Stepping Stones Clinic

Quality Report

16 Cannon Hill Road
London N14 7HD
Tel: 07864 254 257
Website: www.steppingstonesclinic.uk

Date of inspection visit: 13 and 15 August 2019
Date of publication: 30/09/2019

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
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 and Deprivation of Liberty Safeguards

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

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

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

Summary of findings

Overall summary

This was the first time we have inspected and rated this service.

We rated Stepping Stones Clinic as good because:

- Young people and their carers were extremely positive, describing staff as 'superb', 'brilliant' and 'fantastic'. Staff were described as discreet and of displaying high levels of empathy. Young people and carers were fully involved in all aspects of their care. A feedback survey from young people and carers was very positive.
- Staff provided a range of treatment and care interventions for young people based on national guidance and best practice. The service had developed its own mobile app for young people focusing on coping skills. The design of the app was evidence-based, easy to use, and allowed users to download their own content to personalise it. A range of tailor-made, jargon-free, leaflets had also been developed. These provided information and practical advice and were written in a way which empathised with young people's, or their carers, experiences.
- Young people and carers were able to become involved in the management and operation of the service. This included attendance as a service user representative at the weekly management meetings.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for young people, carers and staff.
- A staff satisfaction survey reported 98% of staff had job satisfaction, found the management team accessible, felt involved in decisions and considered the leadership team demonstrated the service values.
- Operational performance and risks in the service were managed well.

However:

- Information concerning young people was not always stored in young people's care and treatment records. This included the details of physical examinations and investigations, the reasons for prescribing specific medicines and detailed risk management plans. Clinical staff may not have had all of the information required to provide safe care and treatment.
- Clinical staff contracted to work in the service had one professional reference before starting work in the service, rather than two. All other staff checks were completed. The service did not have a system in place to record and monitor when clinicians had received supervision.
- When staff were working alone with clients there was no system where they could summon urgent assistance.
- Young people and their carers did not have a care plan which they could easily understand and refer to. There were no 'easy read' leaflets or leaflets available in languages other than English, for young people or their carers.
- The complaints policy did not describe how complainants' could appeal if they were dissatisfied with the outcome of a complaint investigation or how it was investigated.

Summary of findings

Contents

Good

Stepping Stones Clinic

Services we looked at
Specialist community mental health services for children and young people

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. This includes all children and young people up to the age of 25 years. The service provides assessment and treatment by a range of professionals.

The families of young people fund their care and treatment at the service, or funding is provided by insurance companies. The service provides care and treatment for young people in London and from further afield including Essex, Kent, Somerset and Hertfordshire.

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 we had not inspected this service previously.

Our inspection team

This inspection was undertaken by two CQC inspectors and a CQC specialist advisor, who was a consultant in child and adolescent psychiatry.

Why we carried out this inspection

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

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the environment
- spoke with three young people who were using the service
- spoke with six carers of young people using the service
- spoke with the registered manager
- spoke with three other staff members who were all clinical psychologists
- Looked at 12 care and treatment records of patients:
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Young people and their carers were extremely positive, describing staff as 'superb', 'brilliant' and 'fantastic'. Staff

Summary of this inspection

were described as discreet and displaying high levels of empathy towards young people and their carers. Young people and carers reported that staff made a particular effort to fully understand them and their needs.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Information concerning young people was not always stored in their care and treatment records. This included details of physical examinations and investigations. This meant clinical staff may not have had access to all of the information they needed to provide appropriate care and treatment.
- The reason why certain medicines were prescribed for young people was not recorded. This included 'off label' medicines prescribed in a way not covered by the medicines licence. Best practice guidance concerning such medicines was not followed.
- Clinical staff contracted to work in the service had one professional reference before starting work in the service, rather than two. All other staff checks were completed.
- Although young people's risk management plans were discussed with young people and their carers, they were not documented in detail in young people's care and treatment records.

However:

- The premises where young people and carers received care was safe, clean and well furnished.
- Staff assessed and managed risks to young people. They responded promptly to sudden deterioration in a young person's health. Staff worked with patients and their families and carers to develop crisis plans.
- 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.
- Staff regularly reviewed the effects of medicines on each young person's physical and mental health.
- The team had a good track record on safety. The service managed safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- Staff assessed the mental health needs of all young people. They worked with young people and families and carers to develop individual care and treatment plans.
- The service had developed its own mobile app for young people focusing on coping skills. The design of the app was evidence-based, easy to use, and allowed users to download their own content to personalise it.
- Staff provided a range of treatment and care interventions for young people based on national guidance and best practice.
- The service included or had access to the full range of specialists required to meet the needs of young people under their care. Staff had a range of skills needed to provide high quality care. The service supported staff with appraisals and opportunities to update and further develop their skills.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how 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.

However:

- Young people and their carers did not have a care plan which they could easily understand and refer to.

Are services caring?

Good

We rated caring as good because:

- Young people and their carers were extremely positive concerning staff in the service. Staff were described as 'superb', 'brilliant' and 'fantastic'. Young people and carers reported that staff made a particular effort to fully understand them and their needs. The quality of these relationships was recognised as very important by young people, carers and staff.
- A range of leaflets had been made by the service tailored to the needs of young people, and separately, for their carers. These leaflets were jargon-free and provided information and practical steps to minimise young people's distress. The leaflets were written in a way which empathised with young people's, or their carers, experiences.
- Young people and carers were fully informed and involved in all aspects of their care. They were asked for their views which were then integrated into young peoples' care and treatment plans.

Summary of this inspection

- Young people and carers were able to become involved in the management and operation of the service. This included attendance as a service user representative at the weekly management meetings.
- The latest feedback questionnaire from young people and carers indicated 89% of them were very satisfied with the service. Ninety four per cent felt that they were understood, all areas they raised were addressed and that they would recommend the service to family or friends.
- Staff had no hesitation in raising any issues concerning discrimination towards young people or their carers. They were confident their concerns would be taken seriously and did not expect there to be negative consequences for them for raising concerns.

Are services responsive?

Good

We rated responsive as good because:

- The service was easy to access. Its referral criteria did not exclude young people who would have benefitted from care. Staff assessed and treated young people who required urgent care promptly and young people who did not require urgent care did not wait too long to start treatment. Staff followed up young people who missed appointments.
- The service ensured that young people, who would benefit from care from another agency or professional, made a smooth transition.
- The service had a complaints policy and staff knew how to handle complaints. There had been no complaints about the service in the previous year.

However:

- The complaints policy did not describe how complainants could appeal if they were dissatisfied with the outcome of a complaint investigation or how it was investigated.
- Although the service had undertaken a 'green light toolkit' audit, information for young people and carers was not available in an 'easy read' version. Information was not available in languages other than English.

Are services well-led?

Good

We rated well led as good because:

Summary of this inspection

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for young people, carers and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively and that performance and risk were managed well.
- A staff satisfaction survey reported 98% of staff had job satisfaction, found the management team accessible, felt involved in decisions and considered the leadership team demonstrated the service values.
- The service had developed a bespoke mobile app for young people and were planning to apply for network accreditation from the Royal College of Psychiatrists.

However:

- The service did not have a system in place to record and monitor when clinicians had received supervision.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had received training in the MCA. They understood the legal framework concerning capacity, both under the MCA and Gillick competency, for young people aged 16 years or over. The service had a mental capacity policy.
- Staff in the service assumed a young person had the capacity to make decisions regarding their treatment. Where young people were not Gillick competent and their carers made decisions regarding treatment, this was not always formally recorded.
- The service had an Independent Mental Capacity Advocate (IMCA) who could support young people over 18 years of age who did not have the capacity to make certain decisions regarding their treatment.

Specialist community mental health services for children and young people

Good

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

Are specialist community mental health services for children and young people safe?

Requires improvement

Safe and clean environment

The service operated from a clinic providing dentistry and chiropody. Two consulting rooms were used by the service. The service did not manage the building. Nevertheless, staff in the service monitored the cleanliness and health and safety of the premises. Staff undertook audits for cleanliness, infection control, fire safety and maintenance. Fire equipment was maintained and portable electrical appliances were tested. There were infection control and hand hygiene policies.

The consulting rooms in the service did not have alarms. A risk assessment for the service assessed the risk of violence and aggression as low. There had been no incidents of violence and aggression in the previous year. However, there was a risk that staff alone in a consultation room would be unable to call for help if needed.

All areas of the service were clean with comfortable furnishings. The building was well maintained with bright décor and a small outside area with seating.

The service did not have a clinic room. However, there was an automated external defibrillator in the service. This is used to restart a person's heart, if required. Staff also used a portable electronic sphygmomanometer (blood pressure machine). Both items of equipment were calibrated to ensure they worked effectively. Oxygen on the premises had also been tested.

Safe staffing

The service was open on the telephone Monday to Friday from 8am to 8pm. Staff were not always based in the service during those times, but were in the service every day.

A consultant psychiatrist was the registered manager and was assisted by an office manager and secretary. Other clinicians working in the service were independent contractors and worked as required. The service checked that all clinicians had current professional registration, appropriate clinical experience and academic qualifications, professional indemnity insurance, and a disclosure and barring service (police) certificate. However, the service received only one professional reference, rather than two, for clinicians. The consultant psychiatrist had, however, handpicked the clinicians contracted to work with the service.

The consultant psychiatrist in the service was on-call throughout the day and night. Young people or carers had the telephone number of the consultant. During periods of absence or sickness, arrangements were in place for another consultant psychiatrist to provide input into the service.

The provider required all staff to undertake 11 types of training. These included fire safety, health and safety, infection control and information governance. All staff had undertaken these types of training. However, the provider's training matrix recorded that four staff had undertaken basic life support training and this was valid for two or three years. Two staff members had undertaken this training in 2017. Guidance from the UK Resuscitation

Council is that life support training should be undertaken every year. The registered manager was aware that this training should be undertaken annually. They had planned to address this.

Assessing and managing risk to patients and staff

When young people first attended the service, staff undertook a risk assessment of the young person. This consisted of past and current episodes of risk behaviour involving the young person. Risk assessments were updated after any incidents.

Young people's risk management plans were based on their assessed risks. This could involve a parent sleeping in the same room as their child at home for a period of time. This was to reduce the risk of the young person self harming. However, details of how young people's risks would be managed and reduced were not always documented in detail. There was not always a record of how high risk situations would be identified and minimised in young people's risk management plans. When young people had thoughts of suicide and self harm, they or their carers were given a specific leaflet. This described how young people could develop coping strategies to deal with those thoughts. Young people's incidents of risk behaviour were discussed amongst the staff team and documented in the monthly risk report for the service.

Young people and their carers had crisis plans. These were, however, general. They consisted of having the consultant's number to contact if required. For young people with thoughts of self harm and suicide, carers were provided with a crisis plan leaflet. This included possible triggers for self harm and a practical, structured approach to dealing with young people's emotional crisis. Young people were also directed to the mobile app designed by the service. This app was specifically for young people with thoughts of self harm or suicide. It included distraction techniques, and emotional and biological moderation techniques. The app clearly signposted young people to the most appropriate techniques when they were experiencing a crisis. If the matter was very urgent young people and carers were to attend an emergency department.

The service had a lone working policy for when staff were working alone in the service. However, the service had not implemented appropriate safety protocols for staff to summon assistance from other people in the building.

Staff were trained at level three in safeguarding children. This is the standard required for staff in child and adolescent services. Staff had a good understanding of safeguarding and the service maintained a safeguarding register. Staff in the service had made four safeguarding referrals to the local authority in 2019. These involved young people harming themselves or being at risk of harm from others.

Young people's care and treatment records were stored on a 'cloud' system. This meant they were accessible to involved clinicians at any time. Clinicians notes of sessions did not always describe the interventions used. This meant clinicians did not always have access to the information they may need.

Staff in the service did not administer or store medicines. The consultant psychiatrist was the only clinician who prescribed medicines to young people. Young people's carers would supervise young people's medicines including their safe storage. Young people were provided with a chart specific to their prescribed medicine. This was to record, every day, any side effects from their medicine. This was best practice. Young people and their carers were also provided with leaflets, developed by the service, concerning medicines they were prescribed. The consultant also had a telephone appointment with the young person or their carers one week after prescribing medicine. This was to check on any unwanted side effects. Young people's GPs were informed when medicines were started or changed.

The consultant did not always record the reasons for the choice of medicines they were prescribing to young people. They did not record that young people or their carers were informed of the risks and benefits, or reasons, when unlicensed medicines were being prescribed, as recommended in best practice guidance (Good practice in prescribing and managing medicines and devices, General Medical Council,2013).

Young people had their blood pressure and weight recorded before medicines were prescribed. The service communicated with young people's GPs for other physical health assessments or investigations. The consultant said that she actively tracked and monitored physical health assessments and investigations required for young people. An audit of this was also undertaken. However, the outcome of these assessments or investigations were not always clearly recorded in young people's care and

Specialist community mental health services for children and young people

Good

treatment records. For example, young people prescribed antipsychotic medicines should have an electrocardiogram. Young people prescribed medicines for attention deficit hyperactivity disorder should have any heart risks assessed and reviewed. There was no record of these assessments or investigations.

Track record on safety

There had been no serious incidents in the service in the year before the inspection.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Young people's incidents of risk behaviour were discussed amongst the staff team and documented in the monthly risk report for the service. The service had an incident policy.

Incidents were reported within 24 hours of staff becoming aware of it. An incident investigation was then undertaken within two weeks. All staff received an email concerning the incident and the outcome of the investigation. This included learning points from the incident. Staff told us about lessons learnt from an incident involving a young person. This learning had re-emphaised the importance of considering substance misuse when staff assessed young people's risks.

Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Staff in the service knew and understood the duty of candour and its requirements.

Are specialist community mental health services for children and young people effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Young people had a comprehensive assessment when they first attended the service. This included information from their carers together with an interview with the young person alone. If a young person was thought to have attention deficit hyperactivity disorder or attention deficit disorder, information was obtained from many sources, such as the young person's school. The young person's assessment incorporated their family, social, educational and medical history. Young people's blood pressure and weight were recorded. Other referral information, such as information concerning young people's physical health was not available, in detail, in their care and treatment records. When young people had previously been assessed as having autism or attention deficit hyperactivity disorder, there was no record in their care and treatment records of who, how and when they had been given this diagnosis.

Young people's plan of care and treatment was discussed with them and their carers. However, there was no written care plan for young people and carers to refer to. The consultant said that the letter sent to young people's GP was their care plan. However, these letters were written in language for other professionals rather than young people or their carers.

Best practice in treatment and care

For young people prescribed antidepressant medicines, best practice guidance from the National Institute for Health and Care Excellence was not always followed. The National Institute for Health and Care Excellence recommend fluoxetine is initially prescribed for children or young people due to evidence that the benefits of that medicine outweigh any risks (Depression in children and young people: identification and management, 2019). The consultant prescribed other antidepressants in the same group of medicines. They also closely monitored the side effects of these medicines. However, for young people who did not respond to any other antidepressants, the consultant prescribed venlafaxine. National Institute for Health and Care Excellence guidance specifically states that venlafaxine should not be used for the treatment of depression in children or young people (Depression in children and young people: identification and management, 2019). The summary product characteristics for venlafaxine state that if used in this way there must be careful monitoring for side effects. This was undertaken by the consultant. When a young person experienced a lack of sleep due to their depression, the consultant prescribed the medicine mirtazapine. This was a prescription outside of the licence for mirtazapine.

Specialist community mental health services for children and young people

Good

Young people with attention deficit disorder or attention deficit hyperactivity disorder were prescribed specific medicines following best practice guidance (Attention deficit hyperactivity disorder: diagnosis and management, National Institute for Health and Care Excellence, 2018).

A range of psychological therapies were available for young people. These included cognitive behavioural therapy, group dialectical behaviour therapy, mentalisation-based therapy and different types of family therapy. The type of therapy most appropriate for the young person was based on a comprehensive assessment and best practice guidance from the National Institute for Health and Care Excellence. An example of this was that young people receiving antidepressant would also have 12 weeks of cognitive behaviour therapy (Depression in children and young people: identification and management, 2019).

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 all of the time. The app used recognised techniques to minimise young people's distress. It contained features such as mindfulness and guided meditation, guidance to help reduce temperature and pulse rate, using exercise as a coping mechanism, and guidance on using touch therapeutically. Young people could also upload calming and pleasant photos and music. The language used in the app could be understood by a range of age groups and clearly identified different strategies for young people to use at different times. For example, the 'rescue me – life jacket' section was for when young people felt overwhelmed and at risk of self harm.

Other therapists were available to meet the specific needs of individual young people. A dietitian was available, particularly for young people with an eating disorder. An occupational therapist worked with some young people, such as supporting them in public places to reduce their anxiety.

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.

A number of clinical audits were carried out in the service. These included a monthly audit of young people's care and treatment records and physical health monitoring of young people. A medicines management audit was also undertaken, as well as an audit to review if young people's treatment was delivered in accordance with National Institute for Health and Care Excellence best practice guidance. This audit identified all young people were receiving treatment in accordance with National Institute for Health and Care Excellence guidance. As the rationale for prescribing specific medicines was not always documented, it was not possible to confirm this.

Skilled staff to deliver care

The service had access to staff who could provide the full spectrum of care and treatment approaches required by patients. These included clinical psychologists, psychotherapists, occupational therapists, a family therapist and a dietitian.

The clinicians working in the service had extensive experience of providing care and treatment for children and young people. They had the required qualifications and had undertaken additional postgraduate education and training. This meant that staff had particular areas of specialisation and could meet the varied needs of the young people who used the service. These included staff with specialist knowledge and experience in autism, self harm, attention deficit hyperactivity disorder, eating disorders and various treatment approaches.

The consultant psychiatrist had regular peer supervision. Staff contracted to work in the service had their own supervision arrangements. However, the provider did not have details of these to ensure that all clinical staff had regular supervision. Discussions had taken place for clinical psychologists working in the service to start their own peer supervision group. At the time of the inspection, this had not commenced.

There were team meetings every three months. These were virtual internet meetings and discussed operational matters such as audits, risks and quality. Any emerging issues which could not wait for the next team meeting were emailed to all clinicians by the service manager.

All staff had received an annual appraisal concerning their work in the service. This appraisal reviewed their work over the previous year. It also identified the staff members' learning needs and how they would aim to achieve them.

Multi-disciplinary and inter-agency team work

Multi-disciplinary meetings were scheduled to take place every two months. This was a forum to discuss young

people with complex needs. However, clinicians also contacted each other in between these times to discuss particular clients and to handover information. This included contact by email and telephone.

The service worked well with other agencies and professionals. For example, therapists closer to young people's homes were often contacted to provide a service. Contact with the service was then maintained to co-ordinate the young person's treatment. The service also had contact with NHS services when required and provided detailed information concerning young people to them. Letters to young people's GPs were sent regularly to inform them of treatment. However, information from other agencies or professionals was not consistently uploaded to young peoples' care and treatment records.

Good practice in applying the MCA

All staff had received training in the MCA. They understood the legal framework concerning capacity, both under the MCA and Gillick competency, for young people aged 16 years or over. The service had a mental capacity policy.

Staff in the service assumed a young person had the capacity to make decision regarding their treatment. Where young people were not Gillick competent and their carers made decisions regarding treatment, this was not always formally recorded.

The service had an Independent Mental Capacity Advocate (IMCA) who could support young people over 18 years of age who did not have the capacity to make certain decisions regarding their treatment.

Are specialist community mental health services for children and young people caring?

Good

Kindness, dignity, respect and support

Young people and their carers were extremely positive concerning staff in the service. They used the words 'superb', 'brilliant' and 'fantastic'. Young people described the consultant psychiatrist as 'naturally kind and caring' and they felt safe talking to her.

Staff were described as discreet and displaying high levels of empathy towards young people and their carers. Young people and carers reported that staff made a particular effort to fully understand them and their needs. The quality of these relationships was recognised as very important by young people, carers and staff.

Young people and their carers were provided with information to understand and manage their mental health problems. A range of leaflets had been made by the service tailored to the needs of young people, and separately, for their carers. These leaflets were jargon-free and provided information and practical steps to minimise young people's distress. The leaflets were written in a way which empathised with young people's, or their carers, experiences. Young people with suicidal thoughts or who self harmed could use the specially designed app to help them manage their feelings.

Young people and their carers were supported to access other services when this was convenient for them or necessary. If young people travelled a long distance to the service, the service located specialists nearer to their home to provide treatment. The service had referred young people to child and adolescent community services and crisis teams when necessary. If there was an urgent crisis, young people and their carers were advised to attend an emergency department. They were also advised to give the consultant psychiatrist's telephone details to staff in the emergency department. This meant that emergency department staff could contact the consultant for detailed information about the young person. Staff also referred young people and carers to support groups and other organisations locally to them.

Young people's assessment for the service was comprehensive, and included the young person's personal, cultural, religious and social needs. These were then incorporated into the young person's care and treatment.

Staff had no hesitation in raising any issues concerning discrimination towards young people or their carers. They were confident their concerns would be taken seriously and did not expect there to be negative consequences for them for raising concerns.

Staff were careful to maintain the confidentiality of young people and their parents. At their first appointment, the consultant psychiatrist saw the young person and their

Specialist community mental health services for children and young people

Good

parents or carers separately, and then together. Two siblings had been treated at the service. The clinical psychologist for one of the siblings did not access the care records of the other as they did not have consent to do so.

The involvement of people in the care they receive

Young people and carers were fully informed and involved in all aspects of their care. They were asked for their views which were then integrated into young peoples' care and treatment plans.

Young people and carers were able to become involved in the management and operation of the service. This included attendance as a service user representative at the weekly management meetings.

Young people and their carers were able to provide feedback about the service in a number of ways. There was a group for young people to provide feedback about the service. After their first appointment, a feedback questionnaire was sent to young people and their carers by email. The response to this questionnaire was anonymous when it was received by the service. The latest feedback from young people and carers indicated 89% of them were very satisfied with the service. Ninety four per cent felt that they were understood, all areas they raised were addressed and that they would recommend the service to family or friends.

A group for carers had been planned. Due to unforeseen circumstances it had been delayed but was due to start later in 2019.

Are specialist community mental health services for children and young people responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Young people were seen within a target time of four weeks from referral. In practice, young people were usually assessed within two to three weeks of referral. When information indicated an assessment was required more urgently, the consultant psychiatrist assessed the client within 24 hours.

When young people or carers contacted the service they received a prompt response. If the consultant was unavailable, the office manager or secretary would take the call. In some cases, they interrupted the consultant's other work when the matter was urgent. Carers reported that the consultant was very accessible and that they had found the service responsive to their needs.

When young people or carers stopped using the service in an unplanned way staff in the service attempted to contact them. This continued until staff in the service could speak to the young person or carers and establish that they were alright.

There was some flexibility in appointment times, with evening appointments available for children and young people. On some occasions, appointments were less flexible and this was due to the specialist skills of a specific clinician and when they could attend the service. Appointments were not cancelled, only occasionally rearranged, and ran on time.

Young people and carers were supported by staff during transfers of care. This included when young people required inpatient mental health care. The consultant had access to such beds. If a young person attended an emergency department the consultant was available to provide a detailed handover to staff at the hospital. A similar handover was provided when young people were transferred to a crisis team, community child and adolescent mental health service or other therapists.

The facilities promote recovery, comfort, dignity and confidentiality

The consultation rooms in the service had adequate soundproofing to maintain confidentiality during meetings with young people and carers.

Young people were supported to engage with the community and maintain relationships when their mental health problems affected this. An example was of the occupational therapist having a programme of community activities for a young person. This was to assist them in overcoming anxiety.

Meeting the needs of all people who use the service

The service made adjustments for young people and their carers when necessary. For example, a young person who was a wheelchair user was seen in a ground floor office. Other young people were seen in first floor consultation

Specialist community mental health services for children and young people

Good

rooms. Some young people and their family members and carers did not speak English. A clinical psychologist working with the service provided interpretation. The service would book interpreters if required.

Young people and carers were provided with information concerning their specific needs. This included verbal and written information concerning treatment and other services appropriate for their needs. Young people and carers were advised of how they could make a complaint about the service.

The service had undertaken a green light toolkit audit before the inspection. The green light toolkit is a recognised audit to assess how user-friendly mental health services are for people who have a learning disability or autism. The audit had highlighted that no easy read information and leaflets were available in the service. The service was in the process of developing specific leaflets.

Staff in the service supported young people and their carers to attend activities specific to their protected characteristics. Staff supported young people from a black, minority ethnic background and young people who identified as LGBT+.

The service had not produced leaflets in different languages. One young person and their carers, in the previous year, had not spoken English as a first language. A clinician in the service interpreted. Interpreters were available when staff could not speak English well.

Listening to and learning from concerns and complaints

The service had received no complaints in the year before the inspection. Young people and carers were aware of how they could complain about the service if they wished to.

The service had a complaints policy. Overall, this followed best practice guidance. However, the complaints policy did not describe how complainants could appeal against the outcome or of how the complaint was investigated. Staff were aware of how to handle complaints and concerns.

Are specialist community mental health services for children and young people well-led?

Good

Vision and values

The vision of the service was to provide safe, high quality and effective care and treatment to young people when they needed it. This meant there were limited waiting times and young people and their families could access treatment and support for all of their needs at the same time.

Staff and clinicians working in the service were enthusiastic in embracing the vision of the service. This had been clearly communicated to them and they reflected the vision in the way that they worked.

Many young people's care and treatment was funded by health insurance companies. Some young people required treatment beyond that agreed with the insurance company. Any barriers to funding additional treatment were overcome without delay to ensure young people's treatment could continue.

Good governance

There was a clear framework of policies, procedures and practices which ensured that the leadership were sighted on safety and quality issues in the service. The system of audits, performance reports, and governance meetings ensured that incidents, safeguarding referrals and complaints were reviewed and discussed regularly. There was a specific focus on ensuring the virtual team of clinicians were provided with up to date information so that they could learn from incidents and were aware of changes to the provider's systems. However, there was no record that the provider had oversight of clinicians receiving regular supervision.

The service had a risk register, which reflected risks to the service. A business continuity plan was in place which identified how the service would continue to operate in case of unplanned disruption.

There were policies available to staff via the 'cloud' and staff were informed when new policies and procedures were introduced. The service had a 'being open' and whistleblowing policy. Staff were confident in raising concerns to the leadership team without fear of any consequences.

Specialist community mental health services for children and young people

Good

Leadership, morale and staff engagement

The leadership team in the service were experienced, skilled and capable to ensure the service was operated in a way that provided high quality care. They were accessible to young people, carers and staff.

A staff satisfaction survey was undertaken in June 2019. Ten staff (59%) completed the survey. Job satisfaction, accessibility of the management team, involvement in decisions and demonstrating values all received a score of 98%. Staff felt connected to, and engaged with, the service leadership and were complimentary regarding the systems developed to communicate with a virtual team.

Commitment to quality improvement and innovation

The service had developed its own mobile app for young people focusing on coping skills. The design of the app was evidence-based, easy to use, and allowed users to download their own content to personalise it.

The service was in the process of seeking accreditation of the Quality network for Community CAMHs from the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI).

Outstanding practice and areas for improvement

Outstanding practice

The service had developed its own mobile app for young people focusing on coping skills. The design of the app was evidence-based, easy to use, and allowed users to download their own content to personalise it.

Areas for improvement

Action the provider MUST take to improve

- 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 two professional references are obtained for clinicians contracted to work in the service. Regulation 19(3)(a)

Action the provider SHOULD take to improve

- The provider should ensure a system is in place which records when clinicians have received supervision.
- The provider should ensure that young people and their carers have a care plan which is easily understood and describes what treatment is being provided and how.
- The provider should ensure the complaints policy describes the information that should be given to complainants to appeal the outcome of a complaint or how a complaint has been investigated.
- The provider should ensure that information for young people and their carers is easily accessible, including easy read versions and versions in different languages.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed