Good

Barnet, Enfield and Haringey Mental Health NHS Trust

Specialist community mental health services for children and young people

Quality Report

Trust Headquarters
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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	Barnet Adolescent Service	HA8 7AB
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 Trust. Where relevant we provide detail of each location or area of service visited.

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

Summary of findings

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

- The trust had made progress with addressing the areas for improvement identified at the last inspection. Since the last inspection there had been changes to the teams in terms of their size and some of the processes they used. This meant that the service delivered to children and young people had improved, although there were still areas for further development.
- Staff were compassionate, demonstrated an in-depth knowledge of the young person's circumstances and were respectful towards them. Young people felt listened to and said that their views were valued. The majority of carers were positive about the service they had received. They said that staff appeared to understand their child and their needs.
- Staff completed comprehensive assessments of the children and young people referred to the service. They recognised patients' physical health needs and communicated with their GP where needed. They delivered treatment and therapies in accordance with NICE guidance. Staff completed and updated risk assessments in line with trust policies.
- The trust was almost meeting their target times for referral to assessment of 13 weeks. At the time of inspection, 93% of children and young people were being assessed within the 13 week trust target of 95%. Teams knew how they were performing against targets and were working hard to ensure patients were seen as quickly as possible. The trust was almost meeting their referral to treatment target time of 18 weeks but it had only recently begun to monitor compliance against this target.In September, almost 95% of children and young people were being seen within 18 weeks.
- Arrangements were in place to see young people quickly who were assessed as needing urgent treatment. For other young people who were waiting for an assessment or treatment, they were monitored and were advised how to seek support if needed.
- Safe staffing levels were maintained. Recruitment was ongoing and agency staff covered the majority of unfilled posts. Caseloads were within national guidance. They were manageable and were kept under regular review. Teams were made up of a wide range of professionals. Staff were highly skilled and experienced. Team managers were experienced and led staff teams effectively.
- Young people engaged with the services. They were able to provide feedback and get involved in aspects of the service such as the recruitment of staff. In Haringey young people were offering peer support to other young people using the service.
- Managers had governance systems in place to monitor service provision and performance. Waiting lists were managed on a weekly basis across the service.
- Staff demonstrated a sound understanding of the Mental Capacity Act and Gillick competency.

However:

- Alarm systems at Barnet to ensure the safety of staff and patients were not in place.
- Whilst the majority of physical health tests were carried out by GPs, some checks were carried out by staff. Not all equipment used in in these checks was regularly calibrated. At some sites, children and young people's privacy and dignity were compromised as height and weight measurements were taken in a corridor.
- Staff did not clean toys at the Haringey and Barnet sites regularly. This could present an infection control risk.
- Responding to formal complaints was taking too long.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- Staff completed risk assessments and put appropriate management plans in place to support children and young people.
- Safe staffing levels were maintained, vacant posts were being recruited to and the majority of vacant posts were covered by agency staff in the interim. The teams had an increase in staff at Enfield to meet the demands on the service. Caseloads were within national guidance and were managed effectively.
- At the last inspection in December 2015, we found that not all staff followed the lone working policy. At this inspection, all staff we spoke to followed safe lone-working processes.
- Staff received safeguarding training and followed robust systems to protect and safeguard children. The trust had safeguarding champions and leads across the service.
- At the last inspection in December 2015, staff did not report all incidents, and the teams did not always share learning from complaints and incidents. At this inspection, we found this had improved significantly. Staff reported incidents and these were investigated. Systems to learn from incidents, including serious incidents were in place and changes were implemented as a result of this learning.

However:

- Alarm systems to ensure the safety of staff and patients were not in place in at Barnet.
- Staff did not calibrate all equipment regularly and the defibrillators to assist someone in the event of a cardiac arrest had pads that were out of date.
- Toys at Haringey and Barnet sites were not regularly cleaned, which could present an infection control risk.

Are services effective?

Good

We rated effective as good because;

- Staff comprehensively assessed children and young people. The service measured outcomes, to see how children and young people benefitted from their treatment.
- Staff were highly skilled and experienced and undertook additional training for example in psychological approaches so they could provide this support to children and young people.

Summary of findings

- Staff delivered psychological therapies in line with NICE guidance. The service worked closely with partner organisations including schools, paediatrics and voluntary agencies.
- The teams included a wide range of professionals including psychiatrists, psychotherapists, family therapists, nurses, psychologists and social workers. All staff including agency staff received a local and trust-wide induction.
- At the last inspection in December 2015, we found that not all staff were receiving appropriate supervision and that this supervision was not always recorded. At this inspection we found this had improved. Overall most staff across the teams were receiving regular monthly supervision and could access additional supervision when necessary. At Enfield and Barnet the teams had a 100% compliance rate with supervision; Haringey had the lowest compliance rate at 72%. All teams ensured that agency staff also received monthly supervision. The teams had an electronic system in place to record supervision.
- Staff demonstrated a sound understanding of the Mental Capacity Act and Gillick competency.

Are services caring?

Good 

We rated caring as good because;

- Staff were caring, empathetic and demonstrated an in-depth knowledge of the young person's circumstances and were respectful towards them. Children and young people were treated in age appropriate way and were involved in their treatment.
- Young people felt listened to and that their views were valued. Young people were positive about the service they received and praised the staff for their caring approach. Carers told us that staff involved them and they felt understood. Progress in treatment was regularly reviewed.
- The majority of carers were positive about the service they had received. They said that staff appeared to understand their child and their needs.
- Across the service there were parents and carers groups offering support. The trust had also set up a new peer mentoring group in Haringey. Members of the group shared their experiences of using CAMHS and the progress they had made.

Summary of findings

- The website for the CAMHS had pictures of the environment and gave information about what the child or young person could expect when attending an appointment.
- We observed interactions and discussions of children, young people and their families that were caring and supportive.
- All staff were highly motivated to deliver care that is kind and compassionate. Staff used creative ways to engage young people which included using cartoons, drawings and collecting them from school to enable a 'walk and talk' session or to meet them in a non-clinical setting to put them at ease.

Are services responsive to people's needs?

Good

We rated responsive as good because;

- Referrals into CAMHS services were screened daily and young people could gain quick access into the service with urgent referrals being seen within 24 hours. Children and young people could be easily referred to specialist adolescent outreach services that supported patients at home or at school.
- The trust was almost meeting their target times for referral to assessment of 13 weeks. At the time of inspection 93% of children and young people were being assessed within the 13 week trust target of 95%. Teams knew how they were performing against targets and were working hard to ensure patients were seen as quickly as possible. The trust was almost meeting their referral to treatment target time of 18 weeks but it had only recently begun to monitor compliance against this target. In September, almost 95% of children and young people were being seen within 18 weeks.
- The service could access rooms in GP surgeries and other locations to allow children, young people and families, to attend appointments nearer to where they lived. There were interpreter services for young people and families who needed them.
- Young people were involved in the development of the service and in recruitment of staff.
- Staff attended weekly multidisciplinary meetings where there was clinical case discussion. We found that staff worked effectively and shared information and formulations regarding the young person or child in relation to risk.
- We found that the service displayed a range of information in waiting areas including leaflets for mental health conditions such as anxiety and depression and local support groups.

However:

Summary of findings

- At all sites, children and young people's privacy and dignity were compromised as height and weight measurements were taken in a corridor.
- Complaint response times were taking on average 56 days which missed the trust target of 25 days.

Are services well-led?

Good

We rated well-led as good because;

- Managers ensured there were thorough and effective checks on the quality of the service through business meetings and audits.
- Team managers were experienced and led staff teams effectively.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. We found posters in staff areas in Haringey which had ideas for how staff could manage stress and improve their work-life balance.
- Staff we spoke with were aware of the Freedom to Speak Up guardians and felt able to report concerns.
- Since the December 2015 inspection staff were reporting incidents and lessons learnt were shared across the service.
- Staff had the opportunity to develop their clinical skills.
- The service was participating in quality improvement projects to improve clinical and non-clinical outcomes.

Summary of findings

Information about the service

Barnet Enfield and Haringey Mental Health NHS Trust provided 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. CAMHS provided a specialist service for children and young people with severe, complex and persistent mental health problems. These services consisted of multidisciplinary teams. Within the CAMHS service, each borough had a number of specialist sub-teams. These included a learning disability team, an adolescent outreach team, looked after children's team, paediatric liaison team and a service for children and adolescents with neuro-developmental difficulties.

This inspection focussed on the generic CAMHS services including the adolescent outreach teams provided by the trust. We inspected the Barnet adolescent service which provided care and treatment for young people aged 12 to 18 years of age who need assessment and treatment for various mental health conditions including depression, anxiety and self-harming behaviours. We also inspected the Haringey and Enfield CAMHS teams which provided care and treatment for children and young people presenting with a range of mental health problems including, self-harm, depression and anxiety

Our inspection team

The team that inspected this core service consisted of one inspector, three specialist advisors, all of whom were nurses with a background working in child and adolescent mental health services, a consultant psychiatrist who is the CAMHS national professional advisor for the CQC and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using mental health services.

Why we carried out this inspection

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

At our last comprehensive inspection of the trust, in December 2015, we rated specialist community mental health services for children and young people as requires improvement overall. We rated specialist community mental health services for children and young people requires improvement for safe, good for effective, good for caring, requires improvement for responsive and good for well-led.

Following the December 2015 inspection, we told the trust that it must take the following actions to improve specialist community mental health services for children and young people;

- 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.

We issued the trust with a requirement notices in relation to Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 and Regulation 9 HSCA (RA) Regulations 2014 Person centred

Care.

We also told the trust that it should take the following actions to improve specialist community mental health services for children and young people;

Action the provider SHOULD take to improve

Summary of findings

- The trust should ensure that young people on the waiting list for a service are monitored so that their care could be prioritized if needed.
- The trust should ensure that that individual risk assessments 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. They should also ensure that the number of appraisals across the teams meets the trust's target.
- The trust should ensure consent to treatment is recorded.
- The trust should ensure that consent to share information with parents/carers is recorded 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 the data on this is accurately collected.
- The trust should develop information about how teams operate to give to young people and their relatives and carers.
- The trust should ensure that all staff are aware of how young people can access the advocacy service available to them.

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.

During the inspection visit, the inspection team:

- visited three community child and adolescent mental health teams and looked at the quality of the environment and observed how staff were caring for patients
- spoke with two young people who were using the service
- spoke with 13 carers or parents
- received 46 comments cards completed by patients and carers and young people
- spoke with two service directors and three team managers
- spoke with 18 other staff members; including psychiatrists, nurses, psychotherapists, psychologists and social workers
- attended and observed a clinical appointment for a young person, three multidisciplinary team meetings, a senior leadership team meeting and a supervision session
- looked at 18 patient care records
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

We spoke to two young people and 13 family members or carers. Most spoke highly and were positive about the service and its staff. They said staff were compassionate, caring and offered interventions that had made a difference to them.

Some carers said the wait for assessment and treatment was too long. However, they praised the support staff care children and young people when they saw them. Most carers and young people told us the environment in which they had their clinical appointments was clean and comfortable.

The majority of the 46 comments cards received from young people and their carers were positive about the service. All of them said they felt listened to and supported by staff.

Good practice

- The trust had set up a peer mentoring group in Haringey. Members of the group shared their experiences of receiving support from CAMHS and their progress.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that all members of staff in the Barnet CAMHS have access to alarms to call for support if needed.
- The trust should ensure that physical health monitoring equipment is well-maintained and calibrated in line with trust policies. The trust should also ensure that the content of first aid kits and pads for defibrillators, if these are going to be used, are in date and fit for purpose.
- The trust should ensure that physical monitoring of patients is conducted in a way that does not compromise their privacy and dignity.
- The trust should ensure that there are cleaning rotas in place for toys and equipment to minimize the risks of infection control.
- The trust should ensure that children and young people's access to assessment and treatment continues to be monitored and that referral to treatment times are monitored by the board.
- The trust should respond to complaints in a timely manner.

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
Barnet Adolescent Service	Trust Headquarters
Haringey CAMHS including the Adolescent Outreach Team (AOT)	Trust Headquarters
Enfield CAMHS including the SAFE and Alliance team	Trust Headquarters

Mental Health Act responsibilities

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

All staff had received training in the Mental Health Act. Staff understood the requirements of the Act, the code of practice and its guiding principles, in relation to children and young people. At the time of inspection, no children or young people were subject to a community treatment order.

Consultant psychiatrists across the service were Section 12 approved doctors who had completed additional training in the Mental Health Act and could assess young people under the Act.

Staff had access to administrative support, training and advice on the implementation of the Mental Health Act and its code of practice. The provider had relevant policies and procedures in place and staff knew how to access these.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had completed training in the Mental Capacity Act 2005 which met the trust's target. This course was part of their induction to the trust.

The Mental Capacity Act only applies to young people who are 16 years or older. Gillick competency (a test in medical law) is used to decide whether a child younger than 16 years is competent to consent to medical examination or treatment without the need for parental permission or knowledge. Staff had a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles and Gillick competency. There were no recent examples of children and young people having had their capacity assessed for specific decisions. No children or young people were subject to best interests decisions at the time of our inspection. We found evidence in a care record of Gillick competency being recorded.

Staff knew where to get advice regarding capacity issues. Staff and managers told us that if a decision specific capacity assessment did take place, this would be recorded in the young person's clinical notes. Staff were unclear what trust policy was in relation to this. No audits or other arrangements to monitor adherence to the Mental Capacity Act were in place.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- Staff monitored the environment where they saw children and young people to ensure it was safe. Staff in the Enfield team had completed ligature risk assessments as part of an environmental audit of Charles Babbage House. Staff accompanied children and young people at all times to reduce the risks associated with these. Staff monitored patients in the reception areas at Burgoyne Road, Barnet Adolescent Team (AOT) Enfield and St. Ann's Hospital.
- Interview rooms at Haringey and Enfield were fitted with an alarm system, which could be activated by staff carrying personal alarms. At Barnet, staff did not carry personal alarms. Staff told us they would raise the alarm by using their mobile phones. Staff did not work in the buildings alone to see children, young people and their families, which meant they could summon help if required.
- None of the sites we visited had designated clinic rooms. Staff had equipment to take physical healthcare observations such as blood pressure, pulse, weight and height. At the Barnet site, we did not find any paediatric blood pressure cuffs on site. This meant that the measurements may not be accurate. At the Haringey and Enfield sites, the scales for weighing children and young people were out of date for calibration.
- First aid kits were available, but the contents of the first aid box at St. Ann's and Enfield CAMHS sites were out of date. At Enfield, a new first aid box had been ordered. Each site had defibrillators, but the pads had expired in May 2017 at both Haringey and Barnet. This issue was raised at the time of inspection and staff told us the pads would be replaced immediately.
- All three sites were visibly clean and had comfortable furnishings. Team sites at Barnet and Enfield were well maintained. At the St Ann's hospital site in Haringey the premises were not well maintained. We saw that some areas of the building were currently being re-decorated. The rooms at St Ann's had office equipment in them and were also used as therapy space.
- Staff adhered to infection control principles, including handwashing. Information about infection control was displayed at each of the sites we visited. However, there were no cleaning rotas in place for toys at Haringey or Barnet, which could pose an infection control risk. Staff told us that toys were cleaned periodically to maintain cleanliness. We found the toys and equipment at Haringey visibly dusty.
- All three locations had an identified fire warden, fire extinguishers and fire exit signage visible.

Safe staffing

- Staffing levels were sufficient to meet the needs of patients. At the time of inspection, each team we visited had vacancies. Haringey had the highest vacancies for clinicians at 12% and medical staff at 42%. This was because two specialist registrar psychiatrists had left recently from an establishment number of 4.75 whole time equivalent psychiatrists. At Enfield the vacancy rate was 6% and this was due to the withdrawal of administration staff by the local authority. Barnet had the lowest vacancies. Active recruitment was taking place and some posts had been appointed to, with staff due to start. Managers were able to use locum agency staff and bank staff to cover the majority of unfilled posts.
- The trust had calculated staffing establishments using guidance from the Royal College of Psychiatrists.
- Caseloads averaged between 20-40 cases which was in line with the guidance from the Royal College of Psychiatrists.. Team managers and service directors reviewed clinicians' caseloads regularly through supervision and business meetings. Across the services each full time clinician conducted up to four face to face appointments with children and young people each day as a minimum.

Good

Are services safe?

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

- All of the teams kept staffing levels under review. At Enfield, the team had received funding to increase the staffing from 32 whole time equivalent (WTE) to 42.6 WTE clinicians posts. This was a 26 per cent increase in staffing to meet the increasing referral rate.
- There was rapid access to a psychiatrist from Monday to Friday between 9 am and 5 pm and there was an on-call rota to provide emergency medical cover out of hours.
- Sickness rates were low across the service at two per cent as of the 31 May 2017. Managers reported no staff were off due to work-related sickness. We spoke to a clinician who had felt supported during a period of long term sickness and a phased return to work.
- There was a high turnover rate of 21% for substantive staff across all three locations including psychiatry. Managers told us that this was due to staff retiring or moving to different areas. At Barnet, the service was re-tendering and 40% of staff were on fixed term contracts. Staff turnover and recruitment was reviewed at monthly business meetings to try and reduce the turnover rate.
- Seventy-eight per cent of staff across the teams had completed mandatory training courses, which was below the trust compliance target of 90%. Completion rates of mandatory training varied between teams and for the Barnet Adolescent Service was 100%.

Assessing and managing risk to patients and staff

Assessment of patient risk

- At the last inspection in December 2015, we found staff did not always update risk assessments. At this inspection, we found that staff updated risk assessments. For children and young people deemed low risk, staff updated the assessment annually. Where the risk was medium or higher, staff updated the risk assessment six monthly or more frequently if the risk changed.
- Staff completed risk assessments at the time of the initial assessment and in conjunction with the young person in most of the18 patient care and treatment records we reviewed. We found that 83 % of patients risk assessments had been updated within the three or six monthly or annual timescales.
- Staff used a generic risk assessment tool that was not CAMHS specific. Managers and staff recognised this tool was not child and adolescent friendly, but they told us it was part of the electronic records system and was being used effectively.
- Staff created and made good use of crisis or safety plans which were shared with patients and their carers'. We found evidence of safety and crisis plans within the electronic notes.

Management of risk

- At the last inspection in December 2015, we found that staff could not always access accurate information because individual risk assessments had not always been updated. At this inspection, we found this had improved. We saw that clinicians updated risk assessments when a patients' situation changed.
- The teams had systems in place to identify and respond to changes in risk for patients waiting for assessment and treatment. All referrals were screened for risk by a duty clinician. If they identified risk behaviours, they would complete an initial risk screening tool and escalate the referral as appropriate. Following initial assessment, staff told families who to contact if there was a change in the young persons' presentation. When children and young people presented with a high level of risk, the teams offered urgent appointments within 7-14 days on average. The adolescent outreach team and service for adolescents and families in Enfield told us they were able to allocate appointments within 24 hours where appropriate. At Haringey we found that a young person had used the "walk-in" service to access support. Staff responded appropriately if contacted by patients or carers who were waiting for their treatment to start
- In Enfield, the service for adolescents and families offered intensive support to adolescents with a high level of need and to help prevent admission to in-patient services. In Haringey and Barnet, out-of-hours children and young people could go to the local accident and emergency department to access help.
- The trust did not provide intensive crisis support out-of-hours. They had recognised this as a gap, and staff had developed a plan to introduce this. The service gave advice to parents/carers and young people regarding how to access services outside of normal office hours.

Good

Are services safe?

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

Two carers told us that if the service had a crisis team out of hours then that may have prevented an admission to the in-patient adolescent service. Another parent said that they felt it was inappropriate for their child to stay on a paediatric ward over the weekend because there was no out of hours crisis team provision however they were seen quickly when the referral was made to CAMHS.

- At the last inspection in December 2015, we found that not all staff followed the lone working policy. At this inspection, we found that staff were aware and were following safe lone working practices. Appointments outside of the clinic bases were logged in a clinician's electronic diary and the addresses registered at each service location. Practitioners would 'buddy up' with a colleague who called them if they had not made contact following the community visit. Staff only saw children and families outside of office hours at a hospital or place of safety.

Safeguarding

- Staff were trained in safeguarding. Most staff had attended levels one, two and three safeguarding children training, which covered different themes such as neglect, female genital mutilation, gangs, physical and psychological abuse. In addition, there were safeguarding leads and champions across the service who had received level four safeguarding children's training. As of 15 July 2017, 88% of staff had completed safeguarding children level three training and 78% of staff had received safeguarding adults training levels 1 & 2 which was below the Trust target of 90%.
- Staff knew how to raise a safeguarding concern and did so when appropriate. Each team had a lead safeguarding champion. The service had a safeguarding champion forum where safeguarding issues were discussed from across the trust. Senior staff who undertook safeguarding lead roles had time allocated within their job roles for training and supervision.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Staff access to essential information

- Staff had access to an electronic records system. All staff including agency workers received training in using these systems and had individual logins and secure smartcards in order to access them. Information needed to deliver patient care was available to all relevant staff when they needed it and in an accessible form. That included when patients moved between teams.
- Staff recorded the routine outcome measures such as the health of the nation outcome scales and the strengths and difficulties questionnaires on a separate computer system or on paper records, which caused them to spend more time recording this information. The trust had recently invested in a new system to collect feedback using an electronic tablet.

Medicines Management

- None of the teams administered medicines on site or in patient homes. Psychiatrists and nurse prescribers used prescription pads that were audited and secured according to the trust pharmacy guidance.
- Local arrangements were in place for children and young people's general practitioners to undertake blood tests and other physical health investigations such as electrocardiograms.
- All prescribing was audited by the trust and results feedback through business meetings.

Track record on safety

- Across the three sites visited there were 81 incidents from April 2017 to the 28 September 2017. The Barnet Adolescent Service reported nine incidents, Haringey 33 and Enfield 39.
- In the year from 1 July 2016 to 30 June 2017 there were three serious incidents across the service, one of which involved the death of a young person in the community at school. The young person had been seen by the service and was awaiting treatment. The service was conducting an independent review into the death but initial learning points had been shared amongst teams and ongoing support offered to the school and its staff. Other incidents recorded included abuse against staff and safeguarding incidents.
- There were comprehensive investigations following serious incidents.
- There was appropriate support in place for staff for example de-briefings and additional supervision.

Good

Are services safe?

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

Reporting incidents and learning from when things go wrong

- At the previous inspection in December 2015, we found that staff did not report all incidents and managers did not ensure that learning from incidents and complaints was shared across the service and the trust. At this inspection, we found that this had improved. All the members of staff we spoke to knew which incidents to report and how to report them. Managers told us that incident reporting had increased substantially. For example, the Haringey CAMHS had seen a more than seven-fold increase in the reporting of incidents.
- Staff we spoke with knew about the duty of candour requirement and what this meant in relation to being open and transparent with young people and their carers when things went wrong. The trust audited their duty of candour compliance, and at the time of inspection it was 100%.
- Team managers discussed incidents across the service at weekly business meetings. Staff told us information regarding incidents was shared through team meetings. Service managers and directors attended an operational management meeting where they discussed incidents. Following these meetings, they shared lessons learnt with staff teams.
- Staff made changes as a result of incidents. For example, following a recommendation from an investigation that risk assessments be updated every three months to ensure the information is accurate and up to date, the Haringey team had started producing a monthly report for each clinician to prompt them when a risk assessment was due for an update.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- Staff completed comprehensive mental health assessments. Assessments were completed in a timely manner following the initial appointment with the clinician and then updated in the notes when circumstances changed.
- Staff recorded information about a young person's physical health, including allergies. For children and young people prescribed medication, staff completed physical observations such as blood pressure, height and weight and recorded these in the notes. The child or young person's GP undertook more complex physical healthcare observations, for example, blood tests.
- At the previous inspection in December 2015, we found that not all children and young people had their care plans updated. At this inspection, we saw that this had improved. Staff developed care plans that met the needs of patients identified during assessment and updated these regularly. The majority of care plans had been developed and shared with the young person and their carer through a letter to the referrer which was copied to them.
- At the previous inspection in December 2015, we found that not all care plans were holistic and person centred. At this inspection we found that this had improved. Staff had developed care plans that were personalised, holistic, and recovery-oriented based on the young person's strengths or goals for 11 of the 15 patients whose care plans we reviewed. Some staff had used creative ways to engage the young person. For example, one member of staff had used cartoons to illustrate treatment approaches.

Best practice in treatment and care

- The services provided psychological therapies in line with NICE guidance including children and young people's improving access to psychological therapies (CYP-IAPT), art therapy, family therapy, cognitive behavioural therapy and psychotherapy. Clinicians across the three locations we inspected were qualified to deliver recommended psychological therapies and more staff planned to undertake this training.
- Services followed NICE guidance in relation to the treatment of mood disorders including anxiety and depression, schizophrenia, psychosis, eating disorders and self-harming behaviours.
- A young person accessing the service would be offered a treatment approach according to their individual needs. In Haringey, the service could refer children and young people to a child and family service, first step service and the adolescent outreach services. In Enfield, the teams had access to family therapy. Barnet CAMHS also offered family therapy.
- The teams offered parents and carers psycho-education groups. In Haringey and Enfield, staff ran groups for parents of children and young people with ADHD.
- Staff provided treatment in schools. In Barnet, the primary and secondary schools project and teams provided this service, and in Haringey and Enfield, the Health and Emotional Wellbeing Service provided this service. Clinicians offered, where appropriate, between six and eight sessions or longer term work where necessary.
- Staff prescribed medicines to children and young people in accordance with NICE guidelines.
- Staff ensured that patients' physical healthcare needs were being met, including their need for an annual health check. Staff referred children and young people to their GP for physical health tests.
- Staff supported patients to live healthier lives. For example, staff screened young people over the age of 14 for smoking and alcohol consumption and referred them to services for substance misuse if required.
- The service used a range of outcome measures to monitor the child or young person's progress during treatment. These included the children's global assessment scale, strength and difficulties questionnaires, goal based outcomes and the revised child anxiety and depression scale. All staff we spoke with were aware of these measures and routinely used them.
- Staff used technology to support patients effectively. The trust had recently updated the website for CAMHS. The website had information for children, young people and their parents or carers as well as for professionals.

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.

- Staff participated in clinical audit. They regularly audited waiting times, care plans, supervision, risk assessments, premises and equipment, and outcome measures. They discussed the outcomes of these audits and any actions needed to improve in team business meetings. Managers had an electronic system that informed them of upcoming audits to be completed. The trust's central clinical auditing department processed the results from audits and provided feedback to managers.

Skilled staff to deliver care

- The multidisciplinary teams had a broad range of clinicians who had various skills and training in mental health.
- Staff were experienced and qualified, and they had the right skills and knowledge to meet the needs of the patient group. The service employed clinicians who had a mental health qualification or professional qualification such as psychology, mental health nursing, art therapy, family therapy, psychotherapy, social work or psychiatry. We found that all teams had a stable team of core professional that had been working in the service for many years.
- Managers provided new staff and agency staff with an appropriate induction. Staff received a trust wide induction and then a local induction to the team.
- Staff received regular supervision, either individually or in a group. Supervision included elements of both management and clinical discussion, in accordance with trust policy. Staff we spoke to told us how highly valued supervision was to their roles.
- The trust had an electronic system in place for recording supervision dates. Supervision rates varied between services. In Enfield, 100 % of staff, received regular monthly supervision. In Barnet, CAMHS including Barnet Adolescent Service 83 % of staff were receiving supervision. The lowest supervision rates were at Haringey. From April 2017 to August 2017, 72% of staff received monthly supervision which was below the trust target of 80%. Agency staff received monthly supervision.
- Staff had access to regular team meetings. Staff told us they were able to speak freely at these meetings and they were used effectively to improve the work of the team.
- Staff received appraisals annually. We found that the majority of staff had received an appraisal. The Haringey manager told us two staff had not yet been appraised. The teams at Barnet and Enfield reported that all staff had received an appraisal in the last twelve months.
- The majority of staff told us that they could access training relevant to their role to enhance their knowledge. Staff received support to meet their training needs. For example, the service had invested in recommended psychological therapy training for clinicians.
- Managers dealt with poor staff performance promptly and effectively. We saw an example where managers were appropriately addressing a performance issue.

Multi-disciplinary and inter-agency team work

- Staff attended weekly multidisciplinary meetings where there was clinical case discussion. We observed one of these meetings and found that staff worked effectively and shared information and formulations regarding the child or young persons' mental health needs. If staff had a concern around changes in a child or young person's risk of treatment, they could discuss this with the team.
- Staff shared information about patients at handover meetings within the team. When staff went away on holiday or were on long term sick, managers made arrangements to cover their caseload.
- Teams had effective working relationships, including good handovers, with other teams within the organisation. Each borough had specialist teams within CAMHS including looked after children, neuro-developmental disorders, learning disabilities, adolescent outreach, primary and secondary schools project and health and emotional well-being.
- Teams had good working links, including effective handovers, with primary care, social services and other teams external to the organisation. The service provided 'in-reach' to schools. Staff provided appointments,

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training for teachers and allied professionals, and specialist consultations in complex cases. In addition, the four access teams provided advice and support to external stakeholders, including schools and GPs.

- In Enfield, the Alliance team provided intensive care and treatment to young people in the community with the aim of preventing them being admitted to an in-patient ward. To achieve this aim, they worked alongside the adolescent outreach team and in close partnership with the specialist CAMHS teams and other stakeholders.

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

- All staff had received training the Mental Health Act (MHA) as part of their trust induction**.** Managers told us that there was no requirement by the trust for CAMHS staff to update this training as part of their ongoing mandatory training. Staff understood the requirements of the MHA, the code of practice and its guiding principles in relation to children and young people. At the time of inspection, no children or young people were subject to a community treatment order.
- Consultant psychiatrists across the service were Section 12 approved doctors who had completed additional training in the MHA and could assess young people under the Act. Non-medical staff told us they accessed advice from the on-call psychiatrist if they considered the young person might require a MHA assessment.
- Staff had access to administrative support and advice on the implementation of the MHA and its code of practice. The provider had relevant policies and procedures in place and staff knew how to access these.

Good practice in applying the Mental Capacity Act

- At the last inspection in December 2015, we found that staff did not always record consent to treatment in the care records. At this inspection, we found that this had improved. Out of 15 care records we looked at 11 had consent to treatment recorded in the notes. For three out of the four records where it was not recorded the patients were under 12 years of age when consent would be implied. The trust undertook audits of consent. These showed most staff recorded consent. For example, the most recent audit in Enfield found staff had recorded consent to treatment in 96% of records.
- All staff had completed training in the Mental Capacity Act 2005 (MCA) during their induction to the service. Staff did not undertake Mental Capacity Act training as part of their ongoing mandatory training.
- The MCA only applies to young people who are 16 years or older. Gillick competency (a test in medical law) is used to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge. Staff had a good understanding of the MCA, particularly the five statutory principles, and Gillick competency. We found three recent examples of clinicians discussing with young people their capacity to consent to treatment and this was documented in the clinical notes. No children or young people were subject to best interests decisions at the time of our inspection.
- Staff knew where to get advice regarding capacity issues and the provider had information relating to capacity on the CAMHS website. No audits or other arrangements to monitor appropriate use of the Mental Capacity Act were in place.

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

- Staff interactions with patients demonstrated that they were respectful, caring and responsive. They provided patients with help, emotional support and advice at the time they needed it. Staff supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services when appropriate.
- We observed appointments and meetings where staff spoke in a respectful way with the young people and their carers. Staff spoke with young people in a way that engaged them and was dignified, child or young person focussed and supportive.
- Young people were very positive about the service and praised the staff for their caring approach. All the young people we spoke with told us they felt listened to and their views were valued. Young people said they were treated in an age appropriate way.
- Young people had access to on-line support via the CAMHS website for the trust, which provided useful information about activities and services they could access to help support their emotional well-being and mental health issues.
- The service provided a 'Choices' one-off appointment for children and young people in Haringey. This service received over 50% of their referrals from young people directly. This provided one hour face-to-face meetings with children, young people and their families in convenient community based locations. In these appointments, a member of the team would help families with emotional wellbeing concerns identify what help is available in Haringey. This could include advice, signposting to other local organisations.
- Most of the carers were positive about the service. They said that staff appeared to understand their child and their needs.
- Staff demonstrated an in-depth knowledge of the individual needs and circumstances of the young people they supported. This was particularly evident in the case discussions we observed. Staff spoke about young people in a professional, dignified and respectful way.
- Staff told us they felt able to report abusive or discriminatory behaviour towards them by patients. Incidents of abuse had been recorded using the trust incident reporting procedure.
- Staff understood the need to maintain confidentiality. They locked their workstations when not using them. Records were held securely on an electronic system. Staff asked young people if they would like their carers present during assessments and therapy appointments. We saw that young people could have an appointment alone with staff and then their parent or carer was invited in towards the end to discuss what would happen next. Staff explained to young people and their carers when they needed to share information with other parties. They discussed this with them in advance and, where needed, sought their permission.

Involvement in care

The involvement of patients

- Staff involved patients in care planning and risk assessments. In care plans and risk assessments, staff communicated with children and young people in ways they could understand, for example, using cartoons and drawings to illustrate therapy approaches.
- The service sought feedback from children and young people and involved them in decisions about the service. The service had recently purchased electronic tablets to improve how it obtained feedback from young people on their experience of the service.
- Young people sat on interview panels to assist in the recruitment of new staff into the service.
- At the inspection in December 2015, we found some staff did not know how young people could access the advocacy service. At this inspection, staff could tell us what advocacy support was available and how they signposted patients to it when necessary. The services did not have information on advocacy services readily available in waiting areas.

Involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed. All 13 parents and carers we spoke with said they had been fully involved with their child or young person's care and treatment.

Good

Are services caring?

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- Staff enabled families and carers to give feedback on the service they received. The service offered coffee mornings for parents and carers in Haringey. In Enfield, parents and carers ran a forum group called 'Our Voice' where a parent we spoke with reported all attendees felt the service was fantastic. The trust had also set up a new peer mentoring group in Haringey Members of the group shared their experiences through their journey through CAMHS.
- Carers were provided with information about how to access a carer's assessment and the service had clear information about groups and services that offered support on the CAMHS website. The Choices service was engaging with CAMHS service users to develop the use of social media.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- At the last inspection December 2015, the trust had long assessment to treatment times for young people waiting to access some parts of the services. At this inspection, we found that this had improved. Investment in new staff and teams had improved waiting times. However, teams were just missing targets for referral to assessment or referral to treatment times.
- The trust needed to improve waiting times for children and young people requiring a neuro-developmental assessment. We found that the waiting time for this was up to 30 weeks across the service.
- The service had a target to assess 95% of children and young people within 13 weeks of their being referred to the service. It had also recently introduced a new target to treat 95% of children and young people within 18 weeks of their being referred to the service. The services assessed most children and young people within 13 weeks, but they did not meet the target to assess 95% of them. From April 2017 until August 2017, staff assessed between 90% and 93% of children and young people within the 13 week timescale.
- Staff monitored the waiting list to ensure they saw all children and young people as soon as possible. The teams reviewed their waiting times weekly to identify the children and young people they had not seen within 13 weeks. Staff in the Enfield and Haringey CAMHS had booked appointments for all the children they had not seen within 13 weeks. At the time of the inspection, Barnet Adolescent service had no waiting list.
- The service had clear criteria for which patients would be offered a service. A suitably qualified clinician screened and triaged all referrals. Each borough had a CAMHS access service, which provided a central point of referral for professionals to refer young people with mental health concerns. Staff in the access teams discussed referrals with the young person, their family or the referrer before sending the referral to the most appropriate team or signposting the child or young person to other support in the borough.
- When access teams triaged a referral as requiring an urgent appointment, staff could see the child or young person within 24 hours. The average wait was seven to 14 days for those children and young people who presented higher levels of need or complexity. Access teams could refer children and young people directly to specialist sub-teams, for example, the neuro-developmental team or the learning disabilities team. When required, the adolescent outreach and crisis teams across the service offered assessment and treatment. In Haringey, young people could "walk-in" and be seen that day if required. All the carers we spoke with said they were able to access the service by telephone and would receive a response.
- For out of hour's emergencies the young person would have to go to the local acute hospital accident and emergency department. When a child had self-harmed, they were admitted to a paediatric ward where mental health staff aimed to attend the ward and assess the child or young person within four hours and if needed, a CAMHS on-call psychiatrist could attend.
- Staff assessed looked after children and children referred from the youth offending teams within seven days of referral.
- The trust was making good progress in meeting their referral to treatment target time of 18 weeks.Across the service in September 2017 48 (5%) children and young people out of 918 awaiting treatment were not seen within the trust target time of 18 weeks from referral to treatment. Enfield had the highest number of children and young people waiting however all patients had appointments for treatment booked. There were variations between different parts of the service. The neurodevelopmental teams had the longest waits.
- Staff sought to support children, young people and parents and carers whilst they waited to be assessed and treated. The teams reviewed their waiting lists on a weekly basis, and they offered telephone support and parents/carers groups and workshops to support the child and family in the interim.
- The teams had tried to reduce their waiting lists. For example, in Haringey, staff had undertaken a project to reduce the waiting times by offering an attention deficit hyperactivity disorder assessment clinic each month.

Are services responsive to people's needs?

Good

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

- At the inspection in December 2015, we found that not all staff knew what steps to take if a young person did not attend their appointment. At this inspection, we found that all staff could tell us what steps to take.If a child of young person did not attend an appointment, staff tried to make contact with them. Administration staff would also routinely telephone or send a letter to parents/carers and young people who did not attend their appointments.
- From 1 April until 31 August 2017, between 9% and 11% of children and young people 'did not attend' (DNA) their appointment. The service routinely offered a second appointment for young people who did not attend their initial assessment. To help reduce the number of DNAs, the service now sent reminder text message to either the carer or young person. Staff had also begun to offer appointments in convenient locations, for example, in GP surgeries or at the young person's school.
- When children and young people did not attend their initial appointment, staff could not always rearrange a new appointment in the following week. Sometimes, they could not arrange to see the child or young person until four weeks after the initial appointment if the appointment was non-urgent. This caused delays in staff completing initial assessments, which impacted the teams' performance against their targets.
- When possible, staff offered patients flexibility in the times of appointments. Staff cancelled appointments only when necessary. When they cancelled appointments, they explained why and helped patients to access treatment as soon as possible. Appointments usually ran on time, and staff kept patients informed when they did not.
- The services had systems in place to support young people transferring from CAMHS services to adult services. When a young person approached 18 years of age and needed transfer into adult mental health services, clinicians and managers met with staff from the adult community mental health team to facilitate the transition. The service followed national guidance around transition of young people into adult services called 'preparing for adulthood' as part of the special educational needs and disabilities provision. For young people with a learning disability, the service supported patients until 24 years of age. Staff planned to increase this to 25 years of age.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had a range of rooms and equipment to support treatment and care. Waiting areas included adequate seating. Interview and therapy rooms were available. There were toys and child-friendly furnishings at all three locations. At Burgoyne Road in Haringey, the interview room near reception was not sound-proofed. Staff expressed concern regarding the impact this had on privacy and dignity. All the other rooms were appropriately sound proofed.
- None of the sites had designated clinic rooms. At all sites we visited, the height and weight equipment was located in a corridor. This compromised patient privacy and dignity.

Patients engagement with the wider community

- Staff encouraged patients to develop and maintain relationships with people and services that mattered to them. We saw that children and young people were supported to engage with wider family networks and encouraged to engage with education. This was supported by the schools programme.

Meeting the needs of all people who use the service

- All the sites we inspected were wheelchair accessible and had wheelchair accessible toilet facilities. Staff conducted home and school visits for children and young people who found accessing the service difficult because of mobility or other issues.
- The teams displayed a range of information in waiting areas including leaflets for mental health conditions such as anxiety and depression and local support groups. The Haringey team had placed a whiteboard for user feedback in the reception area, which had been well used by children and young people.
- Staff could access interpretation services centrally from the trust. One carer we spoke with had been offered the

Are services responsive to people's needs?

Good

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interpretation service for sessions but did not feel they needed it. Staff could arrange for letters to be translated into different languages. In Haringey, staff provided information on outcome measures in different languages, which met the needs of the diverse population. Leaflets in other languages were not displayed. Staff told us they were able to print these when needed. Leaflets in easy-read format for those young people with a learning disability were also not displayed but could be provided if needed.

Listening to and learning from concerns and complaints

- From 1 April 2016 until 31 March 2017, the service received 52 compliments. Complaints related to admissions, discharges and transfer arrangements, all aspects of clinical care, appointments delayed/ cancellation, communication to patients written or oral and failure to follow agreed procedure.
- Staff managed informal complaints at a team level.
- Staff did not respond to all complaints quickly. It took on average 56 days for a final response to be sent to the complainant which exceeded the trust target of 25 days.
- Most of the young people and carers we spoke with knew how to complain and the ones that did not felt able to raise concerns freely. None of the parents, carers or young people we spoke with had complained about the service.
- Staff demonstrated an understanding of the complaints process and gave examples of how they would invite parents or carers in for a face to face meeting or telephone them in order to try and resolve the complaint.
- Staff received feedback on the outcome of complaints investigations and acted on the findings. We found an example of where a parent had complained about the tone of a letter to the referrer and the team had reflected on this and change the style of the letters sent out to the GP and copied to the parent/young person.

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

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. Managers were from health and social care backgrounds. Two teams had interim managers on fixed term contracts until the post could be filled. The manager of the Barnet Adolescent Service was due to leave in October as their contract had finished and a new manager had been recruited. The service was actively recruiting to the remaining managers post.
- Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Managers and directors knew the key pressures affecting the services and how they needed to support staff. For example, staff told us how the withdrawal of administration staff at Enfield by the local authority and retirement of senior, highly skilled professionals had impacted on the teams
- Leaders were visible in the service and approachable for patients and staff. All of the staff we spoke with told us they felt their managers were approachable and understanding. Staff reported that senior managers were visible in the service and there were opportunities to feedback about the service. All staff we spoke to were highly complementary about the managers across the service.

Vision and strategy

- Staff were passionate about helping young people with emotional well-being and mental health difficulties. This was in line with the trust's visions, which focussed on "Live, Love, Do" and the values of compassion, respect, being positive and working together. The majority of staff we spoke with knew these values. All staff demonstrated the trust values in their behaviour and attitude.
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. For staff in the Barnet Adolescent Service, the re-tendering process was an added stress and this was acknowledged by the senior managers and leaders.

Culture

- Staff felt respected, supported and valued. Overall, staff reported that morale was good and that colleagues supported each other. Some staff we spoke with said that morale fluctuated, mainly as a result of work pressures. Staff said there was an open and transparent culture within teams.
- All staff we spoke with felt able to raise concerns with their managers without fear of reprisal. They knew how to whistle-blow if needed. Staff knew of the Freedom to Speak Up guardians and understood their role.
- Teams worked well together. They were multidisciplinary with each profession's contribution valued. We found they worked in a non-hierarchical way in which each person's view was welcomed.
- Staff appraisals included conversations about career development and how it could be supported. The appraisal encouraged staff to set their own individual goals in relation to their professional development.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. We found posters in staff areas in Haringey, which had ideas for how staff could manage stress and improve their work-life balance.

Governance

- The services had systems and procedures to ensure that the premises were safe and clean. They had enough well-trained and supervised members of staff who assessed and treated children and young people well. They ensured staff reported incidents, which they investigated and learned from.
- The teams in each borough had regular clinical meetings, leadership meetings and business meetings. These used standardised agendas that ensured staff discussed incidents and concerns, waiting lists, safeguarding, and complex cases.
- Staff had implemented recommendations from recent investigations. Following an incident in Haringey, for example, staff now updated risk assessments on a three monthly basis so that information was up to date.

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- The trust had 'deep dive' meetings with managers. In these meetings, managers told us they looked at a clinical audit or incident in detail to obtain learning and to create action plans. We found evidence of this in the minutes from these meetings.
- Staff undertook clinical audits of the premises and environment, consent, care plans, risk assessments and waiting times. The trust had recently undertaken an audit of supervision to review its quality, which managers had discussed in a "deep dive" meeting.

Management of risk issues and performance

- Staff maintained and had access to a local risk register, which could feed into a directorate and trust wide risk register. Team managers had identified recruitment challenges and staff shortages as local risks. These had been escalated to the trust risk register and the trust human resources department was working to address these.
- Staff recorded potential risks identified through clinical and environment audits on the local risk register. The risk registers corresponded with concerns raised by staff during the inspection.

Information management

- Some of the systems the services used to collect data placed extra administrative workload on clinicians. For example, staff recorded information on consent to treatment and consent to share information form on electronic notes. Managers had identified this as an area for improvement and had begun to make changes. For example, staff now collected outcome measures on electronic tablets. Staff had access to the equipment and information technology needed to do their work, but staff told us the IT system was not always reliable.
- Team managers had access to information to support them with their management role. Managers had access to dashboard of information. This included information on the performance of the service, staffing and patient care. Information was in an accessible format and delivered on a monthly basis including the trust key performance indicators.
- Staff made notifications to external bodies such as NHS England and the local authority when required.

Engagement

- Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. We saw examples of how patient and carer feedback had been used to improve services and make changes. There were comments boxes visible at each location, and managers were aware of feedback and issues raised by children and their families. There was evidence that this feedback was discussed and had influenced planning for service development.
- The service had close links with other trusts and voluntary services, for example, partnership working with other trusts locally.
- Directors of the service engaged with external stakeholders, for example, the various different clinical commissioning groups who commissioned the services and the local authority would meet with service managers.

Learning, continuous improvement and innovation

- The adolescent team at Enfield was participating in an accreditation scheme for the quality network for community CAMHS (QNCC) at the time of this inspection. Managers of the other teams told us that due to budgetary constraints participation in accreditation schemes was not possible at this time.
- In Haringey the service had completed a quality improvement project to look at caseloads. Following this project there was a 30% reduction in caseloads for clinicians. This meant that there was a monthly review of caseloads to monitor progress.