Stepping Stones Clinic Limited

Stepping Stones Clinic

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service provided safe care. Clinical premises where young people were seen were safe and clean. The number of young people on the caseload of the team, and of individual members of staff, was not too high to prevent staff from giving each young person the time they needed. Staff managed waiting lists well to ensure that young people who required urgent support were seen promptly.
- Staff treated young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of young people. They actively involved young people and carers in care decisions.
- In most cases, staff assessed and managed risks to young people and themselves well. When necessary, staff worked with young people and their families to develop crisis plans, this included the use of the service's coping skills app. Staff followed good personal safety protocols. Staff had a good understanding of the safeguarding procedures within the service.
- Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave young people honest information and suitable support.
- Staff developed holistic care plans informed by a comprehensive assessment. Young people and carers told us they were involved in planning their care and treatment. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the young people.
- The team had access to a range of specialists required to meet the needs of the young people. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation. Managers provided an induction programme for new staff.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people. They managed and recorded decisions relating to these well.
- Staff used recognised rating scales to assess and record severity and outcomes. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service. They were approachable for young people and staff. Staff felt respected, supported and valued. They could raise any concerns without fear.
- The service was well led and the governance processes ensured that procedures relating to the work of the service ran smoothly.

However:

- When a new referral was received, there were no formal processes in place for these to be reviewed by a clinician. Administrative staff initially screened all new referrals. There were also no formal processes in place to ensure there was clinical oversight of the signposting of inappropriate new referrals and management of potential risk whilst a young person is awaiting their first appointment. Following the inspection, the service informed us they had implemented a process where a consultant psychiatrist reviewed all new referrals each day.
- In most cases, staff recognised incidents and reported them appropriately. However, we saw examples in a care record where incidents were documented, but were not reported in line with the service policy.
- Risk was generally documented well, however there were instances where risks had not been documented within the specific risk assessment table. This posed a risk that information could be lost and not shared with the young person's GP. One carer told us they had not been informed of the all risk issues that related to their child.
- Whilst all young people had care plans, these were not written from the perspective of a young person and in general the care plan did not have a space to include their views.

Summary of findings

- Most medicines were prescribed in line with national guidance, however, when a medicine was prescribed outside of the national guidance, the rationale was not always documented. We saw 1 example of a young person's medicine being changed without the clinician reviewing the young person.
- The online record system did not always capture a young person's protected characteristics, such as their ethnicity, religion, disability, and sexuality.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist community mental health services for children and young people	Good 	Please see above for summary

Summary of findings

Contents

Summary of this inspection

Background to Stepping Stones Clinic

Stepping Stones Clinic provides mental health care and treatment for children and young people on an out-patient basis.

At the time of inspection, the service had 1202 young people on their active caseload. The service also worked with young people over the age of 18 where needed, to support their transition to adult services. Of those young people open to the service, 134 were aged between 18 and 20.

The service provides assessment and treatment by a range of professionals, such as psychiatrists, psychologists, and psychotherapists.

The service provides care and treatment for young people in London, as well as those from other areas of the UK.

In most cases, the families of young people fund their treatment at the service, or funding is provided by insurance companies. However, the service had recently secured NHS spot purchasing contracts to provide outpatient treatment to young people within 2 areas neighbouring London.

Stepping Stones Clinic is registered to provide treatment of disease, disorder or injury.

There was a registered manager in post at the time of this inspection.

Stepping Stones Clinic was registered with the Care Quality Commission in July 2018 and was previously inspected in August 2019. The service was rated good overall, with the safe domain rated as requires improvement.

The service had 3 requirement notices issued under the safe domain:

- The service must ensure that all information concerning young people is stored in their care and treatment records. This must include results of physical examinations and investigations, the rationale for prescribing medicines and detailed risk management plans for young people. Regulation 17(2)(c)
- The provider must ensure that there is a system which staff who are lone working can use to summon urgent assistance. Regulation 17(2)(b)
- The provider must ensure that 2 professional references are obtained for clinicians contracted to work in the service. Regulation 19(3)(a)

At this inspection the requirement notices were being met.

What people who use the service say

We received feedback from 7 young people and 16 carers. Feedback was very positive. People told us the staff were kind, caring and professional. They told us they felt listened to, and appointments were not rushed. They felt staff were responsive to their needs and were easily contactable between sessions. We were told staff were flexible in being able to offer appointment times that suited their needs. Young people told us the staff made them feel at ease, which helped them being able to open up about their concerns. They told us staff validated their feelings and they did not feel judged.

Summary of this inspection

One carer told us they would have liked more information on the conditions that their child had been diagnosed with. The same carer told us important risk information related to their child was not always shared with them.

How we carried out this inspection

The team that inspected this service consisted of 3 CQC inspectors, an expert by experience and a specialist advisor who had experience working within children and young people's mental health services.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions therefore formed the framework for the areas we looked at during the inspection.

During the inspection visit, the inspection team:

- visited the clinical areas, observing the environment where young people were seen for face to face appointments
- spoke with 7 young people who were using the service and 16 carers. We also reviewed the most recent young people and carer feedback surveys
- spoke with 10 members of staff including, the registered manager, consultant psychiatrists, psychologists, a psychotherapist and an administrator
- reviewed 9 patient care and treatment records
- reviewed information and documents relating to the operation and management of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The service had created an app to support young people with their coping skills. The app had a range of information and support, such as alternative techniques to self-harm, mindfulness exercises, soothing images and audio, guided meditation, and distraction word games.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

Summary of this inspection

- The service should continue to review their referral process to ensure there is a formal process in place for clinicians to review new referrals, to assess the risk of those awaiting their first appointment and to ensure inappropriate new referrals are signposted as required.
- The service should ensure that all staff can confidently report incidents in line with the service's incident management policy.
- The service should ensure that all staff know that risk, including those disclosed in therapy sessions, is documented in the service's designated risk forms. Where applicable, carers should be updated on risk information about their child.
- The service should ensure young people's views are captured within care plans.
- The service should ensure rationales are documented within patient records when medicines are prescribed outside of National Institute for Health and Care Excellence (NICE) guidance and the prescriber's own medicines policy.
- The service should ensure they collect and document information around young people's protected characteristics, such as ethnicity, religion, disability, and sexuality.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Specialist community mental health services for children and young people

Good

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

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean environments

All clinical premises where young people received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Some staff reported it would have been useful to have more rooms to see young people in.

Appointments for this service were carried out in person at the clinic and remotely via teleconferencing facilities.

The service had 4 rooms within the clinic. These rooms were located on the first floor. The number of referrals to the service had increased and some staff reported some difficulties in being able to book rooms at the same time. This concern was on the service's risk register and there were plans in place to move into a nearby location with more space. In the meantime, the service was able to use additional rooms as available on the ground floor.

Clinic rooms had alarms to call for assistance. Clinicians also had work mobile phones to call for assistance if needed.

Whilst the service did not manage the building, they carried out their own health and safety risk assessments to ensure the clinic areas were fit for purpose. This included, cleaning audits, infection prevention and control audits and fire audits.

Staff made sure cleaning records were up-to-date and the premises were clean. They carried out 6 monthly steaming for all of their clinical rooms.

The service carried out an annual fire risk assessment. They tested their fire alarms weekly and had fire drills every 6 months. The service had fire extinguishers, which were in date. The other service operating within the clinic also carried out their own fire risk assessments, which were shared with Stepping Stones Clinic.

Medical equipment was available for staff to use, which included blood pressure machines, weighing scales and a defibrillator. This equipment had been calibrated and portable appliance testing (PAT) was completed. PAT testing ensured the equipment had been tested for electrical safety.

Specialist community mental health services for children and young people

Good

Safe staffing

The service had enough staff who knew the young people and received basic training to keep them safe from avoidable harm. Whilst the number of new referrals had increased, staff told us their caseloads felt manageable.

The service had enough staff to keep young people safe. At the time of inspection, the team consisted of 36 members of staff. The team consisted of psychiatrists, psychologists, psychotherapists, child and adolescent practitioners, assistant psychologists, a practice manager and medical secretaries who were also administrative support. There were no vacancies at the time of inspection.

The medical team and administrative team were permanent members of staff. The therapy team were contracted associate team members working a set amount of hours with the service each week.

Levels of sickness throughout the service were low. If a psychiatrist was on annual leave or sick leave, arrangements were made within the team ensuring urgent queries were managed by those psychiatrists who were at work.

Employment records for staff were complete with all pre-employment checks. This included their signed contract, 2 references, their CV, and indemnity arrangements where needed. Managers carried out regular audits to ensure they had all the relevant information documented.

Where staff had professional registrations such as being a doctor, psychologist or psychotherapist, there was documented evidence they were registered with the relevant regulatory bodies, such as, the General Medical Council (GMC) and the Health and Care Professions Council (HCPC).

Mandatory training

Staff had completed and kept up-to-date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of young people and staff. The service required staff to complete training in 13 areas. This included safeguarding, health and safety, infection prevention and control and equality, diversity and human rights. The service had recently introduced 3 new training courses for all staff. These courses were, conflict resolution, managing complaints and bullying and harassment.

At the time of inspection, 97% of staff had completed yearly resuscitation training.

The staff members were able to access mandatory training through the service, or externally. All staff were required to show training certificates if their training was completed externally.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers and the staff member would be alerted by the online software when a training course was nearing its expiry.

Assessing and managing risk to patients and staff

In most cases, staff assessed and managed risks to young people and themselves well. When necessary, staff worked with young people and their families to develop crisis plans, this included the use of the service's coping skills app. However, 1 carer told us they were not kept up to date when their child disclosed risk

information. Staff followed good personal safety protocols. At the time of inspection, the service did not have a formal process where clinicians reviewed new referrals or had oversight to ensure young people were signposted to the correct service where applicable. Since the inspection the service informed us all referrals were reviewed by a clinician each day.

Assessing and managing patient risk

Young people were assessed by a psychiatrist when they were referred to the service. The psychiatrist assessed the young person's risk and documented this on their clinic letter. The risk assessment from each clinic letter would remain in place and was updated at each review.

Therapy staff did not use a structured notes template. Therapy staff assessed risk and documented it within clinical notes. The service did not have a central live document that all clinical staff updated when a risk incident occurred. In 1 of the records we reviewed we noted a therapist documented an incident of self-harm. A psychiatrist reviewed the young person the following week, however this risk incident was not documented in the consultant letter or risk assessment table. In another 2 records we saw the psychiatrist discussing risk in the main text of the clinic letter, but this was not pulled through to the specific risk assessment table. Instead, the table said 'see below'. There was a possibility that this important risk information could be lost if it was not documented and logged within the designated table. Therapy notes were not routinely shared with other services due to confidentiality. It was therefore important that psychiatry clinical letters held all risk information as this was shared with relevant services, such as the young person's GP. Following the inspection, the service implemented a new system of communication which alerted psychiatrists when self-harm was disclosed in therapy sessions. The service also informed us they had updated their incident and risk reporting policy. This was shared with all staff in feedback meetings as well as via email. A new audit was due to be carried out on the notes system by the service's newly appointed compliance manager.

One carer told us they were not informed by the clinic that their child had self-harmed. They had found this information out through their insurance company and clinic letter. The carer spoke with the clinician who was apologetic, stating they thought the carer was aware. The clinician had since supported the carer in providing more information on self-harm, including ways to support their child.

The staff we spoke to were aware of the range of potential risks present for the young people they were seeing. They could also discuss the risk management plans in place related to the young people on their caseloads.

The documented risk management plans for young people were often generic plans which stated the young person should contact their psychiatrist with concerns and out of hours they should seek support from emergency services. Where young people had thoughts of self-harm, leaflets with coping strategies were available for young people and carers. These leaflets also contained information on where to seek support when the clinic was closed.

The service had also created an app to support young people with their coping skills. The app had a range of information and support, such as alternative techniques to self-harm, mindfulness exercises, soothing images and audio, guided meditation and distraction word games.

The service reviewed a young person's level of risk on referral. Staff reported they did not accept those who were high risk and they had an exclusion criteria which they followed as part of their risk management strategy. For example, the service did not accept young people who were requiring hospital admissions, those with very low body mass index, forensic cases or those with active drug or alcohol addictions. If a young person's needs could not be safely met by this service they would discuss other more appropriate options with the referrer, for example a hospital admission or specialist community services.

Specialist community mental health services for children and young people

Good

The administrative team were responsible for reviewing new referrals in the first instance. They reviewed referrals in line with the service's exclusion criteria. Where administrative staff were unclear on a decision, they would informally discuss the case with a psychiatrist.

As soon as an appropriate referral was received the administrative staff would book them in for their first appointment with a psychiatrist. Young people who were deemed as higher risk would be able to access more urgent appointment slots with a psychiatrist. When a young person was not deemed appropriate for this service, they were signposted to other services.

Due to a high number of young people referring themselves to the clinic there was a potential for more inappropriate referrals, compared to those sent by other clinicians. There was no formal process in place for a trained clinician to regularly review the risk for new referrals and for those awaiting their first appointment. This meant that patient risk may not be appropriately identified. A more thorough risk assessment would not happen until the client had been formally assessed. There was also no formal process in place for clinicians to ensure inappropriate referrals were signposted to the correct services in a timely manner.

Following the inspection, the service informed us they had implemented a process where a consultant psychiatrist reviewed all new referrals each day.

The responsibility for young people remained with the referrer until an initial appointment with the service took place. When young people referred themselves to the service it was unclear who held this risk and clinical responsibility whilst awaiting their first appointment.

Around half of the young people chose to have their appointments remotely, via teleconferencing facilities. Staff told us if they had concerns for a young person's wellbeing they would ask them to attend the clinic to be seen. However, a staff member reported this was not always possible due to some young people living far away from the clinic. In all cases, emergency information, such as telephone numbers and local emergency departments, were shared with young people and their carers. All assessments for autism were completed face to face.

Young people and carers told us they were offered more frequent appointments when they were going through challenging times, for extra support.

The service had a lone worker policy which included the use of alarms in clinic rooms. The staff we spoke with were aware of the lone working policy. Some staff did not see young people face to face, however, were still aware of the policy in place. All staff were encouraged to use their work mobiles to call for support with any concerns.

There was an emergency grab bag available to staff working at the clinic. This contained items to be used in a physical health emergency, such as, a stethoscope and an airways management kit. The service also had a defibrillator available. Emergency medicines were stored with the ground floor service, which Stepping Stones Clinic were able to use.

Safeguarding

Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The service had a named lead for safeguarding.

Staff received training on how to recognise and report abuse, appropriate for their role.

Specialist community mental health services for children and young people

Good

Staff kept up to date with their safeguarding training. At the time of inspection 100% of staff had completed level 3 safeguarding training for both children and adults.

Staff knew how to recognise adults and children at risk of, or suffering harm and worked with other agencies to protect them. The registered manager was the safeguarding lead for the service, and they had links with the local safeguarding team. They met with a link social worker monthly to discuss any cases and seek advice.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Due to the service accepting young people from a range of areas, staff were aware they needed to contact the young person's local authority safeguarding team for any referrals or support. The local authority safeguarding service was also supportive in providing guidance and signposting to young people living outside of the borough.

From May 2022 to April 2023 the service had safeguarding concerns for 11 cases. These cases were discussed with local safeguarding services for advice. Where necessary safeguarding referrals were made.

Staff access to essential information

Staff kept secure records of young people's care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The service had recently migrated their patient records to a new electronic patient record system. The service provided training to all staff on the new system. The feedback we received from staff on the new system was positive.

All staff could easily access the new system. Staff reported the system was easy to navigate.

The care records we reviewed showed, in most cases, the information needed to deliver safe care and treatment was available to all staff in an accessible way.

Records were stored securely on an online password protected system. The service did not use paper records.

When needed, the service shared confidential information with young people through password protected files.

We saw evidence of young people's information being shared between other services who were involved in the client's care, for example, GPs and schools.

Medicines management

In most cases, the service used systems and processes to safely prescribe and record medicines. Staff regularly reviewed the effects of medicine on young people's mental and physical health. On 1 occasion we saw that a medicine was prescribed to a young person without them being reviewed by the clinician. Most medicines were prescribed in line with guidance, however, when medicine were prescribed against guidance, a rationale was not always documented.

This service did not administer or store medicines onsite. We reviewed 9 patient records, which included their medicines records.

Specialist community mental health services for children and young people

Good

Consultant psychiatrists prescribed medicines. Prescribers held prescription pads to be able to prescribe controlled drugs. These were kept in locked cupboards in the psychiatrist's homes, unless travelling to the clinic. Prescriptions were given to young people at clinic appointments. For remote appointments prescriptions were posted or delivered by a community pharmacy service.

When medicines were prescribed, a copy of the prescription was saved in the young person's notes.

In most cases, psychiatrists prescribed medicines after reviewing the young person. However, we saw 1 example where a psychiatrist prescribed a new stimulant to a young person in between sessions. A medicine was changed following updated information from their carer. The young person had begun to experience negative side effects from the prescribed medicine. A decision was made to start a new medicine in between sessions. This young person was initially seen for a review 2 months prior, as well as seen in a follow up appointment around 7 weeks after the medicine was amended. Their carer was in regular contact with the service, providing updates and physical health monitoring results. Following the inspection, the service informed us they had updated their medicines policy to ensure they capture a young person's consent to changes in medicine.

Psychiatrists reviewed a young person's medicine regularly. They provided information to young people and carers on the different types of medicines. The service had also created easy read leaflets on medicines and common conditions.

Side effects were reviewed and documented. For example, we saw some evidence that when a medicine was discontinued, staff documented the unwanted side effects.

A young person's GP was informed when a medicine was started or changed. Clinic letters showed d the rationale for prescribing these medicines . However, we noted 1 record did not have the rationale documented for a medicine a young person was prescribed. This was raised with the service at the time of inspection, and it was addressed. Other medicines prescribed within this record did have the rationales documented.

Most young people consented to the GP being sent information regarding their care at the clinic. Where young people did not consent, staff spent time explaining the rationale for information sharing. Most psychiatrists told us they would not prescribe medicines, such as those that needed physical health follow up, to a young person if their GP was not involved. However, 1 psychiatrist told us they would prescribe medicine, including controlled medicines, if a GP was not involved. The service's medicines policy stated if staff did not have access to a young person's medical records they must not prescribe controlled drugs, or any medicine where monitoring would be required. In the 9 records we reviewed, we did not see any evidence of young people not consenting to their GP being involved in their care.

Off licenced medicines were being prescribed for young people. An off licence medicine is a medicine which is being prescribed against its original marketing authorisation, but there is clinical experience to support its use. Whilst the clinic letters did not explicitly state when a medicine was being used off licence, the psychiatrist did, in most cases, note the rationale for prescribing a particular medicine. The service's medicines policy stated the prescriber must make a clear record stating why they were not following common practice and the reason for prescribing the medicine.

Following the inspection, the service informed us they had updated their medicines management policy. The service also updated their clinic letters to include a new section to complete when medicines were being prescribed outside of guidance. This new section on the form included a space to state the young person was given information on the off licence medicines, as well as documenting that they consented to the treatment. These documents were to be audited every 3 months by the service.

Specialist community mental health services for children and young people

Good

Young people were able to have their blood pressure and weight monitored when they visited the clinic. For young people accessing the service remotely, carers were required to support young people in obtaining these physical health checks and informed the service of the results. These results were uploaded onto the young person's care record. If a young person required blood tests or an electrocardiogram, the clinicians wrote to GPs requesting this. The service also had links with external services who could carry out these tests, if required.

The service carried out audits related to medicines to ensure correct prescribing processes were followed. The medicines audit from April 2023 looked at 28 cases. This audit found 100% compliance in most areas, such as notes containing consent to treatment, side effects were explored and the GP was informed of all medicine changes. They found 93% of records looked into the young person's relevant family physical health history where indicated. An action plan was put in place for psychiatrists to enquire about a family's physical health history before prescribing stimulant medicines. This action plan was shared with psychiatrists via email and in their weekly group supervision meetings.

On occasions the service supported young people over the age of 18. Not all psychiatrists were insured to prescribe to adults. The service had a specific policy on prescribing to those over 18 within the service. The policy stated if a psychiatrist was not insured to prescribed to an adult, the young person would be transferred to another psychiatrist within the service who did have the ability to prescribe to this client group. One psychiatrist within the service was insured to prescribe medicine to those over 18 years. All other psychiatrists were insured to prescribe to those aged 18 or over as long as they were still in school. This allowed young people time to finish their exams prior to being transferred to an adult psychiatrist.

The service did not have any external links to a pharmacist for support.

Track record on safety

The service had a good track record on safety.

From May 2022 to April 2023 there had been 42 incidents reported by the service. In most cases, these incidents were reported following young people disclosing self-harming behaviours or safeguarding concerns within their appointments.

There had been no serious incidents within this time frame.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. In most cases, staff recognised incidents and reported them appropriately. However, we saw 2 incidents in 1 care record where incident reports were not completed. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave young people honest information and suitable support.

Most staff knew what incidents to report and how to report them. The staff we spoke with all confirmed they had access to the system to report an incident and were confident in completing an incident form.

In most cases, staff raised concerns and reported incidents and near misses in line with the service's policy. However, in 1 patient record we noted 2 incidents of reported self-harm that had not been reported as incidents. Not reporting incidents in line with policy meant these incidents were not reviewed by senior leaders. This also made it difficult to track themes or potential increase in risk factors for this particular young person.

Specialist community mental health services for children and young people

Good

Since the inspection the service informed us they updated their incident reporting policy to ensure the process was clear for all staff. All staff were informed of the updated process for reporting an incident. The service also hired a compliance manager who will complete monthly audits on care notes to ensure all incidents are reported in a timely manner, in line with policy.

The staff member who noted the incident was responsible for reporting the incident. They were also responsible for collating the information related to the incident. Once the form was completed it was sent to the registered manager for their review. The registered manager worked alongside the clinician, young person and carer to investigate the incident. They created action plans where needed and recorded any learning from the incident.

Learning from incidents was shared with staff through email and team meetings. For example, staff were reminded to be mindful with young people going through transitions, such as changing schools or attending university, as this may have had an impact on their risk and level of support needed.

Staff understood the duty of candour. They were open and transparent, and gave young people and families a full explanation if and when things went wrong.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all young people. They worked with young people and families to develop individual care plans and updated them at each doctor appointment. Care plans reflected the assessed needs and were recovery oriented. However, care plans did not always clearly document young people's views.

At a young person's first appointment, the psychiatrist completed a comprehensive mental health assessment. This included their past medical history and an assessment of risk. Assessments included feedback and information from carers.

Within the clinical letters, psychiatrists documented care plans. Care plans were generally categorised into 3 main headings. The 'keeping me well' plan looked at the treatment being offered. The 'keeping me safe' plan contained risk assessments, protective factors, mitigation of risks and crisis plans. The 'keeping me healthy' plan contained physical observations, physical health conditions and any interventions. The care plans also had headings to document any educational or cultural needs to be addressed.

Care plans had limited detail, however they reflected the young person's treatment plans. The documented care plans were not written from the perspective of a young person and in general the plan did not have a space to include their views. However, all young people and carers we spoke to reported being involved in the care plans. Since the inspection, the service informed us they had updated their care plan document to include a separate section which captured young people's views about their care.

Care plans were updated each time a young person had an appointment with the psychiatrist.

Clinic letters, which included the care plans, were sent to young people, their carers and their GP after each appointment with a psychiatrist. Some letters explicitly stated they were sending a copy to the young person, however others did not. All young people and carers we spoke with confirmed they received clinic letters after each appointment. Young people and carers told us the clinic reports were detailed, informative and a true reflection of their needs and concerns.

Best practice in treatment and care

Staff provided a range of treatment and care for young people, which was mostly based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit and quality improvement initiatives.

Staff provided a range of care and treatments suitable for the young people in the service. Young people who accessed the service were treated for a range of different mental health conditions. The care each young person received was tailored to their individual needs. The service prescribed medicines, carried out specialist assessments and offered therapeutic treatments.

Prescribing was mostly done in line with National Institute for Health and Care Excellence (NICE) guidance. However, we saw 1 young person who was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) prescribed guanfacine as their first line treatment. NICE guidance suggests this medicine should only be prescribed after other medicines, such as methylphenidate, had been tried and was unsuccessful. There was no documentation within the notes which stated why this medicine was prescribed in the first instance. This particular young person was later prescribed methylphenidate after having side effects from guanfacine. Following the inspection, the clinician was able to provide a detailed rationale as to why this medicine was used, based on the young person's clinical presentation. They have since taken this as learning to ensure rationales for prescribing will be clearly documented in all cases.

Young people had access to a wide range of psychological therapies as recommended by NICE. These included cognitive behavioural therapy, dialectical behaviour therapy, mentalisation-based therapy and psychodynamic therapy. The service also offered weekly dialectical behaviour therapy in a group setting. One young person told us they would have found it helpful to have a peer support group with others who had also recently been diagnosed with Autistic Spectrum Disorder (ASD), to share coping strategies and experiences.

Young people who had thoughts of suicide and self harm were directed to a mobile app of coping skills, designed by staff in the service. This meant young people could have ways of reducing their distress with them at all times. The app used recognised techniques to minimise young people's distress. It contained features such as mindfulness and guided meditation, distraction activities and examples of coping strategies. Young people could also upload personal, calming photos and music.

Staff made sure young people had support for their physical health needs, either from their GP or community services. The clinic was able to monitor young people's weight and blood pressure. Should a young person require further physical health monitoring, the service would contact the GP to request these. The psychiatrists monitored and assessed the side effects of the medicines they prescribed.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. For example, the service used the revised children's and anxiety depression scale (RCADS) and the Vanderbilt ADHD diagnostic rating scale (VADRS) as clinical outcome measures for young people. Clinicians told us they used other outcome measures for young people where needed, in line with their presentation and treatments.

Specialist community mental health services for children and young people

Good

Staff used technology to support young people. Young people were able to complete ADHD assessments using an online programme. Since the service updated their records system, young people and carers had access to an online platform where they could book and manage their upcoming appointments.

Staff took part in clinical audits and quality improvement initiatives. The service carried out a range of clinical audits, such as care note audits, medicines audits and audits related to the health and safety of the environment. Managers used results from audits to make improvements. For example, reminding all staff to ensure they document any risk concerns within every clinic note.

Skilled staff to deliver care

The team had access to a full range of specialists required to meet the needs of young people under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals and supervision. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the young people at the service. This included psychiatrists, psychologists, psychotherapists, child and adolescent practitioners, assistant psychologists, and administrative support.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the young people in their care. Audits were carried out regularly to ensure all staff were fit to practice. Managers reviewed staffing within the organisation regularly and advertised vacant roles when needed.

Managers gave each new member of staff a full induction to the service before they started work. At the time of inspection, 100% of staff had completed an induction with the service. Staff were provided with an induction booklet which contained information on the service's vision and values, the safeguarding processes, information on how to use the record system, how to log incidents and how to access policies. The booklet also contained specific information for different disciplines, such as a psychiatrist, therapist or administrator.

Managers supported staff through regular, constructive appraisals of their work. Staff were required to complete an appraisal with this service. The appraisal system was ongoing, and at the time of inspection, all staff had completed their appraisal for the 2022 year cycle. All staff within the service had dates booked to complete their appraisals for the 2023 cycle.

Staff within the service were required to have monthly supervision. This did not have to be completed within the service; however, clinicians were required to provide evidence that they had received supervision externally each month. At the time of inspection 96% of staff had received monthly supervision.

Therapy staff within the service met monthly for peer support. Clinicians would bring cases for discussion with the wider team for advice or discuss any concerns as needed. Doctors within the service met together weekly to discuss their cases. The administrative team had a weekly meeting to discuss any concerns.

Managers supported staff to access training. The service encouraged staff development. For example, a therapist told us the service had supported them to attend a mentalisation based training course, funded by the service.

One staff member told us it would be useful to have training sessions, put on by other members of the team, in areas they were skilled in to share learning and support everyone's development.

Specialist community mental health services for children and young people

Good

Staff within the service kept up to date with best practice through attending conferences and classes when available. Doctors told us they discussed new relevant scientific papers within their weekly peer support meetings.

Managers recognised poor performance, could identify the reasons and dealt with these. There had been no recent staff performance issues reported within the service.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit young people. They supported each other to make sure young people had no gaps in their care. They had effective working relationships with other relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss young people and improve their care. Team meetings took place every 3 months. Team meetings had agenda's which included, service updates, risks, performance, lessons learnt and recent quality audits.

Some staff told us team meetings were difficult to attend, due to the time they were scheduled, clashing with other work. The managers had attempted to have these meetings at times which suited most clinicians, however due to the nature of associate staff, it was not always possible to accommodate all staff members. Managers sent the team meeting minutes to all staff members after each team meeting.

Staff made sure they shared clear information about young people and any changes in their care. Staff told us there was good communication between staff members when they worked with the same young person. Clinicians would update each other in meetings, telephone calls and via emails. Clinicians documented their sessions on the same record system, so other professionals were able to see this information as needed. However, we saw 1 record where risk information did not appear to have been shared between therapist and psychiatrist. The service had since updated their communication systems to ensure all psychiatrists were informed of risk information related to their clients.

Therapy staff told us psychiatrists always made time to discuss a young persons care when there were concerns about risk. A staff member told us it would also be useful to have more dedicated time to discuss treatment plans of those young people who were less risky, as riskier young people took priority for a doctor's time.

Psychiatrists within the service met weekly to discuss any concerns for young people they were treating. Assistant psychologists met weekly with the clinical director where they could discuss their cases or concerns.

Staff had effective working relationships with external teams and organisations. For example, staff members made links with young people's local community mental health services, schools, paediatricians, dietitians and GPs where needed. They also had good links with the local safeguarding team who offered advice and support. A carer told us the clinic made referrals for medical investigations when needed. Staff told us they had attended a range of external meetings to support the young people in the service, for example, school meetings, child in need meetings and attended joint meetings when young people were transferred to other services.

We saw evidence in young people's notes where staff had written letters to schools and employers where extra support was needed.

Specialist community mental health services for children and young people

Good

Good practice in applying the Mental Capacity Act

Staff supported young people to make decisions on their care for themselves. They understood the policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly.

Staff received and kept up to date with training in the Mental Capacity Act. At the time of inspection 100% of staff had completed this training. This training also included information on Gillick competence.

The Mental Capacity Act applies to people over the age of 16. For decisions about care and treatment in those under 16, staff referred to guidance on Gillick competence. This is a test established by case law to assist clinicians to determine whether a child of 16 years or under is competent to consent to medical examination or treatment. If a child is Gillick competent, they can give informed consent to an informal admission and treatment.

There was a clear policy on the Mental Capacity Act, which staff knew how to access. Staff knew where to get accurate advice on Mental Capacity Act. Staff told us they would discuss any concerns related to capacity and consent with the psychiatrists within the team.

Young people or carers voluntarily approached the service to be seen. Young people were asked to sign an initial consent form prior to their first appointment. The form contained information on confidentiality, the records system, the nature of the service, and funding arrangements. The form also sought consent for the young person to be seen by the service and to have their information shared with others where needed, such as their parents, their GP, and their school.

The service made it clear in this form they would need to share concerns with other services or parents if there were concerns for the safety of the young person or others.

Capacity to consent to treatment was then reviewed at each appointment with a psychiatrist and documented in letters shared with the GP.

Managers audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. Senior leads carried out audits on the young people's care records to ensure capacity was documented within clinical letters. Audits were also carried out to ensure capacity was documented when discussing medicines and treatment with young people.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated young people with compassion and kindness. They understood the individual needs of young people and supported them to understand and manage their care, treatment or condition.

Staff were respectful and responsive when caring for young people. Young people and carers spoke highly of the staff at the service. They told us staff were kind, caring, and understanding. They described good relationships with their

psychiatrists and therapists. People told us staff understood their needs and created safe spaces for young people to comfortably discuss their concerns. Young people and carers told us staff were easily contactable; if they had questions between sessions, the doctors and administrative staff were quick to respond. Young people told us staff validated their feelings, and they did not feel judged.

Young people told us the service was responsive to their needs, for example, a young person asked for their medicine to be reviewed, and said this was organised immediately. Another young person asked the service for support with pre-employment checks, which was also completed in a timely manner.

Staff supported young people to understand and manage their own care, treatment or condition. Young people and carers told us treatments had been discussed in a way they understood. Young people were encouraged to use coping strategies to manage their feelings outside of appointments, this included using the coping skills app.

Staff directed young people to other services and supported them to access those services if they needed help. For example, the service had close links with an education consultant who was able to work with young people and families to support young people back into education. The service also referred young people to their local child and adolescent community services and crisis teams when necessary.

Staff followed policy to keep young people's information confidential. Young people were asked prior to their first appointment if they consented to information being shared with third parties, such as their GP and school.

Involvement in care

Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved young people and gave them access to their care plans. All young people and carers we spoke with reported being involved in their care planning and received copies of their clinic letters.

Staff made sure young people understood their care and treatment and found ways to communicate with young people who had communication difficulties. Carers told us staff were able to communicate effectively with their children. This included not pressuring them to talk when feeling unable or uncomfortable. Young people told us treatments were explained using words they understood.

Young people and carers could give feedback on the service and their treatment and staff supported them to do this. Staff sought feedback from young people throughout the year. Between April 2022 and March 2023, the service received feedback from 116 young people. The feedback from this survey was positive and found 93% were very satisfied with their assessment, 95% understood their care and treatment, 94% felt all areas of their care was addressed and 98% of young people would recommend this service to their friends and family.

The service also sought feedback from young people after they had assessments for Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD). Eight young people provided their feedback in March 2023. One hundred percent of young people felt understood, and were made to feel comfortable throughout the assessment. Eighty-seven percent of young people felt this assessment helped other people to understand them better.

The young people had access to advocacy services via the clinic as needed.

Specialist community mental health services for children and young people

Good

Involvement of families and carers

Staff supported, informed and involved families or carers in young people's care. We spoke with 16 carers, and feedback was very positive. Carers spoke highly of the staff at the service and felt involved in their child's care. They were able to contact the service with any concerns between appointments and received quick responses. One carer told us the service gave their child hope and built up their confidence. Most carers felt the service provided them with enough information about their child's care. However, 1 carer told us more information on what ADHD was would have been helpful.

The service collected feedback from carers, specifically those who had attended with their child for ASD and ADHD assessments. The feedback was from 3 carers, who were very positive about the service. All carers reported feeling listened to, that any worries were handled sensitively, that the facilities were comfortable, and they would all refer the clinic to their families and friends.

Whilst the service did not offer structured family therapy, the clinicians often saw young people with their families and offered support. When a family required more structured family therapy they were referred to external services.

The service ran a regular carer group for those with children who had been diagnosed with ASD. Prior to the pandemic, the service also offered support groups for carers, such as specifically for those with children who self-harm. The service spoke of plans to restart these groups.

One carer told us they were involved with service developments. They had been involved in developing a parent workshop and helped to co-facilitate this meeting. The service had completed 1 carer workshop, and planned to offer more sessions throughout the year.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and waiting times

The service was easy to access. Wait times were low and the service had capacity to see young people more urgently when needed. The service ensured that young people made smooth transitions to other services. This included ensuring that transitions to adult or local children's mental health services took place without any disruption to the young person's care.

Referrals for this service were mostly received through word of mouth. Individuals would contact the service asking to be seen. Referrals were also sometimes received from insurance companies and GPs.

Information regarding the service was available to all via the service's website. Once a person contacted the clinic they were sent links with more information on the specifics of the service and treatments offered. Some young people and carers told us they were provided with photographs of clinicians so they knew who they would be meeting.

Specialist community mental health services for children and young people

Good

In April 2023, new referrals waited on average 3 weeks for their first appointment with a psychiatrist. In February 2023, this was a 1 week wait. Managers reported if the wait list reached 3 months, they would close to new referrals. This enabled them to effectively manage and treat the young people who were already open to them. The wait to see a therapist was also 2 to 3 weeks.

Psychiatrists held appointment slots to be able to review young people urgently if needed. This included those who were new referrals and those already opened to the service.

Young people had some flexibility and choice in the appointment times available. Young people were able to choose appointments in the office or to have these remotely. Some therapists worked earlier or later to enable young people to attend sessions before or after school.

Young people and carers reported appointments ran on time.

Staff supported young people when they were referred or transferred between clinicians or services. Young people may have needed to transfer between clinicians in the service if they turned 18. This was done carefully to ensure continuity of care. Some young people accessed this clinic whilst awaiting their initial appointment within their local child and adolescent service. The service ensured they shared their clinical notes with the new services if this was appropriate.

Facilities that promote comfort, dignity and privacy

The layout and furnishings of treatment rooms supported young people's treatment, privacy and dignity.

Around half of the young people accessed their appointments online, the other half attended the clinic.

The service had access to consulting rooms within a clinic and had access to equipment to support treatment and care. Some rooms were small, and there were some occasions where staff felt more rooms were needed to be able to see more young people at the same time. The young people and carers we spoke with all reported the rooms to be appropriate for their sessions and were comfortable. The service told us they received some feedback from young people in the summer that some rooms were too warm.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

The service had a plan in place to move to a bigger premises in the coming months where they had access to more rooms, which were larger.

Meeting the needs of all people who use the service

The service made adjustments for young people when needed. Young people had access to easy read documents, as well as information in their chosen languages. However, the notes system did not always capture a young person's protected characteristics.

Staff completed training in equality, diversity and human rights. At the time of inspection, 94% of staff had completed this.

When reviewing young people's care records we did not see individual characteristics captured such as ethnicity, religion, disability and sexuality. Some clinic letters had a 'cultural needs' heading to ensure these discussions were had, however this information was not always filled in. Following the inspection, the service informed us they had updated their initial referral forms to ensure they captured young people's protected characteristics.

The service could support and make adjustments for disabled people, those with communication needs and those with other specific needs. Whilst all clinic rooms were on the first floor, the service was able to use a manager's room on the ground floor for an appointment if needed. Staff told us they rearranged appointments around religious holidays for young people when needed.

The clinic did not have its own dedicated waiting area. This impacted on the leaflets available for young people to come across whilst waiting for their appointment. However, young people were able to access leaflets on treatments, conditions and medicines from their clinicians. The service was due to move into a new premises where they would have their own designated waiting area. Following the inspection, the service was converting leaflets into QR codes for young people to access from the waiting areas. This was to ensure young people had access to this information whilst awaiting the move to the new building.

The service provided information in a variety of accessible formats so the young people could understand information more easily. We saw easy read leaflets about medicines and mental health conditions which were available for young people.

The service provided detailed instructions on how to get to the clinic for appointments. A young person told us this helped eased their anxiety. One carer told us the clinic supported their child to provide written explanations on how they were feeling when they found it too difficult to speak about their difficulties.

The service was able to translate information leaflets into languages spoken by the young people when needed. They were able to book interpreters and signers should a young person or carer require this.

The service completed a yearly green light toolkit audit. This was last completed in November 2022 and scored 100%. This audit looked at improving the service so that it was effective in supporting autistic people and people with learning disabilities. For example, having an open culture to safeguarding and learning from incidents, as well as having access to easy read materials and rooms having soft lighting and fidget toys available.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. Managers shared learning with the whole team and wider service.

Young people and carers knew how to complain or raise concerns. Whilst some did not know if there was a formal complaints procedure, all young people and carers reported feeling able to raise concerns with their clinicians or the service leads.

Staff understood the policy on complaints and knew how to handle them. Staff were aware complaints were managed by the practice manager.

The service had a leaflet detailing the complaints procedure for young people. It contained the email address to send their complaint to and information on additional sources for support. It also detailed what a young person should do if they were not happy with the service's response to their complaint.

From July 2022 to April 2023 the service had logged 8 complaints. Four of these were formal complaints and 4 were informal complaints.

Specialist community mental health services for children and young people

Good

Managers within the service investigated complaints and identified themes. Staff knew how to acknowledge complaints and young people received feedback from managers after the investigation into their complaint was completed.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, the service received a complaint from a carer that their appointment was disrupted by another member of staff who required equipment for their assessment. Following this the equipment was moved into communal areas to avoid any further disruptions. This learning was shared with the team via email, as well as shared in the team meeting. Another complaint came from a carer who was not sure how to get their child's blood pressure measured at home. Following this the service created clearer instructions which were given to carers describing how to get these readings at home.

The service carried out a lessons learnt audit each month. This audit collated all of the incidents, complaints and compliments each month, and they shared this with the whole team on what the service had learnt.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service. They were approachable for young people and staff.

The registered manager had a good understanding of the service they managed. They could explain clearly how the teams were working to provide high quality care and they knew the individual young people well. The leaders in the service were motivated and enthusiastic about supporting the client group.

Managers within the team were easily accessible to young people, carers and staff.

All staff we spoke with described the morale within the team as high. They were proud to work for the service and being a part of the team. They found the registered manager approachable and supportive. Staff told us managers responded to any queries they had in a very timely manner.

Staff we spoke with told us the service had an open and transparent culture and they were able to raise any concerns with seniors and were listened to.

Senior leaders sought regular feedback from young people and carers on how their care and treatment was progressing. They used this feedback to improve a young person's experience of care.

The service conducted a yearly staff questionnaire. Sixteen staff members completed the most recent survey. It found 81% of staff agreed the management team engaged with the staff team enough and 75% of staff agreed they felt involved in the decisions that affected their work. All staff agreed the service made good use of their skills.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Specialist community mental health services for children and young people

Good

The service had clear vision and values that were shared with all staff. Their values aligned with the Care Quality Commission's key lines of enquiry, that is, to ensure care was safe, effective, caring, responsive and well led. The vision of the service was to ensure they were providing a quality service, which was sustainable, open, and honest. They aimed to provide a tailor made treatment plan, in a timely manner, for all young people.

All staff were committed to providing a high-quality service, offering treatment plans based on individual needs. Wait times to access the service, therapies and assessments were low. In the most recent staff survey, 100% of staff agreed the service lived up to their values.

Young people and their carers told us they were very happy with the care they had received, and they were fully involved in their care and treatment.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

Staff that we spoke to felt respected, supported and valued. Staff told us they were happy working within the service. In the most recent staff survey 81% of staff agreed that they felt valued within the service.

Staff told us they could raise concerns and were encouraged to do so. They had confidence that these concerns would be addressed.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints.

The provider was aware of and ensured compliance with the requirements of the duty of candour. For example, staff were apologetic and open when a carer complained they had not been informed of risk information relating to their child.

There were processes for providing staff with the development they needed. This included receiving training, a regular annual appraisal, supervision and peer supervision. They were also supported to attend external training, if this supported the clinician in their role. For example, training in mentalisation based therapy.

Staff members within the service attended external events to support them in their role. For example, attending conferences and forums to keep up to date with the current best practice.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

There was a clear organisational structure and staff understood their own roles and responsibilities. The management team worked closely with staff so that young people received a high quality and responsive service.

Governance arrangements were in place to assess, monitor and improve the quality of the service. There were incident and complaint reporting systems in place which enabled learning. There was a system in place for young people and staff to provide feedback. Feedback was reviewed by managers and improvements were made where needed.

Specialist community mental health services for children and young people

Good

The service had a board meeting every 3 months. The members of the board consisted of 2 executive staff members and 3 non-executive directors. The board met to discuss the risk report, health and safety, audit outcomes, human resources updates, finance reports and policy reviews. These meetings were minuted.

Team business meetings were held every 3 months. These meetings provided all staff an update on the service, risks, performance, governance and lessons learnt. All staff were encouraged to attend this meeting. Minutes were sent to the staff members who were unable to attend the meeting.

A manager's meeting was held every week, attended by the registered manager and the practice manager. This meeting covered risks, quality, performance, safeguarding, governance and business matters.

The service had assurances that staff received appropriate training, supervision and appraisals. Recruitment paperwork was documented to ensure staff were vetted and had the relevant specialist skills and qualifications before commencing work.

Whilst the service had good governance process and internal oversight, the clinic lacked formal external oversight. The service managers were however able to get additional support from external organisations with specific queries, such as their safeguarding link and their medical council.

The service had discussed in a recent board meeting a particular agency who could provide external regulation and add credibility to their performance measures. The service noted this agency for future consideration.

Management of risk, issues and performance

The service had effective risk management systems in place.

The service held a risk register which identified risks such as their premises, staff retention and recruitment and optimising their online record systems. The mitigations and action points were reviewed regularly in the service's various governance meetings. Staff at all levels could escalate concerns for the risk register when required.

The risks highlighted on the risk register matched those raised by staff. For example, the current building sometimes being busy due to the available space.

The service had a business continuity plan in place in case of emergency. The plan detailed what should happen in the event of scenarios occurring that may disrupt the service. For example, insufficient staffing, loss of electricity and a loss of access to their online systems. The service had also created a specific business continuity plan during the pandemic which was shared with staff.

Information management

The team had access to the information they needed to provide safe and effective care and they used that information to good effect.

Managers had access to information to support them with their management role. This included information on the performance of the service and the care they provided. This enabled leaders to maintain clear oversight of the service and identify good practice, as well as areas for improvement.

The service had created a range of audits to keep track of key elements of care, for example, care note audits and audits on staff recruitment documentation.

Information governance systems included confidentiality of young people's records. Training in information governance was included in the service's mandatory training. At the time of inspection 91% of staff had completed this training.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the record keeping system, worked well. The service used technology to support them with Attention Deficit Hyperactivity Disorder (ADHD) assessments.

Staff made notifications to external bodies as needed, including the Care Quality Commission. The service made safeguarding referrals to local authority safeguarding teams when they were concerned about possible abuse of young people.

Engagement

Young people, carers and staff were able to provide feedback to the service. Managers used this feedback to make improvements. Managers worked with other organisations such as schools, local authorities and GPs to ensure their young people were supported.

Staff and young people had access to up to date information about the work of the clinic and the services they used.

The management team worked closely with the young people and staff in an open and approachable manner. Young people and carers had opportunities to give feedback on the service they received. They were encouraged to fill in user satisfaction surveys regularly.

Managers had access to the feedback from young people, carers and staff. They used this feedback to make improvements, for example, providing clearer guidance on how to obtain blood pressure results at home, and securing a larger premises for clinic appointments.

Staff liaised with schools and GPs to ensure joint up care. The registered manager had regular meetings with the local safeguarding team to discuss the best ways to support their young people who were most at risk. The service had shared care agreements in place with GPs to enable clear joint working procedures for young people who had received diagnosis and were prescribed medicines.

Learning, continuous improvement and innovation

The service had a complaints and incident reporting process that supported continuous learning and improvement. The service had systems to make sure learning was shared with all staff groups. Staff told us they were updated following incidents and complaints at team meetings as well as through email.

The service carried out a range of audits to support learning and improvements. Where improvements were noted, this was shared with the team. Staff gave examples of learning that was shared with them, such as, reminders on what information should be included in all clinical notes.

The service had developed its own mobile app for young people focusing on coping skills. The app was easy to use and was able to be personalised by each young person.

In the most recent staff survey 100% of staff agreed the management team demonstrated a commitment to quality within the service and 100% of staff would refer this clinic to their friends or family.