

Requires improvement 

West London Mental Health NHS Trust

Specialist community mental health services for children and young people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RKL14	Lakeside Mental Health unit and Hounslow community services	Hounslow CAMHS	TW3 3EL
RKL79	Hammersmith and Fulham mental health unit and community services	Hammersmith and Fulham CAMHS	W6 0LS
RKL53	St Bernard's and Ealing community services	Ealing CAMHS	UB2 4SA

This report describes our judgement of the quality of care provided within this core service by West London Mental Health NHS 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.

Summary of findings

Where applicable, we have reported on each core service provided by West London Mental Health NHS Trust and these are brought together to inform our overall judgement of West London Mental Health NHS 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?

Requires improvement



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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated specialist community mental health services for children and young people as **requires improvement** because:

- The staff working in the teams were not all having the opportunity to hear about and learn from incidents which had occurred across the service.
- Some clinical equipment was not being regularly checked to ensure it was working accurately.
- Some of the clinic environments were not meeting the needs of young people and staff, for example they did not have sufficient rooms for appointments or provide reliable disabled access. Sessions were disturbed by alarms ringing and lights going on and off.
- Whilst many staff said they had good morale a smaller number did not feel so positive and further work was needed to improve staff engagement.
- Team managers did not have access to timely and accurate management information to support their role.
- There were several different paper and electronic patient records and information was not always stored consistently.

- There were long waiting times for the neurodevelopmental service although it was acknowledged that this was linked to how the service was commissioned.
- Young people sometimes experienced long waits for accessing specific psychological therapies.

However:

- Staff could access advice from psychiatrists and see urgent referrals quickly. They assessed risks regularly, used effective crisis plans, knew how to make safeguarding referrals and managed medicines appropriately.
- Staff planned and provided personalised and holistic care. Young people could access a range of evidence-based therapies and fed back about their experiences positively.
- Staff reported good working links with external services.
- At the last inspection we recommended that staff ensure rooms were soundproofed. The trust had completed this work.

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:

- Although staff knew how to report an incident, services did not have effective systems for learning lessons and feeding these back to staff.
- Some clinical equipment had not been checked to ensure it was working correctly.
- Staff did not respond appropriately to alarms in therapy rooms.
- Staff did not record updates of risk assessments in the allocated space on the electronic records, which could lead to confusion when staff tried to find them.
- Whilst most mandatory training was up to date, there were some such as information governance where training needed to be completed.

However:

- Psychiatry staff were available at all times for advice and staff saw urgent referrals quickly.
- Staff assessed risks regularly and used crisis plans where necessary.
- Staff received training in safeguarding children and knew how to make safeguarding alerts.
- Staff followed appropriate medicines management practices and shared information about medicines with young people and families.

Requires improvement



Are services effective?

We rated effective as good because:

- Staff completed holistic care records. They updated these regularly and provided care in accordance with them.
- Young people and families said they made good progress with the support of CAMHS.
- Most staff received regular supervision. Staff attended regular clinical and business meetings.
- Staff reported good working links with external services.
- Young people received appropriate, evidence based therapies from a range of professionals.

However:

- Staff did not complete the new young person friendly care plan consistently.
- Staff stored information about patient care in three places, which could lead to information not being easy to find.

Good



Summary of findings

- Staff supervision was not consistently recorded which meant it was not possible to ensure this was completed to an appropriate standard.
- Only 61% of staff had an appraisal in place.
- Consent to share information was not consistently recorded and so it was not possible to ensure that this had been discussed with the young people.

Are services caring?

We rated caring as good because:

- Young people and families said staff were extremely helpful, positive and caring. They said staff were skilled and helped them to support themselves or their child.
- Families and young people said they could access the service on the phone and staff would phone them back quickly.
- Staff involved young people in developing the CAMHS website, which was informative and engaging.

However:

- Staff did not record a young person or family's active involvement in care plans consistently across the teams.
- Some staff did not know the details of local advocacy groups.
- Some young people and carers were not aware of how they could provide feedback about the service.

Good



Are services responsive to people's needs?

We rated responsive as requires improvement because:

- The environment of Hammersmith and Fulham CAMHS did not meet the needs of service users. It did not have enough therapy rooms and the lighting and alarm system was disruptive.
- The trust had not made sufficient adjustments to ensure disabled people could access Hammersmith and Fulham CAMHS.
- Small numbers of young people were regularly waiting over 18 weeks between their referral and the start of their treatment, although this was mostly caused by the young person cancelling their appointment.
- Some teams had internal waiting lists of over 18 weeks between an assessment and the start of their specific psychological therapy treatment.

However:

- At the last inspection we recommended that staff ensure rooms were soundproofed. The trust had completed this work.

Requires improvement



Summary of findings

- Services provided a range of information about CAMHS in a variety of formats, including online, in leaflets and in languages other than English.
- Staff knew how to handle formal complaints and made changes in response to complaints.

Are services well-led?

We rated well-led as requires improvement because:

- Trust level systems and processes did not support management staff sufficiently to have access to clear management information to support their leadership of the service.
- Whilst work had taken place to improve staff engagement, there were a number of staff who felt unsupported and intimidated and so further work was needed.

However:

- Services participated in national quality improvement schemes.
- Staff were positive about support they received from their colleagues.

Requires improvement



Summary of findings

Information about the service

West London Mental Health Trust provide specialist community child and adolescent mental health services (CAMHS) for children and young people up to the age of 18 across the boroughs of Hounslow, Ealing and Hammersmith and Fulham.

CAMHS services are divided into Tier 2 and Tier 3 services. Tier 2 services provide support to children and young people with mild to moderate emotional wellbeing and mental health problems. This inspection focussed on the Tier 3 services provided by the trust.

Tier 3 services provide a specialised service for children and young people with more severe, complex and persistent mental health problems. These services consist of multidisciplinary teams made up of staff from a range of mental health professions, such as nurses, psychologists, psychiatrists, social workers and family therapists. Staff in each borough worked in sub-teams providing specialist interventions. This included neurodevelopmental teams, adolescent teams and child and family teams.

Our inspection team

The team consisted of one CQC inspector, one CQC analyst, one consultant psychologist and one nurse with experience of managing services and working with young people and families.

Why we carried out this inspection

When we last inspected this service in June 2015, we rated specialist community mental health services for children and young people as **good** overall;

After the inspection, we made no requirement notices but we did recommend a number of areas where the service could improve.

This inspection was to follow up the findings of the previous inspection.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all three services and looked at the quality of the environment and observed how staff interacted with people using the service
- spoke with 31 young people and parents/carers who were using the service
- spoke with the clinical director, the service director and the operational manager for the teams
- spoke with 33 other staff members; including doctors, nurses, social workers, family therapists, psychotherapists and psychologists
- attended and observed five clinical meetings

Summary of findings

- collected feedback from 41 young people and parents/ carers using anonymous comment cards
- looked at 15 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

Parents and young people were very positive about staff and said they were professional, supportive and tried to understand each young person individually. They could contact staff easily and services could be accessed quickly in an urgent situation. Young people and parents said both the environment and the staff were welcoming and that staff listened to them. Most people we spoke with described CAMHS as having a positive impact on their family's life.

Parents and families of young people accessing the neurodevelopment teams in Hounslow and Ealing said they had to wait a long time to access services, which sometimes had unnecessary negative effects on their child's self-esteem or education. Once receiving care, they said care was very good and psycho-education groups for parents were very helpful.

Good practice

- The service had created a care plan document with young people who had used the service. This was written in clear language aimed at the young person, rather than clinician. It included areas for the young person to outline their personal goals, as well as treatments and risks. The consent to treatment section was very clear and included a space for a young person, or their parent if applicable, to sign it. Each section of the document was explained clearly and set out in a simple way.
- Hounslow CAMHS had specialist teachers who worked with children and young people experiencing difficulties at school relating to their mental health needs. They were able to work with young people at their school or at the CAMHS office and could support parents and school teachers as well.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure the systems for feedback and learning from incidents is effective.
- The trust must ensure there is a system in place to ensure medical and emergency equipment is regularly reviewed.
- The trust must ensure all clinic environments meet the needs of service users.
- The trust must ensure team managers have access to timely and accurate management information to support their role.
- The trust must continue to work to improve staff engagement across CAMHS.

Action the provider **SHOULD** take to improve

- The trust should ensure that staff record when cleaning toys and resources has taken place and have a system in place to monitor this.
- The trust should ensure all staff know how to respond to a raised alarm in the therapy rooms.
- The trust should ensure mandatory training is completed.
- The trust should work to improve the patient record system to move away from multiple records and ensure information is recorded consistently so it can be located when needed.

Summary of findings

- The trust should continue to roll out the new young person care plan format and to record the involvement of the young person and their family in the care planning process.
- The trust should ensure staff complete their appraisal and supervisions are recorded consistently and to a high standard.
- The trust should ensure training on the MCA includes Gillick competency for staff working with young people.
- The trust should ensure that consent to treatment and consent to share information is recorded.
- The trust should ensure staff know about local advocacy services so they can pass this information to young people when needed.
- The trust should continue to work with commissioners to reduce waiting times for neuro-developmental services, reduce waiting times for access to specific psychological therapies and ensure that young people are supported to attend their initial assessment within 18 weeks.

West London Mental Health NHS Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Hounslow CAMHS	Lakeside Mental Health unit and Hounslow community services
Hammersmith and Fulham CAMHS	Hammersmith and Fulham mental health unit and community services
Ealing CAMHS	St Bernard's and Ealing community services

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.

Staff had access to mandatory training in the Mental Health Act 1983 (MHA). Training compliance was 78% across the three boroughs.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated a working knowledge of the application of capacity and consent for children and young people. Mental Capacity Act 2005 (MCA) training compliance was 53%. However, the trust had only recently introduced this mandatory training.

Records showed that staff considered Gillick competence and recorded assessments clearly. The trust did not provide training on Gillick competence.

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

- Staff could access wall or hand held alarms in therapy rooms. However, staff did not always respond promptly when they had been pressed. During the inspection we observed two occasions when no staff responded when alarms had been pressed, once at Ealing and once at Hammersmith and Fulham CAMHS. Management had identified a need to improve the use of panic alarms and had included this was in the CAMHS risk register. The action outlined that the protocol was being updated.
- All services had clinic rooms and first aid boxes with the necessary equipment to carry out physical examination or first aid. However, the teams followed no clear system to ensure equipment was regularly reviewed to ensure it was functional, within date and calibrated. Not all equipment was calibrated or within date. Equipment that is not calibrated regularly may produce inaccurate readings. At Hammersmith and Fulham and Ealing CAMHS, labels showed that weighing scales were due to be recalibrated. One label showed this should have taken place several years ago. A diagnostic instruments set was within date but had no batteries. At Hounslow CAMHS one first aid box contained out of date contents, some of which expired over six years previously.
- All services had emergency equipment available, including a defibrillator. However, at Hammersmith and Fulham and Ealing CAMHS the pads for adults had expired 13 days before the inspection. This was fed back to senior staff at the end of the inspection who ordered replacements and identified staff to manage a quarterly checklist to monitor equipment.
- All areas we visited appeared clean. The trust used an external cleaning company to carry out daily cleaning tasks and records showed cleaning took place regularly. However, the service had no records to show toys in waiting rooms and therapy rooms had been cleaned. Staff said the external cleaning company cleaned these

regularly, but the checklist used by the cleaning company did not include wiping down the toys. This means toys may not always be cleaned, which could increase the risk of spreading infection.

- The clinic rooms were clean and all contained clinical waste bins. Staff had access to sinks and soap dispensers in clinical rooms and bathrooms. Wall mounted hand hygiene soap dispensers were placed throughout the services.
- Fire extinguishers were placed in communal areas and had been recently serviced by an external company.

Safe staffing

- Each borough had a set number of staff and vacancy rates for positions unfilled by agency staff were low at 3%. However staff said teams were under a lot of pressure to meet the demands on services. At a business meeting in July 2016 staff discussed feeling overworked, with limited changes after feedback to senior staff. Several staff said the new job plans had been helpful to make capacity clear. Staff at Hammersmith and Fulham CAMHS were developing ways to support teams to close cases more effectively, increasing throughput and were adapting their assessment and treatment model to allocate work fairly.
- Services had difficulty in recruiting specialist permanent staff to vacant posts. Recruitment strategies were in place and agency staff were employed, but this meant there wasn't a continuity of care when they left. Recruitment difficulties were listed on the CAMHS risk register.
- There was no clear system of regular assessment of caseloads in relation to individual capacity. Individual clinicians reviewed their caseload as part of their supervision. One staff member said their caseload meant they worked extra hours and there had been no support when they raised this with managers. Ealing had a caseload of 924 young people with 28.65 whole time staff. Family therapy staff had the highest caseload of 227 young people between 6.2 whole time staff. The caseload in Hammersmith & Fulham was 519 with 13.8 whole time staff. The caseload in Hounslow was 1176 with 24.43 whole time staff.

Are services safe?

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

- The numbers of cases recorded as allocated to psychiatrists varied across the boroughs. In Ealing the caseload of psychiatry staff was 32 for 3.3 whole time staff. In Hammersmith and Fulham two psychiatry staff had a caseload of 92 young people and in Hounslow 2.9 whole time psychiatry staff had a caseloads of 233. Senior staff said this was due to the different systems of allocating patient referrals and the type of input from psychiatry staff in each borough. For example, in Ealing services were consultant-led, rather than consultant-delivered. Staff from a range of disciplines at Hammersmith and Fulham CAMHS said they felt that psychiatry time was not enough to meet the demands on the service. Staff had fed this back to the trust but did not feel listened to.
- Staff said they could always access a psychiatrist when needed, including out of hours. Ten psychiatrists shared an out of hours rota which worked on a on a ten week rotation.
- The trust target for compliance with mandatory training was 90%, which was not reached in 14 of 20 courses. The average training rate was 82% and 17 of the 20 courses had a compliance rate of over 75%. Training rates in information governance and automated external defibrillator were low at 69% and 67% respectively. Between April and September 2016, 17 information governance incidents were reported by staff. In Hounslow CAMHS, a small number of staff said demands on clinical time could be so high that mandatory training could sometimes be missed.
- Where appropriate, staff developed crisis plans with young people and families. Young people and families said they were aware of what to do in a crisis and several had used these plans.
- There was no formal monitoring system for people on the waiting list, although information about how to access services if there was a deterioration in health was sent out at referral. Young people and parents we spoke with said they had received this information and knew what to do if they became more unwell. Staff said that due to workloads, people on the waiting list were not formally monitored.
- Staff were trained in safeguarding, both for adults and children, and knew how to make safeguarding alerts when appropriate. Safeguarding children levels one, two and three had compliance rates of 93% to 100%. The compliance rate for specialist level three training was 85%.
- There were lone working practices in place across the services that staff were aware of and put into practice. Staff at Hammersmith and Fulham CAMHS said there were occasions when colleagues did not update their calendars or fill in forms to let others know their location.
- Staff followed appropriate medicines management practices.

Assessing and managing risk to patients and staff

- Records showed staff assessed risks at referral and completed risk assessments with young people during their first appointment.
- Staff re-assessed risk during appointments with young people, although records showed they did not always record this in the correct place on the electronic system. This meant updates about risk were hard to find. Staff we spoke with confirmed this is how they did it. This was fed back to senior staff during the inspection who created an action plan with immediate and longer term actions to address this.

Track record on safety

- There were seven serious incidents reported between April 2015 and September 2016. Five involved a young person being admitted to an adult mental health ward whilst waiting for a bed to become available on a CAMHS inpatient ward. Staff discussed serious incidents at clinical governance meetings.

Reporting incidents and learning from when things go wrong

- Staff knew how to report an incident, however, the systems for local feedback and learning from incidents was not effective. Business meeting minutes from June to September 2016 showed incidents were an item on the agenda, however no discussion was recorded. Some staff said the learning from incidents was not good within the organisation.

Are services safe?

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

- Staff knew the types of incident that should be reported, however it was not clear whether all incidents were being reported. Some staff said that only major incidents were reported due the pressure of workload. We saw during the inspection that the breakdown of a lift for wheelchair users at Hammersmith and Fulham CAMHS was not reported as an incident. Some staff said the system to record incidents was not clear when it came to incidents that occurred off site, for example on a home visit.
- A small number of staff said there was a fear of victimisation if incidents were reported, although we saw evidence in meeting minutes that senior staff were aware of this and encouraged staff to feel confident in reporting.

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

- Thirteen of 15 care records contained up to date, personalised and holistic information about care, although staff did not record or store this consistently. At Hounslow CAMHS staff used a service user designed care plan. At Ealing and Hammersmith and Fulham CAMHS care plans were set out in letters to GPs or in progress notes on the electronic system.
- We observed five clinical meetings and saw staff discussed cases in a holistic way, covering a young person's risks, education needs, physical health, family, behaviours and peer groups.
- Information needed to deliver care was stored securely on electronic systems or in offices.
- Staff stored information about care in up to three places. Staff used paper files for the referral form, screening measures and questionnaires, and electronic recording system and some also stored additional information in paper notes. This could lead to a delay in accessing information or incomplete records on the official care record system.
- Admin staff said there was a pressure on their workload and we saw this affected how quickly paper documents were scanned into electronic records. Although two temporary admin staff were employed, we saw three examples of consent forms or outcome measures not being scanned into records after several weeks or months.

Best practice in treatment and care

- Young people received a range of appropriate therapies. Young people and families were positive about the progress they were able to make with CAMHS. The trust were part of a pilot programme running from October 2016 to October 2017 to deliver safe care in the community and reducing the number of young people accessing inpatient beds far away from their home.
- Staff had not completed the physical health assessment form on the electronic record system. Staff said physical health needs were addressed by the GP.

- Staff carried out the appropriate physical health checks for young people prescribed medication and provided young people and families with information.
- Staff used a range of outcome measures, although this was not fully embedded. We saw references to outcome measures in half of the records we looked at. Meeting minutes showed management staff reminded and encouraged staff to do this and received weekly reports about which clinicians needed prompting. Hammersmith and Fulham clinical commissioning group reported that outcome measure data was not available in the quality needed to measure impact and quality of care.
- Clinical staff did not carry out clinical audits regularly.

Skilled staff to deliver care

- Teams included a range of mental health disciplines who were skilled and experienced.
- New staff accessed a corporate induction and then completed a local induction. The teams also arranged in house training on specific topics relating to CAMHS.
- Staff received regular supervision, however systems to measure this were not effective. Supervisors used a dual recording system of paper records and the trust intranet, however not all supervision sessions were recorded on the intranet. Information provided by the trust stated the average rate of clinical supervision was 39% however this figure did not accurately reflect the supervision that had taken place.
- Information from the trust showed that the average appraisal rate was 61%. Revalidation rates were 100% for doctors.
- Staff accessed regular clinical and business meetings. Each sub team had weekly meetings where staff discussed cases, new referrals, risks and safeguarding. We observed one neurodevelopmental team meeting and saw this was well attended and well-led. A monthly business meeting and nurses forum also took place. We observed this forum and saw it was well structured, inclusive and had a clinical and patient focus.

Multi-disciplinary and inter-agency team work

- Staff felt they were well integrated with tier two teams.
- Staff reported good working links with external services. Clinical commissioning groups (CCGs) reported

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.

receiving positive feedback from service users and schools about care. Ealing CCG said the new care pilot was progressing well. A Quality Network for Community CAMHS report from November 2015 stated that partner agencies praised the Ealing CAMHS team for effective communication. At Hammersmith and Fulham CAMHS a schools link programme meant that two staff spent between two and three hours a week at two local learning disability schools. We observed a meeting about young people who were currently in inpatient facilities where keyworkers showed a detailed knowledge of the care being provided to the young person whilst an inpatient.

- At Hounslow CAMHS three specialist teachers were part of the multidisciplinary team and could engage with young people outside of the CAMHS environment. They provided intervention and support to both young people, parents and school teachers, such as solution-focussed therapy, behavioural management and school based assessments. Clinical staff were very positive about having these teaching staff as part of the team.

Adherence to the MHA and the MHA Code of Practice

- The trust provided training in the Mental Health Act 1983 (MHA) and staff could access training from psychiatrist colleagues if there was a need. Training compliance was 78% across the three boroughs. Staff reported one incident in April 2016 where a patient was assessed as requiring an inpatient admission, however staff were unaware of the process to facilitate this. Services did not have young people under community treatment orders.

Good practice in applying the MCA

- Staff demonstrated a working knowledge of the application of capacity and consent for children and young people. Mental Capacity Act 2005 (MCA) training compliance was 53% however, the trust had recently introduced this mandatory training. This training was specifically in relation to young people aged 16 to 18.
- Staff considered Gillick competence and carried out assessments where necessary. Gillick competence determines whether a young person is able to make decisions for themselves, without their parent being involved. The trust did not provide training on Gillick competence, but relied on staff past knowledge.
- Staff did not regularly complete forms for consent to treatment and consent to information sharing.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Young people and families said staff were extremely helpful, positive and caring. They said staff listened to them and were skilled at supporting both the family and young person. Feedback was very positive about the reception staff working across the boroughs.
- We received 41 anonymous comments cards in the weeks before the inspection and 34 were positive comments. Seven suggested improvements for care or the environment. For example, one person identified that the sign in book was not confidential. The positive feedback reported friendly staff who listened, a safe and clean environment and care that was individual.
- The trust had a leaflet about a patient's rights to confidentiality and providing information in an accessible format. This is in line with the Accessible Information Standards which came into effect in July 2016. This included information about how and when parents have a right to access their child's care records. We saw staff discussed this in meetings.

The involvement of people in the care they receive

- Staff did not consistently record the involvement of young people and families in care plans. This was consistency recorded in nine of 11 records at Ealing and Hounslow, but at Hammersmith and Fulham CAMHS this was seen in one of four records.
- Services provided support groups and psychoeducation groups for parents. For example, groups for parents with children with ADHD or autism ran for six weeks, three times a year. We observed one session of the

psychoeducation group for parents with a child with ADHD. The facilitator and trainer were skilled, treated parents/carers respectfully and encouraged participation from everyone in the group.

- Families and young people said they could always get through to the service on the phone and if they left a message, a clinician would always call them back.
- Staff were not aware of advocacy services. The complaints leaflet included information about how to contact advocacy services, however members of staff we spoke with across the boroughs were not aware of advocacy services. Advocacy services work independently of health services and can support someone to defend and promote their rights and be involved in decisions about care.
- Young people could attend a participation group at Hounslow CAMHS, however these were being developed or reintroduced in the other boroughs. Across all boroughs there was a LGBTQ+ support and action group that met regularly. In August 2016 the group developed presentations to facilitate meetings with teachers and students at a school in Hounslow to consider the topic of bullying. The group also looked over the content and layout of the LGBTQ+ section of the CAMHS website and made some amendments which were in the process of being implemented by the trust.
- Young people and parents were able to give feedback about the care they received through survey questionnaires. Not all families we spoke with were aware that they were able to do this. Services had 'you said, we did' boards in communal areas which outlined actions staff had taken following feedback.

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

- Staff were able to start treatment for most young people within 18 weeks. The trust reported on how many young people were or were not seen within this time to their commissioning groups and had a target of meeting this 18 weeks for 85% of young people. Data from the trust showed that in July 2016, an average of 91.6% of young people were seen within 18 weeks. In August 2016 this was 87.5% and in September 2016 this was 82.8%. Where the number of young people not seen with 18 weeks fell below 85%, the trust listed reasons for commissioners. Reasons included families cancelling appointments and staff waiting for information from other agencies before starting treatment. Staff said it would be helpful if there was a system to alert them when a young person was close to reaching 18 weeks of waiting.
- The longest waiting times of up to 39 weeks from referral to assessment was for young people accessing the neurodevelopmental teams in Hounslow and Ealing. The average waiting time between July and October 2016 was 26.2 weeks in Ealing and 36.6 weeks in Hounslow. We spoke with 12 parents of young people accessing the neurodevelopmental team in Ealing who all said they had waited between six months and one year to access the service and had no contact with staff in the meantime. They felt intervention, information and support for young people and parents was helpful once it was received, but some had waited up to 18 months to access the psycho-education group. Three parents said a delay in receiving a diagnosis and support had negative impacts on their child's self-esteem, sleep and education.
- Some teams had internal waiting lists for specific psychological therapies, where young people who had been fully assessed had to wait to start their agreed treatment. These young people were waiting up to 34 weeks to access treatment. For example, the Hounslow adolescent team had 16 young people on an internal waiting list for various interventions. Thirteen of 16 patients had waited between 14 and 34 weeks for cognitive behavioural therapy (CBT), four young people had waited between 14 and 33 weeks and two had waited between 17 and 26 weeks for dialectical

behaviour therapy. The children and families team in Hounslow had 25 children awaiting a specific intervention after having a full assessment. Five of 13 young people had been waiting between 14 and 24 weeks for family therapy and six of 13 had been waiting between 14 and 21 weeks for CBT. Staff used a monitoring form for young people on the internal waiting list. This identified priority based on clinical need and age.

- Despite the long waiting lists for routine referrals, teams were able to see urgent referrals quickly. One member of staff from each sub team was on duty from 9am to 5pm each day and could attend to young people in a crisis or offer consultation to colleagues and external agencies. Between 5pm and 12am a nursing member of staff was based in an A&E where young people would go in a crisis. Some staff said this had reduced stress in the team and was positive for morale. Families and young people who had accessed the service in a crisis said they were seen quickly and they were happy with the system. Most appointments took place during the day with only a small number outside of school hours. Hammersmith and Fulham were planning to pilot having appointments until 7pm one day a week.
- Staff took active steps to engage with young people who were reluctant to engage. We saw evidence of this in meetings and records.
- DNA rates were below the maximum trust target of 15%.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff at Hammersmith and Fulham CAMHS said they booked sessions without being able to book a room and informally relocated throughout the day if their office was needed. Staff said this caused anxiety within the team.
- The environments were well maintained at Ealing and Hounslow CAMHS, however the lighting system at Hammersmith and Fulham CAMHS did not meet the needs of the service. The lighting system was centrally controlled and lights turned off during sessions. The light panel also sounded an alarm throughout the day which could be distressing or distracting for some young

Are services responsive to people's needs?

Requires improvement 

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

people. We observed this occurring three times throughout the inspection. At Hammersmith and Fulham CAMHS not all furniture was well maintained and some therapy rooms were very cold.

- All services had waiting rooms that were welcoming and comfortable. Waiting rooms had water dispensers available but there no cups seen on the inspection days, or a sign to say where to get a cup. All services had information boards with staff names and photographs available.
- Feedback from young people and families was positive about the environments of the services.
- At the last inspection we recommended that staff review team bases to ensure rooms were sufficiently soundproofed to avoid confidential conversations being overheard. This had taken place. As a result, two rooms at Hounslow CAMHS were no longer used as clinical rooms, as they were not found to provide sufficient sound proofing.
- Services provided a range of information about CAMHS that was available in several formats, both online and in leaflets. Some information was designed to be accessible for younger children. A website that was developed in collaboration with young people and offered a lot of helpful, clear information about CAMHS and external sources of information.
- Throughout the services there were posters that had been made by young people. These included posters saying it was ok to request a different clinician, how to cancel and appointment, invitations to art groups and posters asking for feedback about the service.

Meeting the needs of all people who use the service

- Adjustments for people requiring disabled access to Hammersmith and Fulham CAMHS were not sufficient. There was a stair lift available at the front of the building, however staff reported that this frequently stopped working and this occurred during the inspection. The front door of the building did not have a button to open the door automatically and was heavy,

meaning it would be hard for someone with limited mobility or in a wheelchair to open the door. The bathroom available for people with a disability did not have hand rails or an emergency call alarm fitted. Staff said that at times staff would carry out home visits to people with known limited mobility rather than see them at the service. Staff did not report when the stair lift stopped working as an incident on each occasion, so there were no records of how frequently this happened. The last incident about this was reported in July 2016 where the fire brigade had to be involved in releasing someone in a wheelchair from the lift. Staff at the service said they had fed this back to the trust on several occasions over a number of years, however no change had been made to the lift or options considered for a ramp at a different entrance to the building. Poor disabled access to the building was added to the risk register two months before the inspection. There was one action outlined to address this, which was to escalate this to estates and facilities, which was marked as complete in January 2016.

- There were posters on the wall that outlined how to get support to access any information in other languages. At Hammersmith and Fulham CAMHS there was a welcome poster in 18 different languages.

Listening to and learning from concerns and complaints

- Information about how to make a complaint was available and outlined how to access this in other languages or formats, for example braille.
- In the twelve months up to June 2016 there had been 15 complaints with two fully upheld and eight partially upheld. No complaints were referred to the ombudsman. The majority were about general care such as staff not returning a call, unhappy about a diagnosis or discharge or waiting for appointments.
- Staff were aware of how to handle formal complaints and had made changes following complaints. Meeting minutes showed management staff encouraged clinicians to share compliments with the team as well.

Are services well-led?

Requires improvement 

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 at Hounslow CAMHS said there was a good relationship with senior leadership who provided feedback about how the trust was developing. Several other staff said they felt disconnected from the most senior managers as they did not receive feedback from them. Two staff said feedback was not well received at this level.

Good governance

- There was a senior management team in place to support services. The trust systems and processes did not sufficiently support management staff to collect and gauge important information about services. For example managers had not received governance reports consistently due to staff shortages within the trust. The recording system for supervision was not being used effectively. The incident reporting system meant staff did not have an overview of all reported incidents.
- Clinical commissioning groups for the eating disorder and the out of hours specifications said monthly reporting of data was not being provided by teams. Where they had received data, some was inaccurate and did not have all the information commissioners required.
- There was a CAMHS risk register in place which incorporated information about risks in each borough.

Leadership, morale and staff engagement

- At Hammersmith and Fulham CAMHS a local staff survey showed that staff were positive about their local team and direct line manager, but were not positive about the trust. For example, 75% answered disagree or strongly disagree to whether they felt the trust listened to staff views and 50% answered that that the trust did not have a positive culture. Over 80% said they felt colleagues were friendly and they could rely on them.
- A small number of staff reported feeling victimised, bullied and intimidated in their roles. This was fed back to the most senior managers in the trust at the end of

the inspection. A small number of staff said they were aware of this taking place, although they had not felt victimised themselves. Most staff said they were not aware of any bullying or victimisation.

- Staff knew how to use the whistle-blowing process.
- Most staff reported morale as good within their direct teams, although four staff from across the Ealing and Hammersmith and Fulham teams said it wasn't great. Three staff at Hammersmith and Fulham CAMHS said pressures and stress could be perceived as low morale, but at a local level, there was a supportive attitude and people enjoyed their work. Staff said they were part of cohesive clinical teams where they could freely voice their opinions. Two staff from Hammersmith and Fulham said senior staff did not attend the service as frequently as they did other sites. Four staff members across all boroughs said the management systems were top down rather than supportive. For example, they had tried to address issues through their supervision, but had not received support. They said concerns were deflected with no offer of resource or support. Not all staff from particular professions felt valued for their profession.
- At the last inspection in June 2015, we said the trust should ensure staff were appropriately supported in the light of increasing workloads and restructuring across the three boroughs. During this inspection records showed health and wellbeing sessions were delivered annually on the main trust sites and in June 2016 there were sessions delivered at Ealing CAMHS. A health at work day at Hounslow was arranged for staff as staff could not easily access this. A programme of resilience training was developed.
- Trainee staff said they felt able to provide feedback on their placements and saw this being acted upon.

Commitment to quality improvement and innovation

- All boroughs were involved in the Quality Network for Community CAMHS. This is a national peer reviewing programme where staff review other CAMHS services against a set of national standards in order to share learning and good practice.
- Staff participated in award schemes, both internal and external to the trust. Three nursing staff from CAMHS were nominated for awards with external organisations

Are services well-led?

Requires improvement 

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.

in the 12 months before the inspection. These were awards for nurse of the year and rising star from the Nursing Times Award and a leadership award from The Royal College of Nursing. The Ealing CAMHS admin team

were nominated for team of the year for the trust quality awards and the family and young people service team secretary was nominated for the employee of the year award.

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

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The trust had not ensured all premises and equipment was suitable and properly maintained.

There was no effective system to ensure emergency medical equipment was in date and regularly reviewed.

Some premises were not suitable. Adaptions for people with a disability were not effective. Sessions were disturbed by ringing alarms and lights going on and off.

This was a breach of Regulation 15(1)(c)(e)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and processes were not established to monitor and improve quality and safety of services.

Learning and feedback from incidents was not embedded.

Managers did not have access to timely and accurate management information to support their role.

Further work was needed to improve engagement with staff.

This was a breach of regulation 17(1)(2)(a)(b)