Good

Birmingham and Solihull Mental Health 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)
RXTC1	Trust Headquarters	Solar, Bishop Wilson Clinic	B37 7TR
RXTC1	Trust Headquarters	Solar, Freshfields Clinic	B98 0QA

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

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

Where applicable, we have reported on each core service provided by Birmingham and Solihull Mental Health NHS Foundation Trust and these are brought together to inform our overall judgement of Birmingham and Solihull Mental Health NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

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Summary of findings

Overall summary

We changed the overall rating of inadequate to good because:

- On inspection we found that the trust had put systems and processes in place to address the actions we had told them they 'must' take to address regulatory breaches we had found on inspection in March 2017. The trust had also taken action to address the 'shoulds' we recommended they take to improve the service.
- Staff completed risk assessments for children and young people. These were recorded in the care records and updated every six months or as needed.
- Staff routinely established and recorded consent to treatment and documented evidence of considering Gillick competence and capacity where appropriate.
- Senior management had reviewed policies and procedures relating to the running of the service. These policies had been agreed by the trust and review dates for 2020 had been set.
- Staff ensured that prescription pads and prescriptions were stored in line with the trust policy.
- Staff monitored the cleanliness and working order of physical health monitoring equipment and therapeutic toys.
- Staffing vacancies had reduced and the service had 15 more whole time equivalent staff than on our previous inspection March 2017. Turnover had reduced from 25% to 13%.
- Staff compliance with mandatory training, supervision and appraisals was good and compliance rates above the trust target level of 90%.
- Work was in progress to make both sites more child and young person friendly and to increase the level of sound proofing within interview rooms.

However:

- The mobile phone staff safety application was not fully working or accessible on 50% of staff mobile phones.
- Staff were using trust templates on the electronic care record system to record care plans. However, we felt that there was further improvement required. Not all care plans were detailed, personalised and holistic. We found evidence of basic care planning in 15 of the 28 care records we reviewed. The majority of these basic care plans were found within the eating disorders team. Care plans did not always record or reflect the voice of the patient, or reflect the quality of care staff were providing.
- The service did not undertake regular audits of care records to assure progress in this area.
- We were not assured that staff reported all incidents on the trust incident recording system or aware of what they should report. We were told of two incidents that should have been reported and had not been reported.

Summary of findings

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

Are services safe?

Good

We changed the rating for safe from requires improvement to good because:

- The service had addressed safety issues identified during inspection March 2017.
- All patient care records we reviewed had an up to date risk assessment.
- Staff had identified ligature risks on the environmental risk assessment and put plans in place to reduce risks.
- We found safeguards in place to address shared waiting rooms and access at the Freshfields site.
- The service had issued staff with personal alarms to use in an emergency. We saw documents to confirm that the service were installing wall alarms in consultation rooms and work had been undertaken to prevent children and young people from locking themselves in consultation rooms.
- Staff completed risk assessments and risk management plans; these were accessible to all staff on the electronic recording system.
- Staffing had increased across the service and turnover rate had reduced.
- Staff assured that equipment for physical health monitoring was kept clean and maintained or calibrated in line with manufacturer's recommendations.
- Staff understood infection prevention and control, ensuring toys and therapeutic equipment was cleaned after use and when needed.
- Staff followed the trusts policy on the safe storage of prescription pads and prescriptions.
- The trusts had reviewed the non-medical prescribing policy which we found to be in date.

However

- The mobile phone staff safety application was not fully working or accessible on 50% of staff mobile phones. The trust was aware of this issue and was in the process of addressing it.
- We were not assured that staff reported all incidents on the trust incident recording system or aware of what they should report. We two incidents in care records that should have been reported and had not been reported. We were told of one incident that had also not been reported.

Summary of findings

Are services effective? Good

We changed the rating for effective from inadequate to good because:

- Staff routinely identified and documented parental responsibility.
- Staff considered Gillick competence when necessary and documented the outcome. All staff had received training on Gillick competence and capacity to consent.
- Staff had completed appraisals or had set dates. Management had implemented processes to monitor and record managerial and clinical supervision. All staff had regular supervision.
- The trust had updated the Mental Health Act policy.
- Children and young people and or their families and carers had access to a wide range of psychological therapies as recommended by National Institute of Care and Excellence.
- Staff worked effectively with other agencies to provide the appropriate service for the patient.
- We found improvement in staff documenting consent to treatment. Staff had a good working knowledge of consent, capacity and competence.

However

- There had been improvement in the recording of patient care records. However, 15 of the 28 care plans we reviewed were recorded in a basic style and lacked personalisation. Care plans did always reflect the voice of the patient and at times lacked detail.

Are services caring? Good

We rated caring as good because:

- At the last inspection in March 2017 we rated caring as good. Since that inspection we have received no information that would cause us to change the rating.

Are services responsive to people's needs? Good

We rated responsive as good because:

- At the last inspection in March 2017 we rated responsive as good. Since that inspection we have received no information that would cause us to change the rating.

Are services well-led? Good

We changed the rating for well led from inadequate to good because:

Summary of findings

- Since April 2017, there had been a stable management structure across the service. This meant the management team had developed an action plan to address all the concerns highlighted in the March 2107 inspection. All staff we spoke with commented that this had led to systems and processes that were previously lacking, had been implemented.
- During our inspection in January 2018, we could see that the core leadership team and staff had worked hard to develop and implement an action plan to address concerns the CQC had highlighted in the March 2017 inspection. We also recognised the hard work of all the other staff within the service, to carry out the action plan, input and feedback about changes in service practice and continue to provide clinical care.
- Policies and procedures for the service which had not been in place during the inspection in March 2017 were now in place. The service had a standard operational policy and an additional standard operating policy specific to the eating disorders team.
- Mandatory training, supervision and appraisal rates were above the trust targets.
- On inspection in March 2017 we had identified a number of policies which had not been reviewed in line with identified timescales. On inspection in January 2018 we found they had all been updated and reviewed.

However

- The service was not completing formal clinical audits of care records. However, the management team were aware of this and were in the process of formalising an integrated care records audit.

Summary of findings

Information about the service

The Solar Emotional Wellbeing and Child and Adolescent Mental Health Services (CAMHS) provide multidisciplinary mental health services to children and young people with mental health difficulties and disorders. The service aims to ensure effective assessment, treatment and therapeutic support for them and their families and works in collaboration with two independent partners. The service had two community sites, Bishops Wilson and Freshfields. Staff worked from both sites and each site had adequate consultation rooms and administrative support.

Our inspection team

The team was comprised of:

Four CQC inspectors and one specialist nurse advisor.

Why we carried out this inspection

We undertook this unannounced inspection to find out whether the trust had made improvements to their specialist child and adolescent community mental health services since our last inspection in March 2017.

When we last inspected the specialist child and adolescent community mental health services in March 2017 we rated it as inadequate overall. We rated the service as requires improvement for safe. We rated it good for caring and responsive. We rated it inadequate for effective and well-led.

Following the March 2017 inspection, we told the provider that it must take the following actions to improve the service related.

The provider must ensure that:

- Consent to treatment is routinely established and recorded within care records.
- Consideration of capacity to consent and Gillick competence is routinely established and recorded within care records.
- Identification of parental responsibility is routinely established and recorded within care records.
- Care plans and risk assessments are completed in a standardised format and shared with people using the service.
- Prescription pads are stored securely in line with trust policy and guidance.
- Audits are carried out of prescribing protocol and practice in the community teams.
- Policies and procedures are reviewed and updated in line with identified timescales.
- Ligature risks are identified and mitigating factors put in place to reduce risk to people using services.
- Locations with shared access to waiting rooms must have safeguards in place to monitor people entering or leaving the building.
- Lone working practice and personal safety protocols are used in both community locations in accordance with trust policy and guidance.
- Interview rooms are fitted with alarms and staff have access to and are trained in the use of personal alarm systems.
- There are sufficient numbers of skilled and qualified staff to provide an effective service.
- Staff receive appraisals and managerial supervision in line with trust policies, and records are maintained of this process.
- Equipment for the use of physical health monitoring is maintained in line with manufacturers' recommendations.
- Cleaning and maintenance schedules and audits are in place for toys used by children and young people at the community teams.

Summary of findings

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred Care
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 11 HSCA (RA) Regulations 2014 Need for consent
- Regulation 15 HSCA (RA) Regulations 2014 Premises and Equipment
- Regulation 17 HSCA (RA) Regulations 2014 Good Governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

We also told the provider that it should take the following actions to improve:

The provider should ensure that:

- Interview rooms are sufficiently soundproofed to ensure confidentiality is maintained.
- Information for people using the service is available in a range of languages and child friendly formats.

How we carried out this inspection

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 children and young people, families and or carers.

During the inspection visit, the inspection team:

- visited two community locations and looked at the quality of the environment and observed how staff were caring for children and young people
- spoke with 23 other staff members; including doctors, nurses and social workers
- interviewed the service manager with responsibility for these services
- interviewed the local commissioner
- observed two hand-over meetings, one referrals screening meeting and one multidisciplinary meeting
- observed one clinic appointment
- spoke with four children and young people and five carers
- looked at 28 treatment records of children and 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

We reviewed comments from the friend and family test gathered over the six months prior to inspection. Of the 67 comments, 63 people reported they were likely or extremely likely to recommend the service to friends and family. They expressed positive comments about receiving good support, being made to feel welcome, understanding and supportive staff and improvement in their own mental health wellbeing. A small number of negative comments were made. Two comments referenced long waiting times to be seen from referral and one about negative attitude from staff and disappointment in the frequency of change in consultants. Feedback from other agencies that worked with the Solar service was very positive, we received feedback from service commissioners who said that the service worked collaboratively and effectively with them to provide care for children, young people and their families.

Summary of findings

Good practice

Staff who worked with looked after children continued to deliver adoption preparation training, provided clinical advice on attachment, brain development and trauma and delivered a fostering resilience programme to parents beginning their fostering journey.

Areas for improvement

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

The trust should ensure:

- Staff should ensure care plans are recorded to reflect the voice of the children and young people, that they are holistic, personalised and recovery focused, and recorded on the trust documentation tool.
- The trust should ensure that staff report incidents in line with the trust incident reporting policy.
- The trust should ensure that staff have access to a working mobile phone safety/ lone working application.
- The trust should ensure that all staff document consent to treatment.

Birmingham and Solihull Mental Health 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
Solar, Bishop Wilson Clinic	Trust Headquarters
Solar, Freshfields Clinc	Trust Headquarters

Mental Health Act responsibilities

- At the time of our inspection we saw that 100% of staff had received training in the use of the Mental Health Act.
- When we inspected in March 2017 we found that the trust Mental Health Act policy had not been updated in line with the Mental Health Act Code of Practice. On this inspection we saw that the Mental Health Act policy had been updated. Staff were able to access the policy on the trust intranet.
- Staff told us they could obtain support and advice on the application of the Mental Health Act and Mental Health Act Code of Practice from the trust Mental Health Act administrators. Staff also reported that they could approach the consultant psychiatrists for advice on the Mental Health Act.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- On inspection in March 2017 we found that staff did not routinely record consent to treatment, identify parental responsibility of children or consider Gillick competence.
- On inspection January 2018 we found significant improvements. Staff had a good understanding of capacity, the Mental Capacity Act and Gillick competence. Staff had received additional training. Most staff were identifying parental responsibility, considering Gillick competence and capacity where appropriate.
- The trust had added guidance on the application of Gillick competence to the trust Mental Capacity Act policy.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- On inspection in March 2017 we found that interviews rooms across the two sites did not have alarms. Staff did not consistently use personal alarms. This meant staff and visitors could not call for assistance in an emergency. On inspection in January 2018 we saw staff had been issued personal alarms to use and alarm response protocol to follow if alarms were sounded. The trust had plans for a wall mounted alarm system to be fitted in all clinical areas. We saw evidence that this would be completed by the end of January 2018. The trust had also planned place viewing panels in all consultation room doors. This meant staff would be able to check inside rooms without opening doors and disturbing occupants.
- On inspection in March 2017 we found consultation rooms could be locked by children and young people from the inside and prevent access by staff. On inspection January 2018 we these found locks had been replaced to prevent this happening.
- Staff had completed and updated environmental risk assessments for both sites. We saw that these had been updated since the inspection in March 2017. Where risks had been identified, actions had been taken or control measures were in place to reduce risks.
- The community sites did not have specific clinic rooms for physical health checks. Physical health monitoring equipment, such as weighing scales, blood pressure monitors and height measurers were located in consultation rooms. We saw that the equipment was visibly clean, maintained and or calibrated to manufacturers' standards. We reviewed documentation that showed staff recorded when they carried out daily/ weekly checks to ensure equipment was clean and maintained. We reviewed emergency lifesaving equipment at both sites. They were in working order and staff completed documentation to confirm they were regularly checked.
- The environments across both sites were visibly clean and well maintained.
- Staff followed cleaning schedules and recorded when therapeutic items, such as toys, were cleaned.
- Staff adhered to infection control principles including hand washing. Staff undertook hand hygiene audits. Hand washing basins and hand hygiene soap was available for staff and visitors to use.

Safe staffing

- At the time of inspection there were 35 whole time equivalent staff working across the service. This was an increase of 15 whole time equivalent staff since March 2017. Staff included clinical psychologists, community psychiatric nurses, mental health practitioners, family therapists, a dietician and consultant psychiatrists.
- As at January 2018, across the service there were five whole time equivalent vacancies. This was 1.5 whole time equivalent less than the previous inspection March 2017.
- Since the last inspection in March 2017, the increase in staffing levels had mainly covered the staffing of the crisis intervention team for the service. An additional associate nurse post had also been created and filled.
- Staff sickness rates for the service six months prior to inspection were an average of 6.8% between June 2017 and November 2017.
- At the last inspection in March 2017, staff turnover rates for the service was 25%. From June 2017 to November 2017 turnover rates had reduced from 25% to 13%.
- The trust estimated staffing needs taking into account the local population and health economy and could be varied to meet the needs of the service. The service had completed a workforce plan for 2017 – 2020 in partnership with the commissioning team.
- Staff we spoke with told us that staffing had improved and that funds to back fill posts of clinicians undertaking training were secured.
- The average caseload was 17. Staff did not voice concerns about caseloads and said they were regularly reviewed within supervision.

Good

Are services safe?

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

- Managers confirmed that they were able to use bank and agency staff to cover vacancies to ensure patient safety.
- Medical staff for the service consisted of three whole time equivalent consultant psychiatrists. Staff reported they could access a psychiatrist when needed. The service was not commissioned to provide child and adolescent psychiatrist cover out of hours. If a patient required a psychiatrist out of hours this would be provided by the trusts general psychiatrist out of hour's rota.
- Staff were able to access a range of mandatory training provided by the trust. This included: Clinical and non-clinical personal safety, risk assessment, clinical supervision, health and safety, fire safety, health care records keeping, infection prevention and control, information governance, Mental Health Act and Mental Capacity Act training, emergency life support, Safeguarding children and Safeguarding vulnerable adults. On inspection we found the overall training compliance rate had improved from 85% to 97%. This was above the trusts minimum training rate of 90%.

Assessing and managing risk to patients and staff

- When we inspected in March 2017 we found that risk assessments were not routinely completed or in a consistent format. We found that risk assessment's completed on the trust's risk screening tool were absent in 28% of the records reviewed. Crisis and contingency plans lacked detail and personalisation for young people and their support networks. On this inspection we found improvement and were assured that staff undertook and documented risk screening, assessment and management of patient risks.
- We reviewed 28 care records from across the teams within the service. This included the eating disorders team, crisis team and theteam. Of the 28 records we reviewed, 27 had an up to date risk assessment in place. Staff had completed an initial risk screening tool and then if indicated completed a full risk assessment. Of the 27 risk assessments we reviewed, 14 were completed to a good standard including detailed risks, protective factors and risk management plans. We found one record which had no risk assessment completed. Risks for this patient had been assessed, but had been documented in progress notes.
- Staff undertook an initial risk screen of all new referrals daily. We observed staff at this meeting. We saw they prioritised referrals according to risk and signposted the referral to the appropriate level of service needed.
- The crisis team staff triaged all crisis team referrals to see if appropriate and to ascertain level of risks.
- The service had systems in place to enable staff to respond to a sudden deterioration in a patient's health. Staff participated on a duty rota which undertook this role. If necessary the crisis team undertook assessment and offered interventions. This was available seven days a week 8am – 8pm.
- National guidance from an intercollegiate document published by the Royal College of Paediatrics and Child Health set out minimum safeguarding children training requirements for NHS staff. All staff within a child and adolescent mental health service should be trained to level 2 minimum and all clinical staff that works directly with children and young people should be trained to minimum level 3. At the time of inspection 95% of staff had completed level 3 training in safeguarding children and 93% of staff had also undertaken safeguarding vulnerable adults training.
- The service had a named doctor and nurse with responsibility for safeguarding. The trust safeguarding team had allocated safeguarding workers who visited the service weekly. Staff received supervision and training from the safeguarding workers. The trust monitored staff attendance at safeguarding supervision. All staff had received training in identification of child sexual exploitation and used a screening tool to help identify children and young people who may be vulnerable to child sexual exploitation.
- When we inspected in March 2017 staff did not have access to personal safety protocols and did not always use the sites signing in and out book. On this inspection we found that staff were aware of the lone working policy and staff were aware of each other's whereabouts. Staff told us that they often buddy up when going on home visits to ensure staff return from visits. The trust had also introduced a mobile phone application to work mobile phones to use in an emergency. However, at the time of our inspection only 50% of staff were able to access this system. A fault had been identified and it was in the process of repair.

Good

Are services safe?

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

- During the inspection in March 2017 we found prescriptions and prescription pads were not stored in line with the trust policy and the non-medical prescribing policy was out of date. On this inspection we found that both sites had appropriate systems in place to ensure prescriptions and prescription pads were stored securely and in line with trust policy. The trust had also reviewed and updated the non-medical prescribing policy.

Track record on safety

- The service had not reported any serious untoward incidents in relation to the service inspected.

Reporting incidents and learning from when things go wrong

- On inspection we reviewed the incident report for the period of 4 April 2017 to 31 December 2017. In that period staff had reported 49 incidents. Incidents were rated in terms of harm from no harm through to catastrophic harm. One incident was catastrophic but related to the primary care aspect of Solar which was provided by a partnership agency. All other incidents were categorised as no harm or mild harm. Of these, eight incidents were reported as physical or verbal assault, six for documentation errors , 22 safeguarding alerts, four for patient self-harm and three for under staffing. However, we were not assured that staff reported all incidents. We found two incidents documented within children and young peoples notes that had not been reported. One member of staff told us of a reportable incident which they had not reported.
- Staff discussed incidents and lessons learnt in team meeting and these were also communicated from the senior management through a team brief and email. We saw evidence of this documented in team minutes and within the team brief.
- Staff said they were supported by each other and management following any serious incidents.

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 reviewed 28 care records from across the service. All had a comprehensive assessment of need in place and had been completed in a timely manner.
- On inspection in March 2017, we found staff did not routinely complete care plans and were not consistently using the trust standard care planning documentation. On inspection January 2018, we found improvement in the recording of care plans. Of the 28 care records we reviewed, 27 had a completed and up to date care plan. Of the 27 care plans 12 were completed to a good standard. We found them to be personalised, including the view of the patient, focused on outcomes, strengths and goals. However, the remaining 15 care plans we reviewed were basic. Most of these care plans were for children and young people cared for by the eating disorders team. They lacked detail and were not personalised. They did not reflect the patients' goals or wishes, or the care and treatment the team provided. We did find evidence of detailed care in progress notes and letters, but this took a while to find.
- Staff reported they had received additional care planning training and that care plans had improved since the last inspection. However, there was acknowledgement from some staff that there was room for improvement and was work in progress. This was also reflected in clinical commissioning review report of December 2017.
- All information relating to patient care was stored securely. The trust had an electronic record keeping system in place which staff were able to access across both sites. Paper records were kept for the storage of communication of documents received from other services, such as physical health examinations. These were electronically scanned and uploaded to the trust's electronic record keeping system by administration staff.

Best practice in treatment and care

- Staff followed guidance from the National Institute for Health and Care Excellence when prescribing medication for children and young people, including guidance for the treatment of depression in children and people (CG28).
- The service was part of the Children and Young People's Improving Access to Psychological Therapies Programme (CYP-IAPT). This is a transformation programme delivered by NHS England. It aimed to improve patient access to evidence based therapies through self-referral and receiving regular feedback by using session by session outcome measures to track symptoms and severity of mental health. CYP-IAPT also aimed to improve patient participation in treatment, service, design and delivery and train managers and leads in how to manage and implement change and balance demand and capacity. Nine staff had secured CYP-IAPT training for 2018. This included systemic family practice, depression and self-harm, Cognitive behavioural therapy and recruit to train posts.
- The service offered a number of psychological therapies recommended by National Institute for Health and Care Excellence (NICE) and as part of CYP-IAPT programme. These included; cognitive behavioural therapy, attachment based parenting and family therapy. Play therapy, art therapy, parenting therapies and dialectical behavioural therapy.
- Clinical staff in the eating disorders team were working towards offering a family based treatment model of care. We saw evidence to show they followed Junior MARSIPAN. (The Management of Really Sick Patients with Anorexia Nervosa.) The staff were also trained in CBTe. This is an enhanced cognitive therapy specifically for patients with eating disorders.
- Staff reviewed physical health care needs where appropriate, for example within the eating disorders team. Staff recorded physical health care monitoring in progress notes. All patients had weekly weights and heights checked. Staff referred children and young people to the local general hospital if more detailed physical health examinations including electro cardiograms and bone mass scans were necessary.

Are services effective?

Good

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

- Staff considered educational and social needs. We observed one clinical meeting and saw staff discussed cases in a holistic way, covering children and young people' risks, personal, social and educational and emotional needs.
- The service used the Choice and Partnership approach (CAPA). This is a nationally recognised CAMHS service model complete with assessment and care planning tools. All qualified clinical staff completed choice appointments. During choice appointments, a plan of care was agreed and if appropriate partnership appointments offered to begin treatment.
- Staff used a range of outcome measures to measure the effectiveness of interventions offered, this included the children's global assessment scale, the strengths and difficulties questionnaire and index of family functioning.
- The trust had started to complete an integrated care records audits across the service. The audit was in test phase during inspection. The service was also in the process of evaluating the crisis team with support from a local university.

Skilled staff to deliver care

- The team consisted of a wide range of mental health disciplines including; nurses (registered mental health and learning disability), psychologists, dietician, family therapists, psychotherapists, counselling psychologists, psychiatrists, primary mental health workers and an occupational therapist. Staff were experienced and sufficiently qualified to carry out their roles.
- The service had one advanced nurse practitioner/ non-medical prescriber.
- The eating disorder team received national training as a whole team. Staff felt that it had been beneficial to the whole team enhancing clinical skills and resources.
- Staff told us that the trust was supportive of ongoing additional training. One member of staff was being supported to complete an art therapy degree.
- The service gave staff one afternoon a week protected time to run skills workshops and to take part in reflective practice groups.
- The trust provided all new staff with an induction. We spoke with to a new member of staff who confirmed that this had been completed as well as a local induction to the service.
- In March 2017, we found the staff appraisal rate was 61%. On inspection January 2018 the appraisal rate was 97%. Managers had implemented systems to ensure staff received appraisals.
- On the previous inspection, staff had reported irregular managerial supervision due to turnover of managers. On this inspection we found managerial supervision rates had improved and that staff also received regular clinical supervision. We saw documentation that evidenced staff received both managerial and clinical supervision as per trust policy.

Multi-disciplinary and inter-agency team work

- All teams within the service had weekly multi-disciplinary team meetings. Agenda items included case discussions and reviews of young people that either did not attend or were not brought to planned appointments, with actions required by the team.
- The crisis team had effective handovers between shifts. We observed two as part of the inspection. We saw that staff discussed workload, new referrals, current patients and assessments to be undertaken. Staff gave each other detailed information effectively and discussed any risks. We observed mutual respect between the staff and a good discussion about the parental responsibility of a patient.
- The service worked in conjunction with two other providers. Barnardo's provided primary mental health care to Solar. During our inspection we saw that the two services worked closely together to ensure a clear care pathway through primary care to CAMHS (secondary care). We saw that the two services reviewed referrals together to ensure that patient received the appropriate level of support needed. The trust and Barnardo's jointly undertook reviews into any care complaints or incidents.
- The service has seconded an occupational therapist from another trust to focus on offering specific occupational therapy interventions for those patients with sensory needs. They will be offering training to other staff on sensory interventions.

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.

- We found evidence within care records of effective joint working with organisations external to the trust. Staff from the service worked with local schools to develop education health and care plans. We also found evidence of detailed joint working with the police and local multi agency safeguarding hub for children identified as at risk of potential child sexual exploitation.

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

- At the time of our inspection 100 % of staff had completed Mental Health Act training.
- During our last inspection March 2017, we found that the Mental Health Act policy had not been updated in line with the Mental Health Act Code of Practice 2015. On this inspection, we found it had been reviewed and updated.
- Staff were able to access the Mental Health Act on the trust intranet site.
- Staff were aware they could access support from Mental Health Act administrators to ensure the correct application of the act.
- The service did not have any patients on a Community Treatment order.

Good practice in applying the Mental Capacity Act

- The Mental Capacity Act only applies to young people 16 years old and over. For young people under 16 years old, Gillick competence is used to determine if the young person is able to consent to their treatment. That is, that they are believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. Otherwise, someone with parental responsibility can consent to treatment for them.
- On inspection in March 2017, we found consent to treatment had not been established or recorded in 89% of care records. We found no evidence of the consideration of Gillick competence and no evidence of the documentation of parental responsibility in 98% of care records. However, on this inspection we found significant improvement.
- Managers had designed and implemented a capacity and consent to treatment form. All staff completed this with patients and or their families and carers on initial assessment. The document explained to patients/ families/ carers the reason to identify parental responsibility, Gillick competence and need for consent.
- Of the 28 care records we reviewed 23 had evidence that capacity and consent to treatment formed had been completed. This was a significant improvement.
- Staff we spoke with were aware of their responsibilities in obtaining consent and understood the need to consider Gillick competence for young people under the age of 16. They told us that they had attended training provided by the child and adolescent psychiatrist to gain a better understanding.
- We reviewed the trusts Mental Capacity Act policy and saw that a section on and about Gillick competence had been added. This would provide staff with additional guidance in ensuring the correct application/ consideration of Gillick competence.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

At the last inspection in March 2017 we rated caring as good. Since that inspection we have received no information that would cause us to change the rating. However, below is additional evidence we gathered on this inspection.

The involvement of people in the care that they receive

- The trust employed a see me worker. The see me worker collected feedback from patients and family and or carers. They worked two full days across both sites; this meant they were accessible to patients and families weekly. The see me worker was supporting the service to set up a youth forum and working alongside patients/ families to get involved in the development of the service, for example patients on staff interview panels.
- Since the last inspection, the service had developed a new service leaflet in partnership with patients. The leaflet explained the journey through the service and what services were available.
- The trust had an online friends and family tool which was child and young person friendly. Feedback from this was reviewed at governance meetings.

Are services responsive to people's needs?

Good

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

Our findings

At the last inspection in March 2017 we rated responsive as good. Since that inspection we have received no information that would cause us to change the rating.

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 values were honesty and openness, compassion, dignity and respect and commitment. Staff we spoke to within the community teams were able to describe these values and gave examples of how they were demonstrated through the care they provided. Staff were also aware of the service vision and plan.
- The service had held a team away day to reflect on progress over the six months prior to inspection and to look at future vision and promotion of team wellbeing. A service commissioner told us that they had been impressed with the service and felt staff had a clear vision for service.
- All staff knew the structure of the service management team and senior management within the whole trust. Staff reported that senior management visited sites through the year.

Good governance

- On inspection in March 2017 we found there was poor governance across the service which had led to an inadequate rating. However, on inspection January 2018 we found significant improvement. This had largely been due to the implementation of a new and consistent management team, who had implemented new systems and processes to ensure that requirement notices were met. This meant:
- There was 97% staff compliance with mandatory training.
- All staff received regular appraisal and supervision.
- Incidents were discussed and reflected upon with clinical governance and team meetings.
- Staff had begun to take part in clinical audit.
- Staff were now routinely considering, gaining and recording consent appropriately.
- Policies and procedures had been developed for the service and trust wide policies amended. An additional appendix specifically for the eating disorder team had been added to the service operational policy.
- Safety within the team environments had improved and there was a plan of work to improve patient facilities to promote comfort and recovery.
- The clinical governance meeting had been improved to include to all sub teams within the service. This enabled the teams to capture and share information more clearly. The see me worker also attended the clinical governance meetings, and was a standing agenda on the governance meetings.
- Performance of the service was monitored using a range of key performance indicators accessible via a monthly team data quality report. Key performance indicators included referral to treatment times, rates for people that either did not attend or cancelled appointments, referrals into the service and individual wait times for specialist interventions.
- The team manager felt they had sufficient authority to make changes to improve the service and had sufficient administrative support.

Leadership, morale and staff engagement

- The service leadership team had changed since the last inspection March 2017. During our inspection in January 2018, we could see that they had worked hard to develop and implement an action plan to address concerns the CQC had highlighted in the March 2017 inspection. We also recognised the hard work of all the other staff within the service, to carry out the action plan, input and feedback about changes in service practice and continue to provide clinical care.
- Most staff we spoke with felt that the service had been constantly improving over the eight months. However, three members of staff felt it was now target driven and there was a disconnect between quality and governance operations.
- Most staff we spoke with felt that the new management team were supportive. Some concerns were raised with regard to some of the management team not being from a CAMHS background. However, it was acknowledged that improvements had been made. Most staff felt that it was an open and transparent place to work and felt listened to by senior managers.

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.

- The service leads had introduced a monthly team brief as one way to keep staff informed of governance, service plans and trust communications. It was introduced November 2017.

Commitment to quality improvement and innovation

- All staff we spoke with reported there had been changes and improvements with the systems and processes within the service since the last inspection March 2016 and the work was ongoing.
- The Clinical Commissioning group, carried out an assurance inspection in December 2017. They recommended that the service carried out care plan audits to ensure compliance.