

Pennine Care NHS Foundation Trust

# Specialist community mental health services for children and young people

## Quality Report

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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RT210	Heathfield House	Healthy Young Minds Bury	BL9 7TD
RT210	Heathfield House	Healthy Young Minds Oldham	OL1 2JH
RT210	Heathfield House	Healthy Young Minds Trafford	M33 7ZF

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

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

Where applicable, we have reported on each core service provided by Pennine Care NHS Trust and these are brought together to inform our overall judgement of Pennine Care NHS Trust.

# Summary of findings

## Ratings

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

### Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Good 

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated specialist community mental health services for children and young as **GOOD** because:

- Staff managed patient's risks. There was a proactive approach to managing patients on waiting lists. This meant staff were able to identify changes in risk and prioritise urgent cases.
- There were processes in place to support safeguarding and the management of patients at risk. There were good links with local safeguarding bodies.
- Patients had access to a range of psychological therapies in line with National Institute for Health and Care Excellence guidance.
- There was a multidisciplinary approach to the delivery of care. Staff groups worked together to meet the needs of patients.
- Patients and parents were involved in decisions about their care and treatment. Feedback from patients was positive. We observed patients being treated in a respectful manner and with a caring and empathetic approach.
- Patients and parents were able to give feedback on the care they had received and input into decisions about the service.

- There were processes in place to manage adverse incidents and complaints. There was evidence that learning from incidents and complaints were shared across the service.

However

- Not all staff were receiving regular managerial supervision. The service did not collate information on compliance with supervision. This meant that the service could not be assured that staff were supported in their role.
- There were waiting lists in place in two teams. Some patients had not been seen within the 12 week to assessment and 18 week to commencement of treatment targets.
- Whilst morale in the Bury and Oldham Healthy Young Minds teams was good. Staff told us that morale at Trafford Healthy Young Minds was mixed. The Trafford team was going through a process of organisational change. Some staff told us they did not feel engaged with the trust or with the change process.

# Summary of findings

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

### Are services safe?

We rated specialist community mental health services for children and young as **GOOD** for safe because:

- Staff were assessing and managing patient risk.
- Staff caseloads were within guidance levels as stipulated by the Royal College of Psychiatrists.
- There was a proactive approach to managing waiting lists and prioritising individuals based on risk.
- Compliance with mandatory training was good.
- There was a policy in place to support lone working. Staff understood the policy and were using it in practice.
- Staff were knowledgeable around safeguarding and understood trust policies and procedures in this regard. There were good links with local safeguarding bodies.
- There was a process in place to report adverse incidents. Staff knew how to report incidents and there was a process to launch a formal investigation where required. There was evidence of learning from incidents.

However

- There was inconsistency in the documentation used to assess and review risk. Not all teams were regularly using the trust approved risk assessment document.

Good



### Are services effective?

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

- Patients had access to a range of psychological therapies in line with guidance from the National Institute for Health and Care Excellence. Therapy sessions were provided in both group and 1:1 formats.
- Teams included a range of mental health disciplines and there was effective multidisciplinary working embedded in practice.
- Staff used outcome measures to rate severity and monitor patient progress. These were reviewed regularly.
- Staff had access to specialist training to further develop their skills and offer a wider range of treatment options to patients.

However

- Supervision of staff was not occurring regularly in all teams. There was no central recording of supervision to monitor compliance.

Good



# Summary of findings

## Are services caring?

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

- The feedback we received from patients and parents was positive.
- People who used services told us they were actively involved in decisions about their care and treatment.
- Staff treated patients with kindness, dignity, respect and compassion.
- There was access to support for parents and carers of people who used services.
- Patients had the opportunity to give feedback on the service they received.
- Patients were involved in decision making about the service.

Good



## Are services responsive to people's needs?

We rated specialist community mental health services for children and young as **REQUIRES IMPROVEMENT** for responsive because:

- There were waiting lists in place for patients in the Bury and Trafford Healthy Young Minds teams.
- Some patients had been longer than the 12 week target for assessment and the 18 week target for commencement of treatment.
- There were issues with data collection around waiting lists and waiting times.

However

- There were processes in place to prioritise referrals and respond to urgent referrals.
- There was access to translation services including face to face, telephone and document translation.
- There was a process in place to manage complaints. Staff were aware of the policy supporting the complaints process.

Requires improvement



## Are services well-led?

We rated specialist community mental health services for children and young as **GOOD** for well-led because:

- There were regular governance meetings within the service to discuss and review performance. Monthly performance reports were produced for each team on a monthly basis.
- There was strong team working and mutual support between staff.
- Staff felt able to raise concerns and were aware of the whistleblowing policy.

Good



# Summary of findings

- There was monitoring of compliance with mandatory training.
- The service had a risk register in place and teams had business continuity plans.

However

- Morale at Bury and Oldham Healthy Young Minds teams was good. However morale at Trafford Healthy Young Minds was mixed. Staff attributed this to a period of change and continued uncertainty about the team's future and structure. Some staff did not feel like they were part of the trust and believed changes were being imposed on the team without consultation.

# Summary of findings

## Information about the service

Pennine Care NHS Trust provided specialist community mental health services for children and adolescents across Bury, Oldham, Rochdale, Stockport, Trafford and Tameside and Glossop. Over the previous 12 months the service had engaged with stakeholders and renamed the services Healthy Young Minds. A specialist website had also been created for the services.

The services provided assessment and treatment for a range of mental health illnesses. Care pathways included self-harm, depression, attention deficit disorder, eating disorders, psychosis and autism.

As part of our inspection we visited:

Bury Healthy Young Minds

Oldham Healthy Young Minds

Trafford Healthy Young Minds

Specialist community mental health services for children and young people had not previously been inspected by the Care Quality Commission.

## Our inspection team

Our inspection team was led by:

Chair: Aiden Thomas, Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Sharron Haworth, Inspection Manager, Care Quality Commission

The team that inspected specialist community mental health services for children and young people was comprised of five CQC inspectors and three specialist advisors. The specialist advisors were a psychotherapist, a nurse and an occupational therapist who work in specialist community mental health services for children and young people.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

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

- spoke with the manager of each team
- spoke with 28 other staff members including operational managers, consultant psychiatrists, nurses, support workers, psychologists and administrative staff



# Summary of findings

- spoke with 10 young people using the service and 11 carers
- attended and observed two multidisciplinary meetings, reviewing referrals and ongoing care
- attended and observed one assessment appointment and two 1:1 follow up appointments
- attended and observed two inpatient liaison visits
- attended and observed one group reflective practice session and one staff consultation clinic where cases were discussed
- attended and observed a fostering attachment group
- looked at 26 care records of young people
- looked at a range of policies, procedures and other documents relating to the running of the service

## What people who use the provider's services say

During the inspection we spoke with 10 patients and 11 parents and carers. We also observed five clinical engagements including assessment appointments, review meetings and ward liaison visits. Feedback from patients who used the services was positive. Patients considered staff to be caring and supportive. Patients and parents were involved in decisions about their care and

treatment. One parent raised concern over the length of time it had taken to access the service. However, they also stated that once they were engaged with the service the care had been very good.

Our observations of staff interaction with patients were good. Staff engaged with individuals in a respectful manner and provided space for them to express their opinions.

## Good practice

## Areas for improvement

### Action the provider MUST take to improve

#### Action the provider MUST take to improve

- The trust must ensure they reduce waiting times and waiting lists in the Bury and Trafford Healthy Young Minds teams.

### Action the provider SHOULD take to improve

#### Action the provider SHOULD take to improve

- The trust should ensure consistent use of the trust approved risk assessment tool and review sheet across services.

- The trust should ensure that all staff receive clinical supervision and that this is accurately recorded
- The trust should ensure staff at Trafford Healthy Young Minds receive managerial supervision in line with trust policy.
- The trust should ensure that there is effective communication and consultation with staff around changes to the Trafford Healthy Young Minds team.

## Pennine Care NHS Foundation 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
Healthy Young Minds Bury	Trust Headquarters
Healthy Young Minds Oldham	Trust Headquarters
Healthy Young Minds Trafford	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.

Training on the Mental Health Act was not mandatory for staff in the child and adolescent mental health community services. However, staff had received training and across the three teams we visited the average compliance was 86%. Staff displayed a good knowledge of the Mental

Health Act and the Code of Practice. They were able to access support from a central Mental Health Act team. Briefing sheets on the Mental Health Act and Code of Practice were available for staff and there was a trust policy in place.

Staff told us that the Mental Health Act was rarely used within the community teams. At the time of our visit there were no individuals on community treatment orders.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training on the Mental Capacity Act and the use of Gillick competence assessments. Data provided by the trust showed that across the three teams we visited the average compliance with training was 86%.

Staff showed a good understanding of the needs to assess capacity and understanding. They were able to access advice from a central trust team if they required it. We saw evidence within care records that capacity was considered at assessment.

# 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

The buildings we visited were clean and well maintained. Cleaning records we reviewed showed that premises were cleaned regularly. Cleaning materials were stored in locked cupboards and control of substances hazardous to health assessments were in place. General office equipment was well maintained. Portable appliance testing had been carried out on all relevant equipment.

Buildings had secure entry and exit procedures. Reception staff managed a signing in and out system for visitors and staff. Fire safety measures were in place and equipment had been tested. At Trafford Healthy Young Minds an audit had shown that the documentation for fire alarm tests had not been sent by the building provider. This was being addressed by the Head of Estates. Environmental risk assessments were in place and up to date.

Clinic rooms we checked were equipped with the necessary equipment to carry out examinations as required. Equipment was well maintained and checked regularly. However we found one set of weighing scales at Oldham Healthy Young Minds that were a month overdue for an annual maintenance check. This was raised with the manager who confirmed they would address the issue.

Staff showed an awareness of infection control. Staff received infection control training as part of the mandatory training programme. Posters advising on proper hand washing techniques were on display in toilets.

### Safe staffing

The trust provided the following staffing establishments for the teams that we visited:

#### Bury Healthy Young Minds

- consultant psychiatrist – 2
- clinical psychologists – 2
- psychotherapist – 0.5
- mental health practitioners – 7
- allied health professionals – 0.2
- support workers – 1
- social workers – 1
- operational manager – 1

- administrative support – 5

The Bury Healthy Young Minds team had vacancies for one band seven neurodevelopmental lead and one band five nurse. The team had also received funding from the local transformation programme to recruit to a band seven single point of access lead and a band six link worker.

Data provided by the trust showed that in the last three months Bury Healthy Young Minds had used bank or agency staff to fill 70 shifts. There had been no shifts that had not been filled. There had been two substantive staff leave the service in the previous 12 months. The sickness rate for that period was 2.6% which was below the England average.

#### Oldham Healthy Young Minds

- consultant psychiatrist – 3
- clinical psychologists – 5
- psychotherapist – 0.5
- mental health practitioners – 16
- social workers – 1
- operational manager – 1
- administrative support – 6

The Oldham Healthy Young Minds team had vacancies for one band four administrator and one band three administrator. Data provided by the trust showed that in the last three months the Oldham Healthy Young Minds team had not used bank or agency staff to fill shifts. However, during our visit the operational manager and team lead confirmed that there were two clinical agency staff working in the team. They were a cognitive behavioural therapist and a mental health practitioner in the initial assessment team. There had been four substantive staff leave the service in the previous 12 months. The sickness rate for that period was 4.8%

#### Trafford Healthy Young Minds

- operations manager - 1
- team leader - 1
- consultant psychiatrist – 2.8
- clinical psychologist – 6.6
- psychological therapist - 8
- specialist mental health practitioner (Youth offender services link worker) - 1

# Are services safe?

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

- mental health practitioners - 3
- assistant psychologist – 2
- family support worker – 1.5
- family therapist – 0.6
- play therapist - 0.6
- primary mental health workers - 2.8
- senior primary mental health workers - 8
- administrative support – 4

Trafford Healthy Young Minds team had vacancies for one band two receptionist, a 0.5 whole time equivalent band six 'front door' practitioner and a one band six mental health practitioner.

Data provided by the trust showed that in the last three months Trafford Healthy Young Minds had used bank or agency staff to fill 41 shifts. There had been 20 shifts that had not been filled. There had been 15 substantive staff leave the service in the previous 12 months. The sickness rate for that period was 5.1%.

Teams had developed their staffing establishment in different ways. In Bury Healthy Young Minds the operational manager told us that staffing levels were historical. However, there were plans to carry out a skills analysis as part of the service development plan. This would then inform the future staffing establishment. In Oldham Healthy Young Minds the staffing establishment had been identified following a service redesign carried out in collaboration with clinical commissioning groups. Trafford Healthy Young Minds had inherited the existing staffing establishment. The trust was in the process of implementing a choice and partnership capacity and demand approach. The choice and partnership approach is a clinical system that has been implemented within the United Kingdom, New Zealand and Australia. The model aims to bring together the active involvement of patients and their families whilst applying demand and capacity concepts to help improve the throughput of patients and promote discharge. The staffing establishment and skill mix was being changed to support the implementation of this model.

Caseloads within teams were within the guidance levels stipulated by the Royal College of Psychiatrists. The Royal College of Psychiatrists recommend a maximum case load of 40. Data provided by the trust showed that the average

caseload in Bury Healthy Young Minds was 30. In Oldham Healthy Young Minds the average caseload was 35. In Trafford Healthy Young Minds the average caseload was between 30 and 40.

Teams had access to psychiatrists within their structure. There were consultant slots that staff could book for urgent cases. Staff told us that doctors were responsive and that they did not have problems accessing them including in an emergency.

There was a mandatory training programme in place for staff. Staff told us mandatory training was delivered in both e-learning and face to face formats. Attendance at required training was monitored through electronic systems and supervision. Staff compliance with mandatory training was good. Overall compliance for the three teams was:

Bury Healthy Young Minds – 87%

Oldham Healthy Young Minds – 90%

Trafford Healthy Young Minds – 83%

Within Bury Healthy Young Minds there were three courses where compliance fell below 75% compliance. They were,

- level two conflict resolution (62% compliant with eight out of 13 staff having completed the course);
- paediatric life support (57% with four out of seven staff having completed the course)
- level two infection control (50% with two out of four staff having completed the course).

Within Oldham Healthy Young Minds there were two courses that fell below 75% compliance. They were,

- level two conflict resolution (40% with six out of 15 staff having completed the course)
- basic life support (36% with five out of 14 staff having completed the course).

A breakdown of compliance against each course was not provided for Trafford Healthy Young Minds.

## Assessing and managing risk to patients and staff

The service used the trust approved risk assessment tool to assess risk to patients. We reviewed 26 care records. We found that seven did not have a risk assessment in place. However, there was evidence within those care records that risk had been assessed and was being managed. Completed assessments were generally comprehensive

# Are services safe?

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

and of a good standard. There was evidence that risk was reviewed and of actions being taken when risk changed. There was a trust approved risk assessment review sheet to record changes although this was not evident in all records. An overview of risk and associated actions were recorded in letters sent to the young person and family, GPs and relevant stakeholders.

We saw evidence of crisis plans within notes. They included details of crisis and out of hours services and other support agencies. In Trafford Healthy Young Minds the letter sent to the young person and family contained the name of the assessing practitioner as a crisis contact during working hours.

Staff proactively engaged with patients on waiting lists. In Bury Healthy Young Minds staff were ringing individuals on the waiting list on a weekly basis. There were reviews of patient risk and where appropriate individuals were prioritised or referred to other services. In Trafford Healthy Young Minds a review of the waiting list had been carried out in February. Individuals were reviewed to assess if treatment was still required or if there were alternative services that could be appropriate. Where this was the case referrals were made. The review included staff contacting the individual via telephone to discuss care options with them. Waiting lists continued to be reviewed on a weekly basis. Patients on the waiting list were contacted by staff. This enabled staff to reassess patients risk levels. There was an escalation process in place in the event that a patients risk or need had increased. There was an on-call consultant psychiatrist and consultant psychologist to respond to urgent concerns.

Safeguarding training was part of the trusts mandatory training programme. Staff received training in safeguarding both vulnerable adults and children. In Bury Healthy Young Minds staff were 88% compliant with level one child safeguarding training (14 out of 16 staff). They were 67% compliant with level two child safeguarding training (six out of nine staff) and 80% compliant with level three child safeguarding training (eight out of 10 staff).

In Oldham Healthy Young Minds staff were fully compliant with level one child safeguarding training (33 staff). They were 83% compliant with level two child safeguarding training (15 out of 18 staff) and 84% compliant with level three child safeguarding training (16 out of 19 staff). A breakdown of compliance for the Trafford Healthy Young Minds team was not provided.

Staff we spoke to demonstrated a good understanding of safeguarding and how to identify concerns. Staff were knowledgeable on the process for raising safeguarding alerts and knew how to access advice when it was required. There were good links with the trust safeguarding team and local authorities. We saw evidence of safeguarding being managed in case notes. This included the safeguarding of a young person whose parents were heavy drinkers.

There was a lone working policy in place and each team were following local protocols. These included the use of a buddy system, phoning in to admin staff or the duty worker and the sharing of diaries. Where risk assessments detailed the need staff visited people in pairs. Staff we spoke to were aware of lone working practices.

## Track record on safety

Between January 2015 and December 2015 the community child and adolescent services reported four serious incidents requiring investigation. There were two serious incidents requiring investigation reported by the teams we visited. These were:

- attempted suicide reported by Bury Healthy Young Minds
- suspected suicide reported by Trafford Healthy Young Minds

We reviewed two investigation reports including the report into the attempted suicide at Bury Healthy Young Minds. Investigations were comprehensive and detailed contributory factors, lessons learnt and areas of good practice. There was evidence of involvement of families and carers and of the support provided to family and staff following the incident. Investigations had actions plans in place which were written using specific, measurable, achievable, relevant and timely criteria. There was evidence that actions had been completed.

A policy was in place to support the investigation of incidents. Some staff we spoke to had received training to undertake incident investigations.

## Reporting incidents and learning from when things go wrong

Staff reported incidents using an online electronic recording system. Staff understood the reporting process and were aware of what to report. Across the child and adolescent mental health services a total of 106 incidents had been reported in the previous six months.

## Are services safe?

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

Incidents were reviewed by local team managers and by senior managers within the service. Staff received feedback through team meetings and supervision. We reviewed minutes of team meetings which showed learning from incidents was being shared. The trust had also introduced a seven minute briefing. The seven minute briefing was circulated around all teams following the investigation of a serious incident in order to share and promote learning.

Staff we spoke to showed an understanding of Duty of Candour. Duty of Candour is a statutory requirement that ensures services are open and transparent with patients and carers. This includes informing patients about adverse incidents related to their care and treatment, providing support and offering an apology.

# 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

We looked at 26 care records across the three teams we visited. Each record had an assessment in place which had been completed in a timely manner. Assessments were completed using the trust's patient assessment document. Assessments were comprehensive and covered mental health and psychological factors, physical health and social and school needs.

The service did not use a separate care plan document. Care plans were captured within notes and in letters that were sent to patients and parents. We were unable to locate evidence of a care plan in two of the records we reviewed. Of the 24 care plans we reviewed 19 were personalised, holistic and recovery orientated. We found three care plans that were beyond their planned review date.

Records were stored in paper and electronic form. The trust was rolling out the PARIS electronic care records system to community child and adolescent mental health teams. However, in Trafford Healthy Young Minds commissioners had requested that the team use the EMIS electronic records system. Paper based records were stored securely in lockable cabinets. Electronic records were password protected. This meant that records were stored securely and that information and data was protected.

### Best practice in treatment and care

The service had designed care pathways in line with National Institute for Health and Care Excellence guidance. The trust circulated information on guidance and any updates via email. Guidance was discussed in both local team meetings and the service wide governance forum.

Patients were able to access a range of psychological therapies across the services. This included cognitive behavioural therapy, dialectical behavioural therapy, family therapy, mindfulness and counselling. Bury Healthy Young Minds did not have family therapist at the time of the inspection. However they were able to bring in sessions from family therapists based at other teams when it was required.

Staff completed physical health assessments as part of the assessment process where appropriate. There was a physical health section of the patient assessment document that was completed. Of the 26 care records we

reviewed, 25 had an assessment completed and one did not. Physical health care assessments that were in place had been reviewed. There was evidence of ongoing monitoring of patients physical health. This was carried out in partnership with GPs. There was a shared care protocol in place to support this. In Trafford Healthy Young Minds shared care arrangements had been agreed with the greater Manchester medication group. Records evidenced regular communication with GPs as well as other relevant stakeholders such as school nurses, dieticians and paediatricians. Staff completed regular physical health checks where required. For example patients with an eating disorder received regular weight checks. These were recorded in notes.

Services used a range of outcome measures. These included the review children anxiety and depression scale, strength and difficulties questionnaires, social developmental history questionnaires, session rating scales and mood and feeling questionnaires. These scales help to track a patients progress and monitor their improvement. We saw examples of these outcomes measures being used in appointments and recorded in case notes.

### Skilled staff to deliver care

Staffing establishments varied according to each service and included psychiatrists, psychologists, therapists, mental health practitioners, support workers and social workers.

Staff were appropriately skilled for their role. The trust had a corporate induction which new staff attended. Staff also received a local induction within their team. We spoke to one new staff member who had shadowed existing staff and completed an induction checklist as part of their local induction.

Staff had completed a number of additional training courses to assist them with their roles. The course included cognitive and dialectical behavioural therapy interventions, family therapy interventions, interpersonal therapy interventions and motivational interviewing. There were three staff trained in the autism diagnostic observation schedule in Bury Healthy Young Minds. There was one staff member booked on to attend. There were five staff trained in the autism diagnostic observation schedule in Oldham



# 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.

Healthy Young Minds. There were three staff members booked on to attend. There were five staff trained in the autism diagnostic observation schedule in Trafford Healthy Young Minds.

The trust had a policy in place to support both clinical and managerial supervision. Teams had supervision structures in place. However the trust told us that the service did not routinely collate compliance against supervision.

Staff at Oldham and Bury Healthy Young Minds told us they received regular supervision. We reviewed six staff files and found that management supervision was occurring.

Staff at Trafford Healthy Young Minds told us they did not receive regular management supervision. We reviewed 10 staff files and found that only four had evidence of managerial supervision occurring outside of an annual appraisal. This meant that six staff had not received the minimum of three supervision sessions a year. The trust Management and Individual Performance and Development Review policy states that staff should receive individual managerial supervision every four to six weeks. At a minimum individual supervision should occur at least three times a year. This can include an annual appraisal known as an Individual performance and development review. Compliance with annual appraisals is included below. This meant that trust policy was not being followed.

Clinical supervision was delivered in a variety of formats including group and 1:1 sessions. We saw evidence of clinical supervision in some of the care records we reviewed but this was not consistent. Each team had a weekly forum for supervision and personal development. In Bury Healthy Young Minds there was a weekly session with doctors and psychologists where staff could book slots to discuss cases. In Oldham Healthy Young Minds there was a weekly therapeutic panel where staff could take cases for discussion. In Trafford Healthy Young Minds there was a weekly consultation clinic. This provided an opportunity for staff to discuss cases and receive clinical supervision within a multidisciplinary setting.

The service provided data on the number of staff who had received an annual appraisal in the last 12 months. In Bury Healthy Young Minds 59% of staff (10 out of 17) had been appraised. In Oldham Healthy Young Minds 76% of staff (25 out of 33) had been appraised. In Trafford Healthy Young Minds 88% of staff (30 out of 34) had been appraised.

There was a trust policy in place to manage poor staff performance and disciplinary issues. Team managers were able to access support from the trust's human resources team when required.

## **Multi-disciplinary and inter-agency team work**

Teams operated within a multidisciplinary framework and we observed a collaborative approach to care and treatment.

There were good links with other teams and services within the trust. These include links with inpatient units, adult services and crisis services. We observed a ward liaison visit in Oldham Healthy Young Minds. The visit was well structured and showed a good working relationship between ward staff and community teams. There were protocols in place to support the transfer of individuals into adult services.

There were good links with primary care, social services and other external providers. These included schools, school nurses, GP surgeries and third sector agencies such as Streetwise. Staff we spoke to told us there were good links with external agencies. Within Oldham Healthy Young Minds there was a project to develop a multiagency single point of access.

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

Training on the Mental Health Act was not mandatory for staff in the child and adolescent mental health community services. However, staff had received training. Data provided by the trust showed that in Bury Healthy Young Minds 73% of staff had completed training. In Oldham Healthy Young Minds 86% of staff had received training. In Trafford Healthy Young Minds 100% of staff had received training. In Bury Healthy Young Minds we saw examples of briefing sheets on the Mental Health Act that had been circulated.

Nursing and therapy staff we spoke to demonstrated a basic understanding of the Mental Health Act. Doctors that we spoke to had a more in-depth understanding. Staff told us that the Mental Health Act was rarely used in relation to children and adolescents using community services and was more applicable to individuals in tier four inpatient services.

Staff were able to seek advice from doctors within their team and also from the trust's central Mental Health Act team. We saw an example in Oldham Healthy Young Minds

# 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.

where the doctor had been required to detain a patient under the Mental Health Act on the paediatric ward during out of hours. At the time there were no child and adolescent mental health inpatient beds available. As a result the patient temporarily fell under the responsibility of the community service. Staff were supported by Mental Health Act administrators and inpatient staff to support the patient until a bed became available.

Patients had access to independent mental health advocacy services. These were advertised within team buildings.

## **Good practice in applying the Mental Capacity Act**

The Mental Capacity Act does not apply to children and adolescents under the age of 16. For individuals under the age of 16 the Gillick competence assessment is used to determine capacity and decision making ability. Gillick competence recognises that some individuals under the age of 16 have a sufficient level of maturity and

understanding to make some decisions themselves. Staff considered whether or not an individual had capacity and a sufficient level of understanding during assessment. We saw examples in clinical records where consideration of capacity had been recorded. Formal assessments were carried out by doctors where required.

Data provided by the trust showed that in Bury Healthy Young Minds 73% of staff had completed training around Gillick competence. In Oldham Healthy Young Minds 86% of staff had received training. In Trafford Healthy Young Minds 100% of staff had received training.

Staff were able to seek guidance around capacity and Gillick competence from doctors within the team and also from a central trust team. There were policies in place to support staff. We saw guidance on Gillick competence that had been circulated to staff in Bury and Oldham Healthy Young Minds.

# Are services caring?

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

## Our findings

### Kindness, dignity, respect and support

We observed five consultations and a therapy session. We also observed interactions between staff and young people on site. Patients were treated with compassion and understanding. Staff engaged with individuals in a respectful and dignified manner. Staff displayed good listening skills and discussed options in a clear manner. Patients and carers were encouraged to voice their opinion and given space to do so. Interactions were positive and recovery focused. Staff showed a good understanding of individual need and were person centred in their approach.

We spoke to 10 young people using the service and 11 parents and carers. Overall feedback on the service was positive. Staff were considered to be caring and responsive. One young person told us it was the best service they had been in. Several parents commented positively on the service their children were receiving. They also told us that staff were able to answer questions they or their child may have, for instance around treatment options.

### The involvement of people in the care that they receive

Patients and carers told us that they were involved in decisions about their care. However it was not always possible to evidence this within care plans. Care plans were not captured on a separate document and details were recorded in letters sent to the patient and where appropriate parents. All the young people and carers we spoke with stated that they had been involved in decisions about their care. They told us they were encouraged to voice their opinion and felt that they were listened too. We observed five clinical consultations. In each session patients and family members were given space to talk and the opinions they expressed were reflected by the clinician. There was a collaborative approach to decision making.

We saw appropriate involvement of parents and family members across teams. Support was also available for parents and family members through referral to appropriate services. For example, there were support groups for parents whose children were diagnosed with an

eating disorder or attention deficit hyperactivity disorder. Oldham Healthy Young Minds linked in with a parent's forum called POINT and were in the process of trying to secure funding to help improve the support provided.

Patients were able to get involved in decisions about the service. Patients had been part of a stakeholder group that had agreed to rename services Healthy Young Minds. In Bury there was a patient forum called circle of influence that the service worked with.

Patients and parents were able to give feedback on the service they had received. There were comments boxes available on site and individuals were also able to complete the friends and family test. The trust provided data on the latest results from those surveys.

In Bury Healthy Young Minds 42 individuals had completed the survey between March and May 2016. Of those responses 57% (24 respondents) stated they were extremely likely to recommend the service. Eight respondents (19%) were likely to recommend the service. Only one individual (2%) stated they would be unlikely to recommend the service. There was one individual (2%) who stated they were neither likely or unlikely to recommend the service. Eight respondents (19%) stated they did not know.

In Oldham Healthy Young Minds 126 individuals had completed the survey between March and May 2016. Of those responses 47% (59 respondents) stated they were extremely likely to recommend the service. There were 42 respondents (33%) were likely to recommend the service. Three individuals (3%) stated they would be unlikely or highly unlikely to recommend the service. There were 11 individuals (9%) who stated they were neither likely or unlikely to recommend the service. Eleven respondents (9%) stated they did not know.

In Trafford Healthy Young Minds 5 individuals had completed the survey between March and May 2016. Of those responses 80% (4 respondents) stated they were extremely likely to recommend the service. One respondent (20%) stated they were likely to recommend the service.

# Are services responsive to people's needs?

Requires improvement 

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

## Our findings

### Access and discharge

The trust had targets in place from referral to assessment and from referral to treatment. The referral to assessment target was 12 weeks. The referral to treatment target was 18 weeks.

Data provided by the trust showed that in Bury Healthy Young Minds there were 95 people on the waiting list for assessment. Nineteen of these had been waiting over 12 weeks for assessment. The longest wait was 15 weeks. Figures provided by the trust showed that in May 2016, 96% of referrals were seen within 12 weeks and the average wait was seven weeks. Within the Bury team, workers who carried out the assessment were allocated to the patient. Figures submitted by the trust showed that in May 2016, 88% of patients accessed treatment within 18 weeks of referral. We queried this with the trust. The trust acknowledged there was issues with data collection as clinicians were required to agree a point at which the coding on the recording system changed from assessment to treatment. There was a data summit planned for September 2016 to address this issue and ensure more accurate reporting.

In Trafford Healthy Young Minds data submitted by the trust showed 26 patients awaiting assessment. Two of these patients had waited 14 weeks. No one had waited above 14 weeks. However, during our site visit we reviewed the waiting list at the time. There were 24 people waiting for an assessment appointment at the time. We reviewed seven cases and found each individual had waited over 12 weeks. The longest wait had been 39 weeks. All of the individuals had either been seen recently or were scheduled to be seen within the next fortnight.

Data submitted by the trust for the time between referral and treatment at Trafford Healthy Young Minds showed there were 20 patients waiting more than 18 weeks to commence treatment. The longest wait was 29 weeks. However during our visit we reviewed the allocation list for 20 June. We looked at 11 cases and found that five had waited more than 18 weeks. One patient had received psychiatric input from the service but had been waiting 64 weeks to access individual cognitive behavioural therapy.

Following an initial assessment patients waiting for an intervention from the service were assigned a case coordinator. Case coordinators provided a contact individual for patients and families on the waiting list.

The Trafford Healthy Young Minds team were using a temporary Sharepoint electronic system to manage waiting lists. The system was due to be replaced by the EMIS electronic system.

There were no waiting lists in place within the Oldham Healthy Young Minds team and targets were being met.

Teams responded to urgent referrals quickly. There were duty worker systems in place to ensure that urgent referrals were picked up. Urgent appointment slots were scheduled each day and urgent referrals were seen within 24 hours. In Trafford Healthy Young Minds in addition to a duty worker they had an identified duty consultant.

Teams responded promptly when patients phoned in. Patients and parents that we spoke to told us that staff were responsive and returned calls if they were not available. Duty workers were also available to speak to. Where individuals did not attend appointments staff followed the trust policy. Individuals who repeatedly failed to attend were risk assessed. If there was no identified risk the individual would be discharged from service. Individuals were informed of this in writing and provided with details of how to reengage with the service if they required too. Where there was risk identified then staff engaged in assertive outreach. This included going through other agencies, such as schools and social services to establish contact.

Services were flexible regarding the time and location of appointments. We saw evidence of appointments that were held in the community and of patients being offered home visits where appropriate. We spoke to one patient who had had appointments outside of normal opening hours to meet their need. Oldham Healthy Young Minds had extended opening hours on a Wednesday and Thursday.

### The facilities promote recovery, comfort, dignity and confidentiality

Buildings that patients visited were well maintained, clean and had appropriate furniture. However, at Bury Healthy Young Minds there was a small waiting area. Staff told us that this could get crowded when group sessions were being held. There was a range of information available in

# Are services responsive to people's needs?

Requires improvement 

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

each team. This included information on services, treatments and local support groups. The Oldham and Trafford Healthy Young Minds buildings had artwork by patients on display.

Each team had access to consultation rooms and rooms for group therapy. However, staff at Healthy Young Minds Trafford told us that planning room management was getting more difficult due to increased demands.

## **Meeting the needs of all people who use the service**

Oldham Healthy Young Minds were based in a single storey building and had full disabled access. Bury Health Young Minds were located on the first floor of their building. There was a lift in place to support disabled access. The building where Healthy Young Minds Trafford met patients was based over three floors. There was no lift in place. However, there were ground floor rooms that staff could use to meet patients with mobility issues. Home visits were also considered in such circumstances.

Staff had access to translation services. This included face to face and telephone translation. At the time of the inspection information leaflets were not displayed in other languages. However, staff were able to access services to have documents translated where required. Language needs were identified through referral and assessment information. Staff told us translation services were generally responsive and of a good quality. Information was available in age appropriate formats.

## **Listening to and learning from concerns and complaints**

Data provided by the trust showed that specialist community mental health services for children and young people had received 31 complaints over the last 12 months. Eight of these complaints were upheld. Ten complaints were partially upheld. There was one complaint referred to the parliamentary and health service ombudsman. The complaint was not upheld.

Information on how to complain was on display in team buildings that we visited. However not all of the patients and carers that we spoke to were aware of how to raise a formal complaint. Those that did not know the formal complaints process stated they would be comfortable raising their concerns with staff. All of the patients and carers we spoke with felt confident that any complaint would be dealt with professionally and taken seriously.

We spoke with one parent who had previously raised a complaint with the Bury Healthy Young Minds team. They told us the complaint had been managed appropriately and that they were happy with the outcome.

Staff we spoke to were aware of the complaints process and how to escalate a formal complaint. Learning from complaints was disseminated through team meetings and supervision.

# Are services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Our findings

### Vision and values

The trust's vision was to 'deliver care to patients, people and families in our local communities by working effectively with partners, to help people live well'. The trust also had ten principles of care which had been developed by staff. They were:

- safe and effective services
- meaningful and individualised
- engaging and valuing
- constructive challenge
- governance procedures enable
- focused and specific
- competent skilled workforce
- clear and open communication
- visible leadership
- shared accountability

Staff we spoke to were aware of the trust's vision and values. In Trafford Healthy Young Minds minutes of team meetings were subdivided to represent the trusts values and help embed them.

Staff knew who the senior managers of the trust were. However, staff at Trafford Healthy Young Minds told us that they had had very little contact with senior management at trust level. They had recently been visited by the child and adolescent mental health services directorate manager as part of the ongoing transformation programme.

### Good governance

Services monitored performance through commissioner targets, commissioning for quality and innovation targets and key performance indicators. Managers had access to performance dashboards on the intranet. There were regular governance meetings at team and service level where performance was discussed. Monthly performance reports were produced for each team.

There was a monitoring system in place to ensure that staff received mandatory training. However, compliance with

supervision was not collected centrally. There were systems in place to promote and share learning from adverse incidents. Safeguarding procedures were in place and followed by staff.

In Trafford Healthy Young Minds staff told us that there was a lack of administrative support. This meant that clinical staff were carrying out administrative tasks such as typing letters that impacted upon the time they could spend with patients. A review of administrative support was ongoing.

Teams had business continuity plans in place. In Bury Healthy Young Minds the team had been forced to move out of their building last year due to leaks and flood damage. The business continuity plan was instigated and the service continued to be delivered from other sites until damage to the building was repaired.

There was a service wide risk register in place. Team managers were able to add items to the risk register by escalating their concerns through the governance structure. The building used by Bury Healthy Young Minds had been on the risk register since it was damaged by floods. At the time of the inspection the only item on the risk register related to waiting lists at the Trafford Healthy Young Minds team. The risk register was discussed and reviewed in service governance meetings.

### Leadership, morale and staff engagement

Within the three teams that we visited sickness and absence rates averaged 4.1%.

Staff we spoke to were aware of the trusts whistleblowing and duty of candour procedures. They reported they were able to raise concerns without fear of victimisation.

Morale was varied across the teams we visited. In Bury and Oldham Healthy Young Minds morale was good. However, in Trafford Healthy Young Minds morale was low. There had been 15 substantive staff leave the service in the previous 12 months. The reasons staff gave for low morale was feeling disconnected from the wider trust and the process of change that the team were going through.

Due to commissioning changes Trafford Healthy Young Minds had been managed by three different trusts over the previous four years. Staff felt that since they had joined Pennine Care there had been little contact with senior trust figures and they did not feel connected with the trust. Some staff we spoke to raised concerns that support services such as occupational health were not as effective

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as under their previous trust. There was also concern that the team were due to implement the EMIS electronic recording system. The rest of the trust and the child and adolescent mental health services were rolling out the use of the PARIS. As a result staff were concerned how this would impact patients if they transferred to another service within the trust and records may not be easily accessible. However it had been a commissioner request to utilise EMIS with Trafford as it links in with local GP systems.

The team was going through a process of change. There was a lot of dissatisfaction amongst staff regarding the proposed changes and the way the process was being handled. The trust was looking to implement a choice and partnership model. This included restructuring of staffing levels and the loss of some senior clinical psychology posts to fund lower level psychology roles. Some staff were unhappy that there was going to be a process of competitive interviewing as part of this restructure. Staff were unhappy with the way the changes were being made and what they considered to be a lack of consultation. Consultation had originally been delayed as there had been no operational manager in post. The trust's organisational change policy required an operational manager to be in post as part of the consultation and change transformation process. Staff also told us that scheduled consultation meetings had been cancelled. On the day of our inspection the team was holding a meeting to discuss the changes and to give staff an opportunity to raise concerns. The trust also provided information showing that further consultation events were planned.

Some staff told us that they felt changes were being imposed on them rather than developed collaboratively. Some staff also expressed concern about the new model and its potential impact on safety and risk. However, the choice and partnership model is an acknowledged way of working that is used by other child and adolescent

community teams across the country. Some staff we spoke to were more positive about the new model and felt it needed time to bed in. The team was in the process of fully implementing the model at the time of our inspection.

The Trafford Healthy Young Minds team had also had vacancies at leadership level. There was a team manager in place at the time of the inspection who was on a three month contract. The previous team manager had been on long term sick. This had created further uncertainty for staff.

Despite these issues and concerns staff at the Trafford team continued to work well together and showed a commitment to the delivery of the service. In Bury and Oldham Healthy Young Minds there was also strong team working and mutual support across staff. Staff told us they enjoyed their roles and felt supported. However within the Bury team there had been a dispute between some clinical staff and administrative staff. The issue was being managed through appropriate policies and procedures but some staff were doing their own paperwork rather than utilise the administrative staff.

Staff were aware of whistle blowing procedures and stated that they would feel comfortable raising concerns. There were leadership development courses available for staff. However, staff told us it was difficult to find the time to attend them.

## **Commitment to quality improvement and innovation**

Teams had links with local universities and had been involved in research projects. For example Oldham Healthy Young Minds had been part of a Manchester University research project looking at family therapy based interventions for self harm. The team were also linked in with Manchester University on a research project around the early diagnosis of autism.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care <b>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</b> <b>How the regulation was not being met</b> There were waiting lists in place in Bury and Trafford Healthy Young Minds teams. Some patients were waiting longer than 12 weeks for assessment and longer than 18 weeks for treatment.  This is a breach of regulation 9 (1) (b)