

Requires improvement 

Royal Free London NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

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Date of inspection visit: 2 - 5 February 2016

Date of publication: 15/08/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RAL01	The Royal Free Hospital	Royal Free CAMHS	NW3 2QG

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

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Royal Free London NHS Foundation Trust and these are brought together to inform our overall judgement of Royal Free London NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Good



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Overall we rated mental health services for children and young people as requires improvement because;

The general CAMHS tier two service was part of the wider children's directorate. At the time of the inspection the team didn't have a service manager and staff felt this was unusual for such a large service. However, the clinical director had recently made a proposal to get a specific service line lead for CAMHS which was a clinical leadership role for the whole of CAMHS.

The site environment was small and staff had problems in accessing space to conduct sessions. We did not find evidence of alarms fitted in therapy rooms for use in an emergency. The rooms did not provide adequate sound proofing and discussions could be heard outside of rooms.

The CAMHS services did not have a formal caseload management system and did not have a system for regularly monitoring non urgent young people on the waiting list to detect an increase in the level of risk.

Transition from CAMHS to adult services was poor and staff agreed that there was a lack of joint care planning and working. However, the operational service manager was actively negotiating with commissioners to improve the transition for young people to adult services. The service did not collect information for waiting times from assessment to treatment.

Parents/carers of young people were not aware of how to access an advocate and felt facilities could be improved.

However;

Staff had a good understanding of risk and reported all incidents. Staff discussed feedback and learning at team

meetings. Staff completed assessments in a timely manner and were responsive to young people's physical health needs. Clinicians used a range of outcome measures to rate outcomes and the severity of illness for young people using the service.

Staff greeted patients in a friendly and supportive manner and young people and parents/carers said staff behaved with respect and were polite. Staff made themselves available and communicated with young people and parents/carers regularly. Staff involved the families and carers of young people and invited them to appointments.

Young people and parents/carers could give feedback on the service in surveys. Young people and parents/carers felt that staff were flexible with appointment times. Parents/carers said they were fully informed by staff and received information about the service. Parents/carers of young people said they knew how to complain and that staff provided feedback.

Staff were experienced and qualified to provide therapeutic interventions to young people. Staff had good access to specialist training and had strong links to external agencies. Staff were aware of and had understanding of Gillick competency and Fraser guidelines.

The team provided young people and their parents/carers with information about how to keep safe and gave them contact information for an out of hours response.

The team had rapid access to a psychiatrist for urgent referrals. Care plans were holistic and recovery focused but there was difficulty in accessing patients records and knowing where to find key documents.

Summary of findings

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

Are services safe?

We rated safe as **requires improvement** because:

- We did not find evidence of alarms fitted in therapy rooms for use in an emergency, and staff did not have access to personal alarms.
- The service did not have a formal system for regularly monitoring non urgent referrals on the waiting list to detect an increase in the level of risk.
- Risk assessments were not always available in patient records.

However, the service had rapid access to a psychiatrist and provided young people and parents/carers with safety plans and contact information for an out of hours response. Staff had a good understanding of risk and reported all incidents. Staff discussed feedback and learning at team meetings.

Requires improvement



Are services effective?

We rated effective as **good** because:

- Care plans were holistic and recovery focused.
- Staff completed assessments in a timely manner and were responsive to young people's physical health needs.
- Staff were experienced and qualified to provide therapeutic interventions to young people. Staff had good access to specialist training.
- Clinicians used a range of outcome measures to rate the severity of illness for young people using the service and outcomes.
- Staff had good links to external agencies.
- Staff had a good understanding of Gillick competency and Fraser guidelines. Need to bring this out in report.

However, staff stored information securely but there was difficulty in accessing patients records and knowing where to find specific documents. Staff felt that transition to adult services was poor and that there was a lack of joint care planning and working. However, the operational service manager was actively negotiating with commissioners to improve the transition for young people to adult services.

Good



Are services caring?

We rated caring as **good** because:

Good



Summary of findings

- Staff greeted patients in a friendly and supportive manner.
- Young people and parents/carers said staff behaved with respect and were polite.
- Staff made themselves available and communicated with young people and parents/carers regularly.
- Staff involved families and carers of young people and invited them to appointments.
- Young people and parents/carers could give feedback on the services in surveys and input to design.

However, parents/carers of young people were not aware of how to access an advocate.

Are services responsive to people's needs?

We rated responsive as **requires improvement** because:

- Clinicians struggled to find space for sessions with young people.
- The service did not collect information for waiting times from assessment to treatment.
- The service did not have a target for young people who did not attend appointments.
- Parents/carers of young people felt the therapy rooms did not provide adequate sound proofing and discussions could be heard outside of rooms.

However, staff were able to see urgent referrals quickly. The service analysed information on referrals including age and gender. Young people and parents/carers felt that staff were flexible with appointment times. Parents/carers said they were fully informed by staff and received information about the service. Parents/carers of young people said they knew how to complain and that staff provided feedback. Staff received feedback and learning from complaints.

Requires improvement



Are services well-led?

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

- Staff knew and agreed with the organisation's values.
- Staff knew who senior managers in the organisation were and said they had visited the service.
- Staff described morale as good and felt it had improved recently with higher energy levels in the team.

Good



Summary of findings

- The Clinical director had identified the need for a service specific manager and made a proposal to recruit for the position.
- Managerial staff were aware of environmental issues and had added this to the risk register as a concern.

However, the team had only one key performance indicator and did not have a target for waiting times from assessment to treatment.

Summary of findings

Information about the service

The Royal Free London NHS Foundation trust provides specialist community child and adolescent mental health services (CAMHS) for children and young people up to the age of 18. The CAMHS service is located at The Royal Free hospital in Hampstead, North London.

The service consists of a multidisciplinary team that works across tier 2 and tier 3 services. Tier 2 general CAMHS services provide support to children and young people with mild to moderate emotional wellbeing and

mental health problems. Tier 3 CAMHS services provide a specialised service for children and young people with more severe, complex and persistent mental health problems. This inspection focused on tier 2 general CAMHS services provided by the trust. The trust worked with the other NHS Trusts who provided trainees.

General CAMHS services provided by The Royal Free London NHS Foundation trust have not been inspected previously.

Our inspection team

The team that inspected the general CAMHS service consisted of an inspector and a consultant psychiatrist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited one team at one hospital site and looked at the quality of the environment and observed how staff were caring for patients
- spoke with six carers or relatives of young people who shared their views and experiences of the service
- spoke with the manager of the service
- spoke with five other staff members; including clinical psychologists, psychiatrists and therapists.

We also:

- looked at nine treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke to six parents or carers of young people during the inspection. We did not get the chance to speak to any young people.

Summary of findings

Parents/carers of young people we spoke to were positive about the service they received. Parents said that staff made themselves available and behaved with respect and were polite. Parents/carers were highly complimentary and thought the team were effective.

Some parents had not been told how to access advocacy services. They also felt the waiting area was cramped, facilities could be improved and that therapy rooms were not sound proofed.

Good practice

- Staff had completed research around implementing goal based outcome measures in a psychoanalytic child psychotherapy service.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that the environment is safe and suitable for young people and staff who work in the service.
- The trust must ensure that the place of consultation with patients does not expose patients' private details to others without those patients' consent.

Action the provider **SHOULD** take to improve

- The trust should ensure that individual risk assessment records are updated and recorded so that staff can access information when needed.
- The trust should ensure patients are monitored while waiting to receive an assessment.
- The trust should ensure the service receives appropriate management.
- The trust should ensure that data on this is accurately collected for young people who do not attend an appointments.

Royal Free London NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)

Royal Free CAMHS

Name of CQC registered location

The Royal Free Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- Training in the MHA and Code of Practice was not mandatory for staff. Psychiatrists had MHA training but there was no MHA services on site.
- There were no young people subject to a community treatment order.
- The service had administrative and legal support in the MHA and training was available to staff.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Ninety-five percent of staff had completed mandatory training in the Mental Capacity Act (MCA).
- Staff told us they did not use the MCA but often considered it at team meetings.
- Staff were aware of and had understanding of Gillick competency and Fraser guidelines.
- The trust had a policy on the MCA which staff were aware of and had support from the safeguarding lead for advice.

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- Therapy rooms were not fitted with alarms. Staff told us there were alarms in the rooms under desks that connected to reception but could not locate them. The service did not have personal alarms for staff.
- The clinic room was clean and had the necessary equipment for physical health assessments such as weighing scales and a blood pressure machine. The service did not keep medication on site.
- The general CAMHS service was based at the Royal free hospital and was located at the rear. The service environment had tired furnishings but was clean and well maintained.
- Therapy rooms were clean, tidy and of a normal standard. Rooms had signs on the doors to maintain privacy whilst some rooms had toys and other resources for young people.
- The service had a waiting room dedicated to young people and families accessing the service. The waiting room was small and if busy, patients had to stand up while waiting for an appointment. The service did not have CCTV to monitor the entrance and had recent incidents of young people running away from the reception areas.
- Staff had complete infection control audits.

Safe staffing

- At the time of the inspection, the general tier two CAMHS service had one vacant post for a CAMHS liaison nurse. The service were actively recruiting for this position. Whilst staff did not know their individual caseload numbers, they told us that they felt their caseload was busy but manageable.
- The service estimated that the average caseload for each practitioner was 37 cases. This was within the limit recommended by the Royal College of Psychiatrists. Staff told us that clinicians may have higher numbers on caseloads than expected as they saw most patients only every three to six months with were very few patients

seen weekly. Staff told us that they were currently undertaking caseload reviews with clinicians to ensure that they had updated closed cases or those in the process of closing on the service database.

- The service did not have a formal caseload management system and staff allocated referrals by need.
- Staff identified that agency workers covered 49 shifts or 2.6% of all shifts. The trust commented that agency workers were only used in the inpatient ward.
- There was rapid access to a psychiatrist for young people in crisis who had access to the CAMHS emergency services. Staff would assess young people in the accident and emergency department. Staff felt they were able to access a psychiatrist at all times if they had concerns. The trust told us that out of hours provision at Barnet Hospital was withdrawn by the CCG in 2014. This meant staff at the Royal Free covered a one in four rota. Staff said the out of hours rotas were disorganised but that it was improving towards a proper rota.
- Staff received mandatory training and the operational service manager had access to staff training records. The operational service manager monitored mandatory training rates, which at the time of our inspection was 94% against the trust target of 95%. Compliance in resuscitation (73%), moving and handling (84%), fire safety (89%), infection control (91%) and information governance (89%) were under the trust target of 95%.

Assessing and managing risk to patients and staff

- Staff screened referrals following the paediatric pathway and undertook a risk assessment of patients on assessment. Staff recorded the risk assessment and scanned it to the electronic system as there was no standardised tool on the system.
- We reviewed nine patients records and six individual risk assessments were missing from the records. This meant that there was a risk that staff would be unable to review risk when needed. Staff explained how they think about risk and that most patients had a risk assessment and risk management plan but the service did not have a

Are services safe?

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

systematic agreement about where they recorded risk.

Staff had a good understanding of risk and attended regular clinical meetings with people that come through A&E every week to think about safeguarding and risk.

- The service provided young people and their parents/ carers with information about safety plans and contact information for an out of hours response or if there was a deterioration in a young person's health. Carers and relatives of people who used the service told us they had contact details for the service and felt staff communicated well and were accessible.
- The service did not have a mechanism to monitor risk for non-urgent referrals from referral to first assessment. Staff were aware of when to send out forms and wrote to patients after a month if there was no response. Staff told us that they felt that families would rather have appointments at the right time and waited for all information to arrive.
- Staff were trained in safeguarding children levels one, two and three. Training rates for staff were all above the 95% trust target. Staff were able to describe safeguarding procedure and could refer to the Trust safeguarding manual.
- The trust had a lone working policy and all staff could access this. Nearly all work carried out by clinicians in the generic CAMHS team took place at the service sites, not in the community. Staff told us no staff member would ever be working alone in the building.

Track record on safety

- There were no serious incidents reported in the last six months prior to the inspection.

Reporting incidents and learning from when things go wrong

- Staff used an online system after initial clinical discussion to report incidents. The operational service manager had access to this information and received alerts about incidents.
- Staff reported all incidents. Staff told us young persons running away from the reception area were the main theme of incidents in addition to the lack of tier 4 beds. Staff discussed feedback and learning from incidents at team meetings though we did not see evidence of changes being made as a result of this. The paediatric risk manager reviewed incidents and held a risk meeting once a month and sent out a risk newsletter. Staff used the meetings to look at scoring of risk and the frequency of incidents.
- Staff were open and transparent with patients and spoke to young people after incidents. The service debriefed and supported staff after serious incidents though they rarely had them.

Are services effective?

Good 

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

Our findings

Assessment of needs and planning of care

- Staff completed assessments in a timely manner. The trust target for completing an assessment was within 18 weeks of the referral date. The service met this target for 88% of young people between July 2015 and December 2015.
- Staff sent letters explaining the care plan to young people and parents/carers relatives and recorded this as a scanned document in the electronic reporting system. Care plans we reviewed were personalised, holistic and recovery focused.
- Staff stored information securely but there was difficulty in accessing the records and knowing where to find key documents. Staff told us they scanned documents on to the electronic system but from the records we reviewed many documents were missing.

Best practice in treatment and care

- The service was made up of a range of disciplines that were able to offer psychological therapies recommended by National Institute for Clinical Excellence (NICE) guidance. This included cognitive behavioural therapy (CBT), family therapy and child psychotherapy.
- The service used NICE guidance to inform treatment pathways and updated staff via governance meetings of any policy changes. Several therapists were tutors on external courses and sat on external service development groups.
- Staff were responsive to young people's physical health needs. The trust considered CAMHS a speciality paediatric service and was part of the children's general directorate. Staff told us they did not conduct annual physical health checks but had good access to specialist and paediatric services. The care records we reviewed showed that staff regularly monitored physical health.
- Staff used a range of outcome measures to rate outcomes and severity of illness for young people using the service. These included goal based outcomes every six months in addition to strength and difficulties questionnaires (SDQ), children's global assessment

scale (CGAS), experience of service questionnaires (ESQ) and other routine outcome measures. Staff recorded scores from outcome measures and rating scales in young people's electronic records.

- The service had a lead for audits amongst the wider paediatric service. The lead presented audits at the children's health audit meeting on a quarterly basis. Staff completed a range of audits that included themes around clinical care, referral treatment and length of stay. Some staff members said they were asked to audit compliance with NICE individually and were confident in the team around NICE guidance, however we did not see any of these audits.

Skilled staff to deliver care

- The service team included a range of disciplines required to deliver care including psychologists, psychotherapists, family therapists and psychiatrists.
- Staff were experienced and qualified to provide therapeutic interventions to young people.
- All CAMHS clinical staff received supervision in accordance with professional standards and clinical managers regularly monitored compliance. Consultants, occupational therapists and therapists received external professional supervision in addition to operational supervision as well as access to regular team meetings. Managers appraised staff annually and at the time of the inspection had appraised 90% of staff.
- Staff had good access to specialist training such as ADHD training. The trust had a practice education team within nursing and education leads organised training. The trust had a study leave policy and staff could go to a panel to request sponsorship for training in addition to the service study leave budget.
- Managerial staff gave an example of how they performance managed a member of staff. This went to mediation and staff felt supported by human resources who promptly addressed the issues around staff performance.

Multi-disciplinary and inter-agency team work

- The service held multidisciplinary meetings once a week. Staff used the meeting to discuss referrals, transfer cases, incidents and room bookings. Psychiatrists told us they did all initial assessments,

Are services effective?

Good 

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

however psychotherapists and psychology staff told us that staff could directly refer patients to them. When we discussed how differences of opinion get resolved staff could not explain and staff were unsure on what other professionals in the team did.

- The trust had integrated general CAMHS services with community and children's services and staff felt this worked well. Staff we spoke with told us that when a young person was going to continue with care in adult services, transition would happen closer to the age of 18. Staff generally felt that transition to adult services was poor and there was a lack of joint care planning and working. The operational service manager was actively negotiating with commissioners to improve the transition for young people to adult services.
- Staff had good working links with external agencies and held regular meetings such as A&E psychosocial meetings that social workers attended. Staff worked closely with schools and delivered training and attended review meetings with educators. Staff in the service felt relationships with commissioners were constructive.

Adherence to the MHA and the MHA Code of Practice

- Training in the MHA and Code of Practice was not mandatory for staff. Psychiatrists had MHA training.
- There were no young people subject to a community treatment order.
- The service had administrative and legal support in the MHA and training was available to staff.

Good practice in applying the MCA

- Ninety-five percent of staff had completed mandatory training in the Mental Capacity Act (MCA).
- Staff told us they did not use the MCA but often considered it at team meetings.
- The trust had a policy on the MCA which staff were aware of and had support from the safeguarding lead for advice.
- Staff were aware of and had understanding of Gillick competency and Fraser guidelines and had training. Staff gave an example of a young person who misused substances and did not want to tell their parents. Staff assessed that the patient was competent to make the decision.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- We saw that staff greeted patients in a friendly and supportive manner. Clinical staff interacted with young people and parents in a kind and respectful way. Staff spoke to young people directly and listened to them.
- Young people and relatives/carers said staff behaved with respect and were polite. Parents told us that staff made themselves available and communicated with them regularly. All of the parents we spoke to were highly complimentary of the service and thought they were effective. Staff gave parents the option to be part of a course that helped and informed parents with children who the service had recently diagnosed with ADHD. Parents told us this course gave them a different perspective as well as behavioural management advice.
- Parents we spoke with told us staff continually explained and asked about confidentiality. We did not speak to any young people.

The involvement of people in the care they receive

- The majority of carers and relatives we spoke to said they had received copies of their care plans.
- Staff invited families and carers of young people to appointments. Staff would see young people on their own and parents could come for therapy and advice without children.
- Staff told us young people and parents/carers had access to advocacy services and that they gave information and leaflets. They said patients could go through voluntary services or access advocates through PALS. However, none of the parents/carers we spoke with said they were aware of how to access an advocate,.
- Young people had involvement in the development of the new paediatric ward on site.
- Young people and parents/carers were able to give feedback in surveys. The majority felt that the help they received was good and would definitely recommend the service to others if they needed similar treatment. Ninety-one percent of respondents strongly agreed that staff treated them well.

Are services responsive to people's needs?

Requires improvement 

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

Our findings

Access and discharge

- The service received referrals from GPs, Schools, children's health and local authorities. Staff screened referrals at MDT meetings once a week and were able to see urgent referrals quickly.
- The service had a target of under 18 weeks for waiting times from referral to assessment. The service met this target for 88% of young people from July 2015 to December 2015. From October to December 2015, staff saw 44% of patients within 6 weeks.
- The service did not routinely collect information for waiting times from assessment to treatment. This was complicated by the fact that the service categorised some initial appointments as both assessment and treatment. In order to provide a response the team measured the time period between first and subsequent appointment using the assumption that the first appointment referred to assessment and the second appointment referred to treatment. The service demonstrated an average wait time of 26 actual days.
- The service collected information on referrals including age and gender. The staff newsletter displayed an analysis of the demographics of those referred.
- The service monitored young people who did not attend appointments (DNA) but did not have a target for it. Data provided by the service showed that they offered 321 appointments to new patients between July 2015 and December 2015 but only 191 attended with a significant proportion rearranged and 21 DNAs (11%). There were 502 follow up appointments booked with 47 DNA which represented a 9% DNA rate.
- Young people and parents/carers felt that staff were flexible with appointment times. Staff offered appointments outside of 5pm from 5-6pm.

The facilities promote recovery, comfort, dignity and confidentiality

- There were a small number of therapy rooms available with one way mirrors and small tables, chairs and toys for children. Therapy rooms did not provide adequate sound proofing and discussions could be heard outside

of rooms. This had been added to the risk register as a general issue with the environment but we had concerns that patients' private details were exposed without those patients' consent.

- Clinicians struggled to find space for sessions and felt the environment was small and cramped. An example of this was a member of staff who told us they had to see a patient in an examination room. The service were aware of the issue and added the concern to the provider risk register, as the earliest they could expect to get an upgrade was with the 2018 development at Chase farm. Staff currently managed this on an adhoc basis. Carers and patients we spoke with told us appointments were rarely cancelled.
- Young people and families did not give negative feedback about the environment but acknowledged the service was making the best use of what it had. In a recent patient survey from October to December 2015, over 50% of respondents felt facilities could be improved and were not very comfortable.
- There were a number of information leaflets in the reception area. These included information about local services, how to complain, confidentiality and physical health. Staff gave leaflets to young people and relatives/carers at appointments.
- Parents/carers and young people said they were fully informed by staff and received information about the service.

Meeting the needs of all people who use the service

- The service was on the ground floor level of the hospital site and allowed disabled access. The size of the reception area meant that while access was possible, staff would have to make special arrangements to increase space.
- Staff said they could access interpreters but had not needed to use them.

Listening to and learning from concerns and complaints

- Patients knew how to complain and staff provided feedback. The service displayed leaflets on how to make a complaint in the reception area and had a complaints policy. Parents of young people and patients often wrote to consultants and staff dealt with the majority of

Are services responsive to people's needs?

Requires improvement 

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

complaints in this manner. The operational service manager dealt with formal complaints while the service directed informal complaints to patient advice and liaison services (PALS).

- Staff knew how to handle complaints. Parents of young people said complaints staff dealt with them professionally and respected their wishes. Staff gave an example where a parent was unhappy with a doctor and wished to change doctors. The service changed the doctor and the complaint was resolved.
- The service had few complaints and many compliments. Most complaints were around issues with social services, miscommunication around therapies and acceptance of treatment.
- Staff received feedback from and learning from complaints. The service discussed complaints as well as compliments at governance and team meetings. The operational service manager copied in staff to final responses to parents/carers and made a list of what learning there has been and what they think will change. The service added this to the quality newsletter for awareness.

Are services well-led?

Good 

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

Our findings

Vision and values

- Staff knew and agreed with the organisations values.
- Staff knew who senior managers in the organisation were and said they had visited the service. Staff felt supported by senior managers and felt they were proactive and responsive.

Good governance

- The operational service manager had some information on the performance of the service. This included data on the compliance of staff with mandatory training, the completion of staff supervision and appraisal meetings, staff sickness rates and the completion of audits on aspects of the service, such as health and safety and cleanliness.
- Staff were able to maximise direct care activities as they delegated the majority of administrative work to one member of the team and were able to submit items to the risk register.
- Staff received feedback and learning from incidents and complaints but did not received shared learning from other services across the trust.
- The service had key performance indicators (KPIs) which included waiting times for referral to first appointment, non attendance of appointments and length of stay.

Leadership, morale and staff engagement

- The operational service manager managed all services within the children's health directorate. The clinical director had recently made a proposal to appoint a

service manager as the team currently did not have one. Staff were pleased about getting a service manager solely for general CAMHS as they felt it was unusual for such a large service not to have one. Staff told us they currently relied on being on good terms with each other to complete work and make decisions. However, with no clear lead consultant, it was unclear if clinicians had differences of opinion who would make the final decision on such matters. Staff did not feel it had an impact on the development of the service. Staff felt positive about the support they received from senior managers. Staff were happy that the clinical director had recently reviewed the service as they had felt neglected due to the lack of space available.

- Staff felt comfortable raising a concern without fear of victimisation and knew how to whistle blow should this be necessary
- Staff described morale as good and felt it had improved recently with higher energy levels in the team and the resolution of a harassment and bullying case which had caused tensions. They told us that they worked well with each other and enjoyed their work.
- The service had low sickness and absence rates of 1.4% against the trust target of 3.4%.
- Staff had input into service development and could apply for funding for transformation. The majority of staff had worked in the team for over ten years and felt the relationships they had led to an open environment that was not hierarchical.

Commitment to quality improvement and innovation

- Staff had completed research around implementing goal based outcome measures in a psychoanalytic child psychotherapy service.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
The trust had not ensured the premises are suitable for the service provided.
This was a breach of Regulation 15 (1)c.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
The trust did not ensure the privacy of service users.
Therapy rooms did not provide adequate sound proofing and discussions could be heard outside of rooms. The premises exposed patients' private details to others without those patients' consent.
This was a breach of Regulation 10(2)(a)