Good

Northumbria Healthcare NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Trust Headquarters
Rake Lane
North Shields
NE29 8NH
Tel: 0344 8118111
Website: www.northumbria.nhs.uk

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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)
RTFFS	North Tyneside General Hospital	Community child and adolescent mental health service	NE29 8NH

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

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

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

Summary of findings

Ratings

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

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

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- The service had clear criteria for referrals into the service with timescales for assessment for urgent, priority and routine referrals.
- Initial assessments were thorough and included a full assessment of risk and staff used a range of assessment and diagnostic tools for specific areas of need.
- The service delivered a wide 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.
- 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 young people's needs.
- Feedback from people who use services and their carers was positive about the care they received.
- Staff were passionate, enthusiastic and dedicated to their work with children and young people.

However:

- Interview rooms were not fitted with alarms and staff did not have access to personal alarms. At the Albion Road clinic, the door from reception area to staff offices and rooms where staff saw patients was not secure.
- Although risk was reviewed with young people and within multi-disciplinary teams, it was not easy to access this from the information in the care records.
- The involvement of young people and parents was not well documented within care records.
- There was insufficient hand washing and sanitising equipment at Albion Road and Baliol Centre.

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 low.
- The service was staffed by a range of professionals including psychiatrists.
- There were effective out of hours arrangements in place.
- Staff had a comprehensive understanding of safeguarding policies and procedures.
- Staff reported and recorded incidents in line with trust policy and demonstrated a good understood duty of candour.

However:

- Interview rooms were not fitted with alarms and staff did not have access to personal alarms. At the Albion Road clinic, the door from reception area to staff offices and rooms where staff saw patients was not secure.
- Although risks were reviewed within follow-up appointments with young people, there was no formal risk assessment tool being used. This made it difficult to easily identify changes in risk from the case notes.
- There was a lack of hand washing and sanitising equipment at Albion Road clinic and Baliol Centre.

Are services effective?

Good

We rated effective as good because:

- Initial assessments were thorough and included a full assessment of risk.
- Staff used a range of assessment and diagnostic tools for specific areas of need.
- Staff used a range of outcome measures to measure the effectiveness of treatment.
- The service offered a wide range of National Institute of Health and Care Excellence approved psychological interventions to meet the needs of young people.
- Staff were involved in a programme of local and national clinical audits.
- Young people had rapid access to psychiatric support when needed.

Summary of findings

Are services caring?

Good

- Young people and parents spoke very positively about the service, particularly in relation to caring and respectful staff.
- 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 young people's needs.
- Staff had good therapeutic relationships with the young people.
- Young people and their parents were actively involved in agreeing and reviewing treatment and care.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The service had clear criteria for referrals into the service with timescales for assessment for urgent, priority and routine referrals.
- Did not attend rates were in line with the national average and staff were proactive in following up on missed appointment.
- Discharge pathways were well developed with particularly good transitional arrangements for young people with ADHD.
- The majority of young people waited less than twelve weeks from referral for treatment to commence.
- Young people and parents knew how to complain.

Are services well-led?

Good

We rated well-led as good because:

- Staff recalled the themes of the trust values.
- Effective governance systems were in place to monitor caseloads, incidents and service level risks.
- 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 involved in a range of local and national clinical audits, with any improvement actions taken forward within the service.
- Staff spoke highly of service level managers and senior managers.
- 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.

Summary of findings

Information about the service

Northumbria Healthcare NHS Foundation Trust provides specialist community mental health services for children and young people aged 0-17 in North Tyneside.

The team provide specialist community mental health services for children and young people. Clinics are held at Albion Road Clinic in North Shields and Baliol Centre in Longbenton. Staff also deliver outreach appointments at locations that are accessible to young people.

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.

The service also provides a primary mental health worker service across Northumberland. This provides early intervention to children and young people, working closely with paediatricians, school health teams, health visitors and GPs. The service provides a consultation line, used by professionals from across Northumberland to seek advice and support from the team on mental health issues in young people.

We have not inspected Northumbria Healthcare NHS Foundation Trust's specialist community mental health services for children and young people before this inspection.

Our inspection team

Our inspection was led by Sharon Baines, CQC inspector and consisted of an inspection manager, two inspectors and one specialist advisor.

Why we carried out this inspection

Northumbria Healthcare NHS Foundation Trust is primarily an acute and community health Trust, which had a comprehensive inspection in November 2015. The trust was rated as Outstanding overall.

The community child and adolescent service was not inspected as part of the comprehensive 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?

The inspection was announced two weeks prior to the inspection taking place. Before the inspection visit, we reviewed information that we held about the service, and asked a range of other organisations for information. We visited the community child and adolescent mental health services in North Tyneside at Albion Road clinic and the Baliol Centre. We also observed outreach sessions delivered from the child health centre at Wansbeck District General Hospital. The primary health mental health team operated a consultation line from Ponteland Health Centre. We visited Ponteland Health Centre to interview staff from the primary mental health team.

During the inspection visit, the inspection team:

Summary of findings

- visited services at four locations, looked at the quality of the environment and observed how staff were caring for patients
- spoke with two young people who were using the service
- spoke with seven carers of young people who were using the service
- spoke with the general manager and operational manager for the service
- spoke with 15 other staff members; including psychiatrists, psychologists, nurses and primary mental health workers
- looked at 21 treatment records of young people who were using the service
- attended and observed a case management meeting, referrals meeting and a team meeting
- attended and observed seven sessions where care was being delivered to children and young people.

What people who use the provider's services say

We spoke to two children and young people, seven parents and carers and observed seven sessions where staff delivered care and treatment to children and young people.

Young people and their parents and carers spoke very positively about their experience of the service. Parents and young people told us that they felt very involved in care planning and spoke highly of staff in the service. There were no negative comments from young people or parents and carers. All of the young people and parents and carers we spoke to said that staff were very respectful and caring.

Areas for improvement

Action the provider SHOULD take to improve

The trust should ensure that the premises at Albion Road has appropriate security systems in place including secure entrance to staff areas and interview rooms.

The trust should ensure that the service meets the trust target of 85% compliance for mandatory training, including training in Safeguarding Level Two and Three and the Mental Health Act.

The trust should ensure that there is adequate access to hand washing and hand sanitisers at Albion Road and Baliol Centre.

The trust should consider how to more accurately record the involvement of young people and parents in decisions about treatment and care.

The trust should consider approaches to record the on-going assessment of risk to ensure this is easily accessible within care records.

The trust should consider how to review the status of young people waiting for treatment.

The trust should ensure all staff receive annual appraisals in line with trust policy.

Northumbria Healthcare 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
Community child and adolescent mental health service	Rake Lane 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. The compliance target within the trust for all mandatory training was 85%. Information provided by the trust showed that between April and August 2016, 36% of staff from the service had completed Mental Health Act training. We discussed the Mental Health Act with staff, who displayed varying degrees of knowledge about it. Staff told us that the Mental Health Act was rarely used in relation to young people who used the service. Mental Health Act legislation would usually only be appropriate for those young people who required inpatient services. Should a young person require detention under the Mental Health Act, the provider of in-patient child and adolescent mental health services would complete the assessment.

Managers told us that the service was not included in the trust audit of Mental Health Act.

Staff knew where to get more information within the trust on the Mental Health Act, although in practice this was rarely needed.

We found that some trust policies had not been updated in line with the Mental Health Act Code of Practice. This was raised with senior managers within the trust during the inspection. Policies were in the process of being updated and were awaiting sign off from the trust's Assurance Committee. These policies were all signed off for implementation on 18 October 2016.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was a mandatory training requirement for all staff and the trust had a compliance target of 85%. The trust provided level one and level two training in Mental Capacity Act. Data provided by the trust for the period April to August 2016 showed that compliance with this training was 100% for level one and 86% for level two. Staff were able to tell us who to contact for advice when they needed information about the Mental Capacity Act.

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 0-18 years old.

For young people under the age of 16, decision making and capacity is determined through the concept of the Gillick competence. This concept of competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. As a result, when working with children, staff should be assessing whether a child has a sufficient level of understanding to make decisions regarding their care. Where a young person had decided they did not want their family to be involved, their competence would be assessed and a risk assessment carried out to ensure the safety of the young person. During our inspection we reviewed 21 care records. All had documented that consent to treatment had been sought. Treatment was agreed with young people and their parents or carers.

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

We visited the Albion Road clinic in North Shields and the Baliol Centre in Longbenton. Both premises were clean and well maintained. Domestic rotas showed there was a regular cleaning schedule. Interview rooms were not fitted with alarms and staff did not have access to personal alarms. At the Albion Road clinic, the door from reception area to staff offices and rooms where staff saw patients was not secure. This meant that visitors to the building had uncontrolled access to some areas of the service, including areas were children and young people were being seen.

Rooms at both locations were clean and equipped with the necessary equipment to carry out physical examinations, including equipment to check height, weight and blood pressure. At Albion Road, we found that two electrical appliances in the staff kitchen did not have up to date portable appliance testing.

Rooms used to carry out physical interventions did not have handwashing facilities. There were no hand sanitisers at either site. We saw an infection control audit for Baliol Centre which had been carried out in July 2015. This audit had identified lack of handwashing/sanitising equipment, but this had not been resolved at the time of the inspection.

Safe staffing

The service was staffed by a wide range of professionals including consultant psychiatrists, psychologists, nurses, primary mental health workers and administrators. The service had a total of 32 whole time equivalent staff. This included 12.9 whole time equivalent qualified nurses.

Sickness levels within the service were very low, with a rate of 1.24% between September 2015 and August 2016. Staff turnover was also low, at 2.94% between September 2015 and August 2016. Although there was no formal tool used to calculate the staffing establishment, managers reviewed staffing levels annually. Managers told us that when a member of staff left, the team would be reviewed to enable a decision to be made as to whether to replace the post 'like for like'. Managers used this as an opportunity to review the skill mix of the staff team and the needs of the patient group. Bank and staff were not used within the service.

At the beginning of September 2016, the total caseload for the service was 2,025 open cases. There were locality and specialist teams within the service with the following caseloads:

- North Team - 337
- South Team - 274
- Assessment clinic - 166
- Emotional disorders team - 185
- Neurodevelopmental team - 221
- Primary mental health workers team - 164
- Specialist Attention Deficit Hyperactivity Disorder team - 632
- Specialist Autistic Spectrum Disorder team - 26
- Specialist eating disorder team - 20

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

The team included a range of professionals including consultant psychiatrists. This meant that young people using the service had good access to psychiatric support.

The operating hours of the service was 9.00am to 5.00pm Monday to Friday. Out of hours, there was a specialist child and adolescent mental health consultant on-call arrangement in place. The service had a clear process for dealing with out of hours referrals.

Mandatory training data for the service was provided by the trust. Mandatory training included infection prevention and control, conflict and resolution, risk management, Mental Health Act, safeguarding, Mental Capacity Act, information governance, basic life support and paediatric life support. The compliance rate for completing this suite of mandatory data was 78%. The trust target for compliance was 85%. Lowest levels of compliance were for Mental Health Act

Good

Are services safe?

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

training with 36%, conflict resolution with 48% and information governance with 53%. Data provided by the trust covered the period April to August 2016. Compliance rate targets were for the period April 2016 to March 2017.

Assessing and managing risk to patients and staff

Risk assessments were an integral part of the initial assessment process. Staff completed an assessment with all young people entering the service. Staff did not use a nationally validated risk assessment tool. Risk was explored as part of the initial assessment process and included information on family background, offending behaviour, developmental history, education, mental and physical health. This included an overview of both long and short term risks and also considered protective factors. Protective factors are conditions or attributes in individuals, families or communities that, when present, can reduce or eliminate risk.

We reviewed 21 care records. We found that risk had been assessed as part of the initial assessment within all of the records. As there was no separate risk assessment tool being used, aside from the questions on risk within the initial assessment, it was difficult to clearly and easily identify on-going risks amongst young people. We saw, in observations of direct interactions between staff and young people that risks were discussed and reviewed. Staff entered a summary of these meeting within the young person's care record, in the case notes. This made it difficult to clearly extract information on risk for each young person.

New referrals into the service were discussed in a daily allocations and referrals meeting. Urgent referrals were picked up immediately by staff via the duty system. Urgent referrals would be seen as a priority, usually the same day. Routine referrals would usually be offered an assessment appointment within six to 12 weeks. Data provided by the trust indicated that between April and August 2016, all referrals had been seen for an initial assessment within six weeks or less.

The service maintained a waiting list for young people referred into the service. The Neurodevelopment team held the biggest waiting list of 30 young people. After initial assessment there was no system to monitor or detect increases in the level of risk. This meant that once on the waiting list the service relied on young people and parents or carers to actively highlight changes in risk, rather than proactively monitoring people waiting for treatment. Managers told us that where risks had changed staff would revisit and if necessary, young people could be seen as an urgent referral by the duty worker.

We observed a referrals and allocations meeting, which was attended by clinical psychiatrist, clinical psychologist and nurses from the team. The risks associated with each young person were discussed in detail. Staff within the team discussed who would be best to take the young person onto their caseload, taking into account the needs of the young person and the skills within the team.

Staff were required to complete safeguarding training. The trust provided three levels of training in safeguarding children and young people. Compliance rates for this training for the period April to August 2016 were:

- Safeguarding children and young people level one – 88%.
- Safeguarding children and young people level two – 73%
- Safeguarding children and young people level three – 67%

Staff within the primary mental health worker team achieved 100% compliance for all three levels of safeguarding training.

Staff demonstrated a clear understanding of the trust safeguarding policy and procedures. Staff used the multi-disciplinary team meetings to discuss any safeguarding concerns relating to young people using the service. There was a safeguarding lead nurse, with whom staff could discuss any issues or concern. Between January and July 2016, there were 14 contacts between the service and the safeguarding team.

The trust had a lone working policy which staff were aware off. Home visits were available, but most children and young people attended the clinics for appointments. Staff in the primary mental health workers team did carry out home visits, and there was a 'buddy' system in place. This ensured that staff contacted their designated 'buddy' prior to and after a home visit.

Good

Are services safe?

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

Track record on safety

Data provided by the trust showed 17 incidents had been reported for the service between April and August 2016. There were no specific themes arising from these incidents. No serious incidents had been reported for the service during this period.

Reporting incidents and learning from when things go wrong

The trust used an electronic incident reporting system to record incidents. All staff knew how to complete a report on the system and the circumstances under which a report should be made.

Incidents were reviewed in a weekly meeting between the service manager, nurse consultant and administration manager. Incidents were also discussed within team meetings.

All staff demonstrated a good understanding of the principles of the duty of candour. Staff were clear about the importance of an apology after an incident.

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

Staff completed the initial assessment with the young person at the first appointment. We observed an initial assessment. This was conducted in a professional, yet friendly manner, to put the young person and their parents at ease. Staff explained the purpose of the session and what would happen during the course of the session. At the end of the session, an initial care plan was discussed and agreed.

We reviewed 21 care records and found that:

- 19 records included a completed initial assessment, which incorporated information on risk
- There was no risk assessment tool to record on-going assessment of risk. This made it difficult to easily identify on-going levels of risk.
- There was no formal care planning document. Care plans were summarised in the form of a letter to young people and parents. These did not always fully capture the involvement of young people within the development of their care.
- Where necessary the service had undertaken physical examinations of young people and that there was on-going monitoring of physical health needs.

Staff used appropriate assessment tools for specific specialisms. There were specific eating disorder assessments and assessments for attention deficit hyperactivity disorder. Staff used the Connors ratings scale. This is a diagnostic tool that is used to assess attention deficit hyperactivity disorder, and is completed by young people, parents and teachers. We saw complete Connors assessments within care records we reviewed.

Staff stored patient files appropriately and securely. Care records were paper based and were a single care record for physical and mental health. Staff told us this sometimes created issues with access to files. For example, if a young person had attended hospital for a physical health appointment, the record may still be held at the hospital. This meant on occasion, records were not available within the service. Staff had previously driven to collect care records or arranged for the records to be sent via taxi. Staff were writing up case notes by hand within patient care records. We found some entries to be very difficult to read due to illegible handwriting.

Best practice in treatment and care

The national institute for health and care excellence sets down guidance on evidence based interventions for children and young people experiencing mental health issues. Staff were very knowledgeable about the national guidelines. We found that there a wide range of national institute for health and care excellence recommended interventions were being delivered. The service was delivering the Children and Young People's Improving Access to Psychological Therapies programme. This is a national service transformation programme delivered by NHS England that aims to improve existing child and adolescent mental health services working in the community. Staff had attended training to deliver systemic therapy and working with young people with eating disorders. Children and young people also had access to cognitive behavioural therapy and dialectical behavioural therapy.

Young people had good access to consultant psychiatrists. Consultant psychiatrists worked within the service to provide medication based treatments for patients where appropriate. 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.

Staff used a range of outcome measures to measure the effectiveness of treatment. These included strengths and difficulties questionnaire (a brief behavioural screening questionnaire) and the CHI-ESQ (an experience of service questionnaire). The experience of service questionnaire was used by young people and parents. Staff also used the Hamilton Depression Scale, which is multiple item questionnaire used to provide an indication of depression, and as a guide to evaluate recovery.

Staff were involved in a programme of local and national clinical audits. This included audits of:

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.

- assessment and diagnosis of autistic spectrum disorder in school age children
- diagnosis and management of depression in children and young people
- social anxiety in children and young people
- use of deliberate self- harm risk assessment tool
- clinical supervision in the service
- prescribing for attention deficit hyperactivity disorder in children, adolescents and adults.

Skilled staff to deliver care

The staff team consisted of a wide range of professionals including consultant psychiatrists, speciality registrars, nurse consultant, nurses, psychologists, social workers and administrators. Four of the nurses were non-medical prescribers, who took a lead in prescribing for patients with an attention deficit hyperactivity disorder diagnosis.

Staff were encouraged to attend specialist training and staff and told us that they were supported to identify training, to meet the needs of children and young people in the service. Staff from the team had either completed or were involved in further training in a range of qualifications as part of the Children and Young People's Improving Access to Psychological Therapies programme.

The trust had a clinical supervision policy which set a standard for clinical supervision to be delivered a minimum of once a month to all clinical staff. Staff felt that the supervision process was very supportive and happened regularly. Staff were required to have an annual appraisal. Data provided by the trust for the period April to August 2016 showed that 54% of non-medical staff had received their appraisal.

The service had five medical staff who had been revalidated which represented 100% of those eligible for revalidation for the period April to August 2016.

Multi-disciplinary and inter-agency team work

Staff were aligned to a number of specialist teams within the service including emotional disorders, neurodevelopment, attention deficit hyperactivity disorder, autistic spectrum disorder and eating disorder. Each of the teams consisted of a range of professionals including psychiatry and psychology. All teams held weekly multi-disciplinary meetings, where new referrals, risk and cases of concern were discussed.

Staff had developed strong relationships with the local authority social work team and the psychologist with responsibility for looked after children.

Staff within the primary mental health work team delivered training to a range of other front line professionals to improve understanding of the child and adolescent mental health service and to ensure other agencies were aware of referral procedures and criteria. Professionals in Northumberland could contact the consultation line, which was resourced by the primary mental health team, for information and support.

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. Data provided by the trust for April to August 2016 showed that the service had compliance rate of 36% for Mental Health Act. The trust target for this training was 85% for the period April 2016 to March 2017.

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 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.

We found that some trust policies had not been updated in line with the Mental Health Act Code of Practice. This was raised with senior managers within the trust during the inspection. Policies were in the process of being updated and were awaiting sign off from the trust Board. These policies were all signed off for implementation on 18 October 2016.

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 of 100% for Mental Capacity Act Level One training.

The Mental Capacity Act 2005 does apply to young people aged 16 to 18 years old. For young people under the age of 16, decision making and capacity is determined through the concept of the Gillick competence. This concept

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.

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. We reviewed 21 care records and saw that consent to treatment had been sought in all cases. There were no records which contained any formal capacity assessments.

Staff were aware that the trust had a Mental Capacity Act policy and knew who to contact within the trust if they had any queries regarding mental health legislation.

The Deprivation of Liberty Safeguards 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 Children's Act 2004, or use of the Mental Health Act 1983.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

During the inspection we observed seven interactions between staff and young people using the service. Staff provided care in a sensitive and thoughtful way. Staff delivered interventions in a way that was insightful and respectful towards young people and their parents and carers.

Several times during the sessions, staff checked with young people and their parents that they understood what was being discussed.

We observed interactions that were empathetic and saw that staff had good therapeutic relationships with the young people. Staff used appropriate language whilst delivering therapeutic interventions which were safe and followed national guidelines.

Staff provided reassurance to young people and parents who were nervous during sessions. For example, we saw staff discussing the need for blood tests with a young person who was anxious about this. The member of staff allowed the young person time to talk about their concerns and provided support and further information to reduce the level of anxiety.

We spoke to two young people and seven parents. Feedback from young people and their parents was very positive. Young people and parents felt that staff were caring, respectful and very supportive. Parents said they had felt supported by staff as well as the support given to young people themselves.

Staff were passionate about the service and were motivated by improving the health and well-being of young people accessing the service. Staff had a good knowledge of the young people as well as the wider family and demonstrated a genuine concern for the wellbeing of the whole family.

The involvement of people in the care that they receive

We reviewed 21 records of young people who used the service and observed seven interventions between staff and young people. During the interventions, staff discussed treatment options, outcomes and progress with young people and their parents. At the end of each session, staff clearly stated what had been agreed during the session and ensured that young people were in agreement and happy with what had been discussed. It was evident from the interventions we observed that young people and their parents were actively involved in agreeing and reviewing treatment and care.

Within care records, we found that there was no formal care plan document. A summary of the discussions and agreed treatment decisions following assessment and review appointments were documented in a letter. This was sent to the young person and parent, and copied into any other relevant professionals, for example the young person's GP. This format did not capture the full detail of the involvement of the young person in the decision making process.

Young people and parents who provided feedback all said they had felt very involved in decisions about treatment and care.

The service actively encouraged feedback from young people and parents and carers. We saw analysis of comments received from parents and young people about their views of the service. 25 parents and 20 young people had completed comments cards. The majority of feedback was positive, with 84% of parents and 75% of young people stating that the service was good and nothing needed to change.

Young people and carers were aware how to access an advocacy service although none of the people we spoke with had done so.

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 from a wide range of professionals, and young people or parents could self-refer. The majority of referrals into the service came from GPs.

The service had clear definitions of categories of referrals consisting of urgent, priority and routine.

A referral pathway document incorporating each category of referral had been developed to provide referral agencies with clarity around criteria for access into the service.

Urgent referral criteria included (but not limited to):

- overdose/other self-harm with intent to commit suicide

- actively suicidal

- acute psychosis

Urgent referrals were discussed via telephone with the referring agency by the duty clinician and prioritised for immediate assessment.

Priority referral criteria included (but was not limited to):

- significant deliberate self-harm
- psychotic symptoms
- eating disorders
- bipolar disorder
- major depressive disorder
- severe anxiety
- obsessive compulsive disorder

Priority referrals would be offered an urgent appointment depending on clinical need.

Routine referral criteria included (but was not limited to):

- attention deficit hyperactivity disorder
- autistic spectrum disorder
- tic disorders
- anxiety
- specific phobias
- low mood

Young people whose referral was considered routine would be offered an assessment appointment within six to twelve weeks. At the time of the inspection, routine referrals were being seen for assessment in less than ten weeks. Young people or their parents or carers were given a contact number for the service to enable them to inform staff if circumstances had changed. This allowed staff to review again the needs of the young person.

Staff triaged all referrals on the day they were received into the service. We observed a referral meeting, where staff came together to discuss new referrals into the service. Staff discussed each referral individually, giving consideration to the specific mental health concerns or diagnosis, assessment of identified risk and appropriateness of the referral.

The most recent data produced by the NHS Benchmarking Network (2015) states that the average national missed 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. Within the service the 'did not attend' rate between April and August 2016 was 12% for new assessment appointments. For review appointments during the same period, the 'did not attend' rate was 10%.

Staff reviewed non-attendance rates at appointments. Staff felt that it would be helpful to have the facility to send reminder text messages to young people and parents, but this was not available. Staff would contact young people and parents to inform them of missed appointments and to communicate the importance of attending all scheduled appointments.

The service accepted 639 new referrals between April and August 2016. Staff monitored waiting times for access into the service. Between April and August 2016, 23% of young people waited less than six weeks, 57% waited between six to ten weeks, 20% waited between ten to twelve weeks.

Between April and August 2016, 526 young people were discharged. There were effective transitions pathways for young people with attention deficit hyperactivity disorder moving into adult services. The service worked collaboratively with the adult provider of attention deficit hyperactivity disorder services, and had developed a nurse-led clinic for young people. Young people started with the transitions clinic before they became 18 years of age, which enabled them to meet with both nurses from the adult and

Are services responsive to people's needs?

Good

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

young people's services. Staff described difficulties in transition arrangements for young people with autistic spectrum disorder, as generally they did not meet the threshold for adult community mental health services.

The facilities promote recovery, comfort, dignity and confidentiality

Young people accessing the child and adolescent mental health service in North Tyneside were generally seen at either the Albion Road clinic or the Baliol Centre. The Northumberland primary mental health worker team saw young people at a range of locations, including schools and GP practices.

The premises at Albion Road and Baliol Centre both had adequate space for the delivery of interventions. The rooms we saw were clean and fit for purpose, although there was a lack of hand washing and sanitising equipment in rooms at both premises.

Young people and parents told us that they found the premises to be accessible and comfortable.

Meeting the needs of all people who use the service

All of the interview rooms in both premises were situated on the ground floor and the buildings had disabled access.

We saw information that was sent to young people and their parents or carers. This included information on how to contact the service and how to complain.

There were some information leaflets available at the Albion Road clinic, but there was no information leaflets at Baliol Centre. Staff accessed on-line materials that could be printed off if young people wanted to take the information away. Staff accessed information about medications via the medicines.org website. Although this information was not specifically designed for young people, staff talked through the content of the information to ensure understanding.

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; although no-one we spoke to had felt it necessary to complain.

Between August 2015 and August 2016, the service received two complaints. One complaint related to an alleged breach of confidentiality and the other related to an allegation of misdiagnosis. Neither of these complaints were upheld. No complaints had been referred to the Parliamentary and Health Service Ombudsman.

Staff dealt complaints with in line with the trust policy

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 had five values:

- Respect
- Everyone's contribution counts
- Responsibility and accountability
- Patients first
- Safe and high quality care

Staff were able to communicate these values in their own words. Staff articulated what these values meant to them and how they guided the work they did. Due to funding reductions in 2017/18, there were some concerns within the staff team about capacity with the service moving forward. Despite this, staff remained highly motivated and passionate about the care of young people.

Staff knew and were positive about local and senior managers in the trust. Service level managers were positive about the senior management and felt supported.

Good governance

We found that local governance systems were effective. The service held a monthly operational group meeting and the service was represented on the child health governance group and child health board meetings. There were effective working relationships between the community child and adolescent mental health service and other departments within the child health business unit.

Staff had supervision in line with trust targets. Data provided by the trust showed that for the period April to August 2016, 54% of non-medical staff had an appraisal. Staff were encouraged to attend specialist training and staff said they felt supported to identify their own personal development needs.

Staff knew how to report incidents and 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 varying levels of knowledge of the Mental Health Act and Mental Capacity Act but knew where to go for further information and advice if needed.

Staff were involved in a range of local and national clinical audits. For each audit undertaken, there was a log of improvement actions to be implemented within the service. This ensured that learning was shared and acted upon.

Managers provided routine performance management reports to their commissioners. We found that both managers and the wider team had a good knowledge of team performance. Managers had a good oversight of the demands on the service and regularly reviewed the skill mix within the team to ensure the service continued to meet the needs of young people.

Managers said 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.

We reviewed the risk register for the child heath business unit. There were three risks related to the community child and adolescent mental health service detailed on the risk register. These all related to funding and capacity within the service, with actions identified to mitigate risk.

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

During the year from September 2015 to September 2016 the overall staff sickness rate very low at 1.2%.

Staff morale was good. Staff described a culture of openness and transparency. Without exception, staff spoke very highly of the team and felt well supported by peers and manager. Staff were proud of the service and were highly motivated in their work.

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 range of professional disciplines. Staff were supported to identify opportunities for development and staff had accessed training to further develop skills and competencies as part of the children and young people improving access to psychological therapies programme.

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.

Commitment to quality improvement and innovation

The service participated in the Quality Network for Community Child and Adolescent Mental Health Services. This is a national network established in 2005 by the Royal College of Psychiatrists. It forms part of the Royal College of Psychiatrists' Centre for Quality Improvement. The most recent assessment had been carried out in March 2016.

The service was part of the Children and Young People's Improving Access to Psychological Therapies national programme. This 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). Staff from the service had either completed or were involved in further training in a range of qualifications as part of this programme.