

Outstanding

Leeds and York Partnership NHS Foundation Trust - Specialist deaf community mental health services for children and young people

Other specialist services

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)
Lime Trees	RGD01	Deaf child and adolescent mental health services (York)	YO30 5RE
Royal Manchester Children's Hospital	RGD01	Deaf child and adolescent mental health services (Manchester)	M13 9WL
Benton House	RGD01	Deaf child and adolescent mental health services (Newcastle)	NE2 1QE

This report describes our judgement of the quality of care provided within this core service by Leeds and York Partnership 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.

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service

Outstanding



Are services safe?

Good



Are services effective?

Good



Are services caring?

Outstanding



Are services responsive?

Outstanding



Are services well-led?

Outstanding



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

Contents

Summary of this inspection

	Page
Overall summary	5
The five questions we ask about the service and what we found	6
Information about the service	11
Our inspection team	11
Why we carried out this inspection	12
How we carried out this inspection	12
What people who use the provider's services say	12
Good practice	13
Areas for improvement	13

Detailed findings from this inspection

Locations inspected	14
Mental Health Act responsibilities	14
Mental Capacity Act and Deprivation of Liberty Safeguards	14
Findings by our five questions	16

Summary of findings

Overall summary

We rated specialist community mental health services for children and young people as outstanding because:

- Feedback from young people and carers who used the services and from those jointly working with the team was universally positive about the way the service responded to individuals.
- Team members consistently tailored evidence based interventions to meet the specific communication needs of children, young people and their families.
- The service delivered an extensive range of psychological interventions recommended by the National Institute for Health and Care Excellence to meet the needs of children and young people who used the service.
- The strong research culture within the service further developed evidence based practice for deaf children, young people and their families.
- Strong and respectful multidisciplinary working took place. Staff were passionate, enthusiastic and dedicated to working collaboratively.
- There was a strong, visible, person centred culture of care and support that included access to advocacy for young people and their families.
- Continuous professional development through training was embedded in the teams, this included sharing knowledge and positive practice across the service.
- The senior management team offered clear leadership and the service committed to a shared vision.
- Effective governance systems were in place to monitor appraisal, training, management and clinical supervision.

Summary of findings

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

Are services safe?

We rated safe as good because:

- The facilities that we visited were clean and well maintained. Those used by the teams that were local to where families live, were compliant with the Disability Discrimination Act 2005.
- Caseloads were managed and reassessed at weekly shared knowledge of cases meant cover for sickness; leave and vacancies could be done within the team by staff aware of the needs of young people and their families.
- Staff sickness and vacancy rates were lower than the trust's average, this offered continuity of care and good organisational memory of cases.
- Compliance with mandatory training exceeded the trust's target. Some mandatory training had been adapted to be accessible to deaf staff.
- Lone working procedures were embedded in practice; the policy had been adapted to be accessible to all staff members, with the systems in place regularly reviewed.
- All staff knew how to report incidents and near misses; there was evidence that the service reviewed internal and trust wide data, sharing lessons learned.
- Staff knew how to make a safeguarding alert when appropriate and were trained to level three safeguarding children; in addition, staff attended child protection supervision quarterly.

However:

- Practitioners in Manchester and Newcastle did not have reliable access to the trust's electronic recording system.

Good



Are services effective?

We rated effective as good because:

- Referrals were discussed ahead of initial appointments to ensure the right mix of specialists at an accessible venue; letters sent to families had photographs of the practitioners they would meet next to their names.
- At the first appointment families were given a welcome pack, complaint and compliment information and user-friendly electronically adapted consent forms.
- Assessment included a communication profile of the young person and their family to ensure effective communication.

Good



Summary of findings

- Assessment reports, which included risk, were available in a variety of formats to ensure young people, their family and other professionals involved in care could access this information.
- Care records showed holistic and recovery-orientated care with personalised care plans that were reviewed regularly.
- Team members offered psychological therapies recommended by the National Institute for Health and Care Excellence that had been adapted and clinically validated to meet the specific needs of service users.
- Strong and respectful multidisciplinary working took place across the service. Shared knowledge of ongoing cases allowed young people and their families' access to the specific expertise of team members when required.
- There was an embedded culture of continuous training and development sharing knowledge and positive practice across and beyond the service.
- Team members understood the need to safeguard children and young people, undertook mandatory training, made referrals if required and reflected on safeguarding practice.

However:

- Although full assessments of risks were completed for each child or young person using the service, these were stored in different places making it difficult to track updates.
- Some of the adapted care plans could not be uploaded onto the trust's electronic recording system.

Are services caring?

We rated caring as outstanding because:

- Feedback from young people, their carers and from those jointly working with the team was universally positive about the service and the way staff treat people.
- Methods of communication with young people and their families through the office staff took into account their preferences; this choice was described by carers as wonderful, different from the rest of the National Health Service and exceeded their expectations.
- Staff delivered care in a thoughtful and sensitive way that was adapted to the needs of the young person. Interactions were at an appropriate level and communicated in ways that focussed on recovery.

Outstanding



Summary of findings

- Staff produced different versions of care plans in accessible formats with reference to the young people's wishes and feelings that could be understood by the young people, their families and others involved in care.
- Young people were empowered as partners in their care. They liked the staff, and believed the team understood them, recognising the totality of their needs and helping them to communicate their thoughts and feelings to others.
- Carers told us the staff were brilliant, caring, and took the time needed to communicate in different ways which meant everyone understood young people's emotional and social needs.
- Young people and their families were active partners in their care and informed service development through feedback.
- A specifically designed iPad project had captured service user experiences in a way that empowered them.
- A strong, visible, person-centred culture of care and support included access to advocacy for young people and their families.

Are services responsive to people's needs?

We rated responsive as outstanding because:

- The service had clear criteria for accepting referrals and an of alternative provision for referrals it could not accept. Ahead of referral, the service offered consultation to discuss potential cases.
- Initial assessment included risk and mental health assessments plus a full communication profile for the young people referred, this ensured the needs and preferences of individuals were central to the planning and delivery of care.
- Pre-planned appointments to offer therapeutic support usually involved more than one worker. These were set up in the locality to provide choice and to ensure young people and their families had continuity of care.
- The staff created bespoke resources to support treatment and care for individuals as required.
- Where appropriate staff worked alongside other care providers to ensure integrated person-centred care, particularly for young people with multiple needs.
- A range of information about the service had quick response codes that could be scanned into smartphones enabling access to information using British sign language.

Outstanding



Summary of findings

- Skilled interpreters able to work with young people using British sign language supported therapeutic work. When a family spoke a different language sessions had involved both language and signed interpretation.
- Discharge was planned and included supporting families to create links with other services who could support them in the longer term.
- The service encouraged feedback and had worked to ensure young people and their parents or carers were able to communicate this to them.
- The service had implemented changes as a result of feedback from young people, their carers and external organisations.

Are services well-led?

We rated well led as outstanding because:

- Staff values reflected those of the trust, the specialist service set internal objectives that were challenging and innovative, yet achievable.
- The senior management team offered clear leadership to a service committed to a shared vision.
- Effective governance systems were in place to monitor appraisal, training, management and clinical supervision.
- The service had a clear commitment to quality improvement, agreed plans motivated staff to go the extra mile. Progress was reviewed and monitored at clinical governance meetings.
- Staff were universally positive about local managers and local managers were in turn positive about their relationships with senior management.
- Team members spoke of feeling valued, being supported and proud to work within the specialist service.
- Staff morale was high; staff were dedicated, motivated, passionate and proud about the work they did to support deaf young people and their families.
- Specific local operational instructions developed for the specialist deaf child and adolescent mental health service supported staff to deliver safe and innovative care.
- The service was actively involved in clinical audits to monitor care and staff at all levels were encouraged to raise any concerns they had.
- The service reported to commissioners annually on key performance indicators. Managers and the wider team contributed to this report using data from team evaluations.

Outstanding



Summary of findings

- The culture within the service was to deliver research based mental health practice to deaf young people and their families. This drove a culture of continuous improvement across the service.
- Innovative practice included the development of technology, working alongside young people to ensure this met their needs.

Summary of findings

Information about the service

Leeds and York Partnership NHS Foundation Trust provide a regionally commissioned specialised mental health services for deaf children and young people with mental health problems. The service also works with hearing children of deaf parents, when the child has a mental health issue. It is part of the national deaf specialist services for children and adolescents with mental health problems.

The service operates a child and family model, employing clinicians (including psychiatrists, psychologists, nurses and social workers). Clinicians work with deaf staff and interpreters to ensure that the child and family can work in their first or preferred language in a culturally sensitive way to address their mental health needs.

Deaf child and adolescent mental health services (Northern Region) have centres in Manchester, Newcastle and York. The service is flexible about where meetings and sessions take place, so distance from a centre was not an issue for families. We visited:

- Deaf child and adolescent mental health services - York
- Deaf child and adolescent mental health services - Manchester

The Care Quality Commission last inspected child and adolescent mental health services provided by the trust

in October 2014, the specialist deaf child and adolescent mental health service was included within the overall reporting of the child and adolescent mental health services. The service was rated as requiring improvement in the safe, effective, responsive and well led domains. Caring was rated as good. This resulted in an overall judgement of requires improvement. Following the inspection, the trust provided us with an action statement that addressed areas we identified as non-compliant regulated activities.

The national deaf child and adolescent mental health service north submitted an action plan completed on 27 June 2016 that evaluated existing technology and discussed with staff improvements that may be required. This led to the development of a specification for additional, improved technology to support communication using sign language.

Information technology systems used in Manchester and Newcastle remain on the trust risk register as the firewalls at these sites restrict access to some of the technology systems used by Leeds and York Partnership NHS Foundation Trust. This meant that some electronic systems remained inaccessible to staff in Manchester and Newcastle.

Our inspection team

The team was led by:

Chair: Phil Confue, Chief Executive of Cornwall Partnership NHS Foundation Trust

Head of Hospital Inspection: Nicholas Smith, Head of Hospital Inspection (North West), Care Quality Commission

Team leaders: Kate Gorse-Brightmore, Inspection Manager, Care Quality Commission

Chris Watson, Inspection Manager, Care Quality Commission

The team that inspected this core service comprised one inspector, one psychologist, one occupational therapist and a registered mental health nurse working within children and adolescent mental health services.

Summary of findings

Why we carried out this inspection

We inspected this specialist service as part of our on going 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 two services at two of the three sites and looked at the quality of the environment.
- spoke with three young people who were using the service.
- spoke with nine carers of young people who were using the service.

- spoke with eight agencies who referred young people and their families to the service and continued to work alongside the specialist practitioners.
- accompanied staff on to two home visits.
- spoke with the three community clinical managers for each service.
- spoke with 12 other staff members including administrators, doctors, interpreters, nurses, psychologists and social workers.
- interviewed the service manager with responsibility for the service.
- looked at 12 treatment records of young people who were using the service.
- attended and observed three sessions where care was being delivered.
- attended and observed two staff meetings.
- attended and observed a clinical governance meeting.

What people who use the provider's services say

During the inspection, we spoke to three young people who use the service and nine carers.

The feedback from the young people was that the team understood them, helped them to understand feelings and communicate these to others. Young people described staff as caring and fun. Young people had copies of their care plan that they understood and were pleased they had workers from the specialist team.

Parents and carers spoke of staff being calm at difficult times and help being available to them if they telephoned. The specialist team were liked, knew how to

communicate with their young person and gave feedback that was useful. Carers commented on the team understanding the whole picture by meeting their child, themselves and by going into school. We were also told workers had really helped other professionals' at large meetings understand their child.

Carers knew what would happen throughout the team's involvement, and that workers from elsewhere would remain involved with their family. In addition to the direct work, staff had opened up networks to help families connect to the deaf community in their locality.

Summary of findings

We also contacted eight external organisations: schools, child and adolescent community mental health teams, speech and language therapists and local authority social workers who referred to and worked with the specialist deaf service north. Without exception these teams spoke

of workers from the team offering professional and effective assessment, support to the young people and families they worked with and clarity particularly around effective communication to colleagues.

Good practice

The culture within the service was to deliver research-based practice to young people and their families. The teams used their meetings to reflect on their practice in ways that fed into service development. Team members spoke of feeling valued and being proud to work within the specialist service that had a culture that encouraged all staff to work together and further develop expertise.

Team members consistently tailored interventions to meet the communication needs of young people and their families. This meant the development of bespoke care tools for individual sessions. Service information contained quick response codes (machine-readable

codes consisting of an array of black and white squares, used for storing information) that allowed documents to be scanned into smartphones enabling access to British sign language.

The service was embedded in the deaf communities it served with links that were both professional and social. This had broken down barriers and reduced stigma for deaf users of the child and adolescent mental health teams.

Supervision and support were available to and accessed by all staff, this included freelance interpreters who worked with the teams.

Areas for improvement

Action the provider **SHOULD** take to improve

The specialist deaf child and adolescent mental health north team members had an inconsistency in their access to the electronic systems used by the Leeds and York Partnership Foundation Trust. This meant the team recording systems were different for the three service areas. For information technology systems to work effectively across Manchester and Newcastle access issues to systems through the firewalls for separate health trusts, need to be reconciled.

Risk and care plans were not consistently available electronically. Whilst in part this was due to staff access to the electronic notes system and the need to develop additional or improved technology to support documentation using sign language or pictures, staff also identified there was need to work more towards consistent recording of practice.

Leeds and York Partnership NHS Foundation Trust - Specialist deaf community mental health services for children and young people

Other specialist services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Deaf child and adolescent mental health services York	Lime Trees 31 Shipton Road York, YO30 5RE
Deaf child and adolescent mental health services Manchester	Harrington Building Royal Manchester Children's Hospital Oxford Road Manchester, M13 9WL

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

At the time of our inspection none of the specialist deaf community mental health team north were involved with a patient detained under the Mental Health Act 1983.

Staff did attend mental health legislation training every two years and showed an understanding of the code of practice and the guiding principles, particularly those relevant to young people under the age of 18.

Staff told us if they were to be involved with a detained young person they would need to access additional support and advice on implementation of the Mental Health Act and Code of Practice. The consultant psychiatrists within the service were identified by staff as the individuals they would go to in the first instance. Staff knew that the mental health office in Leeds would support them directly with any specific queries.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Across the specialist deaf community mental health services for children and young people north 86% of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were aware of the five statutory principles of the Mental Capacity Act and could refer to the trust policy. For patients 16 and under, staff understood and would consider Gillick competence to determine if a patient could consent to his or her own treatment, without the need for parental permission or knowledge.

The work we saw within the specialist deaf community mental health services for children and young people was collaborative. Young people and their parents or carers gave consent. Young people were supported to make the decisions where they could and when this was not possible decisions were made in consultation with those who knew them best, recognising the importance of the young person's wishes, feelings and culture.

Are services safe?

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

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

Our findings

Safe and clean environment

The service had three bases across the north of England and was flexible about where meetings and sessions took place. Families met team members in or near their homes. Patients who lived near to the premises in York, Newcastle or Manchester might be seen on site, although this was unusual.

In York, we saw secure access to the building where the team were based. The systems in place to sign visitors and staff members in and out of the service ensured staff had an awareness of who was in the building at all times and if a session was taking place. No alarms were fitted in the interview room however, all staff; including the receptionist whose desk was directly outside the intervention room had completed personal safety with breakaway skills training. Fire escapes were clear and signage to these was good. The fire alarm was fitted with a light so deaf staff could see that the alarm had been activated.

In Manchester, we also saw secure access to the building where the team were based. Office space was shared and the team administrator had an oversight of any additional rooms pre-booked electronically by practitioners. The environment on the first floor could be accessed by stairs or a lift. The area was shared with two other teams so specific resources required for sessions were carried from the office by staff. Interview rooms had alarms fitted. Fire escapes were clear and well signed.

We were told by staff interviewed using facetime that in Newcastle the office accommodation at the team base was cramped, with limited access to parking. The service was considering re-locating this team to a more suitable office space.

None of the team bases had a clinic room. Physical examinations of young people being seen were the responsibility of referring agencies. Medication was neither dispensed nor stored within these services.

We completed a tour of the premises' visited in York and Manchester. The facilities in both were well maintained and regularly cleaned. At both bases, electrical equipment had portable appliance testing stickers that were visible and in date.

Staff were aware of infection control principles including hand washing, 100% of staff had completed training in infection control.

Safe staffing

All teams worked core hours of 0900 to 1700 Monday to Friday. The service was not set up to respond to crisis, the child and adolescent mental health service in the young person's local area would do this. The number of referrals accepted by the service in 2015/16 was 116; although the service accepted referrals for young people aged 0 to 18, most were in the age group 11 to 16; the gender split of referrals was 65% male, 35% female.

To calculate the number of staff required at each base the provider had looked at referral figures from the previous year within specific geographical areas. The number of staff in each team related to the anticipated number of cases each year. The teams were clear that this was not an exact science. Some team members worked across more than one of the three areas, creating additional flexibility within the system.

The average caseload was 15 cases per full time care co-ordinator. At the time of our inspection there were no service users awaiting allocation of a care co-ordinator. Caseloads were managed and reassessed at regular weekly team meetings and within supervision.

Within the teams, there was shared knowledge of cases. This meant cover arrangements for sickness, leave and vacancies could be done within the team by staff aware of the needs of young people and their families.

Due to the specialist, skills and knowledge required to work within this service agency or bank cover was not used. Staff from within the service covered their own teams leave, sickness and vacancies. This could increase caseloads significantly if cover was unplanned, or over an extended period. The provider made a priority of recruitment to empty posts where vacancies had occurred.

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There was rapid access to a full time consultant psychiatrist when required. In York, the psychiatrist was present on site four days a week, in Newcastle one a day. On days when not physically on site queries were covered by telephone. In addition, a psychiatrist in Doncaster offered one session each week. In Manchester, there was a consultant psychiatrist available two days a week. Their additional roles were on the same hospital site, so there was the flexibility to meet briefly with staff on days when not specifically working in the specialist service should this be required.

Establishment

The overall service manager was York based with administrative support from a team co-ordinator.

The lead psychologist worked across all three sites.

A professor of psychiatry offered two days a month to complete specialist assessments, with one additional session of psychiatry each week in South Yorkshire.

In the York team:

- One team leader
- 0.8 consultant psychiatrist (in York 4/5 days available by phone when in Newcastle)
- One band seven clinical psychologist
- One band six nurse
- Lead clinical British sign language/English interpreter
- Two specialist deaf outreach workers
- One support service secretary/receptionist

There was an additional session each week from a psychiatrist working in Doncaster.

This team was under staffed for a period of time when the previous team leader and a psychologist left. Use of agency or bank had not been possible so the team covered these posts whilst vacant, increasing individual caseloads. At the time of our inspection, one full time staff member was on long term sick. The team had picked up their workload. Whilst managing absences within the team had increased pressure on staff, this had not resulted in a waiting list for patients.

In the Newcastle team:

- One team leader (vacancy with band six nurse acting up)

- 0.2 consultant psychiatrist (in Newcastle 1/5 days covers queries by phone the other days)
- 0.6 band eight clinical psychologist
- One band six community practitioner
- 0.4 team interpreter
- One specialist deaf outreach worker
- 0.4 family support worker
- One support service secretary

Following the promotion of the Newcastle manager, the band six practitioner had covered this vacancy for a three-month period while their own post was unable to be backfilled. The stability within team and shared knowledge of cases meant colleagues managed with the resources available. However even with support, sustaining two roles over an extended period increased pressure on staff. Interviews for this vacancy were to take place the week after our inspection.

In the Manchester team:

- One team leader
- 0.4 consultant psychiatrist (employed by Central Manchester University Hospitals)
- 0.8 band eight clinical psychologist (vacancy)
- One band six mental health practitioner
- 0.5 team interpreter (other freelance interpreters who are used to working within the service were used on a sessional basis)
- Two specialist deaf outreach workers (one on secondment part time training as an occupational therapist)
- One support service administrator (employed by Central Manchester University Hospitals)

At the time of our inspection there were two vacancies, one in Newcastle, one in Manchester, both had been advertised in a timely way to ensure a minimal wait for the staff covering these roles. At 7% for the whole service, deaf child and adolescent mental health services were below the trust average vacancy rate of 14%.

Low staff turnover offered continuity of care and good organisational memory of cases.

Are services safe?

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Overall staff sickness rate in this service was 0.5%, below the trust average of 4%.

The current training compliance (July 2016) for the specialist community national deaf child and adolescent mental health service north was 92%, with no figures below 75%. The trust's target for mandatory training was 90%.

In York, for both teams in the north east, face to face mandatory training was organised over four days each year. Adaptations had been made to some training to meet the needs of deaf staff within the teams. The Manchester team accessed to face to face mandatory training locally. On completion, certificates were sent to a training co-ordinator within Leeds York Partnership NHS Foundation Trust to be added to individual staff records.

We saw specific sections on the management supervision forms that discussed training needs and checked that mandatory training was booked. Staff also allocated time to complete I Learn training.

Access to the electronic systems to complete e-learning training had been a challenge for staff not able to connect to the local intranet. However, recently modules had been moved allowing access through the internet using I Learn. This had made access for staff based in Newcastle and Manchester possible without travel.

Essential life support, infant and child and personal safety with breakaway skills training, had the lowest rate of completion with 79%. Both these courses were to be repeated in October 2016 when eight staff had places booked.

Mandatory training figures

The service had an overall compliance rate of 92% with mandatory training. Staff unable to attend training due to maternity leave, long-term sickness or placement away from the team are not shown in this percentage calculation.

- Clinical Risk 94%
- Duty of Candour 84%
- Equality and Diversity 94%
- Essential Life Support – infant and child 79%
- Fire level 2 100%
- Health and Safety 94%

- Immediate Life Support 89%
- Infection Control Clinical 100%
- Information Governance 94%
- Mental Capacity Act and Deprivation of Liberty Safeguards level 2 86%
- Mental Health Act legislation 89%
- Moving and Handling Principles 100%
- Personal Safety with Breakaway Skills 79%
- Safeguarding Adults 89%
- Safeguarding Children level 3 94%
- Trust Induction 100%

Assessing and managing risk to patients and staff

We examined 12 care records in York and Manchester. All demonstrated good practice however; there were issues around capturing all the intervention information offered by the team on the electronic system in York. The firewall in the Manchester did not allow consistent access to the electronic recording system used by Leeds and York Partnership NHS Foundation Trust. Liaison between the information technology departments of both trusts had been ongoing for over a year. At the time of inspection, the system used in Manchester was entirely paper based.

Ahead of assessment, the referral forms to the teams asked about risk. Following the initial assessment appointment an initial safety assessment management plan was completed by the workers involved.

Having undertaken a risk assessment this was recorded, sometimes in different formats to ensure it would be accessible to patients, their carers and staff. For young people with significant risks 'my plan' an adapted document made accessible to the patient, completed in paper or digital versatile disc format was available. Young people assessed as being at significant risk would usually be open to tier three specialist multidisciplinary child and adolescent mental health teams offering assessment and intervention in their locality and/or specialist residential schools. Other services described communication from the specialist service around risk as both supportive and responsive.

Risks were reviewed regularly with patients in the multidisciplinary meeting, and where appropriate with

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referrers. Risks were being reviewed however, this was not being recorded consistently within the electronic care records. The trust had been asked by the team to make improvements to this system that would allow staff to upload documentation created in an accessible format. Due to the contractual arrangements in place the team had been told this was not possible.

There was a specific plan to support the community staff to improve their recording on the electronic care system over the next six months. In Newcastle, this involved changing the laptops the team used to give them effective remote access to the system. In Manchester, the team were to be given laptops, although staff believed access to the electronic notes system might still present a challenge when linked to the system in the office as their network provider was through a different health trust. Given the team's shared knowledge of cases, with recordings of risk in paper form, and no use of agency staff, there was minimal impact on patient care that not all of the updated information was on the electronic system.

The service was set up to offer specialist advice rather than respond to crisis. However, we saw evidence of the team's responsiveness to young people in crisis during treatment and on the waiting lists. This included supporting the management of a mental health crisis for a patient known to the service by sharing information with carers and mental health staff from locality teams, particularly around effective communication. Staff also attended specific meetings with local services to identify when the timeliest assessment from the specialist team might be for a referred patient in crisis.

The waiting time for a family to see the specialist deaf child and adolescent mental health community service was within four weeks of referral. Young people were referred by other professional services that had ongoing responsibility to monitor and respond to any deterioration in health. We spoke to seven services that have referred young people and their families to the service. All told us that if there had been a deterioration or sudden change in the young person, the specialist child and adolescent deaf service team responded positively offering both families and referrers support and guidance.

There was no dispensing, transporting or storage of medicines by the specialist teams from any of the three sites.

Across all three teams, 94% of staff were trained to level three safeguarding children. Staff attended child protection supervision quarterly. Staff knew how to make a safeguarding alert when appropriate. The teams covered a wide geographical area and liaised directly with the safeguarding teams at the local authorities concerned. Details of concerns were also sent to the trusts safeguarding team based in Leeds.

For children on the child protection register their named key worker actively participated in any 'team around the family' meetings. Staff also worked with the local authorities to safeguard and promote the welfare of children and young people.

Team members never went out alone on a first visit. All staff including administrative workers were trained in personal safety with breakaway skills. The teams operated good personal safety protocols including lone working practice adapted to meet the specific needs of team members. All team members used an electronic diary that could be updated by text from their mobile phone when out of the office. Deaf staff had an app on their phones to ensure they could contact emergency services if needed.

The whereabouts of staff and expected time of return was recorded on a whiteboard; staff not returning to the office let the office know they were safe by text or telephone. If a staff member did not contact the office this was followed up initially by a call or text to the individual, then to their next of kin. If no contact could be made the police would be informed. There were safe words in the form of a sentence to be used verbally or by text to alert the office if a staff member felt in danger. Community and reception staff knew what this was and if used this would trigger contact with the police.

Track record on safety

In the period 1 March 2015 and 23 February 2016, the trust reported 48 serious incidents in total. The specialist deaf community mental health services for children and young people had reported no incidents that met serious incident criteria. Should a serious incident occur this would be recorded by the trust through the incident reporting system.

The updated trust incident data April 2015 to June 2016 showed no incidents reported by specialist deaf community mental health services for children and young

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people. Whilst there had been no serious incidents, the specialist deaf service recorded and reported concerns using the incident reporting system, most frequently under the category of safeguarding.

Reporting incidents and learning from when things go wrong

All staff knew what to report and how to use the systems in place to report incidents. For the specialist deaf community child and adolescent mental health service the highest number of reported incidents were categorised as safeguarding incidents. The service manager reviewed all incidents and complaints. One incident relating to information governance, breach of confidentiality was reported in February 2015. The correct processes had been followed and the outcome recorded as 'no harm caused'.

We attended a clinical governance meeting where trust wide and local incidents were discussed. The emphasis was on cascading lessons learned to the wider teams through their meetings. If appropriate, specific incidents would also be reviewed with an individual practitioner within managerial supervision.

Information about improvements in safety that were specific to this core service included team members driving

long distances. Although no specific incident had occurred, there had been a recent near miss reported. In addition to a discussion about staff management of appointments, supporting staff to access advance driving courses was under consideration.

Staff awareness of duty of candour was raised at the governance meeting with an action of refreshing staff understanding at team meetings on each site. The staff we spoke to were aware of the requirement to be open and transparent with patients and their relatives if things went wrong. From an information governance incident over a year ago, staff were open with the patient and their family about what had happened. Following a review, systems were changed whereby the administrators confirm the school recorded on the notes is the school attended by the child before sending out any information.

Staff received feedback on incidents cascaded through governance to team meetings and if appropriate specific incidents were also reviewed individually within managerial supervision.

Staff believed that if a serious incident took place they would be de-briefed and supported by their peers and the management within the service.

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

For professionals considering referral to the specialist deaf child and adolescent mental health community service the teams offered consultation to discuss potential cases. The referral form contained clear criteria for access to the service, the requirement of parental agreement before referral, and any known risk factors. Referrals to the service were discussed in team meetings ahead of initial appointments to ensure the right mix of practitioners were available to assess.

The service had a guide for parents and carers that explained who the service was commissioned for, how to access the teams and what help could be offered. Young people and their family were seen for an initial assessment within four weeks of referral to the service. A welcome pack, complaint and compliment information and user-friendly electronically adapted consent forms were given to families and the service explained at the first appointment.

We saw comprehensive assessments completed in a timely manner, with an initial assessment appointment offered within 14 days of referral. These assessments involved a team of three, including a deaf member of staff and an interpreter.

During this assessment clinicians began a communication profile of the child and their family; this ensured those working with the child used the most effective method of communication. In addition the children's global assessment scale a numeric scale used by mental health clinicians to rate the general functioning of children under the age of 18 and a safety assessment management plan to identify risk were completed. Assessment reports in the form of a letters written in plain English, digital versatile disc letters in British sign language and child friendly versions with pictures were seen.

Following this a whole team discussion took place to ensure the right resources or specific assessments were available to support care. Key and co-workers were identified for each case, with decisions made about on-going work and any need to change those initially allocated. From this point onwards patients were discussed regularly within the team, this built a shared knowledge of each practitioners caseload. Practitioners with specific skills were involved in casework as required.

We examined 12 care records, which showed holistic and recovery-orientated care. There were personalised care plans that were reviewed regularly, with a system in place that ensured reviews took place a minimum of six monthly. Records of the multidisciplinary team meetings showed regular reviews of patients, practitioner reflection and updating of care. However, the individual electronic records we reviewed did not always capture all this up to date information, nor did they always reflect the range and level of support offered to young people and/or their families.

The co-ordination between the electronic and paper based systems so that all information was readily available in electronic form, was a challenge for this service. The documents within the paris electronic notes system (designed to provide a fully integrated electronic health and social care application for community and hospital settings) were adult and hearing based. Although these were completed initially, they were not regularly updated nor used the way an adult service would. For example, documents from this system were not given to young people because they would not be accessible to them. Instead, the team created digital versatile disc letters or care plans with visual prompts. The service had asked about making changes to paris to allow these documents to be uploaded, but the trust has gone out to procurement for the electronic system, so this could not be actioned. The team in Manchester used an entirely paper based notes system.

Information needed to deliver care was stored securely and was available to staff when they need it.

Best practice in treatment and care

Medication was not dispensed by any of the teams within in the service. The consultant psychiatrist rarely prescribed medication directly. When this did occur, for example, as part of an intervention for a young person with a diagnosis of attention deficit hyperactivity disorder, it was monitored by the prescribing doctor. Information would be shared with the young person's general practitioner (GP) and local psychiatrist. Once the correct dosage was established prescribing would be transferred to the psychiatrist within the local child and adolescent community team in line with current guidance from the National Institute for Health and Care Excellence .

Team members were able to offer psychological therapies recommended by national institute for health and care

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excellence, these included adapted cognitive behaviour therapy to treat anxiety and depression, emotional regulation work to enable young people to adapt or change strategies to successfully meet their needs in stressful situations from ones that did not.

In addition, members of the team were involved in developing national quality standards for working with deaf children for the national institute for health and care excellence. Care pathways, 'working with deaf parents' and 'self-harm' were being submitted to the National Institute for Health and Care Excellence from the service.

We saw good practice shared across the directorate at regional and national days. For example, the Manchester team had shared work on sexually harmful behaviour of deaf children as both victims and perpetrators.

Interventions by the service included support to the schools young people attended. This involved providing consultation and training for staff; preparing reports which included specific interventions and attending meetings.

The young people with access to the specialist deaf community child and adolescent mental health service had physical healthcare checks through their school nursing team and/or the community paediatrician. The prescribing doctor would monitor any mental health medication prescribed.

The health of the nation outcome scales for children and adolescents and strengths and difficulties questionnaires for parents and children had been specifically adapted for young people and their families making it possible to use these tools to measure outcomes within the service. To enable families to give timely and accessible feedback about the service iPads were used to record outcome measures.

Audits and research informed practice. Recent clinical audits included case records and letters sent to young people and their families. The service worked with the research team to ensure adapted techniques and interventions remained evidence based. Team members were supporting work on an adaptation of the autism diagnostic observation schedule.

Skilled staff to deliver care

All staff, including freelance interpreters, had undergone a disclosure and barring service check. The service had a mix of mental health practitioners with strong therapeutic

knowledge, alongside specialist deaf outreach workers who brought personal knowledge and skills that enhanced both communication with and understanding of the patient group.

The range of experienced and qualified staff included: nurses, psychologists, psychiatrists, social workers and skilled interpreters. Freelance speech and language therapists could be accessed locally, or through the team based in London. It was believed that an occupational therapist would enhance the team in terms of their ability to assess for adaptations and support some of the specific physical needs of young people. A business case was being made for their inclusion in the northern service team.

Freelance interpreters known to the team worked alongside practitioners in clinical sessions. All interpreters were registered with their professional body and reached the confidentiality standards required by the health trust. In addition they were supported to learn any specific vocabulary used by team members and were able to work in a child friendly way. The service recognised that at times, these interpreters were exposed to difficult and upsetting dynamics; all three teams' ensured supervision was available to them.

In addition to their professional backgrounds staff continued to develop specialist skills. Specialist training offered to staff was planned through appraisal and supervision processes. Any agreed training was based on staff interest and service need. For example, a nurse within the team had recently undertaken training in autism diagnostic assessment observational schedule and a member of the support staff from the north had been seconded to do training as an occupational therapist.

In addition to specialist training, staff took part in research ensuring they remained in date with developments in this specialised field of work. Across the teams staff shared knowledge and skills; informally through case discussions and more formally at whole service meetings three times a year.

Staff received an appropriate and detailed induction to the deaf child and adolescent mental health team in the north. Key information for an individual included line manager; clinical supervisor and immediate team members. Pre-planned dates for immediate training in deaf awareness and working with interpreters within the team setting for new staff had been identified. Other dates given included

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team meetings; whole service meetings and the whole service training day dates. The induction then set out the focus and expectations over the next 12 weeks with a list of aims, how they would be achieved and who to go to support different aspects of this process for all staff joining the service.

Team meetings were held weekly in York, Manchester and Newcastle. In York, they had trialled moving these to fortnightly but had found this made the meetings longer and less effective, so the decision to revert back to weekly had been made. In Manchester, the teams morning meeting was the only time the whole team were together at the office base. Team leaders made sure everyone had the opportunity to participate and chaired these meetings. Communication at meetings took place verbally and using British sign language, minutes were taken. We attended two team meetings where agendas included: referrals, case discussions, trust and local updates/ correspondence, six monthly reviews, and any other business. The meetings successfully covered clinical work and business items.

Staff in each team received both managerial and clinical supervision. The three teams followed the same supervision policy. Management supervision, defined as reviewing performance and agreeing actions and objectives took place monthly. Employment issues, for example, agreeing annual leave, were included in these sessions with line managers. Clinical supervision was available every four to six weeks, with each clinical supervisor a qualified clinician. This supported the supervisee to focus and reflect upon his/her clinical work and included case discussions personal reflections.

For some staff their clinical and management supervisor may be the same person, in which case they discussed and agreed how they carried out supervision in order to cover the purposes of both, creating separation between the two. Some members of staff also received specialist supervision depending on their continuing professional development and as agreed in appraisal for example, as part of a particular therapeutic training. Freelance interpreters who worked within the service received support in this role; this included having had training from within the teams, and debriefing or supervision when required.

Supervision figures were monitored each month by team leaders. Overall compliance for staff accessing clinical supervision from April 2015 to March 2016 was 88%. Staff compliance rate for managerial supervision from January

to June 2016 was 100%. Staff told us they were able to talk openly and honestly in managerial supervision. They felt treated fairly, with respect and told us that the team and their employer supported professional development.

In addition, specific child protection supervision took place quarterly with an expectation that staff attended at least three times a year. Peer supervision depended on the professional background of the practitioner. Staff were encouraged to access this to maintain their professional registration. Peers from specific disciplines met together within the northern teams, for example there were mental health nurses meetings. At the end of each annual national deaf child and adolescent mental health service away day, time was reserved for colleagues to meet as peers for example administrators, family support workers, interpreters, nurses and psychologists.

At the time of inspection the specialist deaf child and adolescent mental health community team reported 95% compliance with annual appraisal. This was above the trust target 90%.

No formal processes to manage poor staff performance had been required within the service in the last year. If required, team managers would use informal processes in the first instance to address performance issues. These may include some or all of: reduction of caseload, additional supervision, clarity of job plan and if necessary provision of training for any identified areas of skill development.

Multi-disciplinary and inter-agency team work

Strong and respectful multidisciplinary working took place across the three teams. Regular and effective multidisciplinary meetings were held where practitioner's cases were regularly discussed. This enabled the team to share knowledge of ongoing cases and allowed young people and their families' indirect access to the specific expertise of team members. The commitment individual practitioners had to their work and their passion to make a difference to this patient group were described as the main asset the specialist service had. In each team individuals with different strengths and skills, shared these to deliver care. The culture within the teams seemed open, with positives and negatives shared, and therefore resolved.

The service actively fostered strong links with the deaf community. This had been a conscious process to break down barriers and enable family's access to mental health

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professionals for their young people. The specialist service worked jointly with other teams including child and adolescent mental health services local to the young person, social care, speech and language therapists and schools offering consultation and individual case work. We independently contacted eight of these organisations and all were entirely positive about working with deaf child and adolescent mental health north.

Teams external to the organisation spoke of the quality and clarity of communication from the specialist deaf child and adolescent mental health team. Reports requested for specific meetings for example, team around the child and family, were on time and meaningful. Key or co-workers showed a commitment to attend external meetings about young people when requested, and the team were responsive when consultation or advice was sought by telephone. Although the upper age range for young people to access the specialist service was 18, if required, for example to ensure a young person made a smooth transition to higher education, workers were able to follow a case through into adult services to allow a successful and timely handover.

One of the services referring into the specialist deaf child and adolescent mental health services had raised an issue about referrers not receiving feedback from assessments because of confidentiality issues. This was important to the referrer, particularly around communication issues, so they could support the young person and their family in the best possible way. Because of this query, an open discussion took place, and the specialist team reviewed their procedure. The result of this was a new process around sharing information. After assessment two reports were created, a full report was sent to the parents and the young person's general practitioner (GP) and in addition, the parents were sent the draft of a report for other professionals involved in supporting their child. This had any confidential information that was unnecessary removed and a covering letter that listed who the report would go to if the parents gave permission for it to be shared. Following parental agreement, the second assessment report was then circulated to other professionals involved.

We looked at the response of the specialist community team to a patient in crisis. Although not a crisis service, on the occasions when contacted about a young person known to the team in crisis, they had been able to offer

support and guidance to the carer or other professional involved. The administrative staff were confident they could contact a team member during office hours with knowledge of any young person known to the service. Advice given in these situations had usually included the most effective ways to communicate with the young person in distress. If the crisis required an urgent mental health assessment, contact would be made with the crisis service connected to the child and adolescent mental health team in the young person's local area. The specialist community team also had knowledge of and contacts with local authority teams in the geographical areas they covered; this included how to contact children's safeguarding.

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

Staff received training in mental health act legislation every two years. Compliance across the specialist deaf community mental health services for children and young people north team was 89% in June 2016. Staff told us the update training included changes to the revised Mental Health Act Code of Practice.

None of the teams in the service were treating detained patients. Across the team we found an understanding of the guiding principles of the Mental Health Act. Were there to be a young person in the community on a treatment order or detained in hospital staff were aware they would need to ensure the capacity of the young person was correctly assessed, their rights were understood, and access to an independent mental health advocate was facilitated. Staff told us they would need to access additional support and advice on implementation of the Mental Health Act and Code of Practice were they to need this. The consultant psychiatrists within the teams were identified by staff as the individuals they would turn to for guidance in the first instance. Staff were aware that the central office in Leeds would support them directly with Mental Health Act queries.

For young people using the service gaining their consent to treatment was done carefully and sensitively, with accessible formats used. If a young person were to be prescribed stimulant medication, this would be considered with both the young person and their carer. If agreed and consent given, regular reviews took place by the consultant psychiatrist, and information was shared with the general practitioner.

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Patient records showed evidence of their involvement in care planning. Care plans given to patients were created for them to be accessible and understandable. More detailed, adult orientated care plans were available for carers.

Good practice in applying the Mental Capacity Act

Staff received training in Mental Capacity Act and Deprivation of Liberty Safeguards every two years. Across the specialist deaf community mental health services for children and young people north in June 2016, 86% of staff had completed this training.

There was a trust policy on the Mental Capacity Act, which staff were aware of and could refer to. Staff understood and could describe the five statutory principles of the Mental Capacity Act. For patients under 16, staff were aware of and would consider Gillick competence to determine if a patient could consent to his or her own treatment, without the need for parental permission or knowledge.

The work we saw within the specialist deaf community mental health services for children and young people was collaborative. Young people and their carers signed consent forms from initial assessment. Young people were supported to make the decisions they could and when this was not possible decisions were made in consultation with those who knew them best, usually their next of kin. The care plans we saw and the patients and carers we spoke to, suggested the care offered by the team recognised the importance of the young person's wishes, feelings and culture.

Breakaway techniques were taught to staff within mandatory training, restraint was not. There was no record of any young person being restrained within this service. Staff were clear that if this happened, it would be assault and as such reported as a serious untoward incident.

Are services caring?

Outstanding



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

Our findings

Kindness, dignity, respect and support

We observed three sessions of direct care where staff provided both direction and emotional support. Staff were respectful, responsive and caring towards young people and their families.

Young people liked the staff, and believed the team understood them and could help them to communicate their thoughts and feelings to others. Parents told us the staff were brilliant, caring, and took the time needed to communicate in different ways that meant everyone was understood.

The deaf staff employed in the teams provided role models for deaf young people some of whom had never met a deaf adult before.

Carers appreciated the efforts made by team members to provide sessions near to their homes. Methods of communication with young people and their families through the office took into account their preferences, these included use of email, telephone, face time, video and text. This choice was described by carers as wonderful and so different from the rest of the National Health Service.

Ahead of appointments, information in leaflet form was given to families about what the service provided and how the team may help meet the needs of young people referred. The initial consent and confidentiality forms were in accessible formats, and required the signatures of young people (if appropriate), parent/carer and the clinician involved. Specific permission was asked from next of kin, to share confidential assessment information with other services involved with families. This process meant carers felt respected, involved and valued.

The service ensured that personal information about children and young people was kept confidential, unless this would be detrimental to their care. The team understood the nature of information sharing and consent in relation to the legal frameworks in place to safeguard young people. This included the nature of parental responsibility and guidelines, to decide whether a young person (under 16 years) was able to consent to his or her own treatment.

Staff from other organisations seeking consultation and advice, reported being carefully listened to, respected and understood by the specialist deaf child and adolescent community mental health team. Consultation supported professionals to know if a referral was appropriate and if not where else they might access help for young people and their families. Professionals who had experienced consultation with the service spoke of it exceeding their expectations.

The involvement of people in the care they receive

Young people and their families experienced person centred and collaborative care. All initial appointments involved an assessment of communication so any future intervention would be understood by all who needed to. In addition to interpreters, staff within the teams used British sign language alongside verbal communication with ease.

Each young person using the service had a key and co-worker as his or her first point of contact with the team. Young people and their families were actively involved in planning care that reflected their social and cultural needs. Young people's wishes and feelings were explored when considering their emotional and social needs. Care plans were in accessible formats that could be understood by the young person and their families; this might mean staff producing different versions of a care plan to meet different needs.

Adapted intervention tools and outcome measures ensured that therapies offered were both accessible and clinically valid. Staff worked in partnership with young people, their families and those providing education to make sure the young person could realise their potential. Additional plans to support specific agreed interventions were created for use at home and within young people's schools and colleges. Staff from education commented on how useful this was in giving them a greater understanding of the needs of individual young people.

Parents and carers knew what would happen throughout the specialist teams' involvement. They spoke of staff being calm at difficult times and help being available to them if they made contact. Carers commented on the team getting the whole picture by meeting with their child or adolescent, meeting with themselves and by going into schools or colleges. In addition to the direct work, staff opened up networks to help families connect to the deaf community in their locality.



Are services caring?

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

External partners spoke of staff members who really knew the young person and their family. Reports requested of the team for specific meetings arrived in a timely way. Staff from the specialist deaf community team who attended meetings about the young person were described as adding a perspective no one else could which really helped everyone understand the young person's specific needs.

To an extent, the specialist deaf child and adolescent community mental health service acted as advocates for the young people and carers they saw by ensuring effective communication of needs happened. Information about the local patient advice and liaison service who offered confidential advice, support and information on health-related matters was made available. Contact details for the national deaf children's society and teachers of the deaf, both of whom provide support and advocacy, were given to families. Specific mental health advocacy was available through the British society for mental health and deafness.

Feedback was sought from young people and their families. Information given out at an initial session included contact details of the service manager for complaints and/or compliments. When groups ran across the service, part of the evaluation used to inform decisions about the development of future similar groups, was based on feedback from participants.

An iPad project had been specifically designed that allowed service users to feedback on their experience. The feedback from the young people was that the team understood them, they described staff as caring and fun and young people were pleased they had met workers from the specialist team.

At the time of inspection, young people and their families were not part of staff recruitment; this was something under consideration by the team.

Are services responsive to people's needs?

Outstanding



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

Our findings

Access and discharge

The service manager was involved nationally in agreeing access to treatment targets for national deaf child and adolescent community services. Locally the northern specialist deaf service had a target time of four weeks from referral to assessment, this was usually met. The teams within the service did not have a waiting list at the time of our inspection. Initial assessment included risk and mental health assessments plus a full communication profile for the young people referred. This could take a number of sessions to fully complete. Treatment was determined by the needs identified within the assessment, some to be met within the service, others by linking with external organisations.

The teams were not set up as a crisis service, if a young person required an urgent mental health intervention this would be done through the child and adolescent mental health services local to the family. If the team knew a young person, practitioners would support these local services, sharing knowledge with them. Local schools described this as particularly helpful in knowing how best to communicate with a distressed young person. Carers spoke of staff being calm at difficult times and help being available to them if they contacted the office unexpectedly by telephone, text or email.

The service had clear criteria for accepting referrals. Information was available on the trust website and in leaflet form, about who this specialist mental health service work with. This included: children who are deaf or who have a hearing loss; hearing children of deaf parents; families; teachers and education professionals working with these children; child and adolescent mental health teams and other professionals who support deaf children and their families.

In addition to accepting referrals of young people and their families, the team offered consultation to professionals who may be considering a referral, or needed some guidance. These included regular clinics in deaf schools and colleges to discuss potential referrals. Young people and their families could not self-refer however; information was given to people contacting the service about how to get access to the service. The team also had an awareness of and shared information about alternative provision for referrals it could not accept.

Following referral, the service assessed a young person's emotional, mental health and developmental needs. Following assessment, therapeutic support for young people and/or their families was delivered by a key and a co-worker. If geographically possible, in addition to individual work, care may include participation in group work.

Pre-planned appointments usually involved more than one worker and were set up to ensure families and/or young people could attend. We saw professionals changing their plans to fit with a family they knew did not like to attend sessions in a particular building in their locality. Contact was made the day before an appointment to check the young person and their carer could still attend.

The teams covered the whole of the north of England, travelling long distances to appointments. When practitioners were going to be late to a planned appointment due to heavy traffic, a call came through to the office base and the administrator contacted the family to explain this. Staff only cancelled sessions if absolutely necessary and if this did happen contact would be made to re-arrange.

Discharge from the service was done in a planned way. The team acknowledged that clinical goodbyes could be difficult for young people and their families so this was something that practitioners worked towards with them. As part of discharge planning we saw links to and relationships with other services. Resources available in local communities' differed as the service linked to many local authorities and health services with different referral thresholds.

Deaf young people and their families have a high dropout rate from the mainstream national health service appointments. The did not attend rate for young people accessing the specialist deaf community child and adolescent mental health service was consistently better than attendance at their local community child and adolescent mental health services. Staff believed communicating with young people and their parents in their first language contributed to this. Where an appointment was missed this would be followed up by the young person's key or co-worker.

Are services responsive to people's needs?

Outstanding



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

The facilities promote recovery, comfort, dignity and confidentiality

The service planned meetings and sessions for young people and their families near their homes. The facilities used included a range of community resources for example family centres, schools, and health premises that were compliant with the Disability Discrimination Act.

Young people and their families who lived near to team bases in York, Newcastle or Manchester might be seen on site. The clinical areas in Newcastle and Manchester were provided through their local mental health trusts. In York, this provision was part of Leeds and York Partnership NHS Foundation Trust.

The interview rooms we saw had adequate soundproofing and blinds on the windows for privacy.

The waiting area in York was small but welcoming. We saw a range of literature and resources appropriate to the young people and families using the service. In Manchester, the shared waiting area had child friendly literature, although not a great deal about the specialist deaf child and adolescent mental health service.

Resources to support treatment and care were transported by staff to session venues as required. For young people and their families the teams created many of the resources specifically for the individual concerned. We saw an example of an age appropriate, child friendly sleep workbook, with an accompanying summary and additional information for the parent. When appropriate resources to support young people for use within their school or college were also created. Practitioners told us they had access to the practical resources required to complete their work.

Meeting the needs of all people who use the service

Appointment letters sent out had photographs next to the names of the practitioners the young person and their family would be meeting. Venues for appointments were considered carefully before booking both in terms of geographical and physical accessibility. Young people and families had choice about the practitioners they worked with; some had links with individual workers through the deaf community and it would have been inappropriate to use them.

Leaflets about the service were available at all sites; when rooms away from team offices were used, leaflets and information were taken to sessions by practitioners. A

range of leaflets about the service had quick response codes that could be scanned on smartphones enabling access to information using British sign language. Communication with young people and their families included using plain English in letters, pictorial representations and video letters as required. Managers told us that leaflets in alternative languages could also be provided.

The work done by the specialist deaf child and adolescent mental health service was accessible to young people with a learning disability. We saw information that had been translated into different languages and were aware that alongside local community mental health teams, the specialist team co-worked in a culturally sensitivity way. However, we found minimal evidence of engagement with deaf young people from diverse communities. We found no data, targets, or culturally sensitive strategies in relation to this need.

Skilled interpreters were able to work with young people using British sign language supporting the therapeutic work offered by the team. Where a family spoke a different language, to ensure communication was clear, sessions had taken place using both language and signed interpretation.

Listening to and learning from concerns and complaints

Parents and carers told us that they knew how to complain about the service if necessary. Young people using the service were less sure, but said they would talk to their parents if anything were wrong. The teams had established a practice where information about how to complain or compliment the service was given to families at initial sessions with the consent form. This was in letter form with the service manager's contact details including the address and a mobile number to text or call; a quick response code (a machine-readable code consisting of an array of black and white squares, used for storing information) on this document made it accessible to British sign language users. In the reception at York we also saw the trust's 'tell us what you think' information on how to raise a concern.

The service encouraged young people and their parents and carers to give feedback and had worked to ensure communication to do so was accessible. The experience of service questionnaire for parent and child had been sent electronically. An iPad initiative had enabled feedback in electronic form. In addition to encouraging feedback, the

Are services responsive to people's needs?

Outstanding



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

service responded to requests. Examples included, a service user group of young people making an animation digital versatile disc on issues for deaf teenagers. Parents in the northeast had fed back that they wanted a group with other parents of autistic children. This had been set up to meet every three or four weeks to accommodate parents travelling distances, and had a good turnout.

The specialist deaf child and adolescent mental health community service had received no formal complaints during the last fifteen months (1 April 2015 – 30 June 2016). Should a complaint be received this would be investigated by the service manager. Staff knew what the process would be should a complaint be made.

Staff had not received feedback on specific outcomes following the investigation of complaints, as there had been none. However, staff told us that lessons learned, sometimes following investigations elsewhere were shared at clinical governance meetings and those applicable to the service went on to be shared at team meetings. We saw this in practice.

To gain an overview of the service at clinical governance meetings the senior team reviewed compliments and concerns together three times a year. Themes or trends were then fed through and shared at the three localities team meetings.

In addition to compliments made directly to the team in the six months from 1 January 2016 to 30 June 2016, the patient advice and liaison service received three compliments. One was a thank you from the British Society for Mental Health and Deafness following a presentation given by the team that was described as contributing immensely to the mental health and deafness sector knowledge base. Another remarked on an appreciation of changes made to improve liaison from the speech and language therapists' network. The other, was feedback following an appointment with the team from a family who had previously struggled to access health services for their deaf child.

Are services well-led?

Outstanding



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 ambition was to 'work in partnerships, aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives'. Two of the staff we spoke to knew this and felt the specialist deaf child and adolescent mental health service reflected this ambition well.

The six values of the trust were respect and dignity; commitment to quality of care; working together; improving lives; compassion and everyone counts. We found four staff aware of most of these values and those who knew them agreed with them. Other staff who described values in their own words spoke of similar themes.

Good governance

We found that local governance systems were effective. Staff compliance with annual appraisal was 95%; this was above the trust target of 90%. Staff told us that training and development agreed at appraisal were discussed regularly at managerial supervision. The trust's supervision policy distinguished between management and clinical supervision and set a minimum requirement for staff to undertake both at least once every two months. The expectation in the specialist deaf community mental health services for children and young people was that managerial supervision took place monthly and clinical supervision every four to six weeks. In June 2016, staff compliance with managerial supervision was 100% and compliance with clinical supervision was 88%.

Each month the team coordinator received training records and updated the system for the service. In July 2016, training compliance for the specialist community national deaf child and adolescent mental health service north was 92%; this was above the trust target of 90%. No area of mandatory training fell below 75%. There was an ethos where additional specialist training was encouraged. We found that almost all staff were engaged in or had recently completed some form of additional learning.

All staff knew how report incidents. Team leaders and the service manager had oversight of reported incidents, including near misses. Incidents were investigated and actions were taken to prevent their recurrence. Staff had a comprehensive understanding of safeguarding procedures,

reflected together on safeguarding referrals and knew many of the local authority teams in their areas. Staff had a reasonable knowledge of the Mental Health Act and Mental Capacity Act and knew where to go if they required further information.

Staff time was spent working directly with children and adolescents, their carers and agencies supporting the young people. This included time creating individualised resources to ensure access to therapeutic work would be effective. Staff effectively managed diaries to ensure appointments were offered in a timely and travel efficient way.

The service undertook clinical audits and was able to provide examples. Initially completed in 2014, young people's communication profile was re-audited in 2015. This showed improvement in both completion rates and impact. This year, the standards of letters sent out from the service were being audited; at the time of inspection the data collection had been completed with the results still to be analysed.

The service had a quality improvement plan with clear steps to achieve outcomes. Members of the senior management team monitored progress with updates discussed at clinical governance meetings. We saw how actions taken; successes and challenges encountered were reviewed. These informed planning for further improvement.

The service was required to report to commissioners annually on key performance indicators. We saw a detailed report from 01 April 2015 to 31 March 2016 that documented the work undertaken by the service. Managers and the wider team contributed to this report using data from team evaluations of activities undertaken. In 2015/16, these included the British sign language kids group; the parents group for parents of deaf kids with autism spectrum condition; the staff induction pack and training delivered by the service.

Team leaders felt supported by their immediate line manager and had enough authority to do their job. Team members spoke of being supported to work together to be the best that they could be. Administrators felt that they had the support needed to undertake their role, although at times the information technology equipment available meant this could not be completed as well as it might be.

Are services well-led?

Outstanding



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 teams had a local risk register and managers knew how to escalate a risk onto the service-level risk register. The difficulties accessing electronic systems, particularly for staff based in Manchester and Newcastle remained on this register at the time of our inspection.

Leadership, morale and staff engagement

All the staff we met were highly motivated, dedicated and passionate about the work they did to support young people and their families. Team members spoke of feeling valued and being proud to work within the specialist service that had a culture that allowed for all staff to have expertise, yet with no staff member expected to know everything. Staff members spoke about the team being positive and responsive, commenting specifically about a lack of hierarchy. Staff had the opportunity to give feedback on services and input into service development weekly at team meetings, and more formally at regional and national team development days. Staff spoke of caring and supportive managers and colleagues.

Staff knew and were positive about their local and senior managers in the organisation. The trust's associate director and the national specialist deaf child and adolescent mental health clinical lead had visited the team. The senior team told us that the trust understands the service and that this allowed them to continue to develop the clinical work offered to young people and their families.

Mandatory training compliance figures for staff in duty of candour was 86%. Information specific to the specialist deaf child and adolescent mental health had been included in the duty of candour policy to ensure it was operational for the whole service. The staff we spoke to understood the need to be open and transparent and explain to young people and their carers if something went wrong. We heard an example of this when a report had been mistakenly sent to the wrong school. The young person and family were made aware of this, the incident was reviewed, and there was evidence of lessons learned shared within the teams. Processes were then changed to double check the information held by the team ahead of any information being sent out.

No one we spoke to could identify bullying within the teams and there were no reported incidents of bullying or harassment. Managers were able to explain the process for

responding to bullying concerns. Staff were aware of the whistleblowing process although staff believed it was unlikely there would be a need for whistleblowing. The culture described by staff was one where when teams disagree, they disagree well, and so issues would be discussed openly and resolved. Staff knew that the trust offered them a health and well-being service.

The average staff sickness rate was 0.5%, which was below the trust's average of 4%. Staff vacancies were 7% for the service; this was below the average vacancy rate for the trust of 14%. Due to the specialist, skills and knowledge required to work within this service agency or bank cover was not used. Cover for leave, sickness and vacancies were provided internally increasing the workload of colleagues. We found that staff cared for each other, and were aware when a colleague was under increased pressure. In all three teams, staff described a service where people supported each other. The turnover of staff within the service was low, yet staff had been given opportunities to develop leadership within each team.

Commitment to quality improvement and innovation

Specific service local operational instructions were developed for the specialist deaf child and adolescent mental health service to support staff to deliver a safe service, this included communication and transition policies.

Innovative practice included the development of technology for use in practice, working alongside young people to ensure this met their needs. The adaptation of outcome measures ensuring their clinical validity for example, Goodman's strengths and difficulties questionnaire translated into British sign language.

The team had input relating to the standards, training and supervision of interpreters into the National Health Service accessibility standards, published in April 2016.

As part of the national deaf child and adolescent mental health service, team members spoke of a research culture. Research undertaken by the team using the adapted strengths and difficulties questionnaire showed 26% of deaf children were above the threshold for mental health services as opposed to 10% of hearing children.