Good

Leeds and York Partnership NHS Foundation Trust

Child and adolescent mental health services – Community based services

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust Headquarters	RGD01	CAMHS Community Team	YO30 5RE
Trust Headquarters	RGD01	National Deaf Child and Adolescent Mental Health Service (NDCAMH Service)	YO30 5RE

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

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

Where applicable, we have reported on each core service provided by Leeds and York Partnerships NHS Foundation Trust. and these are brought together to inform our overall judgement of Leeds and York Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for Child and adolescent mental health services – Community based services	Good 
Are Child and adolescent mental health services – Community based services safe?	Good 
Are Child and adolescent mental health services – Community based services effective?	Good 
Are Child and adolescent mental health services – Community based services caring?	Good 
Are Child and adolescent mental health services – Community based services responsive?	Good 
Are Child and adolescent mental health services – Community based 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 found the service to be safe: a range of clinical staff, managers, and staff who had a combination of clinical and managerial responsibilities were in place. Within NDCAMH, particular efforts had been made to ensure the staff team included people who were deaf so that a deaf culture and identity was firmly embedded within the team and its practice. Systems were in place which ensured risk assessments were carried out in relation to children and young people who had been referred to the service. Prioritisation of referrals took place by clinical staff. Whilst we saw evidence that initial assessments had been carried out, we found there was an absence of a standardised initial assessment tool. We were told by managers of the service and staff that this had sometimes led to children, young people and parents having assessments repeated. In some circumstances NDCAMH's staff will carry out a second assessment if the first assessment was carried out by a hearing service.

There were appropriate lone working arrangements in place within the NDCAMH service but we found concerns in relation to the lone worker policy and process not being consistently followed within the mainstream CAMHS service. As a consequence, some staff told us they felt vulnerable when carrying out work in the community.

We found incident reporting systems were in place and were being followed. A range of systems, such as debriefing, team meetings and emails, were used to ensure learning from incidents took place.

We found the service to be effective: care plans which adopted a focus on recovery were in place; these were mostly up to date but there was a lack of evidence to show whether children, young people and their parents/ carers were given copies of these. There was evidence that the physical health of children and young people was being considered by the service.

We found the service had an understanding of best practice guidance and it demonstrated a commitment to evidence based practice. We found some therapeutic interventions for children and young people were available and provided.

Staff received supervision and annual appraisals. A range of supervision types were in place such as one-to-one and group supervision. Mandatory training expectations were in place. Whilst many staff were up to date with mandatory training, we found a significant number of staff had some of their mandatory training which was overdue.

The service operated on a multi-disciplinary basis and staff described a mutually supportive team spirit. We found evidence of positive working relationships with a range of agencies external to the service.

We found concern in relation to the absence of training for staff in relation to the Mental Capacity Act and Mental Health Act.

We found the service to be caring: staff working in the service had a caring and compassionate attitude towards children and young people. Staff spoke of how they would ensure the privacy of children, young people and their families was respected where it was safe and appropriate to do so. There was evidence of people being provided with information about the service and what to expect from them. An advocacy service was available and steps had been taken to bring this to the attention of young people and their parents.

Staff were able to demonstrate examples of how they engaged with children, young people and their parents/ carers to ensure they were able to be fully involved in their care.

Overall, the service was responsive to the needs of children, young people and their families: the service provided care and interventions to children and young people from a range of backgrounds and level of need. The NDCAMH service had carried out much work in order to effectively engage and communicate with people who are deaf. Much of this effort was by making what we considered to be innovative use of the technology which was available to them. Some staff, however, from the NDCAMH service did raise a concern with us that the IT systems in place did not always support their needs or support the team fully in their use of technology.

Complaints procedures were in place. Staff were aware of these and steps were taken to bring the complaints process to the attention of the public. The service was able to give examples of changes which had been made in response to feedback received.

Summary of findings

Whilst outpatient facilities were clean, both working space and therapy space were of short supply. Concerns were raised with us by some staff regarding whether patient confidentiality was sufficiently safeguarded in the outpatient facilities used by the mainstream community services.

The service was well led: staff worked in a way which was consistent with the values and strategic direction of the trust. Line management structures were in place and staff understood their roles and responsibilities. Managers had an awareness of where improvements were needed in their services. Staff reported to us a general sense of being supported by their managers. Whilst some staff spoke of feeling under increased pressure because of, for instance, increased referrals, managers were taking steps to try to address this.

Summary of findings

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

Are services safe?

Good

The service had a range of staff in place who worked at different levels of seniority and with a range of professional experience. The NDCAMH service had ensured the team consisted of staff who were also deaf; this was to help ensure there were positive deaf role models available and meant the service could directly benefit from the experiences of people who were from the deaf community.

Systems were in place to ensure risk assessments were undertaken and to make sure the needs of children and young people were being appropriately met. Referrals to the services were prioritised on the basis of clinical need; this prioritisation was carried out by clinical team members.

A lone working process was in place but this was not consistently applied within the mainstream CAMHS service. This led to some staff feeling particularly vulnerable when carrying out community visits.

Incident reporting systems were in place and these were implemented by staff. Most staff we spoke with were able to tell us what they would do if an incident occurred. One staff member told us they had not experienced any significant incidents and so would seek help and advice from their manager should one arise. There were examples which demonstrated changes had taken place as a result of lessons learnt and different systems existed to ensure feedback to staff occurred took place. Examples of this included discussing incidents within team meetings, having debriefing sessions and receiving emails which cascaded information.

Are services effective?

Good

Recovery focused care plans were in place; care plans we reviewed were largely up to date. There was a lack of clear documentation to demonstrate that care plans had been shared with children, young people and their parents/carers. There was evidence of physical health needs being taken in to account within clinical practice.

Although initial assessments were being carried out, both managers of the service and staff told us there was an absence of a standardised assessment tool which had at times led to duplicate assessments taking place.

Working structures and relationships were in place within the mainstream service so that discussions and consideration could be given on how best to meet children's/young people's needs.

Summary of findings

The service had an awareness of best practice guidance and demonstrated a commitment to evidence based practice. Some therapeutic interventions were available for children, young people and their parents/carers.

The service had multi-disciplinary teams in place. Staff received supervision and annual appraisals. Mandatory training was a requirement for staff; whilst most staff were up to date with their mandatory training there was a significant number of staff whose mandatory training was out of date.

Multi-disciplinary working was evident. Staff we spoke with reported a positive working culture within the service. There was evidence of interagency working with a range of appropriate partner agencies. The NDCAMH service had taken steps to ensure it developed working relationships with a range of services for the deaf in the community.

We had concern regarding the lack of training regarding the Mental Capacity Act and Mental Health Act.

Are services caring?

Good

We found staff to be caring and committed to the care and well-being of children and young people. The service recognised the need to maintain confidentiality, where safe and appropriate to do so, and to respect the privacy and dignity of children, young people and their families.

An advocacy service was available; steps had been taken to ensure children, young people and their families were made aware of this service and how it could be contacted.

Information was provided to families about the service and what to expect from the service.

The service was able to provide examples of how they engaged with children, young people and their parents/carers within aspects of their care.

Are services responsive to people's needs?

Good

Referrals to the service were prioritised on the basis of clinical need. Different care pathways were in place to help ensure the needs of children and young people were met.

Outpatient facilities were limited and there was concern about the appropriateness of some of the environments used to meet with children, young people and parents/carers. Office space was limited for staff to work.

Summary of findings

The service carried out much of its work by working within the community. This meant the service was better able to be flexible and provide a more holistic assessment by seeing children and young people in different settings.

The NDCAMH service had demonstrated the innovative use of the techonology which was available in order to communicate effectively with people with different levels of hearing loss.

Complaints processes were in place and steps had been taken to make children, young people and their parents/carers aware of this. Staff were able to give examples of changes which had been made as a result of feedback the service had received.

Are services well-led?

Good

There was evidence that practice took place in a way which was consistent with the trust's values and strategic objectives. Lines of accountability and management were in place and staff were aware of their responsibilities.

Staff received supervision and annual appraisals. There was evidence that where necessary performance management systems were exercised. Managers recognised where their services needed improvement.

Whilst staff spoke of feeling supported in their work, some staff spoke of feeling under increased stress because of increased referrals and changes in systems, such as the move to an electronic recording system.

We saw evidence of particularly good practice with how the NDCAMH service made use of technology to work with people who have a hearing difficulty or are deaf.

Summary of findings

Background to the service

The community based Child and Adolescent Mental Health Service (CAMHS) which we inspected consisted of two different services. These services were the mainstream community CAMHS team and the National Deaf CAMH service. Both services were based and operated from the same site location as the Lime Trees Child, Adolescent and Family Unit in York.

For the purposes of this report, and to help avoid confusion, the mainstream CAMHS service will be referred to as being the mainstream service or mainstream CAMHS, whilst the National Deaf CAMH service will be referred to as NDCAMH. Collectively, the term CAMHS service will be used.

The mainstream CAMHS service works with children and young people, and their parents/carers, who have a range of mental health difficulties, or are in need of specialist mental health assessments. Their work is undertaken on an outpatient basis.

The NDCAMH service works with children and young people, between the ages of 0-18, who have a severe or profound hearing loss, have deaf parents, or use British Sign Language (BSL) as their first language. The service will also work with hearing children with a deaf parent whose first language is BSL The children/young people should also have significant emotional and/or behavioural issues consistent with a childrens global assessment scale rating of 50 or less.

Our inspection team

The team responsible for inspecting Leeds and York Partnership NHS Foundation Trust was led by:

Chair: Michael Hutt, Chief Operating Officer, Cumbria Partnership NHS Foundation Trust

Head of Inspection: Jenny Wilkes, Head of Inspection, Care Quality Commission

The team which inspected the CAMHS outpatient services consisted of a CQC mental health inspector, two nurse specialist advisors, a psychologist and an expert by experience (and their supporter). An expert by experience is a person who has personal experiences of CAMHS either in a personal capacity, or as a relative or carer.

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

We visited the Child and Adolescent Mental Health Services ('CAMHS') on 30 September and 1 October 2014. This consisted on visiting the CAMHS mainstream service and the National Deaf CAMH (NDCAMH) service. These visits were announced.

During the inspection, we reviewed the care records of six children/young people. We also toured the premises. Two parents, and their children, kindly agreed to speak with us about their experiences and views of the service. We spoke with numerous members of staff about the service they provided; this consisted of three psychologists, two nurses, two service managers, a primary mental health worker, specialist consultant who was deaf, two Consultant Psychiatrists. Communication with the specialist consultant who was deaf was facilitated via a British Sign Language (BSL) interpreter.

Before this inspection, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

Summary of findings

To get to the heart of people who use services' experience of care, 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?

41 sets of patient notes.

What people who use the provider's services say

Two parents and two children kindly agreed to speak to us about their experiences of the mainstream CAMHS service. We received mixed feedback from these people which ranged from feeling the service had been life saving to not feeling fully included.

We saw positive feedback which had been received in relation to the NDCAMH service. Such feedback gave praise regarding the service and how it had helped make positive differences in people's lives.

Good practice

The NDCAMH service made good use of the technology which had been made available to them, so that the needs of children, young people and their parents who were deaf could be better met.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider should review the information technology requirements of the NDCAMH service; this is because whilst the service was making good use of the technology they had been provided with, staff using the equipment said the systems could be slow and were not always cost effective for communicating using sign language.The trust should improve the practices and adherence to cleanliness and infection control.

Leeds and York Partnership NHS Foundation Trust

Acute admission wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CAMHS Community Service	YO30 5RE
National Deaf Child and Adolescent Mental Health (NDCAMH) Service	YO30 5RE

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.

Information provided to us by the trust indicated that training in relation to the Mental Health Act (MHA), and the MHA Code of Practice, was not mandatory. Without this training, there is a risk that staff do not operate within the law and may deliver care in a way which does not meet the requirements of the Act's Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

There was evidence that the service had an awareness of the need to consider Fraser/Gillick competency for children aged 15 and under, and mental capacity for young people aged 16 and 17. Some staff told us that children could access the service without parental consent so long as the child had been assessed as being Fraser/Gillick competent. Some staff also recognised that mental capacity issues were required to be considered as part of the trust's risk assessment tool.

There was confusion, however, regarding mental capacity training which was provided within the trust. Two managers of the service told us that the training of staff in relation to the Mental Capacity Act was a requirement but they were unable to advise us of how frequently this should take place or how compliant the service was at meeting this. Information later supplied to us by the trust indicated that Mental Capacity Act training was not mandatory for clinical staff.

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

Summary of findings

Are child and adolescent mental health 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**

The service had a range of staff in place who worked at different levels of seniority and with a range of professional experience. The NDCAMH service had ensured the team consisted of staff who were also deaf; this was to help ensure there were positive deaf role models available and meant the service could directly benefit from the experiences of people who were from the deaf community.

Systems were in place to ensure risk assessments were undertaken and to make sure the needs of children and young people were being appropriately met. Referrals to the services were prioritised on the basis of clinical need; this prioritisation was carried out by clinical team members.

A lone working process was in place but this was not consistently applied within the mainstream CAMHS service. This led to some staff feeling particularly vulnerable when carrying out community visits.

Incident reporting systems were in place and these were implemented by staff. Most staff we spoke with were able to tell us what they would do if an incident occurred. One staff member told us they had not experienced any significant incidents and so would seek help and advice from their manager should one arise. There were examples which demonstrated changes had taken place as a result of lessons learnt and different systems existed to ensure feedback to staff occurred took place. Examples of this included discussing incidents within team meetings, having debriefing sessions and receiving emails which cascaded information.

Our findings

Child and Adolescent Mental Health Service (Community)

Safe staffing

The service had a range of staff employed at different grades of seniority and experience. A number of staff were employed at a senior grade given the specialist nature of the assessments they undertook and the levels of professional autonomy involved. Staff who worked within the service included clinical staff, managerial staff and some staff with both clinical and management responsibilities.

Within the mainstream CAMHS service, an increased number of referrals to the service and the impact this was having on staff and waiting lists had been recognised. Managers had responded to this by developing a paper, to discuss with commissioners of the service, regarding how these additional demands could be appropriately met.

Within the NDCAMH service, we saw particular efforts had been made to ensure the staff included people who were deaf, and staff whose first language was sign language; this was important to the service so that its practice was driven by deaf perspectives and with a deaf culture in mind.

Assessing and managing risk to patients and staff

Systems were in place so the needs of children/young people, who had been referred to the service, were fully considered. A process of prioritisation was also in place to ensure urgent appointments were offered where necessary.

We found that the majority of referrals to the mainstream CAMHS service were initially assessed by primary mental health workers; these staff worked in a level of the mental health service known as tier 2. Tier 2 mental health workers carried out an initial assessment, which would usually be undertaken by means of a home visit, where an

Good

Are services safe?

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

intervention would be determined. Interventions could be the sign posting to a more appropriate agency, providing an intervention of care themselves, or referring the child's/ young person's care to a higher level of support (a higher level of support being provided by what is termed 'tier 3' services).

Staff were able to explain the assessment process and how workers from tier 2 would attend meetings with tier 3 so that they could discuss their assessments when they had any doubts or particular concerns for a child/young person.

We received a frequent concern from the mainstream CAMHS staff regarding risks to their safety whilst carrying out home visits. Staff we spoke with told us there was a lone working system in place but it was usually not followed. One staff member, as an example, told us they were aware that a buddy system should be used when staff were carrying out home visits but in practice it was not always robustly followed. A different staff member said that there was "no real buddy system in place". Managers of the service shared this view; for example, one manager told us they were aware the buddy system "is not always fully applied" and that at times some staff could become "complacent".

The NDCAMH service had a more thorough system in place in relation to visiting people in their own homes. This involved several members of the team, usually consisting of an interpreter, a deaf member of staff and one of the mental health practitioners, carrying out home visits together.

Reporting incidents and learning from when things go wrong

Incident reporting systems and processes were in place. Staff we spoke with were aware of their responsibilities in relation to incident reporting and had knowledge of how incidents should be reported. A minority of staff were unsure of what they should do if an incident needed to be reported but told us they that if such a situation arose they would approach their manager and ask for advice.

Staff across the service were able to give examples of incidents which had been both appropriately identified and reported. Similarly, staff were able to readily identify, and explain to us, incidents which had occurred and how changes to processes and practises had arisen as a result of lessons learnt.

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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.

Summary of findings

Are child and adolescent mental health services effective?

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.

Recovery focused care plans were in place; care plans we reviewed were largely up to date. There was a lack of clear documentation to demonstrate that care plans had been shared with children, young people and their parents/carers. There was evidence of physical health needs being taken in to account within clinical practice.

Although initial assessments were being carried out, both managers of the service and staff told us there was an absence of a standardised assessment tool which had at times led to duplicate assessments taking place. In some circumstances NDCAMH's staff will justifiably carry out a second assessment if the first assessment was carried out by a hearing service.

The service had an awareness of best practice guidance and demonstrated a commitment to evidence based practice. Some therapeutic interventions were available for children, young people and their parents/carers.

The service had multi-disciplinary teams in place. Staff received supervision and annual appraisals. Mandatory training was a requirement for staff; whilst most staff were up to date with their mandatory training there was a significant number of staff whose mandatory training was out of date.

Multi-disciplinary working was evident. Staff we spoke with reported a positive working culture within the service. There was evidence of interagency working with a range of appropriate partner agencies. The NDCAMH service had taken steps to ensure it developed working relationships with a range of services for the deaf in the community.

We had concern regarding the lack of training regarding the Mental Capacity Act and Mental Health Act.

Our findings

Assessment of needs and planning of care

Records we reviewed contained copies of care plans which had been formulated for children and young people. Care plans were largely up to date and adopted a focus upon the child's/young person's recovery. We found, however, that there was an absence of documentation which indicated whether or not young people, and their parents/carers, had been given a copy of their care plans.

Whilst we saw evidence that risk and initial assessments had been completed, there was an absence of a standardised assessment tool. Both managers of the service and staff told us this lack had on occasion led to duplicate assessments taking place. In some circumstances NDCAMH's staff will justifiably carry out a second assessment if the first assessment was carried out by a hearing service.

The physical health needs of children/young people had been taken in to account by the service; examples of this includes the carrying out physical examinations of children/young people with an eating disorder or attention deficit hyperactivity disorder (ADHD). Records we saw demonstrated that medication reviews had been taking place.

Best practice in treatment and care

Staff were aware of the need to provide interventions in accordance with best practice guidance such as that issued by the National Institute for Health and Care Excellence (NICE). There was an audit team in place to review and advise staff on new best practice guidance and there was an expectation that any training which was either requested or delivered would reflect both NICE guidance and other available best practice and research.

The service used various clinical assessment tools, such as the Children's Global Assessment Scale (CGAS) and the Strengths and Difficulties Questionnaire (SDQ) in order to try and rate a child's/young person's clinical presentation.

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.

The service was able to offer various therapeutic interventions based upon, for example, family therapy and cognitive behavioural therapy.

Skilled staff to deliver care

The service had in place a range of different professional disciplines. This included staff who specialised in family therapy, child behaviour support and primary mental health care. There was nursing, occupational therapy, psychiatry and psychology staff within the team. In addition, within the NDCAMH service, there were specialist outreach workers who were themselves deaf, interpreters and a service consultant who was deaf.

Both staff and managers we spoke with told us that they had regular supervision. A range of supervision was available within the service such as peer supervision, one to one line management supervision, and clinical supervision. Child protection supervision was also occasionally provided to staff, by a safeguarding lead, so that staff could discuss any worries or uncertainties they may have regarding a child/young person's welfare.

Most staff told us that their appraisals took place annually; data provided to us by the trust confirmed this.

We saw there was mandatory training which staff were required to complete. We looked at the training records of the CAMHS service and whilst we saw most staff were up to date with their mandatory training, a significant number of staff's mandatory training was out of date.

Multi-disciplinary and inter-agency team work

Multi-disciplinary working was evident within the service. Team meetings regularly took place. Staff we spoke with gave positive feedback about how well they thought the service worked together. One staff member, described their MDT as being "supportive" whilst a different member of staff told us that a "supportive team culture existed" within the service.

Having reviewed records and spoken with staff, we found working relationships with a range of external agencies, such as social services, GPs, looked after children teams and paediatricians existed. Staff from the service would also work with other agencies by means of helping to deliver training and providing telephone advice/ consultancy.

The deaf service had additionally established a range of specialist links within the deaf community. Examples of such links included schools for children and young people who are deaf, and audiology departments within general hospitals; the team had also been proactive in approaching all mainstream CAMHS with the aim of trying to establish link workers.

Adherence to the MHA and the MHA Code of Practice

Information provided to us by the trust indicated that training in relation to the Mental Health Act (MHA), and the MHA Code of Practice, was not currently mandatory. Without this training, there is a risk that staff do not operate within the law and may deliver care in a way which does not meet the requirements of the Act's Code of Practice.

Good practice in applying the MCA

There was evidence that the service had an awareness of the need to consider Fraser/Gillick competency for children aged 15 and under, and mental capacity for young people aged 16 and 17. Some staff told us that children could access the service without parental consent so long as the child had been assessed as being Fraser/Gillick competent. Some staff also recognised that mental capacity issues were required to be considered as part of the trust's risk assessment tool.

There was confusion, however, regarding mental capacity training which was provided within the trust. Two managers of the service told us that the training of staff in relation to the Mental Capacity Act was a requirement but they were unable to advise us of how frequently this should take place or how compliant the service was at meeting this. Information later supplied to us by the trust indicated that Mental Capacity Act training was not mandatory for clinical staff.

Good

Are services caring?

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

Summary of findings

Are child and adolescent mental health services caring?

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

We found staff to be caring and committed to the care and well-being of children and young people. The service recognised the need to maintain confidentiality, where safe and appropriate to do so, and to respect the privacy and dignity of children, young people and their families.

An advocacy service was available; steps had been taken to ensure children, young people and their families were made aware of this service and how it could be contacted.

Information was provided to families about the service and what to expect from the service.

The service was able to provide examples of how they engaged with children, young people and their parents/carers within aspects of their care.

Our findings

Kindness, dignity, respect and support

Staff spoke in positive, compassionate ways about the children, young people and families they worked with. Staff spoke of how important it was to respect the confidentiality of children, young people and their families; staff also spoke about how they would ensure a child's/young person's respect for privacy was safeguarded, where safe and appropriate to do so, from being shared with others. Staff explained how they would support children and young people and offer them a service even if their parents did not agree to this; this involved ensuring the child or young person was Gillick competent, or had mental capacity, to make such decisions for themselves.

All staff we spoke with demonstrated a commitment to good patient care.

There was evidence of the wishes of children, young people and their families being respected. For example, there was an instance of when a young person's worker was changed to a worker of the same gender, and an occasion when a family's wish regarding the sharing of confidential information was respected. One of the parents we spoke with said: "I cannot praise them enough" and went on to describe staff as being "empathic and supportive lifesavers". One of the children told us: "I would say it's a good place to come". A feedback survey we saw, carried out regarding the NDCAMH service, indicated that all families interviewed gave positive feedback and felt the service had been helpful and made a difference in their lives.

The involvement of people in the care they receive

We were informed by one of the managers we spoke with that prior to families attending the service for their initial appointments, information leaflets were sent to families to help inform them of the service and what to expect. Staff working in the service confirmed this.

An advocacy service, for children, young people and parents, was available. Information about how the advocacy service could be contacted was available in the building's reception area.

From the six care records we randomly sampled, we found evidence in only one to show that a care plan had been given to the young person it related to. Staff we spoke with did, however, give us examples of how young people, and their parents, were involved in care planning. For example, one staff member told us they would complete plans with young people, and that phone calls to parents would sometimes take place to discuss the service and appointments which were available.

Good

Are services responsive to people's needs?

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

Summary of findings

Are child and adolescent mental health services responsive to people's needs?

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

Referrals to the service were prioritised on the basis of clinical need. Different care pathways were in place to help ensure the needs of children and young people were met.

Outpatient facilities were limited and there was concern about the appropriateness of some of the environments used to meet with children, young people and parents/carers. Office space was limited for staff to work.

The service carried out much of its work by working within the community. This meant the service was better able to be flexible and provide a more holistic assessment by seeing children and young people in different settings.

The NDCAMH service had demonstrated the innovative use of the techonology which was available in order to communicate effectively with people with different levels of hearing loss.

Complaints processes were in place and steps had been taken to make children, young people and their parents/carers aware of this. Staff were able to give examples of changes which had been made as a result of feedback the service had received.

Our findings

Access, discharge and bed management

Referrals to the mainstream CAMHS service were prioritised on the basis of clinical need. This prioritisation was carried out by clinical members of the team. Different care pathways were in place to ensure that appropriate services and responses were available. For example, there was a specific pathway for children who were looked after by the local authority. A pathway for children/young people suspected of having an autistic spectrum disorder, and a pathway directly to tier 3 services for children/young people who had self-harmed. Urgent appointments were available if this was clinically necessary.

The community CAMHS service only operated during office hours. However, emergency cover for children/young people who may be need of help was provided by means of the on-call psychiatry service which was available via the Accident and Emergency Department.

Referrals to the NDCAMH service were managed by the service itself. Staff told us they were usually able to respond quickly to incoming referrals. An assessment process was in place with regards to the NDCAMH service; initial assessments were predominantly carried out by a service team leader, a member of staff who was deaf and an interpreter. This combination was to ensure that a thorough clinical assessment was undertaken whilst ensuring deaf culture, identity and values were being taken in to account.

Having concluded the initial assessment, the assessment would be discussed within the NDCAMH service's staff meeting where decisions would be made regarding what type of ongoing support may be needed, and which care pathway would be most appropriate for the child/young person.

The ward environment optimises recovery, comfort and dignity

We found the service had limited space in which to work. Whilst the outpatient area was clean and tidy, clinic and therapy rooms were small. Both managers and staff told us that owing to restricted therapy space part of the service would often have to use staff offices as a place to meet with both young people and their families. Both staff and some managers felt these arrangements were not appropriate because some of the rooms were too close to each other and there was a concern that people outside of the offices may hear what was being discussed in a therapy session. In addition, some staff raised a concern that these arrangements meant children/young people would sometimes be required to enter a working environment which, for those who had difficulties with interacting with people, could be stressful.

Comments were made regarding the outpatient building from some parents. One parent described the outpatient environment as being "drab" and "unwelcoming" whilst it

Good

Are services responsive to people's needs?

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

was a different parent's view that the environment was "unwelcoming, dreary and worn". Some staff had similar concerns about the outpatient building. One staff member, for instance, was of the view that the outpatient facility needed to be more child friendly and felt the rooms were "too small" for clinical sessions to take place.

Meeting the needs of all people who use the service

The service worked with children, young people and their families in a range of different environments and settings such as in their homes, schools, and outpatient department. This flexibility meant children's, young people's and parent's individual needs and circumstances could be taken in to account, and also enabled a more holistic assessment of the child/young person to take place.

Staff told us about how they would signpost families to more appropriate agencies if they were unable to assist, and that they would try to be as flexible as possible in terms of appointment dates and times offered.

Interpreters were available to the service for working with children, young people and their parents when their first language was not English.

We saw how the NDCAMH service ensured it delivered care and interventions with people whose first language was sign language. The service gave families a choice of receiving information in a variety of formats such as written English or by means of a personalised recording on a DVD which would be posted out for the family to see.

We found that although the NDCAMH service had been innovative in the use of technology, the trust's IT systems were not always supportive of this. For instance, staff explained to us that the patient database system, where all communications and information about patients should be kept, did not have a facility to store communications sent to people in a sign language format. This meant the service had to save copies of these recordings outside of the main database system. In addition, staff reported some other limitations with the technology they used. For example, staff said the speed of some of the computers they were required to use was not always appropriate for when staff were trying to record video messages to families, and the data allowances on staff phones which were needed to communicate with families by means of Skype and Facetime were at times insufficient.

Listening to and learning from concerns and complaints

A complaints process was in place. Staff were aware of the complaints process and said that if they were aware of any concerns they would attempt to immediately respond to them. Staff explained to us about how they would ensure families were made aware of how to make a complaint. This included giving verbal advice and making complaints leaflets available. We saw information was available in the reception area regarding how to make a complaint, and how to give feedback. Staff were able to give us examples of complaints which had been received and changes which had been made in response to these.

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.

Summary of findings

Are child and adolescent mental health services well-led?

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.

There was evidence that practice took place in a way which was consistent with the trust's values and strategic objectives. Lines of accountability and management were in place and staff were aware of their responsibilities.

Staff received supervision and annual appraisals. There was evidence that where necessary performance management systems were exercised. Managers recognised where their services needed improvement.

Whilst staff spoke of feeling supported in their work, some staff spoke of feeling under increased stress because of increased referrals and changes in systems, such as the move to an electronic recording system.

We saw evidence of particularly good practice with how the NDCAMH service made use of technology to work with people who have a hearing difficulty or are deaf.

Our findings

Vision and values

The trust had in place both strategic objectives and core values. There was evidence of these having been circulated and disseminated to staff. The views of staff reflected the organisation's direction and values. For example, staff were keen to ensure they were able to provide excellent care, and that the care provided was to achieve the personalised goals of individuals. Practices adopted by the service was seen to be in keeping with the trust's vision and values. For instance, the service strove to work in line with best practice guidance and research findings; the service demonstrated a commitment to ensure staff were professionally developed and that their work took place by working in partnership with others.

Good governance

Line management structures were in place; staff were aware of their responsibilities and their lines of accountability. A range of staff were in place with different levels of knowledge and experience in order to provide leadership to the service. Administrative staff had been employed in order to provide business support to the core clinical work.

Supervision and appraisal systems were in place; there were policies and processes in relation staff development and performance management. There was evidence that performance management had been implemented, when deemed necessary, by managers of the service.

Managers of the service had an awareness and understanding of the services they were responsible for; managers similarly were able to identify where improvements could be made.

Leadership, morale and staff engagement

Staff we spoke with described feeling well supported by their managers. One staff member, for example, described this support as being "really good" whilst a different staff member said their line management was both "supportive and understanding". Whilst staff enjoyed their jobs, some staff spoke to us about increased levels of stress within the service because of increased demands being placed upon them. Such demands, reported by staff, included increased referral numbers and the shift towards electronic recording.

Several staff spoke of how they supported each other. Staff reported feeling particularly supported in relation to safeguarding matters. Staff also reported that managers were both visible within the service and easily accessible.

Commitment to quality improvement and innovation

The service demonstrated a commitment to improving both practice and service delivery. For example, the service used a range of clinical tools which could be used to audit the effectiveness of an intervention; such tools included the Strengths and Difficulties Questionnaire (SDQ), Children's Global Assessment Scale (CGAS) and Health of

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the Nation Outcome Scale for Children and Adolescents (HONOSCA). Discussions took place within the service to reflect upon situations so that future practice and service delivery could be improved.

We were particularly impressed by the work carried out by the NDCAMH service in order to be innovative and improving practice. For example, staff from the service outlined how they had made amendments to some of the national clinical assessment tools because without these amendments they would not have been appropriate to use with children and young people who are deaf. Recognising these changes were necessary was extremely important as it meant deaf children/young people were less likely to be misdiagnosed and inappropriate interventions prevented.

We saw how the NDCAMH service made excellent use of technology in order to ensure they were able to communicate effectively and efficiently with people who are deaf. For example, staff, using sign language, could record themselves signing to a computer and this recording would then be burnt to disc and posted to the young person and their parents for them to see. The use of such technology to ensure signed language, as opposed to written language, was readily available was in our view commendable. Staff in the NDCAMH service also spoke to us about how they used different phone applications, such as Skype and Facetime, so that they could effectively communicate with people whose first language was sign language.