Requires improvement

Barnet, Enfield and Haringey 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)
RRPXX	Trust Headquarters	Haringey CAMHS	N4 1AE
RRPXX	Trust Headquarters	Enfield CAMHS	EN1 4TU

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield and Haringey 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.

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

Staff were not always reporting incidents and learning from incidents and complaints needed to be embedded.

Not enough staff had completed an annual appraisal. Some staff working within teams felt they had too much work. Although most staff said they were receiving regular supervision, there was no central recording system for staff supervision and it was not clear whether this was taking place regularly for all staff.

The assessment to treatment times were very lengthy for patients waiting for some interventions. This had been recognised as a problem but the managers had not made the necessary changes to address this issue. This was adversely affecting the treatment for some of the children and young people.

However, there was a commitment to continual improvement across the services. There was a range of experienced and qualified staff to provide therapeutic interventions.

Young people and their parents/carers said staff were very professional, very respectful and supportive and gave positive feedback about the care they had received.

In each borough there was an adolescent outreach service that offered young people an assessment within two weeks of their referral if their need was urgent.

Summary of findings

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

Are services safe?

Requires improvement

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

- Services did not have a formal system for regularly monitoring people on the waiting list to detect an increase in the level of risk.
- Staff were not following the lone working policy as well as they should be.
- Not all incidents that should have been reported were being reported. Staff did not receive feedback from incidents and complaints as a group.
- There was no formal caseload management system.

However, services were provided in safe environments and clinic rooms were clean and had appropriate equipment. Toys and resources were available and a system for cleaning them was in place. There was rapid access to a psychiatrist available for young people in a crisis. Staff assessed risk for each young person at their first assessment using the standardised risk assessment form.

Are services effective?

Good

We rated effective **good** because:

- Staff had good access to specialist training and therapy staff were experienced and qualified to provide therapeutic interventions.
- Records of physical health checks were in place.
- Staff used a range of outcome measures to rate outcomes and severity of illness of young people using the service.
- Staff had a clear clinical audit schedule that covered all three boroughs. Multidisciplinary meetings took place once a week.
- Cases were handed over effectively between the sub-teams in each borough.

However, there was no written assessment pro forma that staff used to undertake assessments and the quality of reports following the assessment could vary. Not all care plan records had been updated.

Are services caring?

Good

We rated caring as **good** because:

- We saw clinical staff interacting with young people and their parents/carers in a responsive and caring way.
- Young people and their parents/carers said staff made them feel at ease and they felt comfortable talking to them.
- Young people and their parents/carers said staff were very professional, very respectful and supportive.

Summary of findings

- Parents and carers were involved in decisions about their child's care.
- Services had young person participation groups.
- Staff used session by session rating scales and feedback forms for therapeutic care and friends and family tests.

However, an external agency provided advocacy to all services with the trust but not all staff were aware of this and did not know how young people could access the advocacy service.

Are services responsive to people's needs?

Requires improvement

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

- The trust did not have a target waiting time from initial assessment to the start of treatment and waiting times for routine access to treatment after assessment varied. There was a four month wait for access to a family therapist and a six month wait for access to a psychiatrist. Whilst work to look at skill mix and caseload management had started, changes to improve access to some treatments had not yet taken place.
- Parents/carers and young people said they had not pro-actively received information about how long they would need to wait for treatment.
- Staff said they did not receive feedback from investigations, incidents and complaints as a staff group.

However, the trust target for completing an assessment was within 13 weeks of the referral date. This target was met for over 94% of young people. In each borough there was an adolescent outreach service that offered young people an assessment within two weeks of their referral. Staff were flexible with appointment times and ran weekly late evening clinics. There were a number of therapy rooms that supported the needs of young people and families. There were information leaflets in waiting rooms in a number of different languages

Are services well-led?

Good

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

- Staff knew who the trust senior managers were and said that very good relationships had been developed with them over the last 18 months.
- Service managers received key performance indicator reports on a monthly basis.
- There were low sickness and absence rates for staff across the teams.
- Staff described morale as good and said that teams were very supportive of one another.

Summary of findings

However assessment to treatment times were too long for young people accessing some treatments and change was needed. The managers had only recently come into post and were working towards making improvements.

Summary of findings

Information about the service

Barnet Enfield and Haringey 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 Barnet, Enfield and Haringey.

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. 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.

Within the Tier 3 service, each borough had a number of sub-teams available. This included a learning disability team, an adolescent outreach team and a generic CAMHS team.

This inspection focussed on the Tier 3 services provided by the trust.

Our inspection team

The team that inspected the CAMHS community teams consisted of two CQC inspectors, a nurse consultant, a clinical psychologist and one expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

Summarise the inspection process, including the activities carried out by those involved, how the core service was reviewed and on what basis; the methods used to gather information from people who use services and staff. Include the following details:

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 two teams and looked at the quality of the environment and observed how staff were interacting with patients
- spoke with 10 young people and their parents and carers who shared their views and experiences of the services
- collected anonymous comments cards from a further 11 service users
- observed one session delivered by a clinician
- observed one supervision session for clinicians
- spoke with the managers for each of the services

Summary of findings

- spoke with 16 other staff members including nurses, clinical psychologists, psychiatrists, family therapists, primary mental health workers, individual and family psychotherapists, family therapists, administrative staff and trainees
- interviewed the divisional director with responsibility for these services
- attended and observed four hand-over meetings and three multi-disciplinary meetings
- 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

We spoke to 10 young people and their families during the inspection. We also received feedback from 11 people from anonymous comment cards.

The majority of young people and parents and carers we spoke with were very positive about the service they had received. People said they were made to feel comfortable and felt listened to. They said staff were very nice and very professional.

Young people told us they felt they were treated as an individual during their contact with the service, were supported to get involved in activities in the community and were asked about a wide range of things.

A number of people, although happy with the service felt the waiting times were too long and would benefit from being reduced. One person was not given an explanation when they had to wait a long time for a delayed appointment.

Good practice

- The Haringey adolescent outreach team won the Health Service Journal Innovation in Mental Health award in November 2015. Young people's case studies were used to develop a theatre show for school assemblies and a film to address the issue of mental health and emotional wellbeing in schools. The project was run from September 2013 and was delivered in conjunction with a number of CAMHS partner agencies.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that staff report incidents and that learning from incidents and complaints is shared in an effective manner across teams and from other parts of the trust.
- The trust must make changes to the teams so that assessment to treatment times can be delivered in a timely manner.

Action the provider SHOULD take to improve

- The trust should ensure that young people on the waiting list for a service were monitored so that their care could be prioritized if needed.
- The trust should ensure that individual risk assessment records are kept updated so that staff can access accurate information when needed.
- The trust should ensure that when staff visit young people and their families in their homes that the lone worker policy is used.
- The trust should ensure that care plans are updated regularly and recorded in a young person's notes.
- The trust should ensure that all staff are accessing appropriate ongoing supervision in their role and that this is recorded.
- The provider should ensure consent to treatment is recorded.

Summary of findings

- The provider should ensure consent to share information with parents/carers is recorded and followed where a young person is able to make this decision.
- The trust should ensure that all staff know what steps to take if a young person does not attend an appointment and that the data on this is accurately collected.
- The service should develop information about how the teams operate to give to young people and their relatives and carers.
- The provider should ensure all staff are aware of how young people can access the advocacy service available to them.

Barnet, Enfield and Haringey 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
Haringey CAMHS	St Ann's Hospital
Enfield CAMHS	Charles Babbage House

Mental Health Act responsibilities

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

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

Training in the MHA and Code of Practice was not mandatory for staff and the trust did not routinely collect training rates. The trust learning and development department arranged monthly MHA training which they rotated across hospital sites. They also delivered MHA training sessions to individual teams upon request.

Staff were aware of the training that was available on the MHA.

The trust had a mental health law department that staff could access for administrative support and legal advice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act (MCA) was not mandatory for staff and the trust did not routinely collect training data. Staff were aware of the training that was available to them around the MCA. The trust learning and

development department arranged twice monthly training in MCA and Deprivation of Liberty Safeguards (DOLs) across hospital sites. They also delivered MCA training sessions to individual teams upon request.

Staff were aware of and had a clear understanding of Gillick competency and Fraser guidelines and were applying these appropriately.

Staff told us that consent to treatment and consent for the sharing of information was recorded at the initial assessment and that young people signed a paper form. These signed consent forms were uploaded to two of 13 people's notes. A further eight notes were examined for a record of consent. Five of these eight had the consent forms present.

Requires improvement

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

- Not all therapy rooms were fitted with alarms. There were a small number of bookable therapy rooms that had wall alarms and staff had portable alarms available if they needed them. Some therapy rooms also had glass panels in the doors allowing staff to see into the room. In Enfield CAMHS there was a sign on the wall that outlined the London Borough of Enfield provided a safe environment for staff and service users and any physical or verbal abuse would not be tolerated.
- All services had clinic rooms that were visibly clean and had necessary equipment for physical health assessments such as weighing scales and blood pressure machines. The weighing scales were calibrated to make sure they were providing accurate readings. Medication was not kept on site at the services.
- The teams were based in several sites in the three boroughs, all were well signposted. Haringey CAMHS was based across two sites, with one at St Ann's Hospital. The trust estates strategy 2010-2017 included plans to redevelop certain parts of St Ann's hospital as this building was old and in need of repair. Staff and young people using the site at St Ann's felt the environment was in need of refurbishment and could be more young person friendly. At the St Ann's site of Haringey CAMHS, paint was cracked and peeling in some rooms and flooring at the entrance of the service was also damaged.
- The service manager for Haringey CAMHS had put two items on the service risk register that related to the St Ann's site. One was that young people regularly declined appointments at the site as they did not like it and another was about a leak in the building.
- The other team sites were in a good state of repair and young people and families did not have negative feedback about the environment. All therapy rooms were clean and tidy and had an in use/vacant sign on the doors to maintain people's privacy.
- Each service had its own monitored entrance and a waiting room dedicated for young people and families accessing the service. Waiting rooms were well maintained and young people had been involved in the design of one of them.
- Therapy rooms had toys and resources available. Some staff kept toys and resources in a cupboard outside of the therapy room when not in use and took them into each session. Clinical staff were responsible for wiping toys down after use with disinfectant wipes. There were notices on the wall about this and disinfectant wipes were present in therapy rooms.

Safe staffing

- There were no vacancies in Enfield CAMHS and managers brought in temporary cover for people on maternity leave or long term sick leave. Staff described feeling stretched but able to manage the team caseload. They felt that if waiting times were to be reduced, a larger staff team would be necessary. Staffing was a standing agenda point for the operational management group meeting that took place once every two weeks.
- In Haringey CAMHS the service manager, who started in April 2015, carried out a review of the staffing establishment and concluded that six members of additional staff were needed within the service. Following this review, two full time positions were filled by agency staff until March 2016 and two permanent staff were sharing a 0.8 whole time equivalent position. Staff at Haringey CAMHS felt under pressure to balance their assessment and treatment work and administrative tasks whilst ensuring young people received an initial assessment with the trust target waiting time of 13 weeks.
- Service managers had been involved in developing service transformation plans for each borough, supported by NHS England and the Department of Health's Future in Mind initiative. These transformation plans outlined the need for an increase in staffing numbers.
- Caseloads varied for each practitioner from 15 to 40 cases. Psychiatrists had the largest caseloads. There was no formal caseload management system or review. Staff felt a more formal system for this would be helpful.

Requires improvement

Are services safe?

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

- There was rapid access to a psychiatrist available for young people in a crisis. Staff felt able to access a psychiatrist at all times if they had concerns. There was an on-call, out-of-hours rota for CAMHS consultants covering Barnet, Enfield and Haringey.
- Staff received mandatory training and service managers had access to staff training records. Service managers monitored mandatory training rates and would address mandatory training compliance in staff appraisals. Mandatory training compliance was over 75% across services apart from in Haringey generic CAMHS, where breakaway training was completed by 71% of staff. Breakaway training teaches staff the skills they need for safe escape from an aggressive situation.
- In Enfield CAMHS some clinicians were employed by the local authority rather than the trust, for example the family therapists and service manager. The trust accepted a number of local authority mandatory training programmes, for example, safeguarding and information governance, so these staff did not have to repeat training.

Assessing and managing risk to patients and staff

- Staff screened all referrals for the level risk and then offered an assessment appointment. During the assessments staff assessed risk for each young person using s standardised risk assessment form. Staff felt this form was developed for use with adults and was not best adapted for use with young people.
- Staff had a good understanding of risk and described assessing risk regularly. In 13 patient records, all had an initial risk assessment present. Of these records, 12 had an up to date risk assessment that had been completed following a change in risk. One person did not have an updated risk assessment in their notes. Staff told us the pressure on their time meant there was sometimes a delay in updating the risk assessment information in the patient record system.
- Services provided young people and their parents/ carers with information about safety plans and contact information for an out-of-hours response. People who use the service told us they had contact details for the service and found the staff easy to access when they needed to.
- Services did not have a formal system for regularly monitoring people on the waiting list to detect an increase in the level of risk. When waiting for therapy after a first assessment, staff gave young people verbal advice and a letter with contact numbers for the service. Staff said that if there was a deterioration in a young person's mental health and they become more unwell, staff could discuss this immediately with a psychiatrist and would be supported in taking the next steps to provide support to the young person.
- Haringey CAMHS recorded the number of telephone contacts they carried out with young people on a monthly basis. This telephone contact was recorded if it was over 15 minutes long and was a clinical conversation. In October 2015 generic CAMHS staff had 67 telephone contacts with young people.
- Staff were trained in Safeguarding Children Levels 1, 2 and 3. Training rates for staff were over 85% for all staff apart from Haringey generic CAMHS where compliance with safeguarding level 3 was 66%. Staff were able to clearly describe their safeguarding procedure and knew who to contact and how to report a safeguarding concern.
- The trust had a lone working factsheet and policy written in March 2015. All staff could access these on the trust intranet. This policy did not clearly outline the steps that staff should take when carrying out visits to young people in the community. Staff were aware of the policy but said it was not being followed robustly. Most work carried out by clinicians in the generic CAMHS team took place at the service sites, not in the community. The adolescent outreach services did more work in the community with young people. In Enfield CAMHS staff said no staff member would ever be working alone in the building. At Haringey CAMHS, the fact of staff not following the lone working policy procedure fully was added to the service risk register in November 2015.

Track record on safety

- There were two serious incidents in the six months prior to the inspection. Managers were able to describe what action had been taken immediately after the incidents and the timelines in which these took place.

Reporting incidents and learning from when things go wrong

Requires improvement

Are services safe?

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

- Staff used an online system, to report incidents. Service managers had access to this information and received an alert about incidents.
- Staff were not reporting all incidents that should have been reported. For two young people that were known to the service and who were involved in an incident, this incident was not recorded. Another staff member described not reporting an incident.
- Staff described feedback from incidents and complaints as limited. Staff also felt there was no robust cross team learning from incidents, for example between the generic CAMHS, the learning disability team and the adolescent outreach service.

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

- There was no written assessment pro forma that staff used to do assessments. Staff told us that new members of the team shadowed colleagues to gain an understanding of the assessment process and what questions to cover. The written reports following the assessment varied between different staff members. The trust target for completing an assessment was within 13 weeks of the referral date. This target was met for over 94% of young people in October 2015.
- Staff did not use a specific care plan document but recorded a care plan in the first assessment report that was sent to young people and/or their parents/carers. Assessment reports outlining care plans were present in all records. Care plans were problem focussed and were not as personalised and holistic as they could be. This varied across different clinicians. At Haringey CAMHS the poor quality of care plans in the patient record system was discussed in September 2015 at a staff meeting. Seven of the 13 care plans had been reviewed and were up to date.
- Records of physical health checks for young people with ADHD were in place. Staff referred young people to paediatric services when they had other physical health concerns.
- Staff entered all information after an assessment onto the electronic recording system. Staff also opened paper case files at the time of referral which contained a paper copy of the referral form, session rating scales and artwork done by the young person. The information on the electronic system and the paper care files were stored securely.

Best practice in treatment and care

- The generic CAMHS teams were made up of a range of disciplines that were able to offer psychological therapies recommended by NICE for different diagnoses. This included cognitive behavioural therapy (CBT), family therapy, child psychotherapy and speech and language therapy.
- There was an unclear pathway for young people with autistic spectrum disorder (ASD) across the services. This was not in line with NICE guidelines which recommend there is a local pathway for the recognition, referral and assessment for ASD. Staff had recognised and highlighted this to their managers. The service manager at Enfield CAMHS was part of group looking into developing one pathway for people up to 18 with ASD.
- The trust carried out an audit for compliance with NICE guidelines in 2015. Haringey CAMHS was compliant with NICE guidelines for 33 conditions, partially compliant with five and non-compliant with ADHD training levels. Partial compliance was for offering CBT for people with obsessive compulsive disorder, carrying out physical health monitoring for pre anti-psychotic prescribing, providing a substance misuse service (this was outsourced to a separate provider) and working with primary care to provide training on depression (this was not fully funded). The final partial compliance was not having robust transition arrangements in place to adult services. Not all staff we spoke to were aware that this audit had taken place.
- Family therapists told us they meet colleagues from across the three boroughs to discuss the latest therapy and treatment options.
- Staff used a range of outcome measures to rate outcomes and severity of illness of young people using the service. These included, but was not limited to, a goal based outcome record sheet, a session rating scale for under and over 13 year olds, the revised children's anxiety and depression scale, the children's global assessment scale and an ADHD assessment form for parent and child. There were posters on the wall in staff areas outlining different types of outcome measures and when to use them. There were records and scores from outcome measures and rating scales present in the young peoples' electronic records and paper files.
- The service in each borough was a member of the Child Outcomes Research Consortium (CORC). Staff supplied outcome measurement data to CORC who aggregated the data and provided an annual report of outcomes.
- The services had also recently joined the Children and Young People's Improving Access to Psychological Therapies programme. This is a service transformation

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.

programme delivered by NHS England. It uses session by session outcome monitoring to help guide therapy to be as effective as possible and works to empower young people to take control of their care.

- Staff had a clear clinical audit schedule that covered all three boroughs. Senior staff from each service completed a monthly quality assurance audit of 10 case notes across all CAMHS in the three boroughs. These staff also completed a quarterly safeguarding case note audit of five case notes. The last was carried out in July 2015. Staff completed a health and safety audit once a year. Results from these audits were fed back to staff at team meetings and included areas of achievement and areas for change. Smoking status and alcohol consumption were added to areas to cover in assessments following a recent quality assurance audit. Enfield CAMHS staff also carried out an audit of social care needs for children and adolescents admitted to inpatient mental health units in July 2015.

Skilled staff to deliver care

- Staff were experienced and qualified to provide therapeutic interventions to young people.
- The generic CAMHS teams included a range of disciplines required to deliver care including psychologists, psychotherapists, family therapists and psychiatrists. Staff felt there was a good range of professional skills across their teams, but that there was limited input from nurses and social workers. Staff felt an increase in nursing staff would benefit the skill mix greatly.
- There was no central recording system for staff supervision. In Haringey CAMHS the service manager had recently developed an electronic recording system. They had also developed a comprehensive and clear supervision template and introduced this to the team. This template covered a range of topics including clinical work and also training, appraisals, incidents, complaints and outcome measurements. Most staff said they had access to monthly supervision within their discipline. Psychotherapy staff accessed group supervision and trainees had weekly individual supervision. During monthly group supervision the group discussed urgent matters on their case load and shared advice. There was also a case presentation for shared learning. Psychiatrists had peer supervision and also linked in with psychiatrists across the neighbouring boroughs. In Enfield CAMHS there was a plan in place for administrative staff to have monthly supervision through the local authority line management structure although this was not yet in place. There was a monthly meeting for administrative staff to raise concerns or issues about workload, which could be escalated as required. Staff at Haringey CAMHS said supervision was occasionally cancelled due to workload pressures.
- Appraisal rates for non-medical staff in generic CAMHS varied across the boroughs. Information supplied by the trust indicated that in Barnet, 98% of non-medical staff had received an appraisal. In Enfield it was 100% and in Haringey it was 84%.
- Revalidation rates for medical staff were 100% in Barnet 57% in Haringey and 50% in Enfield. There were plans in place to address the outstanding revalidation.
- Staff had good access to specialist training. Recent training for staff included awareness of child sexual exploitation, gangs and complex trauma and substance and alcohol misuse. Two staff members in Haringey CAMHS were trained to carry out assessments of young people at schools.
- Staff highlighted that there was a lack of staff trained in ASD. The trust audit for compliance with NICE guideline found that staff at Haringey CAMHS did not have ADHD training.

Multi-disciplinary and inter-agency team work

- Multidisciplinary meetings took place once a week. All staff attended, including staff from the sub-teams such as the adolescent outreach service. Staff said this was a place for professional discussion and challenge. Staff could hand cases over to one another in this meeting and also discuss and transfer cases from one sub-team to another smoothly.
- Haringey CAMHS also held a peer assessment group every two weeks to discuss complex cases. This was highly valued.
- Where a young person was going to continue with care in adult mental health services, staff said they started conversations and plans for transition at age 17 and a half. This is in line with national recommendations.

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.

- Some staff worked across the generic CAMHS and Tier 2 CAMHS. Tier 2 CAMHS support young people with mild to moderate emotional wellbeing and mental health problems. This cross team working enabled clear communication between teams.
- Services had links with external agencies such as children's physical health services, GPs, social services and schools. Up to 77% of cases in CAMHS were known to social services.
- The trust had a contract with the Tavistock and Portman NHS Foundation Trust and young people with particularly complex issues could be referred to their specialist services. This included young people with body dysmorphic disorder or gender identity issues. One psychotherapy trainee from the Tavistock and Portman NHS Foundation Trust was working on a four year placement at Enfield CAMHS.
- Enfield CAMHS was co-located in a building with the local authority and the borough's educational psychology services. Staff said this had led to good working relationships between the services. The local authority funded a number of clinical and administrative posts in Enfield CAMHS. CAMHS and social care ran a forum when necessary to discuss cases.
- Parents said that the communication that staff had with their child's school had achieved positive results for their child.

Good practice in applying the MCA

- Training in the Mental Capacity Act (MCA) was not mandatory for staff and the trust did not routinely collect training data. Staff were aware of the training that was available to them around the MCA. The trust learning and development department arranged twice monthly training in MCA and Deprivation of Liberty Safeguards (DOLs) across hospital sites. They also delivered MCA training sessions to individual teams upon request.
- Staff were aware of and had a clear understanding of Gillick competency and Fraser guidelines and were applying these appropriately.
- Staff told us that consent to treatment and consent for the sharing of information was recorded at the initial assessment and that young people signed a paper form. These signed consent forms were uploaded to two of 13 people's notes. A further eight notes were examined for a record of consent. Five of these eight had the consent forms present.

Good

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 patients being greeted warmly by reception and clinical staff who were supportive and friendly. We saw clinical staff interacting with young people and their parents/carers in a responsive and caring way. Staff spoke to young people directly and listened to them.
- Young people and their parents/carers said staff made them feel at ease and they felt comfortable talking to them. They said staff were very professional, very respectful and supportive. No one we spoke to had any concerns about the way staff behaved towards them. Young people and their parents/carers told us they felt listened to. Feedback from 10 of 11 comments cards said the staff treated young people and parents/carers with dignity and respect and staff made incredible positive differences to people. One person had a negative experience of having to wait over 45 minutes for their appointment and were not given an explanation for this by the clinician.

The involvement of people in the care they receive

- Staff developed care plans during an initial assessment and sent young people an assessment letter which included this care plan. Staff said that involving the young person in decisions about their care was very important but not always done as robustly as it should be. Staff said care plans could be limited in nature and there was not always enough time to give focus to them, particularly at Haringey CAMHS.
- Not all young people and parents/carers said they had a written copy of the care plan or a copy of treatment and personal goals. Young people said they had been spoken to about their care and gave examples of direct involvement in decisions made about their care. This included decisions about medication and the type of intervention they wanted.
- Feedback from parents and carers was generally positive about the involvement they had in supporting their child. They were involved in sessions where appropriate and were supported to access help themselves. Parents and carers gave examples of where they had been involved in decisions about their child's care.
- Some parents and carers said staff could provide more verbal and written information about the service and their child's treatment. This was an outcome from the CAMHS review in September 2015 as well.
- In a supervision session we saw staff considering the individual needs of parents and carers and what they needed to support their child.
- An external agency provided advocacy to all services with the trust. There were leaflets in the waiting rooms with details of the advocacy service available. Not all staff were aware of this and they did not know how young people could access the advocacy service.
- The service managers had plans to involve young people in the recruitment of new staff but this was not yet in place.
- Services had young person participation groups. Information posters about these groups and how to join were displayed in public areas. These posters were clear and outlined the work young people became involved in around improving and developing the service.
- Staff routinely collected feedback from young people and parents/carers which was used to make improvements to the services. There were suggestion boxes and "you said, we did" feedback displayed in public areas. Improvements from these initiatives included changing the chairs in the waiting room, introducing the suggestions box and having one of the young person participation groups involved in re-designing a waiting room.
- Staff used session by session rating scales and feedback forms for therapeutic care. In five paper files sampled, four had copies of completed session rating scales. All four of these scales were positive in their feedback about feeling listened to and talking about things that were important to them.
- Enfield CAMHS collected feedback through a monthly friends and family test. Young people and parents/carers were asked to anonymously answer the question "would you want your friends and family to come here if they needed help?" In October 2015, 24 people filled this form out, 22 said yes (92%). The final two forms were marked as "I don't know".

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

- Referrals were received from GPs, schools, child health and the local authority. Services had systems in place to screen all incoming referrals daily for immediate risk and appropriateness for the service. Staff wrote back to the referrer with an explanation if the referral was not accepted and signposted to other appropriate services, if possible.
- Once a referral was accepted, administrative staff would set up an assessment appointment. The trust target for completing as assessment was within 13 weeks of the referral date. This target was met for over 94% of young people in October 2015. A service review report from September 2015 indicated that the mean waiting time for Haringey generic CAMHS was 71 days (about 10 weeks). This service review noted an improvement in waiting times since January 2015.
- The trust did not have a target waiting time from initial assessment to the start of treatment. Waiting times for routine access to treatment varied between each therapeutic discipline. There was a four month wait for access to a family therapist and a six month wait for access to a psychiatrist. Feedback from parents and carers was that the waiting list for appointments was too long. General feedback about the service was positive, but this was highlighted as a common concern.
- Due to the skill mix, staff were able to deliver a very therapy based model of care. This was highlighted as positive, but staff felt it also created an impact on the waiting times for those accessing the service. Staff felt some cases were held longer than necessary and that introducing nursing care staff and new models would allow young people to access the service and be ready for discharge more quickly. The service review of Haringey CAMHS in September 2015 highlighted that average length of intervention for 2014/2015 in the generic team was 698 days. The average number of appointments was 12. This was double the average number of appointments and length of intervention outlined in the CAMHS benchmarking report from the NHS Benchmarking Network in 2013.
- Staff picked out urgent referrals immediately. Each borough had an adolescent outreach service for people aged 12-18 that would support people with more acute needs. The outreach services accepted self-referrals from young people as well as from GPs and generic CAMHS. All young people referred to this service received an appointment within two weeks. The key performance indicator report from October 2015 showed that the Haringey adolescent outreach service had seen 90% of people for an assessment within two weeks with an average wait of 12 days. If there was a more urgent need, staff would see the young person within 24 hours. These services received around 300 referrals per year in each borough. Generic CAMHS staff told us they felt the outreach teams were very responsive to the needs of young people and were successful in keeping young people from having to access inpatient beds. The Enfield outreach service team had a central location in Enfield, which they felt increased ease of access for young people as there were good transport links. The outreach teams also provided in-reach services to hospitals in their borough. Feedback from parents who had children who were referred urgently said they were seen quickly by the service.
- Services collected and analysed information on referrals, such as age, gender and ethnicity and compared this to the local population census. Referrals reflected the ethnicity of the local population. Haringey CAMHS identified they had difficulty accessing the Black African community.
- The trust had a, did not attend (DNA) policy for people who did not attend appointments which was written in November 2013. This was called the safeguarding policy for children who did not attend or were not brought in by their carers. This policy gave information on themes for DNA and re-referral to CAMHS and outlined steps to re-engage with people who DNA appointments. These steps included looking at the available means of contact including home visits, telephoning and arranging professional consultations. It also outlined clear steps to take following a DNA. These were to check the address of the young person was correct on the system, assess risk, contact the young person or parent/carer via phone and letter, involve referrers and offer further appointments. There was also a key fact sheet about DNA available on the intranet. Some staff were aware of the steps outlined in this policy and actions were recorded in young peoples' notes, but others were not familiar with the policy.

Are services responsive to people's needs?

Requires improvement

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- Key performance indicator reports outlined DNA rates for initial assessments in generic CAMHS. Initial and follow up rates were between 12% and 15% in October 2015, apart from in Haringey generic CAMHS where initial appointment DNA rates were 26%. The CAMHS report from the NHS Benchmarking Network in 2013 reported an average DNA rate of 11% across other services. Staff said this could be a data quality issue.
- The consultant psychiatrists were responsible for carrying out the final diagnoses for young people with ASD and also ADHD. This had become a major part of their role and meant waiting times for this service were up to six months. There had been a formal complaint in the last six months about the waiting time for accessing services for young people with ASD.
- Young people and parents/carers told us that staff were flexible with appointment times and they could change their appointment time if necessary. Enfield CAMHS had a late clinic for appointments on Wednesdays until 8pm. In Haringey, nine percent of appointments took place outside the times of 9am and 5pm.
- Accessing an inpatient CAMHS bed was more challenging than accessing other community CAMHS. One young person was waiting on a paediatric ward for three days before accessing an out of area CAMHS bed. Senior staff raised this case with the commissioners. Having difficulty accessing an inpatient CAMHS bed was highlighted as an issue by 76% of community CAMHS members in the Quality Network for Community CAMHS 2014 annual report.

The facilities promote recovery, comfort, dignity and confidentiality

- There were a number of therapy rooms across the different service sites that staff could book. These provided adequate sound proofing, varied in size and supported the different needs of young people and families. There were family therapy rooms available with one way mirrors and small tables and chairs available for children.
- There were a number of information leaflets in waiting rooms. These included a trust CAMHS leaflet, information about local services, the charity Young Minds, confidentiality, how to complain, sexual health and adult mental health. There were also patient feedback forms available for people to complete. The leaflets were available in a range of languages. In some waiting areas there were "welcome to CAMHS" notices that were written in various languages.
- Parents/carers and young people said they had not pro-actively received information about the service from staff.

Meeting the needs of all people who use the service

- All service sites except St Ann's Hospital allowed disabled access to the waiting rooms and therapy rooms. There were disabled bathrooms at all sites apart from St Ann's Hospital.
- Staff said access to interpreters was not a problem and there was evidence of the use of interpreters, including those for British Sign Language, in case files.

Listening to and learning from concerns and complaints

- The trust had a leaflet on how to make a complaint that was displayed in public areas and a complaints management policy. Staff also said they explained the complaints procedure to young people in person.
- One parent/carer told us they had made a formal complaint and their issue had been addressed. There were low rates of complaints within the service. Managers had access to records of complaints.
- Service managers also kept a record of compliments.
- Staff were aware of how to handle complaints and gave clear examples of this. At Haringey CAMHS a psychologist from the trust's older peoples' service investigated a recent complaint.
- There was no clear framework for joined up knowledge across the CAMHS sub-teams about learning from incidents and complaints.
- Staff said they did not receive feedback from investigations, incidents and complaints as a staff group. Learning from incidents and complaints was an agenda point at staff team meetings, but the team meetings were not long enough to cover this. Staff said complaints and incidents were discussed at management level, but the learning and the themes did not come down to staff in a robust manner.

Are services responsive to people's needs?

Requires improvement

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

- There was also no robust system in place for the sharing of good practice across the whole service.

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

- The organisations values were displayed in staff offices and we were able to see staff behaving in ways that reflected these.
- Staff knew who the trust senior managers were and said that very good relationships had been developed with them over the last 18 months. Staff felt the new medical director for the trust was very supportive to CAMHS and they felt able to access and communicate well with them.

Good governance

- Haringey CAMHS staff were positive about the introduction of an operational service manager to the service in March 2015 and were able to identify positive changes they had implemented. These included identifying that throughput of cases needed to be pro-actively managed, having a clearer expectation of how staff time should be used and having better support structures in place.
- At Enfield CAMHS the service manager was employed by the local authority. In April 2015 the trust employed an assistant clinical director for children services. Before this the trust did not have a lot of involvement of the management of the service. The assistant clinical director introduced trust governance processes to the service. Since this change there was a drive to introduce clarity about staff line management and service management processes. The service was planning to get a section 75 agreement in place by April 2016. This is an agreement between NHS bodies and local authorities to enter prescribed arrangements to carry out their functions if the arrangements are likely to lead to an improvement in the way the functions are exercised.
- Services managers were in the process of embedding clear governance structures. They had made changes such as reducing the number of meetings there were to make them more specific and named them appropriately and meaningfully. In Enfield CAMHS the senior management team had been reduced to include one nominated consultant psychiatrist instead of four.
- Regular senior management meetings were in place. Enfield CAMHS held an operational management group meeting once a fortnight that the trust assistant clinical director for children services attended.
- Staff and managers were clear about the changes they would like to make to the services. These included having a regular discussion about the direction of the service and feedback from incidents and complaints. Staff also wanted to establish clearer agreements about what information needed to be entered onto the patient record system, staff were doing this differently. Staff also wanted a formal mechanism to share good practice, for example having slots in multidisciplinary and governance meetings.
- Service managers received key performance indicator reports on a monthly basis. This included clear information about referrals and waiting times.
- An Ofsted inspection of local authority services for children carried out in January and February 2015 made an overall judgement that the local authority led an effective service that met the requirements of a good judgement.
- Service managers had identified the needs of the service from an operational perspective and were able to communicate these to the trust. In Haringey CAMHS the service manager had identified the need for additional clinical staff and the trust had supported the employment of agency staff to fill some posts. A project manager was also brought in to make changes to the electronic records system. The service manager had identified needing additional management cover to implement changes to make the service more effective and responsive. This was placed on the risk register in December 2015.
- In Enfield CAMHS there was a recent reduction in the number of administrative staff available for the team, changing from eight covering reception, CAMHS and educational psychology, to less than three. This created a backlog of clinical letter dictation. This issue was escalated and additional temporary resource was provided to complete dictation tasks. Clinical and administrative staff felt that if this backlog continued it would turn into an area of concern and start to affect

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the care of patients. Some staff said the increase in administrative work and the clinical demands on their time meant information was not always entered into the electronic system in a timely and thorough way.

- Haringey CAMHS had a risk register that the service manager regularly updated. Where a risk was scored over 12, it would automatically be added to the corporate risk register for the trust. In Enfield CAMHS there was a risk register for the local authority and for the trust. The assistant clinical director for children services employed by the trust could not access the local authority risk register. They had developed a separate trust risk register. As the service did not yet have a section 75 agreement in place there was no clear pathway for staff to follow to submit items to the service risk register. The local authority risk register was discussed at the operational management group meeting. Trust staff felt this risk register did not include clinical details in enough depth.

Leadership, morale and staff engagement

- There were low sickness and absence rates for staff across the teams.
- Staff felt able to raise concerns without fear of victimisation and the trust had a raising concerns policy. Staff felt able to say when their caseload was at an unmanageable level and felt listened to. In Haringey CAMHS there was information displayed in public areas about how to staff could raise concerns in the trust. This included contact details for the head of risk within the trust.
- Staff described morale as good and said that teams supported each other. Staff described their colleagues as committed and caring with a wide range of experience and knowledge. In September 2015 low staff morale had been added to the risk register for Haringey CAMHS. This was no longer on the risk register and staff gave positive feedback. Haringey CAMHS had an away day for staff in June 2015.
- Staff felt there was easy access to support and clinical advice from colleagues when needed. Administrative staff managed calls to the service, some could be from unhappy and unwell young people and families. Administrative staff said that clinical staff were very supportive when this became a challenge.
- Managers recognised that assessment to treatment times were too long for young people accessing some treatments and that change was needed. The managers had recently come in to post and were working towards making these changes.
- Staff were not actively involved in opportunities to give feedback about services and input into service development. Service managers had been involved in developing service transformation plans for each borough, supported by NHS England and the Department of Health's Future in Mind initiative.

Commitment to quality improvement and innovation

- The Haringey adolescent outreach team won the Health Service Journal Innovation in Mental Health award in November 2015. Young people's case studies were used to develop a theatre show for school assemblies and a film to address the issue of mental health and emotional wellbeing in schools. The project was run from September 2013 and was delivered in conjunction with a number of CAMHS partner agencies.
- Staff carried out peer review visits to services in other boroughs. Up to three staff visited another borough to provide assessment of the service and feedback on areas of good practice and areas of improvement. The last one took place in October 2015.
- The service manager at Enfield CAMHS was involved in a number of quality improvement groups.
- Service managers received a quality report every two months that was trust wide. The service manager at Haringey CAMHS wanted to introduce a monthly quality improvement meeting for their 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	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance The provider should assess, monitor and mitigate the risks associated with the health, safety and welfare of patients who may be at risk. The trust had not ensured that all incidents were reported and that learning from incidents and complaints was shared across the CAMHS teams. This was a breach of Regulation 17(2)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014 Person-centred care:** The trust had not ensured the care and treatment of patients was appropriate and met their needs and reflected their preferences. Assessment to treatment times were very long for young people needing to access certain interventions and this was not meeting their individual needs.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 9(1)(2)(3)