Outstanding ☆

Northumberland, Tyne and Wear NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

St Nicholas Hospital
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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)
RX4E4	St Nicholas Hospital	Newcastle and Gateshead - Children and Young People's Service	NE2 1QE
RX4E4	St Nicholas Hospital	South Tyneside and Sunderland - Children and Young People's Service	SR5 1NB

This report describes our judgement of the quality of care provided within this core service by Northumberland, Tyne and Wear NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

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

Where applicable, we have reported on each core service provided by Northumberland, Tyne and Wear NHS Foundation Trust and these are brought together to inform our overall judgement of Northumberland, Tyne and Wear 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?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Good ●

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

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

- National guidance was followed by teams and embedded into the services provided.
- The service delivered an extensive range of psychological interventions recommended by National Institute for Health and Care Excellence to meet the needs of children and young people who used the service
- There was an embedded culture of continuous professional development through training in evidence based interventions
- The service had clear criteria for categorising risk and was able to respond quickly to referrals of young people presenting with high risks.
- Feedback from people who use services and their carers was universally positive about the care they received.
- Staff were passionate, enthusiastic and dedicated to their work with children and young people
- The service was responsive to feedback and we saw examples where the service had used service user feedback to improve the service

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Facilities were clean and well-maintained.
- Staff sickness rate was lower than the trust's average.
- Teams actively monitored caseloads using an electronic tool. This tool allowed managers to adjust caseload sizes when staff were dealing with a number of young people with high acuity.
- Lone working procedures were embedded and regularly monitored.
- All staff knew how to report incidents and there was evidence that the service had taken action in response to incident investigations.
- Staff knew of the duty of candour.

However:

- The service had a standard where staff undertook 13 clinical appointments a week. Some staff were working at double this capacity.
- Although average compliance with mandatory training exceeded the trust's target, eight out of the 19 mandatory training courses had a compliance rate below the trust's target
- The service did not have a system for monitoring the risks of young people on the waiting list for treatment.

Are services effective?

Outstanding

We rated effective as outstanding because:

- The service had embraced key elements of the Department of Health published 'Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing'. The service had implemented this national guidance successfully in everyday practice.
- The service worked collaboratively to efficiently deliver care to young people in a risk based approach.
- Care pathways were established, well-defined and provided a clear plan for both treatment and discharge.
- The service offered an extensive range of National Institute of Health and Care Excellence approved psychological interventions covering the full range of need.
- There was an embedded culture of continuous training and development with the majority of staff undertaking training in evidence based interventions.

Summary of findings

- The service was actively seeking accreditation from national external organisations.

Are services caring?

We rated caring as outstanding because:

Outstanding 

- Feedback from young people and their parents and carers was universally positive about the service.
- Staff delivered care in a thoughtful and sensitive way that was adaptive to the needs of the young person. Interactions were at an appropriate level for young people which focussed on recovery and respected the totality of people's needs.
- We heard examples where staff could push boundaries and go the extra mile in order to deliver better care.
- Young people using services were partners in their care. We saw that care plans were written in a way that captured the voice of the young person which placed them at the centre of their care.
- There was a strong, visible, person-centred culture of care and support within staff teams; one where all staff including those new to the service, reported that they felt supported and cared for by the members of the team.

Are services responsive to people's needs?

We rated responsive as good because:

Good 

- The service had clear criteria for accepting referrals into the service and a thorough understanding of alternative services for referrals it could not accept.
- The service had reduced the total number of people waiting for treatment by 65% within eighteen months.
- Did not attend rates were above national averages but within 1% of locally agreed compliance targets.
- Teams were active in local communities and were piloting new ways of engaging minority groups.
- The service responded to feedback from young people and parents and carers and implemented changes as a result of feedback.

However:

- The trust target from referral to treatment was 12 weeks. The service was not meeting this target.
- The parking facilities at Benton House had a negative impact on the ability of the service to deliver effective care.

Are services well-led?

We rated well-led as good because:

Good 

Summary of findings

- Staff recalled the themes of the trust values.
- Effective governance systems were in place to monitor supervision, appraisal, caseloads, training and incidents.
- The use of key performance indicators was embedded in the service and all staff had an understanding of their individual and team performance objectives.
- Staff were universally positive about local managers and local managers were in turn positive about their relationships with senior management.
- There was a clear commitment to quality improvement and the service was actively seeking national accreditation from the Quality Network for Community Child and Adolescent Mental Health Services

However:

- Staff morale was variable. Some staff told us that they had concerns about the future capacity of the service to manage increases in referrals. The longer term strategy for the service was already starting to have an impact on waiting times for young people.

Summary of findings

Information about the service

Northumberland, Tyne and Wear NHS Foundation Trust provide specialist community mental health services for children and young people aged 0-17 across Gateshead, Newcastle, Northumberland, South Tyneside and Sunderland.

There are three teams that provide specialist community mental health services for children and young people. Each team provides services across a geographical locality. The teams are:

- children and young people's Service – Newcastle and Gateshead
- children and young people's Service – Northumberland
- children and young people's Service – South Tyneside and Sunderland.

As part of our inspection we visited:

- children and young people's service – Newcastle and Gateshead
- children and young people's service – South Tyneside and Sunderland.

The service provides a single point of access to mental health services for children and young people. This includes children and young people with a learning disability or who have an eating disorder.

We have not inspected Northumberland, Tyne and Wear NHS Foundation Trust's specialist community mental health services for children and young people before this inspection.

Our inspection team

Our inspection team was led by:

Chair: Paul Lelliott, Deputy Chief Inspector, Care Quality Commission

Head of Hospital Inspection: Jenny Wilkes, Head of Hospital Inspection (North East), Care Quality Commission

Team leaders: Brian Cranna, Inspection Manager, Care Quality Commission

Jennifer Jones, Inspection Manager, Care Quality Commission

Sandra Sutton, Inspection Manager, Care Quality Commission

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations for information. The inspection took place across specialist community mental health services for children and young people. We sampled community mental health services as part of our new inspection process. The teams that we visited were:

Summary of findings

- children and young people's service – Newcastle and Gateshead.
- children and young people's service – South Tyneside and Sunderland.

During the inspection visit, the inspection team:

- visited services at two hospital sites and looked at the quality of the environment and observed how staff were caring for patients
- visited the call-handlers, duty team and intensive community treatment service for Newcastle and Gateshead at Bensham House
- spoke with 12 young people who were using the service
- spoke with 14 carers of young people who were using the service
- spoke with the community clinical managers for both services
- spoke with 40 other staff members; including doctors, nurses, occupational therapists and psychologists
- interviewed the service manager responsible for these services
- looked at 12 treatment records of young people who were using the service
- attended and observed four staff meetings and one handover meeting
- attended and observed six sessions where care was being delivered to children and young people.

What people who use the provider's services say

We spoke to 12 children and young people, 14 parents and carers and observed six sessions where staff delivered care and treatment to children and young people

Young people who used the service were positive about the service. Young people told us that they felt involved in the care process, that the staff encouraged them to express their opinions and that they had a choice in their care and treatment.

Parents and carers told us that they felt it was easy to access clinicians when they needed to and that they felt that staff genuinely cared for the young people and for the families. We received mixed feedback regarding waiting times to enter the service with some parents and carers describing the process as quicker than they expected and others saying that they felt they had needed to wait a long time before their child received treatment.

Good practice

Two staff members from the South Tyneside and Sunderland children and young people's service were piloting a new project delivering attention-deficit hyperactivity disorder awareness training to local schools. This outreach project targeted education staff in school and was designed to raise awareness and understanding of the symptoms of attention-deficit hyperactivity disorder in children at school. The project aimed for increased early referrals of young people displaying symptoms of attention-deficit hyperactivity disorder from schools. The presentation was piloted at two schools and at the time of inspection staff were collating feedback and refining the presentation to be used in more schools.

Areas for improvement

Action the provider SHOULD take to improve

- The trust SHOULD ensure that parking facilities at Benton House do not disrupt the delivery of effective care.
- The trust SHOULD continue to work with external stakeholders to ensure that the specialist community mental health services for children and young people has the capacity to meet current and future demand.

Summary of findings

- The trust SHOULD ensure that individual staff caseloads in the specialist community mental health services for children and young people are within identified capacity as stated in the caseload tool used
- The trust SHOULD improve mandatory training in areas where it is not reaching compliance targets in the specialist community mental health services for children and young people.
- The trust SHOULD have a waiting list protocol in place to assess risks to children and young people on waiting lists within the specialist community mental health services for children and young people.

Northumberland, Tyne and Wear NHS Foundation Trust

Specialist community mental health services for children and young people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Newcastle and Gateshead - Children and Young People's Service	St. Nicholas Hospital
South Tyneside and Sunderland - Children and Young People's Service	St. Nicholas Hospital

Mental Health Act responsibilities

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

Training in the Mental Health Act was a mandatory training requirement for all staff. Information provided by the trust showed that overall compliance with Mental Health Act training was below 75%. The trust target for mandatory training was 85%.

We found that staff had a basic understanding of the Mental Health Act and that staff knew where to get more information both within the service and within the trust.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was a mandatory training requirement for all staff. We found that compliance with Mental Capacity Act training was at 78% which was below the trust target of 85%.

The Deprivation of Liberty Safeguards does not apply to people under the age of 18 years. The Mental Capacity Act 2005 applies to young people aged between 16 and 18 years old. The service provided services for children and young people 0-17 years old. During our inspection we reviewed care records. We saw in four care records evidence of assessment of mental capacity to make decisions.

For young people under the age of 16, decision making and capacity is determined through the concept of the Gillick competence. Managers described recent cases where the service used assessments of Gillick competence. Staff were able to describe who to contact for advice when they needed information about the Mental Capacity Act.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

The premises we visited in Newcastle and Sunderland were clean and well maintained. Domestic rotas showed that there was a regular cleaning schedule. Interview rooms were not fitted with alarms. However all staff involved in patient care carried an Identicom lone worker device at all times which was used as a personal alarm.

Clinic rooms on both sites were clean and equipped with the necessary equipment to carry out physical examinations, including equipment to check height, weight and blood pressure. The equipment in the clinic room all had up to date portable appliance testing. There were hand washing facilities available in the clinic room in Sunderland. There was no hand wash basin in the clinic room in Newcastle, however there was hand sanitiser and gloves available. Medication was not stored at either site.

The entrance to both sites was through a locked door with access controlled by reception staff. Intercom systems were fitted at the teams entrances that we visited

Safe staffing

Both teams had a wide range of professionals including consultant psychiatrists, speciality doctors, nurses, nursing assistants, psychologists, occupational therapists, technical instructors, medical secretaries, administrators and modern apprentices. There were no qualified nurse vacancies across the two teams. The service is over-established across the professional disciplines with 128.91 whole time equivalents in post against a budget of 91.35 whole time equivalents. The trust had responded to an increase in waiting times during 2015 with a short term investment in increased staffing above establishment levels.

Establishment levels as of April 2016 for Newcastle and Gateshead children and young people's service were:

- Trust levels qualified nurses whole time equivalents - 31.79
- Trust levels nursing assistants whole time equivalents - 5.8
- WTE vacancies qualified nurses - 0
- WTE vacancies nursing assistant - 1
- Qualified nurse vacancy rate% -0.%
- Nursing Assistant vacancy rate% - 17%
- Shifts filled by bank staff to cover sickness, absence or vacancies - 38
- Shifts filled by agency staff to cover sickness, absence or vacancies - 0
- Shifts not filled by bank or agency staff for sickness, absence or vacancies - 0

Establishment levels as of April 2016 for South Tyneside and Sunderland children and young people's service were:

- Trust levels qualified nurses whole time equivalents – 38.44
- Trust levels nursing assistants whole time equivalents – 4.5
- WTE vacancies qualified nurses - 0
- WTE vacancies nursing assistant - 0
- Qualified nurse vacancy rate% -0%
- Nursing Assistant vacancy rate% - 0%

South Tyneside and Sunderland children and young people's service had no use of agency or bank nursing staff as of April 2016. There were no vacancies for either qualified nurses or nursing assistants. The service had the highest number of staff leavers in the last 12 months with 6% although this was still below the trust average of 7.9%. Newcastle and Gateshead children and young people's service had the highest sickness rate of 6% which was above the trust average of 5%.

Sickness and turnover levels as of April 2016 for Newcastle and Gateshead children and young people's service were:

- Whole time equivalent budget – 49.42
- Total number of substantive staff – 63.05
- Total number of substantive staff leavers in the last 12 months – 3.05
- Total % of staff leavers in the last 12 months – 4%
- Total % vacancies overall – 0%
- Total permanent staff sickness overall – 6%

Sickness and turnover levels as of April 2016 for South Tyneside and Sunderland children and young people's service were:

- Whole time equivalent budget – 41.93
- Total number of substantive staff – 65.75

Good

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- Total number of substantive staff leavers in the last 12 months – 4.04
- Total % of staff leavers in the last 12 months – 6%
- Total % vacancies overall – 0%
- Total permanent staff sickness overall – 4%

At the end of May 2016 the total caseload for both teams was 7270 open cases. The children and young people's service in Newcastle and Gateshead had an open caseload of 3753 cases. The children and young people's service in South Tyneside and Sunderland had an open caseload of 3517.

The trust had recognised issues in waiting times in 2015 and had provided temporary funding for an increase in staff numbers above establishment levels. Individual staff caseloads ranged from 10 at the lowest to 148 at the highest. The service had 183 staff members who carried a caseload. 81% of the 183 (124 staff) carried a caseload of less than 30 young people. 90% of staff carried a caseload of less than 60 young people.

Average caseloads were:

- Newcastle and Gateshead children and young people's service – 34
- South Tyneside and Sunderland children and young people's service – 28
- Service average – 31

Teams managed caseloads and there was a system in place to reassess caseloads regularly.

The service had a 'standard job plan' in place for all qualified clinical staff working at band six level. This job plan included a standard of 13 appointments to be completed each week. Clinical supervision arrangements allowed staff to regularly review their individual caseloads with their supervisors. The service used an 'activity tool'. The activity tool calculated percentages based on the number of appointments compared to capacity. This allowed both staff and managers to identify which staff were working at or above their contact capacity. Although the service had identified some mitigating factors, the most recent use of the activity tool noted that some staff were working at double their capacity.

The teams were made up of a range of professionals including consultant psychiatrists. The intensive community treatment service had dedicated consultant psychiatrists working within this team which meant that rapid access to psychiatry was often within hours rather than days.

The service provided services Monday to Friday between 8:00am to 8:00pm. The intensive community treatment service provided services Monday to Friday 8:00am to 9:30pm; Saturdays, Sundays and Bank Holidays were 10:00am to 6:00pm. Out of hours the service had a telephone helpline which linked to the trust's adult crisis services. Crisis teams had access to patient records out of hours using the electronic patient record system RiO. If any 16-18 year olds accessed accident and emergency departments then they would be assessed by the adult crisis service with support from the trust's on-call psychiatrists. The adult crisis service would then inform the children and young people's service in the appropriate locality the next day.

The Newcastle and Gateshead children and young people's service used bank staff. Community managers told us that there had been no use of agency nursing staff in the last year. When the service did use agency staff for other professions, they were contracted for short term contracts for several months. Agency staff received the same induction as staff employed directly by the trust and agency staff were allocated a clinical supervisor as with the trust's staff.

19 modules were classified by the trust as either mandatory or essential training. Figures were provided by the trust for the two services. The trust target for compliance with mandatory training was 85%. Average compliance for mandatory training was 86% between both teams. Eight of the 19 modules were below the compliance target of 85%. Training modules on the Mental Health Act 1983, the Prevention Management of Violence and Aggression (PMVA) breakaway, and safeguarding level three all had an average compliance rate of less than 75% across both teams.

Assessing and managing risk to patients and staff

We reviewed 12 care records in this inspection. The service worked using the choice and partnership approach. Children and young people referred to the service would initially be triaged by the duty team of clinicians. The service had referral criteria based on three categories of risk. High risk cases would be passed to the intensive community treatment service to be seen within a standard

Good

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of 72 hours, although managers told us that it was more often within a few hours than days. Medium risk cases were deemed as 'priority' and would be seen by staff within four weeks. Low risk cases were deemed as 'routine' and would be seen for an initial choice appointment within six weeks.

The service used the Functional Analysis of Care Environments risk profile as the primary tool for assessing and managing risk. The Functional Analysis of Care Environments risk profile was included in the Department of Health's publication, 'Best Practice in Managing Risk' (March 2009), noting that 'there is evidence that the risk indicator sets are internally consistent and that raters agree when completing them independently [and] there is also evidence of good validity'. The risk profile was used to identify risks in multiple areas and also situations where young people would need additional plans for crises.

The service maintained a waiting list for young people referred into the service. After initial triage there was no system to monitor or detect increases in the level of risk. We saw contact details explaining how young people and carers could access help if the young person's mental health deteriorated or risks changed whilst waiting for treatment. However this meant that once on the waiting list the service relied on young people and carers to actively highlight changes in risk rather than proactively monitoring people waiting for treatment. Managers told us that where risks had changed the service could regrade the young person as priority or, if the risks had become particularly high, as urgent to be seen by the intensive community treatment service.

Safeguarding training was separated into different levels. Safeguarding adults level one and safeguarding children levels one and two were mandatory training modules for all trust staff. Safeguarding children level three was mandatory training for all clinical staff in the children and young people's service.

Average compliance across the service was:

- Safeguarding adults level one – 89%.
- Safeguarding children level one – 93%.
- Safeguarding children level two – 93%.
- Safeguarding children level three – 74%.

Staff knew and could describe the safeguarding procedures. Staff were aware of the trust's own safeguarding team and the lead professional for children's safeguarding. Data provided by the trust showed that 174 of the 247 incidents reported by the service in the period April 2015 to April 2016 were classed as safeguarding incidents.

The trust had a lone working policy which it had updated in March 2016. The service issued an Identicom lone working device to all staff engaged in patient care. Once activated the device was capable of making an audio call to a national call centre who could monitor the event and direct assistance if needed. The system relied on staff members stating their location into the device before interacting with patients. Team managers received a monthly usage report which was compared to individual staff diaries to monitor compliance. We saw examples of letters used to remind staff to use the Identicom where usage had been highlighted as an issue.

Track record on safety

NHS trusts are required to report serious incidents to the Strategic Executive Information System (STEIS). Reportable serious incidents include 'never events' which the national Revised Never Events Policy and Framework (NHS England, March 2015) defined as an incident that is 'wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers'. Of the 94 serious incidents reported by the trust between 1 January 2015 - 31 December 2015, four occurred in the children and young people's service and none were classed as a never event.

The types of incidents reported were:

- Two commissioning incidents.
- One apparent/actual/suspected homicide.
- One apparent/actual/suspected self-harm.

These incidents all met serious incident reporting criteria.

In the period between 1 January 2015 and 31 December 2015, the trust reported 149 serious incidents through its Serious Incident Requiring Investigation (SIRI) reporting system. Of these, four related to the children and young people's service. We noted that the four incidents reported to Strategic Executive Information System were the same incidents regarded as a Serious Incident Requiring Investigation.

Between 1 April 2015 to 30 April 2016 (inclusive), the trust reported a total of 34,658 incidents. Less than 1% of the

Good

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trust's total, 247 of the total incidents were reported by specialist community mental health services for children and young people services. Safeguarding incidents accounted for 70% of the incidents reported by specialist community mental health services for children and young people services. This was followed by information governance incidents with nine percent.

Reporting incidents and learning from when things go wrong

The trust used an electronic system to report incidents. All staff knew and could describe how to complete an incident form and could list the circumstances, including near misses, in which a report was required. We found that the service had a process to learn from incidents. Staff described a recent serious incident which was investigated. Whilst broadly supportive of the involvement of the service, the investigation had highlighted issues with record keeping. Following this incident staff attended one of eight additional training sessions on the electronic patient record system as a direct result of the learning from this incident.

Managers described how there was a process in place to review incidents. All incident reports were reviewed by managers before being signed off and sent to the trust. Managers described how they had the option to access reports, how they could request further information from staff and how they classify incidents as safeguarding issues if the staff member had not done so. Business meeting minutes documented how incident themes were discussed at a management level.

All staff, including those relatively new to the service, demonstrated a good understanding of the principles of the duty of candour. Some staff described the duty of candour as being in line with the trust's value of being honest and transparent. Staff were clear about the importance of an apology after an incident. Staff told us how during a recent serious incident investigation they had been commended for engaging and being open during the investigation process.

Are services effective?

Outstanding ☆

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

The service used the choice and partnership approach and we found that care pathways were established and well-defined. The service manager described how this approach removed initial assessment in favour of continuing throughout the care pathway. Staff could, depending on the presentation, use a variety of risk assessments including a core risk assessment, a Functional Analysis of Care Environments risk profile, a separate Functional Analysis of Care Environments risk profile specifically for young people with suspected learning disabilities and a narrative risk assessment. We reviewed 12 care records and found that:

- all 12 records included a comprehensive risk assessment that was up to date.
- all 12 records included a care plan which was up to date.
- all care plans were personalised, included the views of the young person and were written in a thoughtful way that tried to capture the voice of the young person.
- all care plans were holistic, meaning that they covered a wide range of needs and focussed on outcomes, strengths and goals.

We found that when necessary the service had undertaken physical examinations of young people and that there was ongoing monitoring of physical health needs. One record noted that a young person had been prescribed anti-psychotic medication and we saw that the clinical team had requested blood tests from the registered GP, in line with the guidelines for monitoring the physical effects of anti-psychotic medication.

The service used RIO (Version Six) which was an electronic clinical information system used to store care records. Staff were positive about their experience with the system, noting that it was accessible and relatively simple to transfer information between staff and teams. The system was password protected which meant only staff members could access patient records.

Best practice in treatment and care

In 2015 the Department of Health published 'Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing'. One of the main recommendations in this document was the child and adolescent mental health services implement 'clear evidence-based pathways for community-based care'. We found that the service had introduced clear evidence based pathways for a range of mental health problems including (but not limited to) anxiety attachment disruption, challenging behaviour, depression, eating disorder, hyperkinetic disorder, obsessive compulsive disorder, post-traumatic stress disorder, and relational trauma.

The pathway started with referral to the children and young people's service from a range of referral sources. This referral would be triaged by the duty team in the appropriate locality. Young people would be offered an initial choice appointment which identified risks, the needs of the young person and the appropriate clinical pathway based on these needs. The young person would then attend for a 'core partnership' appointment which was the start of treatment with an identified clinician. After six months or six sessions the young person would be reviewed by the multi-disciplinary team. In one example of this approach, a young person with diagnosis of depression would be offered a choice appointment, a 'core partnership' appointment, six sessions of psychological therapy followed by a review by the multi-disciplinary team and after up to six further sessions the service would seek to discharge the young person to an appropriate partner agency or to primary care.

Within these pathways the service was able to offer an extensive range of therapies approved by the National Institute for Health and Care Excellence. Therapies were offered on both an individual and group basis and included both the young person and the parent/carer if appropriate. We requested data to demonstrate the range of therapies offered. The service was able to offer selected data on the number and types of group therapies offered which gave some picture of the range of therapies available:

The Newcastle and Gateshead children and young people's service provided data on the number of weekly sessions offered which from March 2016 included:

- 247 psychotherapy sessions
- 117 art therapy sessions
- 84 Eye Movement Desensitization and Reprocessing (EMDR) sessions
- 66 group sessions of cognitive behavioural therapy
- 39 sessions of interpersonal psychotherapy training for adolescence
- Eight 'Chill Out' group sessions with 5 groups of young people

Are services effective?

Outstanding ☆

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.

- Four groups and 39 individual sessions of dialectical behavioural therapy

The South Tyneside and Sunderland children and young people's service provided data on the number of young people seen for different therapies which from March 2016 included:

- 148 psychotherapy sessions
- 93 sessions of systemic family therapy
- Creative therapies including art and drama for 44 young people
- Cognitive behavioural therapy for 36 young people
- Dialectical behavioural therapy for 18 young people

Teams had good access to consultant psychiatrists. Consultant psychiatrists worked with teams to provide medication based treatments for people who used the service. Staff told us that medication was regarded as one of many options and was not the primary choice for a number of conditions. The teams worked with families and young people to explore a range of non-pharmacological approaches to treating mental health problems. Where medication was prescribed the service had the necessary equipment to undertake basic physical health monitoring such as height, weight and blood pressure checks. Community GP services were requested to complete physical health monitoring such as, blood monitoring.

'Future in Mind' (2015) recommended that child and adolescent mental health services should be able to offer 'intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care' and a swift response if young people are experiencing a mental health crisis. The intensive community treatment team allowed the service to undertake both roles effectively being both a children and young people's mental health crisis team and an intensive home based treatment team.

The intensive community treatment team was responsible for all urgent referrals received by the service, including young people in a state of crisis. The team had a response target of 72 hours however all staff indicated that this was an absolute maximum and the team would normally be able to respond within 24 hours, if not on the same day. The service was confident that all young people were seen within the 72 hour timeframe. Data from the trust showed that on average 85% of young people classed as urgent were seen within 72 hours of referral. The trust stated that this figure was lower than expected and did not represent the true achievements of the service. The figure was taken from the electronic patient record system. After identifying that this was an area where data quality was an issue, the trust undertook to train and update staff in inputting appointments correctly on to RIO so that the data would be a true representation in future.

The intensive community treatment team provided intensive home based treatment for young people. Staff in the team told us that their work was based on individual need and when needed daily interventions were provided to young people. The team had longer operational hours than the main children and young people's service which meant that it could adapt to the different requirements of young people. The intensive services provided by the intensive community treatment team provided early intervention services which reduced the risk of admission to inpatient wards through early intervention. Future in Mind (2015) recognised that not all child and adolescent mental health services had teams such as the intensive community treatment service, and staff told us that without the interventions offered by the team there would have been a significant increase in demand for inpatient admissions for children and young people. As well as preventing admissions, the team worked within inpatient units to facilitate discharge as part of discharge care plans.

The service used a range of outcome measures to measure the effectiveness of treatment and reported on these every quarter to local NHS clinical commissioning groups. The service used the Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA) as one way of measuring compliance with outcome targets. There was a set target that 80% of children and young people who had would have a Health of the Nation Outcome Scales for Children and Adolescents score completed at initial appointment and at discharge. In quarter four of 2015/16 the service had an average compliance rate of 82%.

There was a set target that 80% of children and young people who had 'completed a course of treatment in each quarter would demonstrate a statistically significant medium or higher level improvement' which was again based on scores in the Health of the Nation Outcome Scales for Children and Adolescents. In the most recent data submitted to local NHS clinical commissioning groups

Are services effective?

Outstanding ☆

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.

it was noted that there was 'a statistically significant medium or large improvement in HONOSCA scores (on a sample basis) for patients discharged' across all localities in the service.

The service provided examples of recent clinical audits including an audit into anti-psychotic monitoring in the Sunderland and South Tyneside children and young people's service in August 2015. Some audits had been carried out by staff undertaking doctorates in clinical psychology,

Skilled staff to deliver care

The teams that we visited had a wide range of professionals including consultant psychiatrists, speciality doctors, nurses, nursing assistants, psychologists, occupational therapists, technical instructors, medical secretaries, administrators and modern apprentices. Staff brought to the service experience of a wide range of backgrounds, including some who had worked in the children's mental health inpatient wards.

It was mandatory that all staff undertook an induction programme when starting with the trust. There were 20 new starters into the service from April 2015 to April 2016. Compliance with the induction programme for new starters this period was 100%. Eighteen of the new starters (90%) had completed a local induction to the service, and the remaining two were still in the process of completing their local induction. Staff were assigned to work in care networks and could access specialist training if required. There was a culture in the service where additional specialist training was encouraged and almost all staff told us that they had either completed, been offered, or were about to start additional training courses. Staff could access training in leadership both within the trust and at masters level, as well as further training in positive behavioural support, cognitive behavioural therapy, dialectical behaviour therapy, systemic therapy, interpersonal psychotherapy training for adolescence, and eye movement desensitization and reprocessing therapy.

The children and young people's service sat within the specialist services directorate in the trust and through the directorate staff could access foundation training in:

- assessment and risk and formulation in children and young people
- attachment difficulties
- capacity and informed consent
- common mental health difficulties
- conduct disorder and forensic
- crisis assessment and management
- delivering group work
- eating disorders
- emerging personality disorder including dialectical behavioural therapy
- emerging psychosis
- family development and systems (systemic)
- managing anxiety disorders including foundation cognitive behavioural therapy
- mental state assessment
- neuro developmental disorders – Attention Deficit Hyperactivity Disorder and Autistic Spectrum Disorder
- parental rights and responsibilities
- parenting interventions
- pharmacology, side effects and physical health monitoring
- positive behaviour support
- risk and resilience factors
- self-harm behaviour and management
- substance misuse

In addition the service had committed to six Children and Young People's Improving Access to Psychological Therapies (CYPIAPT) Partnerships in North Tyneside, Northumberland, Newcastle, Gateshead, South Tyneside and Sunderland. Children and Young People's Improving Access to Psychological Therapies is a national service transformation programme led by NHS England. The programme seeks to improve child and adolescent mental health services in part by training existing staff 'in targeted and specialist services in an agreed, standardised curriculum of National Institute for Health and Care Excellence approved and best evidence-based therapies' (NHS England, 2015). Over 20 staff had either completed or were involved in further training in a range of qualifications within Children and Young People's Improving Access to Psychological Therapies principles.

The trust had a clinical supervision policy which was ratified in October 2013, fully implemented in November 2014 and reviewed in May 2015. The policy set a standard for clinical supervision to be delivered a minimum of once a month to all qualified staff and bi-monthly for unqualified staff.. The trust had a compliance target of 85% for clinical supervision. From 1 May 2015 to 30 April 2016 clinical supervision rates in the service were:

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Outstanding ☆

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- Newcastle and Gateshead children and young people's service – 97%
- South Tyneside and Sunderland children and young people's service – 97%
- Service average – 97%.

Staff spoke highly of their experience of supervision sessions, and regarded it as something that supported them in their role. We spoke to some staff who were in professional training. They told us that they received supervision for an hour each week as part of their training programme.

The trust had an appraisal policy which was ratified in January 2015, fully implemented in February 2015 and last reviewed in May 2016. The policy set the standard that all staff would undertake an appraisal once a year. The trust had a compliance target of 85% for appraisals. From 1 May 2015 to 30 April 2016 appraisal rates for non-medical staff in the service were:

- Newcastle and Gateshead children and young people's service – 85%
- South Tyneside and Sunderland children and young people's service – 78%
- Service average – 82%.

From 1 May 2015 to 30 April 2016 appraisal rates for medical staff in the service were:

- Newcastle and Gateshead children and young people's service – 75%
- South Tyneside and Sunderland children and young people's service – 100%
- Service average – 87%

The service had 19 doctors who had been revalidated which represented 100% of those eligible for revalidation.

Multi-disciplinary and inter-agency team work

Staff were allocated to specific care networks in the service. Staff working in a care network met weekly for a 'network meeting' which included case discussion and peer supervision. Staff also met regularly in discipline specific professional groups. We attended the monthly meeting of occupational therapists in the service.

We observed a handover in the intensive community treatment team. In the handover there was a discussion of each case and that the team prioritised cases based on an appropriate assessment of risk. In the handover that there was an effective working relationship between the intensive community treatment service and the early intervention in psychosis team, which included sharing structured assessments tools when appropriate.

The intensive community treatment team worked closely with the trust's child and adolescent mental health wards. Staff told us that the intensive work of the service had been instrumental in reducing and preventing the number of inpatient admissions for mental health difficulties. The team worked with the wards to facilitate discharge to the community.

The service had worked with primary care services and local authorities to strengthen communication and relationships. The community manager of the South Tyneside and Sunderland children and young people's service had delivered a presentation at the December 2015 "Time In, Time Off" conference, attended by local primary care services to raise the profile of the service and to highlight progress and key achievements made by the service in the previous year.

Staff described positive working relationships with mainstream schools and schools for young people with special needs. Staff described that they were able to observe and assess young people when necessary. The service had contracts with Toby Henderson, a third sector organisation which provided additional support for school or home observations for young people starting the autism diagnosis pathway, and with North East Counselling and Washington Mind, voluntary organisations which provided counselling interventions for young people.

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

Training in the Mental Health Act was a mandatory training requirement for all staff. The service had compliance rate with Mental Health Act training which fell below the target of 85%:

- Newcastle and Gateshead children and young people's service – 70%
- South Tyneside and Sunderland children and young people's service – 78%
- Service average – 74%.

We found that staff had a basic understanding of the Mental Health Act. Staff felt that they focussed on working intensively with young people towards recovery from an early stage so that detention under the Mental Health Act

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was not required. Staff described how it was rare for the Mental Health Act to be used in the community services, and most said the consultant psychiatrists would be available to take the lead if the Mental Health Act was needed.

Care records showed evidence of informed consent to treatment which included the discussion of treatment options with young people.

Good practice in applying the Mental Capacity Act

Training in the Mental Capacity Act was considered mandatory training for all staff. The service had compliance rate with Mental Capacity Act training which fell below the target of 85%:

- Newcastle and Gateshead children and young people's service – 80%
- South Tyneside and Sunderland children and young people's service – 76%
- Service average – 78%.

The Mental Capacity Act 2005 does apply to young people aged 16 to 18 years old. We saw in four care records that there was evidence of assessment of mental capacity. For young people under the age of 16, decision making and capacity is determined through the concept of the Gillick competence. This concept recognises that some children will, at a young age, have a level of maturity and understanding sufficient to make decisions regarding their care and treatment. Managers were able to describe recent cases where confidentiality had been maintained between young people and the service without the involvement of parents and carers on the grounds that the young person had been assessed to have the capacity to make this decision.

Staff were aware that the trust had a Mental Capacity Act policy and most cited the Mental Health Act office as where they would go if they had any queries regarding mental health legislation.

The Deprivation of Liberty Safeguards (DoLS) does not apply to people under the age of 18 years. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. These include the existing powers of the court, particularly those under Section 25 of the Childrens Act 2004, or use of the Mental Health Act 1983.

Outstanding ☆

Are services caring?

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

Our findings

Kindness, dignity, respect and support

During the inspection we observed six appointments and the interactions between staff and young people visiting the service. We saw in staff interactions with young people that care was provided in a sensitive and thoughtful way. Care was being delivered in a way that focussed on goals, on recovery and building resilience.

We saw that staff were able to adapt their approach to interact with young people of different ages in a way that was appropriate and pitched at the right level. In a session with a teenage young person we saw that staff engaged in a professional way that was insightful and respected the individual that they were working with. Staff were kind, respectful and creatively explored difficult subjects with young people in an open and non-judgemental way. Staff demonstrated an in-depth knowledge of the young people in the service and could recall small details about young people.

Staff were passionate about the service work and we noted how staff were animated, even excited, by their work with young people. The service allowed staff to push boundaries where there was a clinical need, for example how young people reaching 18 years old would continue to receive involvement from the teams if the service felt that it a successful course of treatment within a time specific period could be achieved instead of transferring the case of the young person to adult services. Staff were also able to recognise the risk that young people may become dependent on the service and they described how this risk was reduced by working with young people in partnership with other services.

Young people who used the service and their parents/ carers were universally positive about the care they received from the service. Young people and their parents and carers praised the service and could provide real examples of how using the service had led to genuine and positive outcomes.

We saw that there was a culture of caring and support within staff teams. Staff told us that they came to work because they felt supported and cared for by their colleagues. Some described how the support they had from their colleagues was what enabled them in turn to support young people. We heard how staff felt that they were never left alone to support young people and that teams embraced and encouraged open discussion. Newer staff told us how the teams had been overwhelmingly welcoming and supportive during their transitions to new roles. Staff and managers appeared to genuinely care about the collective well-being of the team, recognising and adapting to the pressures the team faced. We saw this from all staff in both teams.

The involvement of people in the care that they receive

We reviewed 12 records of young people using the service. We found that young people and their parents and their carers were actively involved in care planning. Care records were written in a thoughtful and person-centred way that captured and expressed the voice of the young person. Young people were given copies of their care plans after the initial appointment in the form of a letter from the service which was documented on RIO.

Both teams had introduced a feature into their waiting areas which documented the feedback given by young people and carers and the response of the service. In Sunderland we saw that the team put comments on to the reception desk window and a description of the actions taken underneath. In Newcastle there was a “you said, we did” board being piloted which captured similar information and included the actions taken in response to feedback or an explanation when the service was unable to take action.

Young people and carers were aware how to access the advocacy service although none of the people interviewed had done so. During the inspection we interviewed young people who were members of the Evaluate Your Experience group. They told us how they felt empowered and more confident through using the service. They described how they had been involved in the recruitment of psychologists. The service had involved seven young people in two days of recruitment panels. Young people had been encouraged to formulate their own questions, criteria and scoring system. The two young people interviewed told us that they had felt involved in the process and that their views had influenced the final choice.

We were shown a film during the inspection which had been co-produced by staff and young people for local NHS commissioners. The film centred on the differing experiences of young people entering into mental health services. Young people in the film were very positive about

Are services caring?

Outstanding ☆

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the work of the service and staff told us some of the young people had chosen to continue their involvement in service development and had moved on to become Youth Commissioners.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The service accepted referrals by phone, fax, email and letter. A performance report from March 2016 listed 27 different sources of referral in quarter four 2015/16, including from GPs, accident and emergency departments, parents and carers, and self-referrals from young people themselves. The significant majority of referrals (over 35%) came from GPs. There was a process in place to triage all referrals on the same day they were received by the service. The service had established 'urgent and priority guidelines' which categorised cases accepted by the service using a traffic-light system based on risk. Target times for referral to assessment and treatment were based on the risk category for each case. The guidelines provided information to clinicians on the clinical criteria for each category, the timescale for the service to respond and the appropriate sub-team within the service with responsibility for ensuring the response.

The criteria for urgent cases included (but was not limited to):

- young people who were at immediate risk to themselves or others with evidence of planning and/or preparation.
- young people with acute or emerging psychosis.
- young people who required medical admission after an episode of self-harm.

Urgent cases were passed to the intensive community treatment service and would be seen for an emergency appointment up to 9:30pm Monday to Friday, and within a target of 72 hours. Staff were clear that although the target was 72 hours the service was capable of responding to young people with high risks on the same day. During our follow-up visit to the intensive community treatment service we observed a discussion of a new referral and saw that staff discussed visiting the young person later the same day.

Young people 16-18 years who presented in a state of mental crisis after 9:30pm were assessed by the trust's adult crisis services. Managers told us that those under 16 would be passed to the on-call medic if in a state of mental crisis out of hours. Young people aged 16-18 years who presented at an accident and emergency department after an episode of self-harm would be assessed by the local adult self-harm services, whereas those under 16 would be assessed by the local children and young people's service during standard operating hours on the following day. The service had close working relationships with the paediatric wards of the local acute hospitals and would be updated daily in case a young person had been admitted on to the ward and needed a mental health assessment.

The criteria for priority cases included:

- young people who refused to go to school for longer than one month where there was an associated mental health difficulty.
- young people who had a persistent or deteriorating low mood.
- young people previously categorised as standard but where there had been a change in presentation/risk.

Priority cases became the responsibility of identified clinicians within the local team. Priority cases were seen within a targeted maximum of four weeks from referral. Cases accepted by the service without the clinical criteria of urgent or priority cases were categorised as standard. These cases were offered the first available choice appointment around six to eight weeks after referral, with a target to be receiving treatment within 12 weeks.

The range of professional disciplines and therapies offered by the service meant that the service had the capacity to offer treatment for a wide range of mental health needs. Data provided by the trust showed that in quarter four on average 89**%** of referrals were accepted by the service. Workflow charts detailed the choice and partnership approach used by the service and showed that in instances where the service was not an appropriate choice for a referral, the young person would be 'signposted' to alternative services. As 'gatekeepers' to the service the duty team had the first responsibility to signpost to other services and we saw as an example in the Newcastle and Gateshead children and young people's service that the duty team had created a notice board full of information about other services which might be appropriate for referrals that did not meet referral criteria for services provided by the teams. The duty team told us that the service would try to facilitate the transfer of a referral to an alternative service if one was appropriate, rather than discharging the young person straight back to the referrer.

The most recent data produced by the NHS Benchmarking Network (2015) states that the average national missed

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appointment or 'did not attend' rate for community mental health services for children and adolescents was 11% in the period 2014/15 and that the rate had remained steady at 11% for the previous three years. There was no target for did not attend rates for the first appointment, and the average rate was 18% in quarter four of 2015/16. Local NHS commissioners had agreed with the service that the did not attend target for subsequent appointments (after first appointment) was 16%. The average did not attend rate for the service was 17% across both teams.

Staff told us that they had taken action to reduce the did not attend rate including making courtesy calls and using a text messaging service to remind young people about their appointments and offering Saturday clinics when needed. Staff described the process for missed appointments where young people would be offered two further appointments. Young people who missed three successive appointments would be sent a letter asking them to 'opt-in' to continue with their treatment. If the service received no response then the young person would then be discharged back to their GP. Staff told us that they though that the did not attend rate was increased by caseloads had increase young people aged over 18 years old who had difficulty in attending appointments due to other commitments such as employment.

Staff and managers raised with us that discharge rates were an area of concern for the service. The average length of time a young person spent receiving treatment from the service was 85 weeks from referral to discharge. The service accepted 1545 referrals of young people in quarter four of 2015/16. Teams discharged 990 young people after they received services from the teams in the same period. This meant that the service was accepting three new patients on to the caseload for every two young people discharged. Managers told us that although this was closely monitored in clinical supervision, the lack of other services for children and young people in the local area had led to a number of staff being reluctant to discharge young people as they felt that the services required were not otherwise available in the community.

In March 2016 the service provided data to local NHS clinical commissioning groups on waiting times. The overall number of children and young people waiting for treatment from the two localities was 1790. In September 2014 the total number was 5101. In eighteen months the service had managed to reduce waiting times across the two localities by around 65%. There was a service-wide target of at least 95% of young people should wait less than 12 weeks from referral to treatment.

In March 2016 compliance with this target was:

- Newcastle and Gateshead children and young people's service – 74%
- South Tyneside and Sunderland children and young people's service – 95%
- Service average – 84.5

The Newcastle and Gateshead children and young people's service had an additional waiting time target of at least 70% of young people should wait less than nine weeks from referral to treatment. Compliance with this target in quarter four of 2015/16 was 74%. The South Tyneside and Sunderland children and young people's service target for nine weeks was a minimum of 50% of young people and compliance averaged at 83%.

The facilities promote recovery, comfort, dignity and confidentiality

The South Tyneside and Sunderland children and young people's service operated from premises at Monkwearmouth Hospital in North Sunderland which was owned by the trust. The Newcastle and Gateshead children and young people's service operated from Benton House in Newcastle, a shared office space leased by the trust and a number of other services. Both facilities presented some operational issues which impacted on the delivery of care.

In Sunderland, although the service had a clinic room and number of rooms available for treatment, the demand on the service meant that there were often issues with rooms being available to book for treatment. Clinical staff told us that if they wanted to bring a patient in for an appointment at short notice it was unlikely that they would be able to book a treatment room. This meant that young people were sometimes waiting for appointments not because of a clinicians capacity but because there was a shortage in treatment space. The service had tried to respond to this issue by agreeing to share space in Cleadon Park, a primary care centre four miles from Monkwearmouth Hospital. This space, which became available a week before the inspection, provided five more treatment rooms to the team from 9:00am to 5:00pm Monday to Friday.

Parking facilities at Benton House in Newcastle were highlighted as an issue by staff, managers, parents and

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Good

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carers, and by young people using the service. The service had flagged the parking facilities as a risk and it was included on both the local and the service-wide risk register. The limited number of spaces meant that staff often double parked in the car park, blocking the exit for other vehicles. On the day of inspection we observed 14 occasions where interviews, staff meetings and young people's appointments were interrupted by staff checking vehicle registration numbers to find owners to move cars. One parent told us that it was a regular occurrence for appointments to be interrupted at least once a session. The limited facilities had the potential to impact on the privacy, dignity and therapy of young people when staff interrupted sessions and clinical staff had to leave young people mid-session in order to move their cars.

Meeting the needs of all people who use the service

Both teams in the service operated from facilities that were compliant with the Disability Discrimination Act 2005. The buildings had a ramp for wheelchair access and mechanically assisted doors. The clinic room and all of the interview rooms were on the ground floor in Sunderland. In Newcastle, where the team provided services across two floors, there was a lift for access to the upper floor.

Leaflets about the service were available at both sites. Whilst some leaflets were noted to be age appropriate for the service, we did not see leaflets in any language other than in English. Managers told us that leaflets in alternative languages could be provided by the trust's patient information service. Data provided by the service showed that there was regular use of 'The Big Word', a commercial translation service for over 30 face-to-face appointments during the period April 2015 to April 2016. The service was also used to ensure that letters from the service were accessible to non-English speaking young people and families. The service had also started building links with the Orthodox Jewish community in Gateshead to raise the profile of children's mental health services and encourage referrals during the early signs of mental health problems.

Listening to and learning from concerns and complaints

Young people and parents/carers told us that they know how to complain about the service if necessary. The service had established a practice whereby complaints received against one of the local teams were investigated by the manager of another local team. Themes of complaints were discussed in the services business meetings.

The service received 19 complaints with 17 fully upheld during the last 12 months (1 May 2015 – 30 April 2016). Two complaints were referred to the ombudsman. 11 of the complaints referred to the Newcastle and Gateshead children and young people's service and eight complaints referred to the South Tyneside and Sunderland children and young people's service.

The service had identified in early 2016 that one of the recurring themes in received complaints was that young people and parents struggled to make contact with the service at peak times because of the capacity of reception staff to handle the volume of calls. The service investigated the issue and concluded over 25% of calls were being missed. At the time of inspection the teams in all three localities (Gateshead, Newcastle, Northumberland, South Tyneside and Sunderland) had been allocated a team of call-handlers. The call-handlers were a new resource, employed and trained by the service to respond to incoming calls in partnership with the duty team of clinicians. Telephony reports indicated that in the six weeks since the call-handlers had taken the responsibility for fielding calls to the service the service had gone from missing 25% of calls to being able to answer almost 400 calls a day within 30 seconds.

The service received two written compliments during the last 12 months (1 May 2015 – 30 April 2016).

Are services well-led?

Good

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

Our findings

Vision and values

The trust's vision was 'to improve the well-being of everyone we serve through delivering services that match the best in the world'. The trust had three values:

- Caring and compassionate
- Respectful
- Honest and transparent

We found that staff awareness of the specific wording of the values was not universal. However, we also found that staff were able to nevertheless describe the themes of the values in their own words. Staff could articulate how these themes were significant to them and how they guided them in their work. Although concerned about the capacity of the service to meet future demand, we found that staff were highly motivated and passionate about the care of young people.

Staff knew and were positive about local and senior managers in the trust. Local managers were positive about the senior management and how described how the triumvirate (the directorate senior management level) were involved in the service. The service manager responsible for all community mental services for children and young people was on site to support teams during both days of inspection.

Good governance

We found that local governance systems were effective. Compliance with supervision was higher than the trust target and compliance with appraisals whilst below trust target was still above 80% for the service. Staff received mandatory training with an average compliance of 85% which was at the trust's target. We did find that eight of the 19 courses classified as mandatory had a compliance rate below the trust target of 85%. There was an ethos where additional specialist training was encouraged and we found that almost all staff were engaged in or had recently completed some form of additional training.

We found that all staff knew how report incidents and that managers had oversight of all reported incidents. Staff had a comprehensive understanding of safeguarding procedures. Incidents were investigated and actions were taken to prevent incident recurrences. Staff had a reasonable knowledge of the Mental Health Act and Mental Capacity Act and knew where to go for further information and advice if needed.

The service undertook clinical audits and the service was able to provide examples where audits were used to examine operational issues such as staff capacity and caseloads. The administration team had recently been absorbed into the operational management structure of the service. Administrators felt that they had sufficient resources and expertise to support the service.

The service was required to report every three months on key performance indicators to the local NHS clinical commissioning groups. We found that both managers and the wider team had an in depth knowledge of team performance. Key performance indicators, in particular waiting times, were used to drive team activity.

Both local managers and the service manager reported that they had sufficient authority to undertake their roles successfully in almost all areas. Staff were universally positive about their local managers and local managers in turn were positive about the trust's senior management. Both teams had a local risk register and managers could explain the process for escalating risks to the service-level risk register and to higher level registers if needed.

Leadership, morale and staff engagement

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 most described that the service had a culture where issues could be discussed openly without the need for whistleblowing.

The average staff sickness rate was 5.2% which was below the trust's average of 5.4%. The service was deliberately over establishment levels for staffing as a response to increased waiting times in 2015. Although some temporary contracts had started to draw to a close, at 5.4% the service still had a lower rate of leavers in the last 12 months than the trust average of 7.9%.

We found that staff morale was mixed. All staff were universally positive about the care of young people and were proud of the service, however most staff reported some worries and concerns about the capacity of the service to meet the local demand in the future from increases in referrals. The trust had recognised in 2015 that

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Good

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the service did not have the capacity to meet targets on waiting times from referral to treatment. The trust made a significant investment to increase the clinical capacity of the service including increasing the number of contracted staff, increasing the use of bank and agency staff and establishing service level agreements with local counselling services.

The long term financial plan of the service accepted that the trust's investment whilst essential in allowing the service to meet targets was also not sustainable and did not provide for the longer term. In May 2016 the service put forward an action plan to address the shortfall between funding and expenditure. By the end of July 2016 the service planned to discontinue all overtime for staff. By the end of June all agency staff contracts were planned to finish and were not planned to be renewed. The service accepted that the planned changes would affect not only waiting times in the future but the broader view of service quality held by young people, parents and carers and other external stakeholders. Whilst the service was engaged in continuous dialogue with the trust and local clinical commissioning groups on this issue, we found that staff were generally uncertain about the future of the service.

We found that staff cared for each other as well as for young people. Staff described a service in which teams supported each other and embraced the skills and expertise of the multitude of professional disciplines. Staff had opportunities for leadership development both within the trust and through external postgraduate courses.

Commitment to quality improvement and innovation

The service was an active participant in the Quality Network for Community Child and Adolescent Mental Health Services, with both teams undergoing the peer review required for membership of the network in 2015. The Quality Network for Community Child and Adolescent Mental Health Services is a members network established in 2005 by the Royal College of Psychiatrists. It forms part of the Royal College of Psychiatrists' Centre for Quality Improvement. The next assessment was planned for July 2016. We noted that managers and business team meeting minutes both indicated that the service was hoping to gain accreditation from the Quality Network. Accredited services are those regarded as providing a level of high quality care worthy of national recognition.

The service had committed to six Children and Young People's Improving Access to Psychological Therapies (CYPIAPT) Partnerships in North Tyneside, Northumberland, Newcastle, Gateshead, South Tyneside and Sunderland. Children and Young People's Improving Access to Psychological Therapies is a national service transformation programme led by NHS England. The programme seeks to improve child and adolescent mental health services in part by training existing staff 'in targeted and specialist services in an agreed, standardised curriculum of National Institute of Health and Care Excellence approved and best evidence-based therapies' (NHS England, 2015). Over 20 staff had either completed or were involved in further training in a range of qualifications within Children and Young People's Improving Access to Psychological Therapies principles.