that accessing the results of these was challenging due to there being no in-house monitoring available. We saw one example where blood tests had been requested but had not been followed up for several months. In the Maidstone locality there was a shared care agreement with GPs to make accessing physical health monitoring more reliable. Other hubs and localities had identified this as an issue and were trying to improve working with the local GP practices and where possible put in place shared care agreements.

## Track record on safety

**The service had a good track record on safety.**

The locality teams we visited had no serious incidents between April 2021 and March 2022.

## Reporting incidents and learning from when things go wrong

**Staff recognised incidents and reported them appropriately. Managers shared lessons learned with the whole team.**

Staff knew what incidents to report and how to report them. Managers were able to discuss learning from incidents and how this was cascaded to their teams. Staff understood their responsibilities to raise concerns and report incidents and near misses and felt confident and supported when doing so. Staff said they were debriefed and supported after any serious incident. They ensured young people, families and carers were updated. Incidents were reported on electronic system. Incidents were added to the team business meetings and discussed when they occurred.

The service reviewed serious incident for themes and patterns. Five young people with links to services died as a result of suicide in the community between March 2020 and July 2020, during the first COVID-19 lockdown. The service conducted a thematic review which identified several actions. These included staff providing face to face follow up within seven days of a crisis assessment in accident and emergency departments; assistant psychologists supporting the neurodevelopmental and learning disability team in contacting all 13 to 16 year olds on the caseload for clinical risk discussions; debriefings for staff involved in cases.

## Is the service effective?

Inspected but not rated



## Assessment of needs and planning of care

**Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, and recovery oriented.**

# Our findings

Staff completed a mental health assessment of each patient. Initial assessments were completed in a timely manner following the initial appointment with a clinician.

Staff made sure that patients had a physical health assessment and knew about any physical health problems. Staff recorded information about a young person's physical health, including allergies. For all people prescribed medication, staff completed basic physical observations such as blood pressure, height and weight and recorded these in patients care and treatment records. Staff liaised with patient's GPs and requested they arrange physical health checks such as blood tests.

Care plans were personalised, and recovery orientated. Staff developed a care plan for each patient that met their mental and physical health needs. Most care plans had been developed with the young person's input and where appropriate their family's input. Young people, parents and carers said they were aware of their care plans and their stated goals.

Young people and parents and carers said they worked with staff to review and update care plans when their needs changed.

## Best practice in treatment and care

**Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.**

Staff provided a range of care and treatment suitable for the patients in the service. The service provided psychological therapies in line with national guidance. These included family therapy, cognitive behavioural therapy, dialectical behaviour therapy, non violent resistance approaches, and trauma-based therapies such as eye movement desensitisation and reprocessing. Clinicians were qualified to deliver recommended psychological therapies and staff were supported to undertake further training in this area. Young people were offered individual and group therapies depending on need. Most young people, parents and carers said that once treatment started the service was excellent. For example, people commented on the 'profound, supportive and powerful' impact of family therapy sessions and the non violent resistance group. They said the change in their lives from these sessions was unbelievable, providing children and young people with the confidence and ability to make friends again, enjoy activities and care for themselves.

Staff delivered care in line with best practice and national guidance. The service provided four pathways within their model of care. These included a pathway for behaviour and conduct, mood and anxiety, complex mental health needs and neurodevelopmental and learning disability needs. The locality teams provided the behaviour and conduct, mood and anxiety, complex mental health needs pathways and the neurodevelopmental and learning disability team provided the neurodevelopmental and learning disability needs pathway. This approach allowed staff to specialise and ensure best practice treatment according to national guidance. Staff used a range of recognised screening tools to support assessment in each clinical pathway. There were occasions when these screeners were sent whilst young people were on waiting lists and there was no record of them being chased when they were not returned.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Care records showed staff liaised with patients GPs where children and young people required regular physical health monitoring.

# Our findings

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Teams used measures such as the mood and feelings questionnaire, the strengths and difficulties questionnaire and the revised children's anxiety and depression scale to measure patient progress.

Staff used technology to support patients. Following success in the neurodevelopmental pathway, there were plans to roll out automated text messages to young people on waiting lists across all clinical pathways. Teams also used online video and telephone calling to engage with young people and their families. Staff said the use of these platforms increased significantly during the COVID-19 pandemic and the service now used a mix of online and face to face communication with patients. The trust also provided a dedicated website for the service which included the contact details for all the teams and services, crisis information and additional community support services.

Staff took part in clinical audits. Teams audited care plans, supervision, risk assessments, premises and equipment, and outcome measures. They discussed the outcomes of these audits and any improvement actions needed in team business meetings. The trust's performance team processed the results from audits and provided feedback to managers.

## Skilled staff to deliver care

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

Each team had access to a range of specialists to meet the needs of patients. Staffing establishments varied from team to team, but included mental health nurses and practitioners, psychotherapists, cognitive behaviour therapists, clinical psychologists and consultant psychiatrists.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work and constructive clinical supervision of their work. Staff said they were able to discuss their wellbeing, case management, personal and professional career development in supervision. They also said they were able to take time to reflect.

Appraisals had been suspended during the pandemic, but had been reinstated. Teams showed a compliance rate of between 83% and 100%. Most staff received regular supervision with supervision records showing a compliance rate between 73% to 100%. The Canterbury team was an exception to this with a compliance rate of 65%. The Canterbury team manager was aware of this and had been conducting a monthly review to support staff complete supervision.

Managers made sure staff attended regular team business meetings or gave information from those they could not attend. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff said there was an extensive range of mandatory and specialist training on offer to develop their professional competence.

## Multi-disciplinary and interagency team work

**Staff from different disciplines worked together as a team to benefit patients. They had effective working relationships with relevant services outside the organisation.**

# Our findings

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We saw good communication and good team working during our observations of multidisciplinary team meetings, handover and safety huddle meetings. Staff valued these meetings, telling us they supported learning and encouraged holistic care.

Staff had effective working relationships with other teams in the organisation. Staff from the locality teams worked closely with staff from the crisis response and enhanced support team when supporting young people through crises.

Staff had effective working relationships with external teams and organisations. Staff built relationships with external service providers such as GPs and local schools teams to support the young people and families they were working with.

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

**Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.**

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice. Staff knew how to access support and advice on implementing the Mental Health Act and its Code of Practice. The trust had relevant policies and procedures and staff knew how to access these. They were available on the trust intranet.

## **Good practice in applying the Mental Capacity Act**

**Staff understood the trust policy on 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 received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The Mental Capacity Act was included in mandatory training and the teams' compliance rates ranged from 92% to 100%. There was a policy on the Mental Capacity Act, which staff knew how to access.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. Gillick competence is a test in medical law to decide whether a child of 16 years or under is competent to consent to medical examination or treatment.

Staff knew how to apply the Mental Capacity Act to patients aged between 16 and 18 and where to get information and support on this. Staff always presumed capacity and would assess a young person's competency in relation to a specific decision if there were evidence to suggest they may not have capacity.

## Is the service caring?

**Inspected but not rated**



## **Kindness, privacy, dignity, respect, compassion and support**

**Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.**

Staff demonstrated a very positive and caring attitude towards the young people they supported. All staff were passionate about the care and support they offered young people, parents and carers. Young people, parents and carers

# Our findings

said staff were respectful, attentive, non-judgemental and caring, and tailored care to their needs. They also reported staff provided helped with additional emotional support and advice when they needed it. Young people, parents and carers said staff treated them well, were kind and were responsive to their needs. We observed a group session where staff engaged with young people in a supportive and dignified manner.

Staff supported young people and their families to understand and manage their own care treatment or condition. Staff directed patients to other services and supported them to access those services if they needed help. Young people, parents and carers said staff made them aware of other services that were available, such as wellbeing hubs and crisis prevention support.

Staff felt comfortable and supported by their colleagues to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential. Young people, parents and carers felt staff were suitably discrete when communicating.

## Involvement in care

**Staff involved patients in care planning and risk assessment** Staff informed and involved families and carers appropriately.

## Involvement of patients

Staff involved patients and discussed their care plans with them. Young people, parents and carers felt they were really listened to and staff fully explained support and treatment available.

Staff made sure young people understood their care and treatment and found ways to communicate with young people who had communication difficulties by using communication aids to illustrate therapy approaches.

Patients could give feedback on the service and their treatment and staff supported them to do this. Young people said they felt their views and choices were respected by staff and were considered when making decisions about their care.

## Involvement of families and carers

Staff supported, informed and involved families or carers. Care plans included family and carers' input where appropriate. Parents and carers felt staff were non-judgemental and valued their input. They commented on staff's inclusive approach to include and support parents, families and carers in the care and support provided. Parents and carers also said staff were responsive and, in most cases, quick to provide information when this was requested.

Staff gave parents and carers information on how to access a carer's assessment. Staff informed and involved families and carers appropriately.

Staff helped families to give feedback on the service. Parents and carers said they were aware of the services complaints process and were confident in raising feedback directly with staff. They reported staff acted on feedback. Teams collected feedback via their friends and family test and 5x5 survey. Feedback was discussed at team and business meetings.

# Our findings

## Is the service responsive?

Inspected but not rated



### Access and waiting times

**Some people were not able to access assessment and treatment when they needed do as there were long waits for young people on the neurodevelopmental and learning disability pathway. Not all young people who were waiting, were updated on when they would be assessed or when treatment would start.**

**The service's referral criteria did not exclude patients who would have benefitted from care. The service ensured that patients transitions to adult mental health services took place without any disruption to the patient's care.**

The majority of referrals within the trusts emotional wellbeing and mental health services came through the single point of access (SPA). The exceptions to this were for young people in immediate crisis, those with a current forensic concern and those with an eating disorder. Improvements at the SPA meant that referrals were mostly screened in a timely fashion and prioritised for follow up by the right team. Each pathway had clear criteria to describe which patients they would offer services to. Referral criteria did not exclude children and young people who would have benefited from the service.

Not all teams met trust target times for seeing patients from referral to assessment. The service aimed to assess all referrals within 12 weeks. Data from February 2022 showed on average the service met this target for 77% of referrals on the behaviour and conduct, mood and anxiety and complex mental health needs pathways. Some individual locality teams were performing better, for example the Thanet locality team team was assessing 97% of referrals within 12 weeks. Other locality teams were performing below this average, for example Canterbury at 67%. This meant for young people in some localities there were longer waits to access services.

For children and young people on the neurodevelopmental and learning disability needs pathway data from February 2022 showed that 17% of referrals were assessed within 12 weeks. This meant most children and young people on the neurodevelopmental and learning disability needs pathway experienced extremely long waits for an autistic spectrum disorder (ASD) or attention deficit hyperactivity disorder (ADHD) assessment. The trust was working with stakeholders to identify ways to reduce waiting times for these assessments.

Not all teams met trust target times for starting patients treatment within 18 weeks of assessment. Waiting list data from February 2022 showed on average the service met this target for 81% of referrals for the behaviour and conduct, mood and anxiety and complex mental health needs pathways. Some teams were performing better than average, for example, the Thanet team had started treatment within 18 weeks for 95% of young people. Other teams were performing below this average, for example in Canterbury, 71% of young people started treatment within 18 weeks.

For children and young people on the neurodevelopmental and learning disability needs pathway waiting list data from February 2022 showed that 22% of referrals started treatment within 18 weeks. This meant most children and young people on the neurodevelopmental and learning disability needs pathway experienced extremely long waits for treatment to start.

# Our findings

Young people, parents and carers expressed concerns over waiting time for assessments and for treatment. Parents and carers understood the pressures on the service but felt they had to continually contact the service to get an update on when their assessment or treatment might commence. However, those on the neurodevelopmental and learning disability needs pathway had now started to receive text updates which they commented were helpful.

The service used systems to help them monitor waiting lists. The service monitored waiting times for all pathways and waiting times for referral to assessment and assessment to treatment were on the trust risk register. Senior leaders and team managers were aware of waiting times. The teams were providing additional assessments over the weekends to reduce the waiting times between referral and assessment. Waiting time data was also fed back and discussed with commissioners.

Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. Urgent referrals were prioritised at the single point of access and forwarded to the appropriate team as a priority assessment. Crisis team referrals were to be seen within 4 hours. When there was a high demand for crisis assessments, the team prioritised community assessments over young people attending at emergency departments. This meant that the 4 hour target was sometimes breached.

Patients had some flexibility and choice in the appointment times available. Young people, parents and carers said they were generally able to arrange appointment times that suited them. Where staff cancelled appointments, they gave people clear explanations and offered new appointments as soon as possible. Young people, parents and carers said most appointments ran on time. Staff supported patients when they were transferred between services.

## **Facilities that promote comfort, dignity and privacy**

**The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.**

The service had a full range of rooms and equipment to support treatment and care. Waiting areas were welcoming. Each site had toys available for children as well as appropriate child-friendly furniture. Patients and carers said premises were suitable and provided privacy and confidentiality. Parents and carers also said the rooms were adapted when requested, for example, removing posters and items from the room that could distract and overwhelm young children.

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

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Staff understood the needs of young people who identified as lesbian, gay, bisexual, non-binary and transgender. Young people said they could be themselves and that staff respected their identities.

Staff made sure patients could access information on treatment, local services, and how to complain. This information was clearly displayed at team hubs.

The service provided information in a variety of accessible formats so the patients could understand more easily. Leaflets at team hubs were available in different languages and formats.

Managers made sure staff and patients could get hold of interpreters or signers when needed.



# Our findings

## Listening to and learning from concerns and complaints

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Young people, parents and carers knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and shared learning with their teams to improve the service. Learning was shared through team business meetings, supervision, one to one sessions and discussed within the multidisciplinary teams. Significant issues that were identified through complaints were escalated to senior leaders.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint. Parents and carers said after complaining they still felt fully supported.

## Is the service well-led?

Inspected but not rated



### Leadership

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

Staff spoke highly of the senior leaders and managers in the service. Leaders in the service could describe how staff were working to provide safe, high quality care and were striving for excellence. They felt the service's managers genuinely cared about the service and the staff. Parents and carers said they felt comfortable in approaching the managers if they needed to. Leaders were passionate about the service and aware of the key risks and challenges the service faced.

### Vision and strategy

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

Staff throughout the service worked in ways that aligned with the trust values. Staff put people first and demonstrated this through their behaviours and interactions. Young people, parents and carers said staff were caring and kind and listened to what they had to say.

### Culture

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

Staff felt very positive and proud about working for the provider, the service and their team. Staff felt respected, supported and valued. They could raise concerns without fear.

Career development was supported. Staff supervision included conversations about career development. Staff said supervisors supported them in identifying and pursuing professional development opportunities.

# Our findings

Staff felt able to raise concerns without fear of retribution. Staff said they would feel comfortable in raising concerns with their colleagues and managers. They felt their views and opinions would be listened to and acted on. Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian.

## 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.**

Governance processes for the service had improved since the last inspection. Leaders ensured there were structures, processes, and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities. The trust had a clear framework of what must be discussed at a ward, team, and service level to ensure essential information was shared and discussed. Staff attended monthly business meetings. Staff followed a standard agenda which included complaints, audits, incidents, and training.

The service managers attended clinical governance meetings and senior management meetings. Managers fed information from these meetings back to their teams at regular meetings. Staff implemented recommendations from reviews of deaths, incidents, complaints, and safeguarding alerts.

The leadership structure which covered Kent and Essex had been expanded which had led to improvements in consistency. The increased leadership resource had also supported improvement.

## Management of risk, issues and performance

Service level risks were identified and had corresponding actions to mitigate those risks. Risk registers reflected the issues and challenges face by the service. Risks noted included staffing levels for non-medical and medical staff, waiting times for children and young people in accessing assessments and treatment, and an increased suicide risk in 13 to 16 year old children and young people during the Covid19 pandemic.

## Information management

**Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.**

The service collected information and analysed it to understand performance and to enable staff to make decisions and improvements. Since our last inspection, the trust had moved to a new platform to collect, collate and share key performance information. This system was relatively new within the service and although managers had recently been trained in using it, they had very limited experience with it. Some managers were not sure that some performance data, for example rates of completion for clinical harm reviews was accurate. Other managers were not confident using the system and were not using it to access performance data.

The service used systems to collect data from the teams and frontline staff did not find these systems over-burdensome. Staff had laptops to assist with their record keeping when out on visits.

The information systems were integrated and secure. Information governance systems included confidentiality of patient records. All patient's records were kept electronically in a password-controlled database that only trust staff could access. Staff used laptops to support patients in their homes and record their visits. This ensured staff could work flexibly in the community.

# Our findings

## **Engagement**

Teams within the service had close links with each other and other local community services. They collaborated to help improve services for children and young people. For example, the Maidstone team had a shared care agreement with the GPs to improve the consistency of physical health monitoring.

Young people and family carers were encouraged to provide feedback to the service using the friends and family test.

## **Learning, continuous improvement and innovation**

The service did not use quality improvement processes in place to improve and develop the service. Whilst managers and staff were clearly committed to improving the service and responded to feedback from young people, parents and carers, we did not hear about quality improvement projects in the service during our inspection.

A clear framework of team business meetings was in place which facilitated sharing of learning from incidents, complaints and safeguarding across the service.

# Our findings

## Areas for improvement

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

### Action the trust **MUST** take to improve:

- The trust must ensure that staff complete all mandatory training (**Regulation 12(2)(c)**).
- The trust must ensure that systems to identify and address changes in risk for young people who are waiting are consistently applied across all teams (**Regulation 12 (1)(2)(a)(b)**).
- The trust must continue work to improve initial assessment and treatment times for young people waiting to access the neurodevelopmental and learning disability pathway (**Regulation 17 (1)(2)(a)(b)**).

### Action the trust **SHOULD** take to improve:

- The trust should continue its work to ensure that young people waiting to be assessed or start treatment are kept up to date about when this will happen.
- The trust should ensure that work continues to recruit permanent staff to reduce vacancy levels.
- The trust should ensure that all staff are confident and capable in accessing the trusts new performance platform.
- The trust should continue work to embed the improvements made to the single point of access to ensure that all referrals are triaged and signposted in a timely fashion.
- The trust should ensure that individual risks, risk management plans and changes in risk are consistently recorded across the service.
- The trust should continue to monitor caseloads to ensure they are manageable.

# Our inspection team

This inspection was carried out by two inspectors, one inspection manager, one inspector who specialised in inspecting the management of medicines, two specialist professional advisors and an expert by experience.