

The Anna Freud Centre

Quality Report

The Anna Freud Centre
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Date of inspection visit: 10 May 2016
Date of publication: 01/08/2016

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

Overall summary

We rated the service as good because:

- The service managed caseloads well so that young people were seen quickly. There was no waiting list to access the majority of specialist teams. Where there were waiting lists, they were between one and six weeks.
- The service's safeguarding procedures were robust. Staff compliance with safeguarding training was high.
- Staff were aware of how to report an incident and there was evidence of change being made within the service as a result of feedback from incidents.
- Staff responded to complaints appropriately and in a timely way.
- The centre offered a range of psychological therapies and research at the centre had directly contributed to NICE guidance. The centre had been involved in using several new models of intervention that were then rolled out nationally.
- Young people and carers said the service was helpful and described the service as brilliant. Staff were available to speak to carers when they wanted and returned calls when necessary. The service had a welcoming waiting room and plenty of therapy rooms.
- The centre had good working links with external organisations.
- The centre website was up to date, young person friendly and informative. The centre was involved in several web-based support services for young people that were developed by young people.

- Staff received regular supervision and felt supported and proud to work at the centre. Staff said the centre had

However:

- The centre had introduced electronic records in January 2016 and thorough recording was not yet embedded across the staff team. We found staff did not regularly record when they reviewed risk and what the individual plans for care were.
- There was no central recording of some health and safety audits and actions. For example there was no evidence that staff regularly wiped down toys and resources after use to reduce risk of spread of infection. Also, staff assessed the environment for ligature risks in 2015, however had not kept a written record of this. There was no written audit plan for when this would next take place.
- The centre did not have written information about sources of support in a crisis. Where other information leaflets were available, for example on how to make a complaint, these did not outline whether they were available in other languages or in different formats, for example in an easy read format or braille.
- In the 12 months leading up to the inspection, the service had not notified the CQC of all reportable incidents in line with statutory requirements.
- The systems and processes around employment records had not highlighted that two staff records did not contain up-to-date disclosure and barring service (DBS) checks.

Summary of findings

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Good 

The Anna Freud Centre

Services we looked at

Specialist community mental health services for children and young people.

Summary of this inspection

Our inspection team

Inspection Lead: Natalie Austin Parsons, Inspector, Care Quality Commission

The team was comprised of one CQC inspector, one CQC inspection assistant, one expert by experience and one specialist advisor with experience of working in child and adolescent mental health services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about 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 the service where treatment was provided, looked at the quality of the environment and observed how staff cared for patients

- spoke with 10 young people and parents or carers who were using the service
- interviewed the clinical director and the medical director for the service
- interviewed 10 other staff members including clinical psychologists, systemic family therapists, heads of service, the operations manager and administrative staff
- spoke with three staff members from schools where the service provided assessment and treatment
- attended and observed a parent's panel meeting
- looked at six care and treatment records of patients
- looked at eight staff employment records
- looked at a range of policies, procedures and other documents relating to the running of the service

Information about The Anna Freud Centre

The Anna Freud Centre is a children's mental health charity providing support and treatment to children, young people and families. The centre provided these care services alongside academic research and training for mental health professionals. Staff in specialist sub teams provided two types of service called helping

families services and trauma and maltreatment services. The trauma and maltreatment service worked closely with social services and court services and supported families involved in court proceedings.

Summary of this inspection

The whole organisation had grown in size over the previous two years and was part-way through a relocation to a new integrated site at Kings Cross. The target date for finalising the move was September 2018.

The Anna Freud Centre was last inspected in January 2014 and met the five essential standards of quality and

safety being inspected. The service is registered to provide the regulated activity of treatment of disease, disorder or injury. There was a registered manager in place at the time of inspection.

What people who use the service say

Young people and parents/carers were very positive about the service they had received and the staff at the centre. Parents/carers said their children responded well to staff and that staff offered family support when needed.

Young people and parents/carers said staff were empathetic, kind and informative. They said staff were

always available to speak to on the telephone and would always call them back if they left a message. Young people and parents/carers particularly mentioned reception staff for their warm and welcoming approach.

People said they felt listened to. They said they had seen the changes in themselves or their children as a result of the support and treatment they received.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as required improvement because:

- Risks were not always followed through to care plans to outline how staff were ensuring the risks were being managed. There was no evidence of when staff reviewed risks for each young person.
- Mandatory training did not include training in a number of areas that could ensure patient safety. This included training on infection control, fire safety and basic first aid.
- There was no evidence that staff regularly cleaned toys. This was an infection control risk.
- In the 12 months leading up to the inspection, the service had not notified the CQC of all reportable incidents in line with statutory requirements.
- There were no up-to-date disclosure and barring service (criminal records) checks for two members of staff.
- Staff did not routinely provide written information about how to access alternative services out-of-hours and in an emergency. The service relied on an informal process to contact service staff to then be redirected if necessary.

However:

- The service managed caseloads well so young people were seen quickly. When staff received a referral they contacted families on the phone to discuss the reason for referral and could establish risk quickly.
- Safeguarding procedures for the service were robust and rates of staff safeguarding training were high.
- Staff knew how to report an incident. There was evidence of change being made within the service as a result of feedback from incidents.
- The service kept three risk event registers covering safeguarding, complaints and serious incidents. These were regularly reviewed and acted upon.
- All areas were visibly clean and well maintained.

Requires improvement



Are services effective?

We rated effective as good because:

Good



Summary of this inspection

- The centre offered a range of psychological therapies and research at the centre had directly contributed to NICE guidance. The centre provided specialist training to professionals, for example it had trained over 5,000 practitioners in mentalization based treatment.
- Staff used outcome measures and evaluated service delivery regularly. The CAMHS Outcomes Research Consortium (CORC) was based at the centre. This is a learning collaboration with over 70 CAMHS members that uses routine outcome measures to improve services.
- In partnership with another service provider the centre developed and implemented a model of care called THRIVE. based on identifying a young person's needs rather than focussing on their diagnosis or the severity of the illness.
- Young people and parents/carers said they found the service helpful.
- Staff received regular supervision and recorded case supervision in individual case notes. Staff had opportunities to attend specialist training run by the centre.
- The centre had good working links with external organisations, for example schools. The centre developed a network for schools and teachers called Schools in Mind. This helped teachers to identify mental health problems in young people and appropriate support.

However:

- We did not find comprehensive written information about the plan for care or evidence that staff regularly reviewed the plan for care. Although young people and parents/carers felt they were aware of the plan as staff shared this information verbally.

Are services caring?

We rated caring as good because:

- Young people and parents/carers gave very positive about staff and said they were kind, caring and extremely supportive. Young people said all staff were friendly and had made them feel welcome.
- Most parents/carers and young people said staff explained confidentiality from the first time they met and understood what this meant.
- Parents/carers and young people said they had discussed a treatment plan with staff. They could contact staff about this if they had questions.
- Young people and parents/carers were able to give feedback about the centre and the care they received.

However:

Good



Summary of this inspection

- Most young people and parents/carers did not have a written copy of their care plan.

Are services responsive?

We rated responsive as good because:

- There was no waiting list to access most services. The specialist teams with waiting lists had them for between one and six weeks.
- Parents/carers said staff were available by telephone to speak with outside of appointment times.
- The service had a welcoming waiting room and plenty of therapy rooms. There was a baby changing room on the same floor as therapy rooms used for baby psychotherapy.
- The centre had a website that was young person friendly and informative. The centre was also involved in several web-based support services for young people.
- The service was accessible to people requiring disabled access and the website was designed to be compliant with guidelines to ensure it could be accessed by partially blind people. Staff accessed interpreter services when needed.
- The service managed complaints well. Staff could describe how to manage a complaint and staff responded to complaints all in a timely way and within the target time of 15 days.

However:

- Not all information leaflets included information about whether they were available in other languages or in different formats, for example in an easy read format or braille.

Good



Are services well-led?

We rated well-led as good because:

- Staff said they felt proud to work at the centre and that there was good leadership. Staff felt the recent change to make two main service lines had made a positive impact on the centre. Morale was good and staff had opportunities to provide feedback and input into service development.
- There were clear lines of reporting and responsibility for incidents, complaints and safeguarding issues
- There were very low rates of sickness and absence across the centre. Staff were aware of the whistleblowing policy and felt able to voice concerns without fear of victimisation.

However:

Good



Summary of this inspection

- Governance processes did not cover all the necessary operational areas of the service. For example recruitment checks, mandatory training and thorough completion of electronic patient records.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff did not receive specific training in the MHA and the MHA Code of Practice. The service did not work with people who were subject to detention under the MHA. In the event that a MHA assessment was required, this would be requested externally.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not receive specific training in the MCA or the MCA Code of Practice. From the end of 2015, the centre introduced information on the MCA to level two safeguarding training which all staff had received.

The centre had a service user consent policy which outlined capacity, incapacity as well as competence. This policy outlined a clear summary of the MCA and how it was relevant to the service.

Staff had a clear understanding of Gillick competence and consideration of this in practice.

Specialist community mental health services for children and young people

Good 

Safe	Requires improvement 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are specialist community mental health services for children and young people safe?

Requires improvement 

Safe and clean environment

- Therapy rooms were not fitted with alarms. Staff assessed potential risks before an appointment and used a therapy room near to reception if needed. This was so they could get assistance quickly, if required. Staff would also advise colleagues of the appointment. An incident of staff raising an alarm had not taken place in the 12 months leading up to the inspection.
- All areas were visibly clean and well maintained. The service had a large rear garden that was well maintained. This could be accessed through meeting rooms on the lower ground floor. A local school used a space in the garden for a school project. The centre used an external cleaning company. Cleaning records showed the cleaning jobs done in each room and how often took place.
- Staff said they regularly disinfected toys and games used in therapy after each use to reduce the risk of the spread of infection. However there were no records to evidence this. Not all therapy rooms contained wipes to carry this out.
- There were systems in place to monitor building maintenance. A noticeboard in the waiting room outlined the fire evacuation routes.

- Staff said they had assessed the environment for ligature risks in 2015, however had not kept a written record of this. Patients used two toilets where a number of ligatures had been removed. The premises security policy stated that children and young people must be accompanied by staff at all times, apart from when using the toilet.

Safe staffing

- Specialist team caseloads and staff number varied in size. The centre monitored caseloads and length of stay to make sure they were manageable.
- In the 12 months before the inspection, vacancy rates were low at 1-2%. Bank and agency staff were not used for clinical positions. The sickness rate was also low at 1-2%.
- Staff were required to undertake four types of mandatory training. These were safeguarding children levels one, two and three and information governance. Compliance with training in information governance was 80% and training in child protection levels one, two and three was over 97%. The level two safeguarding training included training on the MCA and this was not delivered as separate training. Staff were not required to undertake mandatory training in fire safety, first aid, infection control or introduction to the Children Act. Without this training staff did not know essential information in order to keep families and staff safe in the service.

Assessing and managing risk to patients and staff

- Staff assessed the potential risks to young people when they started accessing the service. Each specialist team used a specific tool to assess risks. In six care records,

Specialist community mental health services for children and young people

Good 

five contained a risk assessment. One young person did not have a risk assessment. In the complex cases court service, risks for the young person were high in every case. The service then worked jointly with social services to minimise risks.

- The care records looked at were from six different sub-teams. Across these records, there was no evidence that staff regularly reviewed and updated risk assessments. One risk assessment had been completed five years earlier. Staff said they assessed risk more regularly for those young people with increased risks, however there was no record of this. There was no record that young people assessed as having lower levels of risk were reassessed. Reassessment may have identified if the young person's risks had increased. Risk assessments did not contain an explanation of why staff classified risks as low, medium or high.
- Risk assessments did not always lead to young people having risk management plans. Young people's care plans did not identify how the service would minimise risks. A recent audit of young people subject to safeguarding procedures had been undertaken. Half of the care records did not contain a comprehensive risk assessment and risk management plan.
- The service did not provide out of hours crisis support. Young people and carers did not regularly receive information about how to access support outside of normal working hours. Staff said they would make this clear to a family during the first assessment. Staff shared crisis information verbally and did not record when this took place. Several parents said that if their child became very unwell, they would email or call the centre. This meant that young people and parents/carers may contact the centre when this was not the most appropriate crisis support. This could lead to a delay for young people and carers in receiving appropriate support. No incidents had occurred. However, the lack of a robust system for providing information about support created a risk to young people and carers.
- If the health of a young person deteriorated quickly during their treatment, they would refer them to a community child and adolescent mental health service in the NHS for more urgent care.

- When staff received a referral they contacted young people or parents/carers, depending on the young person's age, on the telephone. They discussed the reason for referral and any urgent needs.
- Safeguarding procedures for the service were robust and staff were trained in safeguarding children levels one, two and three. Staff knew how to escalate safeguarding concerns and the service kept an event register for safeguarding concerns. There was an up-to-date safeguarding policy in place. Staff carried out regular audits of safeguarding practice. In depth analysis and action plans were shared with the wider staff group. Staff were able to access specific safeguarding information in some of the teams, such as the acute trauma and complex cases court services. This was due to the frequency of safeguarding concerns in these teams. There was information about safeguarding procedures displayed in staff offices.
- The centre had a lone working policy which was clear and outlined the requirements for staff during a community visit, for example contacting the centre when the visit had ended, Staff were aware of this policy and the actions required of them.
- We looked at eight employment records for staff. We found that the centre did not have records of up-to-date disclosure and barring service (criminal records) checks for two members of staff. These checks ensure employers can make safe recruitment decisions to prevent unsuitable people from working with vulnerable people. A further five of the eight records showed staff started work at the centre before their DBS check had been returned to the centre. Staff had started work between one and nine days before their DBS checks were returned. We brought this to the attention of the provider who took immediate action and reviewed all DBS records for clinical staff. This showed that the systems to ensure all staff had a valid DBS checks in line with centre policy was not sufficient.

Track record on safety

- There were no serious incidents which met NHS Commissioning Board criteria in the 12 months before the inspection.
- The service kept three risk event registers covering safeguarding, complaints and incidents. Management

Specialist community mental health services for children and young people

Good 

staff had introduced the risk incident register as they felt the previous incident recording system did not fit the needs of the service. The clinical governance leadership board reviewed these registers each month.

Reporting incidents and learning from when things go wrong

- Staff were aware of how to report an incident and filled in an incident form. Staff internally reported incidents that should be reported.
- The service had not notified the CQC of all reportable incidents in line with statutory requirements in the 12 months leading up to the inspection. The centre raised 12 safeguarding concerns with the local authority on 2015 and had one incident involving the police in March 2016 and had not notified the CQC of these. This was highlighted to the centre on the day of the inspection who took immediate action to ensure this would take place.
- The clinical director completed monthly risk reports. These reports described incidents and had recommended actions. The report highlighted who should carry out the actions and by when.
- There was evidence of change being made within the service as a result of feedback from incidents. This included changes to policies to make services more effective. For example under exceptional circumstances staff could use encrypted memory sticks off site in order to access information. This was because remote access was slow and had meant a clinician could not access notes during court for one case. Staff said that information about safety issues were cascaded down very effectively. Staff were aware of recent incidents that had occurred.
- The centre did not provide staff with specific training on the duty of candour, although it was referenced in several policies that staff had access to.

Are specialist community mental health services for children and young people effective?

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- Staff wrote and stored information about care on computers. Each young person had a separate case file. Each case file should have had four folders of information. These were a folder for case management information, such as the referral and records of consent. A folder for outcome measures and patient feedback. A folder for clinical events such as risks and supervision, and a folder for correspondence with families and external organisations. Complex cases court service records also had one additional folder of information with a letter of instruction from a solicitor. A letter of instruction outlines what is required from clinicians when they are involved in family court proceedings.
- Electronic records did not contain the required information about care. We saw comprehensive written information about the plan for care in one of six records. In the remaining five records there was no information about the plan for care. For one young person who had been with the service for years, there was no record of the plan for care in their notes. For another young person, supervision notes contained two sentences summarising discussion with the young person about current issues. These were not related to a plan for care. Other information in care records was not completed, for example one young person seen by the schools outreach team only had four of seven pieces of required information recorded in their clinical event notes. For one young person, their date of entry to the service was not available as staff had not completed forms. The lack of information meant there was no evidence that staff delivered personalised, holistic and recovery orientated care. Before January 2016 staff kept paper records so were new to the system of electronic record keeping. Staff said that the system was new and different clinicians completed different levels of information. Management staff checked case files for information and regular care note audits were in place, however this had not resulted in staff recording information appropriately.
- Records did not show that all staff regularly reviewed the plan for care. In two records, staff had recorded a

Specialist community mental health services for children and young people

Good 

review of care in March 2016 within the supervision notes for the case. These lacked detail and did not reference whether the young person had goals set or if they were meeting them. For one young person their last review had taken place in November 2011.

- An action plan, including regular audits and the development of case note standards, was in place to improve the quality of record keeping. This had been in place since January 2016 when the service moved from paper to an electronic record system.
- There was a record of informed consent to treatment in one of six records. This record contained two consent forms, one for consent to treatment and one for consent to the sharing of information with external agencies. We found goal based outcomes completed in one case record. This was for a young person being supported by the school outreach team.
- Assessments did not include questions about physical health needs and cultural and religious needs. The Royal College of Psychiatrists Quality Network for Community CAMHS recommends these areas are covered as part of holistic assessment and treatment.
- Information needed to deliver care was stored securely on computers that only staff could access. Any paper records were stored securely.

Best practice in treatment and care

- The centre was able to offer a range of psychological therapies recommended by the National Institute of Clinical and Health Excellence (NICE). Research carried out at the centre had directly contributed to NICE guidance. A number of clinical staff had been members of NICE guidance groups. The centre had been involved in using several new models of intervention, for example mentalization based treatment (MBT). MBT is an evidence based psychological therapy for borderline personality disorder and the centre had trained over 5,000 practitioners in the UK and overseas in MBT.
- At the time of inspection the centre had made changes so that specialist sub teams were grouped together into two main service lines. These were called helping families services and trauma and maltreatment services. Six specialist sub teams were available in the helping families services. Five specialist sub teams were available in the trauma and maltreatment services.

Management staff had made these changes to improve working between sub teams and let staff share their expertise with more colleagues. Staff said the management team had sought staff feedback about the change and felt it had made positive impacts.

- In partnership with a separate service provider the centre had developed and was implementing a model of care called THRIVE. The model was based on identifying a young person's needs regardless of their diagnosis or the severity of the illness. For example, some young people may benefit from support in self-management of their illness and others may benefit from extensive support and treatment. The model did not use the tiered model of care, which is commonly used in CAMHS to identify a young person's care pathway. Ten CAMHS across the country had started using this model for care.
- Staff used outcome measures and evaluated service delivery regularly. The CAMHS Outcomes Research Consortium (CORC) was based at the centre. CORC has over 70 CAMHS members that uses routine outcome measures to improve services. CORC staff interpreted and reported outcome measures that services could share with service users and commissioners. CORC staff also compared outcome measures across different services, allowing benchmarking.
- Staff used outcome measures to evaluate interventions with parents. For example parents involved with a training course for those in temporary accommodation completed three forms at the first and last sessions of the course. These forms were the Eyeberg Child Behaviour Inventory (ECBI) and the concerns about my child questionnaire. Eight parents completed the concerns about my child questionnaire, seven completed ECBI. Results showed a reduction in the severity of the problems parents were experiencing. Staff also used other methods to review outcomes. For example in the contact and residency dispute team staff audited chronic litigation cases over 18 months and reported the service were able to make contact between child and parent happen in 96% of cases. Staff in the complex cases court service did not collect outcomes and wrote a service statement outlining the reasons. These were that staff did not feel it was ethical, as it was mandatory for families to have contact with the services by court ruling.

Specialist community mental health services for children and young people

Good 

- In the 12 months leading up to the inspection, staff took part in over 20 clinical audits or evaluations of service. This did not include audits around the physical health needs of young people and parents/carers.

Skilled staff to deliver care

- Teams were made up of a range of professionals from different disciplines. This included psychotherapists, social workers, play therapists, psychiatrists and psychologists. Staff were experienced and qualified to deliver care.
- Staff received an appropriate induction to the service when they started. The centre had an induction policy, last updated in April 2016, which included a clear induction checklist covering the use of equipment, orientation to the site including where policies were held and roles and responsibilities. It also had separate induction requirements for staff in specific roles, such as clinical staff, academic staff and teaching staff. Staff said they had had received an induction and thought it had been good, providing them with all the information that wanted to know. Some members of staff were also able to have periods of handover from other staff when they first started.
- Staff said they received peer supervision every week to four weeks. Staff said they could also request additional supervision outside of this time if they wanted. There was no central recording system for supervision. The centre had a clinical supervision and line management policy which outlined what supervision should take place and the role of line managers. This policy also outlined that staff should record case supervision notes in individual case notes following discussion. Staff said they felt not everyone completed this regularly, but we saw evidence in case notes of staff recording supervision discussions. Some of the recording was brief and did not give a lot of detail about what was discussed and how the plan for care may or may not be affected. Administrative staff also received line management supervision on a regular basis.
- Staff took part in annual review and development meetings. 80% of
- Staff had opportunities to attend specialist training run for external professionals by the centre. On some occasions a small number of places on training sessions could be reserved for centre staff. The centre did not

systematically document which staff had attended which training. Several staff gave examples of requesting training and being supported to access this by their managers.

Multi-disciplinary and inter-agency team work

- The centre had good working links with external organisations and services, for example schools. Parents/carers and staff from schools said when school staff made referrals, they young person was seen quickly, usually within two weeks and it was a very smooth process from referral to assessment. Feedback from staff in schools was that services were tremendously valuable. They gave examples of how centre staff had provided support to young people, parents and also staff within their schools which had led to improved quality of life for the young person, family or staff member. They were able to make referrals through their link contact and said staff would attend meetings with the school and other agency when necessary. They said staff explained confidentiality to them in detail and had an understanding of what information could and could not be shared with the school. Staff were accessible and available on the phone. One teacher said there was good communication with centre staff and they were always willing to be dynamic to meet the needs of children.
- The centre developed a network for schools and teachers to support the identification and support of mental health problems in young people. This was called Schools in Mind and was free of charge. The centre developed several materials and training sessions for teachers, including lesson plans. They also offered access to a website offering self-help techniques for emotions and behaviour for 11-16 year olds. The centre's evidence based practice unit (EBPU) evaluated the Targeted Mental Health in Schools initiative which was a national initiative led by the Department for Education. It found that behavioural difficulties in primary school children could be reduced with mental health support. At the time of inspection the EBPU were evaluating another programme, Headstart, a Big Lottery Fund initiative to improve resilience in young people.
- The centre offered training to health care professionals in a range of interventions. In 2015 the centre trained 2,589 professionals over 87 training events. Of these event, 25 were for internal staff. These training events

Specialist community mental health services for children and young people

Good 

took place across six countries. The centre collected feedback on these training events and average satisfaction was 4.5 out of 5. In partnership with University College London the centre hosted five postgraduate programmes and in 2015 taught 470 students. Feedback gathered from these students showed they rated their satisfaction with the course as 4.5 out of 5.

Adherence to the MHA and the MHA Code of Practice

- Staff did not receive specific training in the MHA and the MHA Code of Practice. Staff said they do not work with patients who are sectioned under the MHA and in the event that a MHA assessment was required, this would be requested externally.

Good practice in applying the MCA

- Staff did not receive specific training in the MCA or the MCA Code of Practice. From the end of 2015, the centre introduced information on MCA to level two safeguarding training.
- The centre had a service user consent policy, which was last reviewed in March 2016. This policy outlined valid consent and stated that the centre's preference was for staff to obtain written consent to treatment. It stated that staff should store the form where the service user expressed their consent in their individual case record. These forms were not present in five of six case notes we looked at. The policy also explained competence, capacity and incapacity and outlined the MCA in detail.
- Staff had a clear understanding of Gillick competence and consideration of this in practice.

Are specialist community mental health services for children and young people caring?

Good 

Kindness, dignity, respect and support

- Young people and parents/carers were very positive about staff and the how they behaved towards them. They said staff were very kind and caring as well as extremely supportive, polite and informative. Parents said their children had reacted positively to the staff and

they had seen a change in their child. Young people said clinical staff were very nice and particularly mentioned reception staff in making the environment welcoming. Young people said it was helpful to always see the same clinical staff at appointments.

- All young people and parents/carers felt staff listened to them, although one parent said there had been a few occasions where they did feel listened to.
- Most parents/carers and young people said staff explained confidentiality from the first time they met and understood what this meant. One parent was able to explain what this meant in detail. One parent said staff did not explicitly explain confidentiality to them. Staff did not routinely share written information about confidentiality with young people and parents/carers.
- Parents/carers said they found the service helpful and described it as a brilliant service that had enhanced their relationship with their child. Those who had attended a parent course said it had really changed their life. Another described the help they had received as had brought them back to life.

The involvement of people in the care they receive

- Parents/carers and young people felt they had discussed and developed a plan for care with staff, including discussing various treatment options. Several parents said staff provided consistent verbal feedback about treatment. Two parents/carers we spoke with had a copy of the plan for care. The remaining eight young people and parents/carers said they did not have a copy of the care plan, although they felt they knew what was going on due to discussions with staff. They also said they felt they were being offered support, rather than treatment, so a treatment plan wouldn't always be appropriate.
- In the six records we looked at, only one included a written plan for care. We also found that staff did not record whether the plan for care had been discussed verbally with the young person or family, meaning staff could not clearly demonstrate that this was taking place regularly. In the documents that were available, staff used a large amount of acronyms in the care records, which meant it may have been hard for families and external agencies accessing the information to fully understand it.

Specialist community mental health services for children and young people

Good 

- Parents/carers said staff were really helpful and helped them with their own motivation and made referrals to external organisations for the family's wider needs, for example financial charity organisations. Parents said staff were kind and went the extra mile in their work. Parent/carers gave examples of how staff had supported them in providing the best care for their child.
- The centre ran several support and intervention groups for parents and families. One example was a parent support programme called Empowering Parents, Empowering Communities (EPEC). EPEC was run by parents who had been trained in facilitation and three groups ran at the Homeless Families Hostel in Camden. The groups were for up to 10 parents living in temporary accommodation and ran for eight sessions. An independent evaluation reported positive changes from the beginning and end of the group and parents gave positive verbal feedback. Parents also carried out their own audit of the programme and made a film of their feedback. The evaluation also showed that 80% of parents involved completed the course of eight groups in their at first attempt, one at second attempt after re-joining the sessions.
- There were four advocacy services available for service users to access. Four parents/carers we spoke with were unaware they were able to access these services. Two staff we spoke with were also unaware of the advocacy services that could be accessed.
- Young people and parents/carers were able to get involved in some decisions about the service. For example, staff collected service user feedback in relation to the move to a new site in Kings Cross. In a parent panel meeting, the group discussed the design of the new campus, for example carpet colour and the level of involvement they were able to have in design.
- Young people and parents/carers were able to give feedback about the care they received. Most young people and parents/carers said they felt able to do this and had provided feedback in the past. The centre routinely collected feedback on the service using the experience of service questionnaire (ESQ). Staff displayed the results in waiting area at the centre. Those displayed at the time of inspection showed that 17 children completed the most recent questionnaires and 82% felt they had received good help and 94% felt listened to. Also, 67 parents completed the

questionnaire and 100% felt they had received good help and 97% felt they were listened to. These results were compared to averages from several services in the country and results for the centre were more positive than the other services. The centre had a section on their website called 'Have your say' which encouraged children, young people and families to contribute to projects. For example, a 'See us Hear us' project where young people produced a photo that answered the question: 'What or who helps young people when they are stressed or upset?'

- A parent's panel met every six weeks. We observed one parent's panel. Participation officers facilitated the group and there were discussions about future initiatives the parent's panel would be involved in. An example was that the panel decided they would put together a hostel survival guide for families. After the meeting the service provided a lunch for staff and parents to eat together. Parents were able to express their ideas and have open conversations with staff about the service. Staff listened to parents and kept minutes and actions for the meeting. Parents felt that actions from these meetings were not always carried out in a timely way and that some suggestions did not lead to change. It was not clear how staff communicated which ideas would and would not be put in place and the reasons behind these decisions. This led to some parents feeling that their ideas were not taken on board.
- Each specialist team within the service had an information leaflet that outlined their services. Some leaflets included information about how people could provide feedback to the centre about their care, but not all. For example, it was not included on the leaflet about parent-infant project.
- Staff also kept informal feedback, such as thank you emails sent to staff from young people and families.

Are specialist community mental health services for children and young people responsive to people's needs?
(for example, to feedback?)

Good 

Access and discharge

Specialist community mental health services for children and young people

Good 

- Most of the specialist sub teams did not have waiting lists for people to access support. The mentalization based therapy for families team had the longest waiting list of up to six weeks. In the trauma and maltreatment sub teams, only one of five had a waiting list that was between one and three weeks. This meant young people and families were able to access services as soon as they needed them.
- In the 12 months before the inspection, the service supported just over 600 young people and families. The length of treatment varied within the teams. Longest interventions were in the child psychotherapy and schools outreach service. These were just over one year. The court services offered appointments once or twice a week over 10-12 weeks. Case loads were broken down by team. The team with the largest case load were the schools outreach team. Seven staff with a total of 175 clinical hours per week worked in this team.
- Parents/carers and young people said they were seen soon after they had been to their GP. One parent said the clinician came to visit them and their child in the community before their first assessment. Other parents/carers said staff contacted them on the phone before the first appointment. One parent/carer who had accessed different sub teams of the service said it was easy to transfer their care from one to another.
- Referral forms included a clear payment structure based on a family's income.
- Parents/carers said staff were available over the phone if they wished to speak to them outside of appointments or rearrange appointments. They said if a message was left with reception, the staff always called back.
- Not all sub teams had clear eligibility criteria for their services. Some outlined these, for example the child psychotherapy service outlined criteria on age, how far the family lived from the centre and the emotional or behavioural issues that the service could support, but for others, this was not recorded anywhere. Staff said there were not strict criteria in place across the teams.
- Where possible, staff offered flexibility in times of appointments. The service was open until seven pm. Reception staff worked from 7.30am until 6pm. Parents/carers said they were able to choose an appointment time that worked for them. Staff from local schools said centre staff were able to offer children and young

people appointment times after school. One parent said staff would give a lot of notice if an appointment had to be cancelled and explain the reason why. They said appointments would be rearranged and this call would be made by the clinician themselves.

- Some sub teams, for example the family assessment service, monitored contact with young people and reported in this. This meant they were able to identify how long people accessed the service for, but they could also see when people did not attend appointments. Staff produced these reports every six months and they were available from 2011 onwards. The report from April to September 2015 showed when children came alone, they attended 85% of appointments, when children were brought by their parents they attended 95% of appointments and when parents came alone they attended 77% of appointments.

The facilities promote recovery, comfort, dignity and confidentiality

- The waiting room was welcoming and provided several areas of comfortable seating. There were toys and other resources available that were appropriate for children and young people of a range of ages. During the inspection we saw that reception staff were very welcoming to visitors.
- The service had over 10 therapy rooms available. Administrative staff managed the booking of these rooms. Staff said there was not a problem in booking a room when one was needed as there were enough to accommodate the centre's needs. All rooms had signs to indicate whether they were vacant or engaged so therapy sessions would not be disturbed. There were toys and resources available in some rooms and also a resource cupboard where extra toys were stored. Several rooms did not contain toys and would be used to meet with adolescents. There were rooms available with one way mirrors and recording equipment for family therapy work. There were several rooms on the lower ground floor of the building for training events and staff meetings that could fit up to 100 people. There were also several smaller rooms that could be used as therapy rooms or breakout rooms during training.

Specialist community mental health services for children and young people

Good 

- There was a baby changing room available. This was on the same floor as therapy rooms used for baby psychotherapy.
- There were information leaflets about the service available near the front door, just outside the reception. They were written clearly and explained what services were in the centre and how to contact them.
- Parents/carers and young people said staff provided them with a lot of information about who they were coming to meet before their first appointment. They said staff were clear with them about what would happen at the first assessment.
- Parents/carers and young people said staff provided verbal information about the treatment they offered. They did not provide any written information, which the parents/carers and young people said was fine at the time. They said staff were always available to speak to, so not having written information was acceptable.
- The centre had a website that was young person friendly and informative. The website was designed so it could be used on mobile phones and provided information about the services at the centre as well as contact details and links for sources for support. This was provided in writing and video format. The website included links to relevant and up to date news articles and podcasts from centre staff, young people using the service and professionals in partner agencies. The website also outlined the centre's vision of 'a world in which children and their families are effectively supported to build on their own strengths to achieve their goals in life.' Parents who had accessed the website said they found it very helpful.
- The Evidence Based Practice Unit of the centre also supported the development of several web-based support resources by young people. Examples were The My CAMHS Choices website which explained the CAMHS process for young people thinking of getting mental health support. The website also linked to a Twitter account meaning it could engage with a large number of young people in this way. Also, Include-Me was an interactive website to support children and young people already accessing CAMHS across England.
- The service was accessible to people requiring disabled access. There was a ramp which allowed access to the lower ground floor which had several rooms available as well as a bathroom for those with a disability.
- Not all information leaflets included information about whether they were available in other languages or in different formats, for example in an easy read format or braille. Staff said that when they identified that a family needed information in another language, this was done using interpreter services. This was not made clear on information leaflets.
- The centre website was designed to be compliant with guidelines to ensure it could be accessed by partially blind people. It also had contact details available for people to make comments or queries relating to accessibility of the website. The website did not mention providing information in different languages or for people with a learning disability.
- Staff were able to access interpreter services.

Listening to and learning from concerns and complaints

- The service managed complaints well. Staff were able to describe how to manage a complaint. In seven complaints from 2015 and 2016, staff responded to all in a timely way and within the target time of 15 days, as outlined in their complaints procedure. Responses were appropriate, for example staff offered a phone call or face to face meeting to discuss the complaint. The service stored complaints in a folder and this information showed staff communicated well with each other about the management of complaints. Staff said the
- The centre website had a section for complaints and stated the centre welcomed feedback of any kind. There was a link to a complaints leaflet that gave step-by-step guidance on how to make a complaint and how long the centre would take to reply.
- Not all parents/carers we spoke with were aware of the formal procedure to make a complaint, but were confident they would be able to find out from staff if necessary.
- There was a centre document outlining how parents, young people and children were able to provide feedback and raise complaints. It was last updated in

Meeting the needs of all people who use the service

Specialist community mental health services for children and young people

Good 

March 2016 and was due to be review date November 2016. It was written for a young person or family member rather than staff and included information on how to make a formal complaint. It was not clear whether this was a document that was regularly shared with people using the services.

Are specialist community mental health services for children and young people well-led?

Good 

Vision and values

- The values of the centre were to be inspirational, pioneering, involved and determined. Staff said they liked working at the centre and felt proud to do so. In a s
- Staff knew who the most senior managers were and said there was good leadership in the centre. They felt senior staff were visible and were aware of ideas to improve the links between the board and clinical staff. Staff felt the recent reconfiguration to make two overarching service lines had made a positive impact on the centre, for example it had increased opportunities for shared learning. The staff survey in July 2015 showed a third of the staff felt opportunities for this were not sufficient.

Good Governance

- There were clear lines of reporting and responsibility for incidents, complaints and safeguarding issues. Information was presented and assessed through several oversight groups. They had an on-going programme of revising and updating policies about good and safe practice within the centre. All policies and procedures are available to staff on the intranet. The clinical director wrote a monthly risk report on three risk event registers summarising an event and the actions and learning from it. This had been in place for two months and risk reports were available for March and April 2016. This provided ongoing updates of risk and learning from incidents within the service.
- The governance processes had not identified the need to improve the robustness of recruitment checks, mandatory training and thorough completion of electronic patient records.

- A central support team for the organisation was based on site and was made up of service such as human resources, finance, training and administration. Administrative staff provided support across all clinical sub teams. Clinical staff said the central administrative team provided fantastic support and very high quality work.

Leadership, morale and staff engagement

- There were very low rates of sickness and absence across the centre. Staff were aware of the whistleblowing policy and said they felt able to voice concerns without fear of victimisation.
- Staff said morale was good and they were happy to work at the centre. They said there was a real focus on driving the centre forward and making improvements. They said there was a strong culture and everyone cared about the centre. Results from a s
- Staff said they felt supported in their roles and colleagues were approachable and helpful. Clinical staff said they felt their professions were valued. Staff said staff worked well together and they were able to approach their direct managers and the clinical director to voice ideas. Staff said it was a good place to work and people were enthusiastic in taking things on.
- Staff were offered opportunities to give feedback about services and input into service development. The centre undertook regular here was evidence that senior staff took on board feedback from staff, for example six changes were introduced following the last staff survey. One change was the development of a new continuing professional development

Commitment to quality improvement and innovation

- At the time of inspection the CAMHS Outcomes Research Consortium was developing accreditation for services and the centre would carry out a self-review against CORC standards in 2016. The centre also developed and hosted the Youth Wellbeing Initiative, devised the Youth Wellbeing Directory. This was an accreditation network for voluntary sector organisations working with children, young people and families with social and emotional needs. Services would be accredited using ACE-Value standards.
- The centre took part in and published research papers looking at a range of their interventions. For example

Specialist community mental health services for children and young people

Good 

they took part in a randomised control trial of parent–infant psychotherapy for parents with mental

health problems. The centre published 21 peer-reviewed papers in 2015. Staff from the parent toddler group wrote a chapter in a book about a psychoanalytic developmental approach to care.

Outstanding practice and areas for improvement

Outstanding practice

The centre had a website and other online resources offering a wide range of information about mental health and support available. This website was created with the input of young people and meant the centre could engage with and support young people in an appropriate and relevant format.

The centre was involved in developing and implementing models of care and intervention that had been rolled out across other services in the country. For examples the THRIVE model of care.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure mandatory training courses include those staff can use to maintain the safety of patients. This includes fire safety, infection control, basic first aid, Mental Capacity Act training and training in the Children Act 2004.
- The provider must notify the Care Quality Commission of incidents in line with statutory requirements.
- The provider must ensure all staff have an up to date Disclosure and Barring Service check and have a system in place to monitor this.
- The provider must ensure that information for young people and families about how to access help in a crisis, including out-of-hours, is provided in writing.

- The provider must ensure that risks identified in a risk assessment are included in a care plan to outline how the risk will be managed. The provider must ensure staff regularly update risk assessments.

Action the provider **SHOULD** take to improve

- The provider should ensure that staff record when cleaning toys and resources has taken place and have a system in place to monitor this.
- The provider should review the governance processes to ensure they cover all the necessary operational areas of the service, for example recruitment checks, mandatory training and thorough completion of electronic patient records.
- The provider should ensure that parents/carers and young people can access information in a language or format most helpful to them.
- The provider should ensure that staff record informed consent in line with the centre's policy.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

Care and treatment must be provided in a safe way for service users.

Staff had not received a comprehensive programme of mandatory training.

Staff did not regularly review and update risk assessments.

Staff did not regularly provide written information about how to access support outside of normal working hours and in a crisis.

This was a breach of Regulation 12(1)(2)(a)(b)(c)(h)

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

The provider had not submitted all necessary statutory notifications to the CQC in the past 12 months.

This was a breach of Regulation 18(2)(e)(f)

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The provider did not have sufficient systems and processes in place to ensure that all staff had up-to-date Disclosure and Barring Service checks.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 19(1)(2)(3)