

Lancashire Care NHS Foundation Trust

# Child and adolescent mental health wards

## Quality Report

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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW5LE	Ashford Road Lancaster	The Junction	LA1 4PW
RW5EE	Avondale Unit Royal Preston Hospital	The Platform	PR2 9HT

This report describes our judgement of the quality of care provided within this core service by Lancashire Care 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 Lancashire Care NHS Foundation Trust and these are brought together to inform our overall judgement of Lancashire Care 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 Lancashire Care Child and Adolescent Mental Health wards as good because:

- Young people were supported by a range of skilled professionals and had access to good information to make decisions about their care; they described a participative service where they felt staff treated them with dignity and respect.
- Young people and their parents/carers were given the opportunity to comment and give feedback about the service they received, feedback about the service was largely positive. Complaints about the service were low and young people and their parents/carers had good information about how to raise a complaint. Complaints were received and investigated in a timely manner.
- Safeguarding processes were clear and complied with local safeguarding children's board procedures. Safeguarding monitoring was in place across the service; staff were trained in safeguarding and had good support to raise safeguarding issues.
- Comprehensive assessment processes, holistic care plans and risk assessments were in place and young people felt involved in the care planning process. Evidence based tools were used in the assessment process and staff used recognised rating scales to measure a young person's progress.
- Staff had access to training and had a good understanding of the Mental Health Act the Mental Capacity Act, and associated code of practice. Staff also had a good understanding of issues of consent and Gillick competence in their work with young people. Young people were given information and support from independent advocates about their rights under the Mental Health Act.

- Referrals, admissions, discharges, length of stay and out of area placements were routinely monitored. Discharge planning was incorporated into the local governance reviews and was planned for on the young person's admission to the wards.
- The trust had systems in place to monitor quality issues and there was a clear commitment for continuous improvement with involvement of young people and their families. The service had a dedicated participation lead that supported a group of former patients and parents with experience of tier 3 and tier 4 services to develop and improve services across the child and adolescent mental health service for Lancashire Care.
- There was mutually supportive and multidisciplinary working across all of the child and adolescent mental health service teams. There were good working relationships with other teams including child and adolescent mental health service community teams, adult services, social services and outreach teams.
- The trust had a clear vision and a strategy for achieving this vision, clear management structures were in place in the service. Staff were motivated and described good teamwork, they talked positively about their roles. Staff felt valued and supported by their colleagues and were aware of the senior management team within the trust although the planned move of premises had affected staff morale.

However:

- Environmental audits did not include all areas of the ward environment which meant that staff were not following trust procedures.
- Compliance with staff supervision and appraisal was low at the Junction.

# Summary of findings

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

### Are services safe?

#### We rated safe as good because:

- The child and adolescent mental health service inpatient service had good rates of compliance with mandatory training and staff felt supported to attend training. Managers monitored and audited training attendance. They took action to increase compliance where they identified deficiencies.
- Staff undertook a thorough assessment of each young person and identified risks on admission to the service. Risks were regularly reviewed with the young person.
- Procedural support and staff training was in place to support safeguarding and staff were clear about their safeguarding responsibilities. Good monitoring and review processes were in place to monitor safeguarding for children across the trust within the child and families network.
- All staff understood how to report incidents, serious incidents were reviewed in a timely manner and actions from lessons learnt were in place to reduce the likelihood of reoccurrence. Risks highlighted from serious incidents were recorded and monitored.
- Each location was clean and well maintained. Staff had systems in place to keep them safe such as training in the management of violence and aggression, alarms within the building to summon assistance, and personal protective equipment.

However:

- Environmental audits did not include all areas of the ward environment which meant that staff were not following trust procedures and young people could be at risk if environmental risks have not been identified and mitigated against.

Good



### Are services effective?

#### We rated effective as good because:

- On admission a full assessment of need was undertaken to inform risk assessment and care planning on each young person's admission to the service.
- Care planning was holistic and included physical health monitoring. Care plans were up to date and recovery oriented.
- Evidence based tools were used in the assessment process and staff used recognised rating scales to measure a young person's progress and inform the ongoing risk assessment process.

Good



# Summary of findings

- Staff participated in local and national audits of care. Audit information was used as a basis of improving care and treatment. The platform and the Junction were registered and accredited with the quality network for inpatient child and adolescent mental health services.
- There was a range of experienced and qualified staff to support young people at the Platform and the Junction. Policies were in place to address poor performance by staff. Poor staff performance was addressed promptly and effectively.
- There was evidence of mutually supportive, multidisciplinary working across all of the child and adolescent mental health service. Staff described good working relationships with other teams including child and adolescent mental health service community teams, adult services, social services and outreach teams.
- Staff had access to training and had a good understanding of the Mental Health Act the Mental Capacity Act, and associated code of practice.

However:

- Compliance with staff supervision and appraisal was below trust targets at the Junction. Supervision and appraisal enables managers to review staff performance and competency and is essential in monitoring and ensuring staff have the skills to do their jobs.

## Are services caring?

We rated caring as good because:

- Staff at the Junction and the Platform were described as caring, supportive and respectful by young people and their carers.
- Young people and their families described positive relationships with staff where a participative approach was encouraged.
- Young people's views about the service were routinely collected using experience of service questionnaires, feedback was mostly positive.
- Parents and young people were aware of the independent advocacy service was widely available. Information on how to access advocacy support was available on notice boards, in the information pack and on the trusts website.

Good



# Summary of findings

- A well-established participation group was in operation, former patients and their families and carers attended these regularly and felt they had a real influence on decisions made about the service.

## Are services responsive to people's needs?

We rated responsive as good because:

- Referrals, admission and discharge for the inpatient wards was monitored closely. Out of area placements, admission to adult wards, delayed discharge and bed occupancy was scrutinised and formed part of the trusts performance monitoring process.
- The average length of stay at the Platform was 30 days and 100 days at the Junction. All young people had access to a bed on return from leave.
- Discharge planning was incorporated into the ongoing review systems in place and was planned for on the young person's admission to the wards.
- Young people had good access to facilities to support their comfort and dignity.
- Young people knew how to raise a complaint or concern in the service, they were provided with information and support about the complaints process. Complaints were monitored and responded to in a timely manner.
- Information was available in differing formats and languages if required.
- Dietary needs were catered for and a range of foods was made available to those who had specific dietary or religious needs.

Good



## Are services well-led?

We rated well led as good because:

- The trust had a clear vision and a strategy for achieving this vision, clear management structures were in place in the service.
- Staff were motivated and described good teamwork, they talked positively about their roles.
- All staff knew how to report incidents and team leaders had input into local and organisational risk registers. Staff were informed of serious incidents from across the trust and involved in action planning to reduce the risk of reoccurrence.
- All staff knew the safeguarding procedures for the trust and were aware of the trusts reporting structures.

Good



# Summary of findings

- Reporting systems were in place to capture performance monitoring.
- Key performance indicators were used to assess the effectiveness of the service offered to young people.
- Senior managers met regularly with the wider integrated children and families' network to discuss issues of performance, workforce issues, risks, incidents and quality issues.
- The trust had systems in place to monitor quality issues and there was a clear commitment for continuous improvement with involvement of young people and their families.

However:

However there was some uncertainty among staff about their future and it was evident that this was affecting staff morale with the forthcoming move of premises and redesign of the service.



# Summary of findings

## Information about the service

Child and adolescent mental health services are delivered within a four tier strategic framework. Child and adolescent mental health services tier 4 are specialised services that provide assessment and treatment for children and young people with emotional, behavioural or mental health difficulties. Tier four services treat patients with more complex needs usually requiring inpatient treatment.

The Platform and the Junction are part of Lancashire Cares adolescent mental health inpatient tier 4 services

child and adolescent mental health services. The Junction and Platform provided assessment for medical treatment for persons detained under the 1983 Mental Health Act.

The Junction provided inpatient accommodation for ten male and female young people between the ages of 12 and 16 years and the Platform provided inpatient accommodation for six mixed sex young people aged 16 to 18 years.

## Our inspection team

Our inspection team was led by:

**Chair:** Neil Carr, OBE, Chief Executive South Staffordshire and Shropshire Healthcare NHS Foundation Trust

**Head of Inspection:** Nicholas Smith, Head of Inspection for mental health, Care Quality Commission

**Team Leader:** Sharon Marston and Nicola Kemp, Inspection manager, Care Quality Commission

The team that inspected this core service was comprised of two CQC inspectors and two specialist advisors one nurse and one social worker.

## Why we carried out this inspection

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

These services were last inspected between 28 and 30 April 2015. At the time of the inspection these services were rated as good overall. We inspected the child and adolescent mental health wards using a comprehensive approach and rated this core service as requires improvement for safe.

Following the inspection in 2015 we issued a requirement notice. We found that staff had not adhered to the Mental Health Act code of practice or followed their own policy regarding seclusion at the Platform. We also found that the environmental assessments and subsequent action plans at the Platform following incidents of self-harm from fixed points in the ceiling did not address safety issues. The trust provided an action plan telling us how they would improve the issues identified.

## 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?

# Summary of findings

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited both wards at two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients and three carers who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 10 other staff members; including doctors, nurses and social workers

- interviewed the divisional director with responsibility for these services
- attended a hand-over meeting and a multi-disciplinary meeting
- attended and observed a participation group meeting.

We also:

- Looked at four treatment records of patients and 16 medicine records
- looked at a range of policies, procedures and other documents relating to the running of the service

## What people who use the provider's services say

All patients we spoke with spoke positively about the service provided at the Junction and the Platform. They felt safe and involved in their care; they described the staff as friendly, helpful and supportive.

## Good practice

The service had a dedicated participation lead who supported a group of former patients and parents with experience of tier 3 and tier 4 services to develop and improve services across the child and adolescent mental health service for Lancashire Care. The CREW consisted of

young children and parents from across Lancashire and were instrumental in the development of policy and procedure, reducing restrictive practices and staff recruitment. The group had been nominated for local and national participation awards.

## Areas for improvement

### Action the provider SHOULD take to improve

The trust should ensure staff follow the trusts policy of environmental risk assessment.

The trust should aim to reach compliance with its procedural targets of annual appraisal and supervision rates for staff.

## Lancashire Care NHS Foundation Trust

# Child and adolescent mental health wards

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Platform	Royal Preston Hospital Preston
The Junction	Ashford Road Lancaster

#### Mental Health Act responsibilities

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

At the time of the inspection we reviewed two records of young people who were detained under the Mental Health Act at the Junction. We saw that the paperwork scanned into the electronic records system of these young people was in order and given under the appropriate legal authority. Young people were supported in their rights under the Mental Health Act we saw that they had their rights reviewed regularly. Supportive information leaflets and booklets were available, and written in a child friendly format.

Independent Mental Health Act support was available for those who requested this and we were informed this was easy to access and helpful to young people for all aspects of their care and treatment.

Staff were knowledgeable about the Mental Health Act and had good rates of completion of Mental Health Act training level 2. The Junction had 82% completion and the Platform 100% completion of training. Staff had administrative support to undertake their responsibilities under the Mental Health Act and knew where to seek advice if necessary. Renewals, consent safeguards, appeals and tribunals were undertaken in a timely manner and managed well and also followed the provisions of the Mental Health Act code of practice. Records of leave included risk and contingency measures.

Care plans were participative and recovery oriented. Care plans were discharge oriented with discharge planning evident from admission to the service. Consent to treatment procedures were in place and information about consent to treatment was available to all young people and their families. There was good evidence in young people's records that consent had been sought and reviewed regularly.

# Detailed findings

Staff were trained in least restrictive interventions and followed trust policy in reducing restrictive interventions. Young people were involved in the review of restrictive practice at both the Platform and the Junction. Seclusion procedures had improved since the last inspection and

staff were no longer using the extra care area to effectively seclude young people, the service had revised practice to be in line with the Mental Health Act Code of Practice and their own policy on seclusion.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Mental capacity is the ability to make an informed (having appropriate information) decision based on understanding a given situation, the options available, and the consequences of the decision. The Act does not generally apply to people under the age of 16. Gillick competence is the term used in British medical law to decide whether a child under 16 years of age is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Children under 16 can consent to medical treatment if they understand what is being proposed. It is up to the doctor to decide whether the child has the maturity and intelligence to fully understand the nature of the treatment, the options, the risks involved and the benefits. A child who has such understanding is considered Gillick competent. Children under 16 who are not Gillick competent and very young children cannot either give or withhold consent. Those with parental responsibility need to make the decision on their behalf. Children aged 16 and over are presumed to have capacity and able to consent or refuse to treatment in their own right. Most of the act applies to young people aged between 16 and 17 years, who may lack capacity to make specific decisions.

People carrying out acts in connection with the care or treatment of a young person aged between 16 and 17 years of age who lack capacity to consent should take reasonable

steps to establish that the young person lacks capacity, reasonably believe that the young person lacks capacity and that the act is in the young person's best interests, and follows the Act's principles.

Staff were able to access training in the Mental Capacity Act. When assessing the young person's best interests, the person providing care or treatment must consult those involved in the young person's care if practical to do so and anyone interested in their welfare. This may include the young person's parents. Young people, parents and carers said staff asked for consent to treatment. The trust had a detailed consent to treatment policy and procedure that included guidance for clinicians on competence, consent, and refusal of treatment for children and young people; the procedure for obtaining consent for people aged 16 to 18 years; and the procedure for obtaining consent for people under 16 years of age. Information regarding consent was included in leaflets in the admission pack.

Capacity assessments were completed on admission to the wards and we saw evidence of capacity being discussed throughout the inpatient stay with corresponding record keeping in the electronic records system.

The Deprivation of Liberty Safeguards only relates to people aged 18 or over. If the issue arises of depriving a person under 18 years of their liberty, other safeguards must be considered, such as the existing powers of the court, particularly those under section 25 of the Children Act 1989, or use of the Mental Health Act 1983.

# 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 ward layout on both wards allowed observation in most areas. At The Platform there were mirrors which mitigated the risk; however, this was not in all areas. For example on one of the bedroom corridors bedrooms were inset which meant staff would not be able to easily observe this area. The unit manager told us staff mitigated this with the use of patient observation levels.

At the last inspection we had concerns about the suspended ceiling at The Platform. There were ceiling struts from which ceiling panels were suspended which patients had used as a ligature point, particularly in areas hard to observe such as the lounge and dining area. During this inspection, we found the trust had not modified the ceiling, although viewing panels had been added to the doors. The manager told us this was because the unit was moving premises in the new year. We reviewed the incidents recorded since 1 September 2015. One patient had attempted to ligature from the metal bar from which the ceiling tiles were suspended since the last inspection, staff had intervened and the patient had not received any life threatening injuries. The ligature risk assessment stated that the risk was mitigated with the use of observation levels.

Staff carried out an environmental ligature risk assessment of both wards. The patient laundry room had not been risk assessed on either unit. Staff had not fully completed the risk assessment at The Junction, rooms where we were told patients were not left unattended, and the rating scale was missing. Staff had written not applicable (n/a) in the comment box because; 'room always fully supervised by staff and young people are directly observed at all times'. Room locked off when not in use'. The trust policy states, 'All internal areas and the immediate areas outside the ward and access routes to and from the ward should be risk assessed. This should include those areas where a local search would occur if an 'at risk patient' was found to be missing (although the trust may not own or lease the area it is useful to know the risks in the surrounding area)'. Staff

had not carried out a risk assessment on any external areas. The risk associated with fixed ligature points was added to the local register in 2013 with the next review date being 30 September 2016.

The Junction and The Platform complied with guidance on same sex accommodation. Both had en suite bedroom facilities and separate male and female lounges could be provided if required.

The Platform and the Junction did not have seclusion facilities, however, they did have an extra care room which could be used as seclusion should it be required. Staff told us that they rarely used the room as seclusion, and when they did they filled in seclusion documentation. Staff adhered to the trusts policy and procedure relating to the seclusion of young people. We saw one example of this during our inspection.

Both units had a fully equipped clinic room and staff were trained in the use of the equipment, which included blood pressure monitors and resuscitation equipment. Staff regularly checked emergency drugs to ensure they were in date.

An external contractor was responsible for the cleaning of the inpatient units. There was a good standard of cleanliness and the premises were well maintained. Staff told us that should there be a need to have repairs carried out the contractor would do this within reasonable timescales as agreed within the service level agreement. The maintenance logged showed where staff had reported work required and when that work had been completed. Staff had access to personal protective equipment and there was alcohol hand gel available around each building.

Patient led assessments are self-assessments undertaken by NHS and independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services. In their last assessment the Junction scored 100% for cleanliness, 98% for condition appearance and maintenance and 89% for disability.

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## Safe staffing

Staffing levels were sufficient to keep patients safe, safe staffing tools were used to calculate the numbers of staff required. Managers could adjust staffing numbers should the level of patient acuity increase. Staff and patients told us staffing levels were good. Where numbers dropped below establishment level bank and agency staff were used who were largely familiar to the wards.

There was no indication that activities and leave were cancelled due to units being short staffed. Patients had the opportunity to have regular one to one time with their named nurse. Medical cover was available during evenings and weekends. This was on an on call basis and a doctor would be available to attend in the event of an emergency.

Establishment levels for The Junction were as follows:

- Consultant: 1
- Consultant on call: 0.40
- Speciality Doctor: 1
- Clinical assistant: 0.18
- Nurse band 3: 11
- Nurse band 5: 10
- Nurse band 6: 5
- Nurse band 7: 1
- Life skills worker band 4: 1
- Dietician band 6: 1
- Occupational therapist band 7: 1
- Psychologist Band 8A: 0.50
- Psychologist band 8B: 1
- Social worker band 6: 0.50

Establishment levels for The Platform were as follows:

- Consultant: 1
- Speciality Doctor: 1
- Nurse band 3: 13
- Nurse band 5: 12
- Nurse band 6: 3
- Nurse band 7: 2
- Occupational therapist band 7: 1
- Psychologist Band 8A: 0.50
- Social worker band 6: 0.50

As at April 2016 vacancies were reported as; two nurses and two nursing assistants at the Platform. The Junction had no vacancies. Thirty seven shifts had been covered by bank staff at The Platform and 57 at The Junction. At The Platform, one shift was not filled by bank or agency and five shifts were not filled by bank or agency at The Junction.

Staff sickness and leavers as of 30 April 2016 at The Junction were reported as three members of staff left and there was a 3.4% level of sickness. The Platform had three members of staff leave and a reported sickness of 5.9%.

Mandatory training for staff at The Junction was overall slightly below trust guidelines at 80%. However, some subjects were significantly below trust targets, including:

- resuscitation basic life support which was 61%
- immediate life support 60%
- manual handling level 1, 67%
- manual handling level 2, 46%
- conflict resolution was 60%

The Platform had an overall compliance of 95%.

## Assessing and managing risk to patients and staff

The 5Ps model of formulation was used to assess risk. This model organizes the young person's presentation into five domains: presenting, predisposing, precipitating, perpetuating and protective factors. These assessments were undertaken on admission and updated at review. All records reviewed were up to date and complete.

Medicines were stored safely and there were good medication management practices in place. Medication records were in order and medication was administered in line with the Mental Health Act documentation and as prescribed by the hospital doctor.

A pharmacist visited the child and adolescent ward twice weekly to complete medicines reconciliation for new admissions and review the prescription charts. The pharmacist also provided clinical advice to the multidisciplinary team and completed drug histories on request to support prescribing decisions for more complex patients. Young people and their carers had the opportunity to speak with the pharmacist about their medicines and leaflets were provided. Patients were provided with information about their medicines on discharge and contact details should they required further medicines support at home.

The child and adolescent wards had moved away from using paper prescription records and the prescribing and administration of medicines were now completed electronically. Medical and nursing staff we spoke with was very positive about this change. They told us they had

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received good support and training during implementation of the electronic system and that it had many benefits. This included the electronic medicines alerts, and electronic link to medicines references and those medicines interventions could be checked when working at other trust sites.

Records of patients' allergies and weight were also made to support safe prescribing. The use of 'when required' medicines was regularly reviewed. However, care plans sometimes lacked detail about this stating only 'medication' rather than which one. For example, information about sleep hygiene and the use of hypnotics was not always discussed with patients. We discussed this with a doctor at The Platform who explained that a consultant led audit of this was planned at both The Platform and The Junction.

There was a blanket restriction at The Junction, patient toilets were locked and patients had to ask to use the toilet. Staff would then open the toilet and wait outside to lock the door when the patient had finished. Staff told us this was because patients would use toilets to self-harm. Patient had access to their bedrooms if staff had risk assessed that it was safe for them to do so.

Information provided by the trust showed that there had been one incident of seclusion in the period from 1 December 2015 to 3 June 2016 which was at The Platform. In the same period there had been 68 incidents of restraint, 19 at The Junction and 49 at The Platform. This related to five different patients at The Junction and 15 different patients at The Platform. None of the incidents of restraint were prone restraint and none had resulted in the use of rapid tranquilisation.

The trust had an observation policy, which was 'The procedure for safe & supportive observation for in-patient mental health services'. The policy was comprehensive and gave guidance on how to assess observation levels and the procedure to follow when considering increasing or decreasing observation levels. Included in the policy was guidance for staff when considering observation levels for patients at risk of self-harm.

Staff understood the safeguarding policy and could confidently explain what constituted abuse and what they would do should they suspect abuse had occurred. The majority of staff were up to date with safeguarding training,

with compliance of 84% for safeguarding children level 3 and 82% safeguarding adults at The Junction. The Platform had a compliance of 93% for safeguarding children level 3 and 97% for safeguarding adults.

## Track record on safety

There were 12 incidents reported as 'severe' in the period from 01 September 2015 to 31 August 2016 which included:

- two suicide attempts at The Platform
- one incident of unsafe staffing at The Platform
- one patient from The Platform absconded whilst on escorted leave
- one patient from The Platform failed to return from authorised leave,
- a bedroom closed to admissions due to damage of facilities at The Platform
- one adverse reaction to medication at The Platform
- a letter had been sent to the wrong recipient by staff at The Junction
- three patients absconded from The Junction without authorised leave
- there was one incident of non-rectifiable error of Mental Health Act documentation at The Junction

Evidence reviewed showed that a thorough investigation had been conducted and lessons learned were shared with staff.

## Reporting incidents and learning from when things go wrong

All staff we spoke with were clear about what incidents to report, all had access to the electronic incident management system used by the trust. Incidents were graded in order of severity with the most severe or repeated incidents being escalated to senior managers.

Incidents reported for The Platform and The Junction were a total of 969 for the twelve month period from September 2015. The Platform reported 494 incidents and The Junction 475. The majority of incidents reported were self-harm with The Platform reporting 272 incidents of self-harm and The Junction 360.

Lessons learnt was a standing item on the governance team meeting agenda. Monthly governance team meeting notes reflected these discussions. Lessons learnt from

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serious incidents were investigated through the trusts governance structures. Recommendations from serious incidents across the trust were cascaded through monthly governance meetings to team leaders. Information from reviews were included on the team information board and discussed at staff supervision.

Staff involved in serious incidents described being supported and debriefed after an incident; they described good support from colleagues when incidents occurred. Staff at all levels were aware of the duty of candour which is a responsibility to inform and apologise to patients when things go wrong and mistakes have been made in patient care that may have resulted in significant harm.

Staff were able to provide examples of changes in practice resulting from the actions and recommendations made from serious incident reviews.

### **Duty of candour**

The duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of candour aims to help patients receive accurate, truthful information from health providers.

Staff we spoke with described an open and honest approach to patients and their relatives/carers when things went wrong. A duty of candour policy was in place and all staff we spoke with were aware of the policy and were able to describe the steps necessary when something went wrong and when an apology was required.



# 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

On admission to the Junction and the Platform staff followed an admission care pathway and a full assessment of the young person's needs was undertaken; this would inform the risk assessment process. Care plans were in place and were reviewed weekly. The care plans identified the young person's strengths and needs and included physical health needs and physical health monitoring. We found that all the records we looked at were up to date and complete. We found that the risk assessments and care planning records were regularly reviewed.

Care plans were up-to-date and were recovery based. The inpatient service also used the Headspace toolkit which is a self-advocacy and rights toolkit for young people in psychiatric units. It provides basic information about being an inpatient, patients' rights, how to speak up (self-advocate) get others to listen and other information. Records were stored electronically and available to inpatient staff when needed.

### Best practice in treatment and care

Therapeutic approaches used within the inpatient child and adolescent mental health service included solution focused approaches, narrative approaches, systemic approaches, mindfulness-based approaches and psycho-education. Psychological therapies offered at the Junction included cognitive behavioural therapy, specialist cognitive behaviour therapy for eating disorders, eye movement's desensitisation reprocessing, family therapy and occupational therapy. Psychological group interventions included a family support group, reflect group, normalising unusual experiences group and a recovery group.

Staff used recognised rating scales to assess and record treatment outcomes. Outcome measures included; health of the nation outcome scales for children and adolescents, children's global assessment scale, strengths and difficulties questionnaire. The CRAFFT screening tool was also used for to assess adolescent substance abuse.

Screening tool for the assessment of malnutrition in paediatrics was used to assess young people's nutrition and hydration needs. This tool is a simple five step tool validated nutrition screening tool for use in hospitalised children aged 2 to 16 years.

Physical health care was included in care planning and discussed at review meetings. Young people had good access to medical support and were referred to tertiary care if necessary. Early Warning Scores were used by the child and adolescent mental health service inpatient services these are a guide used to determine the degree of illness of a patient. It is based on the six cardinal vital signs (respiratory rate, pulse oximetry, temperature, blood pressure, heart rate, alert, voice, pain, unresponsive response) and one other observation.

Staff participated in local and trust wide audits. Results of these audits were discussed in monthly quality meetings and cascaded to teams. Records of these meetings showed that action plans for improvement were put in place as a result of the audit process.

The Platform and the Junction were registered and accredited with the quality network for inpatient child and adolescent mental health services.

### Skilled staff to deliver care

There was a range of experienced and qualified staff to support young people at the Platform and the Junction. These included consultant psychiatrist, psychologist, participation worker, occupational therapist, dietician, social worker, teachers, registered nurses and support workers.

There were variations in compliance with appraisal and supervision rates at both locations. Annual appraisal and supervision enables managers to review staff performance and competency and is essential in ensuring that staff are clear about what they are doing and why, and have the skills to do their jobs which are crucial factors for delivering high quality patient care. The overall appraisal rate for non-medical staff was 31%. The Platform had the highest appraisal rate with 89% and The Junction had a low compliance rate of 20%. Clinical supervision rates from May to July 2016 of non-medical staff were at 95% for the Platform and 66% for the Junction. Appraisal and supervision rates were low at the last inspection in 2015 at the Junction and have remained low on re-inspection.

Policies were in place to address poor performance by staff. Poor staff performance was addressed promptly and effectively, there was one staff at each location undergoing formal disciplinary proceedings and/or sickness monitoring.

# Are services effective?

Good 

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

Staff told us that role specific specialist training was available to meet the needs of the young people in the service. Role specific training such as smoking cessation was available to staff.

## **Multi-disciplinary and inter-agency team work**

Regular multidisciplinary team meetings were held. These are meetings where a group of professionals meet to review and assess a young person's needs. Regular meetings were held and the young people had the opportunity to attend these meetings with support from their care coordinators or an advocate if the young person required or requested this.

A care programme approach was used where a range of professionals and families/carers met to discuss a young person's needs. The care programme approach is a way that services assessed planned, and co-ordinated and reviewed care for someone with mental health problems or a range of related complex needs. Young people and their families told us they felt able to contribute to these meetings which were described as person centred and multi-disciplinary.

There was evidence of mutually supportive, multidisciplinary working across all of the child and adolescent mental health service teams. We heard of examples of how teams worked in partnership with other clinicians, professionals and agencies. Staff described good working relationships with other teams including child and adolescent mental health service community teams, adult services, social services and outreach teams.

There were regular and effective handovers held twice daily at both locations. Observation of one handover demonstrated that staff discussed risk and made efficient use of this time to transfer good quality clinical information about young people to colleagues. Effective information transfer ensures the protection of patients and minimises clinical risk.

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

Staff had access to Mental Health Act training and had a good understanding of the Mental Health Act, and the code of practice. A review of the associated paperwork for two of those young people detained were in order and included evidence that a regular review of rights under the Mental

Health Act was discussed with those detained. These documents were scanned into the electronic record system although they could be difficult to locate within this system.

The wards had moved away from using paper prescription records and the prescribing and administration of medicines was completed electronically. The T2 and T3 forms authorising medicines administration were still kept as paper copies. Nurses completed weekly checks of these to ensure they were in order. We looked at five patient authorisations at The Platform and found that these were up-to-date and reflected the treatment prescribed.

A comprehensive admission pack was available to all young people and their families which included information on legal rights under the Mental Health Act. The HeadStart tool also included this information and was designed in a child friendly format. The admission pack included information on access to independent mental health advocates. Mental health advocates visited the premises regularly and made themselves available to young people on the wards, their contact and support was described as helpful.

Staff had support from Mental Health Act administrators and had regular support from a Mental Health Act forum led by senior managers. Staff described regular audit of records.

## **Good practice in applying the Mental Capacity Act**

The Mental Capacity Act does not generally apply to people under the age of 16. Gillick competence is the term used in British medical law to decide whether a child of 16 years or younger is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Children under 16 can consent to medical treatment if they understand what is being proposed. Children aged 16 and over were presumed to have capacity and able to consent or refuse to treatment in their own right. Most of the Act applies to young people aged 16 to 17 years, who may lack capacity to make specific decisions.

A Mental Capacity Act policy was in place that staff could refer to. Staff had a good understanding of assessment of a young person's competence and understanding to make decisions and had access to training in the Mental Capacity Act. Information leaflets were available to young people and their carers about consent.

## 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.

Capacity to consent was assessed on a young person's admission; forms were completed and entered into the young person's electronic records. There was evidence in the records of ongoing review of a young person's capacity to consent.

There were safeguarding arrangements in place to protect the most vulnerable children. A dedicated safeguarding team provided a resource to the staff and give advice and consultancy in relation to safeguarding and the mental capacity act to support staff and promote the safety of vulnerable children.

# 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

We observed good interactions between staff and young people on the wards. We were informed that staff were courteous, welcoming and respectful. Young people and their carers described caring and responsive support from staff. Young people felt comfortable approaching staff and described excellent practical and emotional support.

All the young people we spoke with said they felt safe in the environments they were living in and were confident the staff were aware of their individual needs. They described positive relationships with staff and that their views were taken seriously.

Young people and their families felt involved in decisions about their care and had good information available to them to help inform these decisions. They had opportunities to provide feedback about the service.

The Junction scored above the national average at 88% in the PLACE assessment relating to privacy, dignity and wellbeing. PLACE assessments are self-assessments undertaken by NHS that include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided.

### The involvement of people in the care that they receive

A comprehensive admission pack was available to all young people on admission to the wards; clear guidelines were in place to orient new admissions to the wards. Information was displayed relating to young people issues such as bullying and available activities.

All young people in child and adolescent mental health tier 4 services were part of the multidisciplinary care programme approach process and had outcome plans, which were developed at each review. Young people and their carers told us that their participation in their care was actively sought and toolkits were in place to elicit young people's views of their treatment and care. Shared pathways were in place and we found good evidence in records that care planning and risk was discussed with

young people and their views were incorporated into these written records. Young people were involved in the review process and supported to do so, independent support was available to those who required extra support. Young people felt they had a voice in their care planning and on the whole were happy with the involvement they had in their care and treatment. One young person described how she had been supported to attend her school which helped maintain her relationships which she found supportive and helpful in her recovery.

The headspace toolkit had a section where young people were encouraged to complete 'planning for tough times' this detailed decisions made in advance of times when a young person may be unable to communicate their views and feelings to others. Young people were also encouraged to make plans for when they left the ward.

A well-established participation group was in operation at both wards; former patients and their families and carers attended these regularly and felt they had a real influence on decisions made about the service. They told us that they were actively involved in recruitment and sat on interview panels for all levels of staff being recruited into the organisation. One young person told us how their views on recruitment were listened to and acted upon. Young people described how they had been influential in the development to provide opportunities to be involved in the production of food at the Junction which was seen as an important and valued improvement to the service.

Young people also told us that they were involved in staff training, policy and procedure development and were very active in reducing restrictive practices on the wards. They felt that their voices were listened to and were respected in the decision making process of the Trust, and were a real and valued participative practice.

Carers and young people's views were actively sought on discharge from the service in order to improve services. Staff told us they had a 'you said we did' forum where the trust demonstrated that the views of young people and their carers were acted upon. One example was ongoing complaints of the food delivered from a central kitchen at the Platform and the subsequent improvements made in corroboration with staff and kitchen staff.

# 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

Tier 4 child and adolescent mental health service outreach service acted as gatekeepers for the child and adolescent mental health service inpatient service and conducted access assessments. The main source of referrals was from community child and adolescent mental health service tier 3 teams and the crisis team including A&E liaison. Referrals and acceptance onto the wards was monitored closely. Following acceptance from the referral assessment a bed would be sought within the local area.

If this was not possible out of area placements would be sought, young people would be repatriated as soon as possible when a bed became available. The Outreach team regularly liaised with out of area placements and local tier 4 services to monitor progress and assist with repatriation when appropriate. NHS England was also kept informed of progress of young people out of area.

Planned admissions and transfers between services generally happened between 9am and 5pm Monday to Friday. The Platform admitted people 16 to 17 years who experienced acute mental health symptoms and could be accessed following assessment by the crisis teams 24 hours daily.

Out of area placements were monitored, the quarterly report from April 2016 to June 2016 showed that the total number of young people placed out of area was ten. Of these, four required a secure environment, four required specialist eating disorder placements, one required a generic unit with specialist eating disorder input and one wished to remain until their treatment was completed.

The mean percentage bed occupancy from the 1 November 2015 to 30 April 2016 was; The Junction at 98% The Platform at 87%. The average length of stay at the Platform was 30 days and 100 days at the Junction. We were informed all young people had access to a bed on return from leave.

Tier 4 inpatient beds were sought after and there were times when young people were admitted to adult wards when beds are un-available. If a bed was not available some young people would be placed in an adult ward if urgently required. From November 2015 to February 2016 there were three young people admitted to adult inpatient

services. The longest stay on the adult wards was three days. This patient was then transferred out of area the other two were admitted to the Platform and the Junction within two days.

Although discharge dates were planned with the multi-disciplinary team, funding issues or complex care package need could often delay the young person's discharge and be identified as a delayed discharge by the service. Discharge planning was incorporated into the ongoing review systems in place and was planned for on the young person's admission to the wards. Discharge was discussed with family, service users and care co-ordinators at their initial care programme approach meeting. Outcome measures and risk assessments were in place to measure a young person's readiness for discharge.

The number of delayed discharges from 1st January 2016 to the 30th of June 2016 was five at the junction and five at the Platform. Lack of suitable accommodation and support and a young person's refusal to return home were some of the reasons identified for delayed discharge. There were no readmissions to the wards in this time period.

### The facilities promote recovery, comfort, dignity and confidentiality

A full range of rooms was available to support treatment and care such as education and activities at the Junction and the Platform. Bedrooms were en suite and all rooms could be personalised by young people. There was use of an outdoor space at the Junction with a garden and football pitch. Outdoor equipment was available for the young people to use such as outdoor games and bicycles. The Platform had a small outdoor courtyard.

Contact with relatives and friends was encouraged as part of the young person's recovery. Telephones were available and young people were involved in the development of the wards policy on the use of mobile phones. All the young people and carers we spoke with described good access to media including skype to keep in touch with their families.

All young people had access to facilities to make a hot drink and snacks, there were some issues highlighted by young people at the Platform about the quality of the food from the central kitchen. We saw notes from meetings with kitchen staff describing dialogue to address the issues that young people had highlighted. Young people told us that they had been involved in developments at the Junction to improve food provision and had been instrumental in

# Are services responsive to people's needs?

Good 

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

negotiating access to kitchen facilities to cook their own food. They described this as an important development in gaining independence. Survey information from PLACE at the Junction indicated that food provision was good with scores of 93% and over for food provision.

Rooms were available for relatives to visit and young people had access to quiet areas when required. There was a variety of activities offered to young people and access to education. The Platform had a dedicated 10 hours education sessions available and the Junction had 25 hours weekly education sessions available.

## **Meeting the needs of all people who use the service**

A lift was available at the Junction which supported accessibility of the building to those with mobility or disability issues. Information leaflets could be made available to those in other languages if required and access to an interpreter could be arranged. Staff supported access to spiritual support.

Notice boards contained essential information for young people and the service had a comprehensive admissions pack to support the decision making processes. The pack included information on complaints and patient rights.

Young people and their carers knew how to raise a compliant or concern and told us that the trusts response to complaints were acted upon in a timely and appropriate way.

Dietary needs were catered for and a range of foods was made available to those who had specific dietary or religious needs. The service employed a full time dietician to provide support and advice to staff and young people on the nutritional content and provision of food.

## **Listening to and learning from concerns and complaints**

The trust had a complaints procedure in place and information on how to initiate this procedure was available in a range of formats for both the young people and their families. Leaflets were available and the trusts website also gave detailed information on the complaints process.

The child and adolescent mental health service inpatient wards received two complaints with one complaint not being upheld from the 1 April 2015 to 31 March 2016. No complaints were referred to the ombudsman. The two complaints were for the Platform. The complaint outcomes were that communication internally required improvement and there was also an inappropriate request for services and treatment by a service user. In this time frame they also received seven compliments with The Platform receiving the most with six compliments.

Staff were supported by a dedicated customer care department to initiate the trusts complaints procedure. Staff from the customer care department received and processed the complaints in line with procedural guidance. Information was collated monthly about complaints and fed back into the trusts governance structures

There was a clear structure in place on the investigation of complaints and team leaders were involved in the investigation of complaints at the service. Staff received feedback on the conclusion of complaints which were discussed in team meetings and supervision in order to improve services.

# 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 a clear vision and a strategy for achieving this vision clear management structures were in place in the service. The values of the trust were on display throughout the service. These values were teamwork, compassion, integrity, respect, excellence and accountability. Staff were generally aware of the vision and values of the trust and were positive about the trusts values which they described as child centred which encouraged the involvement and participation of young people and their families.

Staff described efforts made by senior members of the trust to engage with the ward teams and the communications they had from them.

Staff we spoke with were motivated and dedicated individuals who mirrored the overall vision of the trust to provide excellent treatment and care to young people who require inpatient services.

### Good governance

All staff knew how to report incidents using an electronic database, they informed us that they had input into local risk registers and were supported by their managers to do so. All staff we spoke with knew the safeguarding procedures for the trust and described the local system of reporting safeguarding issues. They were aware of the reporting structure for the trust and who to approach for support with safeguarding issues.

Governance meetings were held monthly where performance targets were discussed with team leaders. Reporting systems were in place to capture performance monitoring. This fed into the child and adolescent mental health service governance structure for the trust. Performance monitoring reports were produced monthly which fed directly into the trusts risk management systems. These performance targets were used as key performance indicators.

child and adolescent mental health service inpatient services had a range of performance standards where reports of quality and safety information and safeguarding were produced monthly. An overview of lessons learnt and any subsequent action plans were discussed within the trust governance structure and disseminated through local

governance meetings with team leaders. Information was shared with the child and adolescent mental health service staff team at staff meetings, clinical supervision and information was placed on team information boards.

Key performance indicators were used to assess the effectiveness of the service offered to young people. Senior managers met regularly with the wider integrated children and families' network to discuss issues of performance, workforce issues, risks, incidents and quality issues.

Mandatory training for staff at The Junction was overall slightly below trust guidelines at 80%. However, some subjects were significantly below trust targets, including resuscitation basic life support which was 61%, immediate life support 60%, manual handling level 1, 67%, manual handling level 2, 46% and conflict resolution was 60%. The Platform had an overall compliance of 95%.

### Leadership, morale and staff engagement

Staff generally talked positively about their roles and detailed good relationships with senior managers. Staff we spoke with were aware of the whistleblowing procedures, they told us that they felt able to raise concerns with senior managers when necessary.

Staff sickness and leavers as of 30 April 2016 at The Junction were reported as three members of staff left and there was a 3.4% level of sickness. The Platform had three members of staff leave in this period and a reported sickness level of 5.9%.

Staff performance issues were dealt with in line with trust policies. There was one member of staff who was undergoing formal disciplinary investigation at the Junction at the time of the inspection. There had been no formal grievances or investigations in the teams we visited in the previous six months prior to inspection related to bullying and harassment.

Staff told us they had opportunities for personal development and were informed of service developments and performance within meetings, supervision and from newsletters produced by the trust. Staff described their colleagues as friendly, caring and that they felt listened to and supported. Staff told us they had the opportunity to give feedback about the service and that their views were actively sought through staff survey.

# 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.

Staff had a clear understanding of their responsibilities under the duty of candour and the need to be open and transparent when things go wrong.

However there was some uncertainty among staff about their future which was evident that this was affecting staff morale particularly at the Platform. There was a proposed move of the Platform and Junction onto one site, this had been approved and supported by NHS England. The service was in the initial stages of staff engagement and staff had been formally informed of the move.

Staff did not feel they had been engaged in the discussions about the planned move of premises to Morecombe. We were informed that staff had begun to leave the service at Preston as travelling to the new site was seen as an issue. Senior managers told us that they had planned more staff consultation sessions.

The participation group at the Junction also felt that their input into the forthcoming move had been minimal and were disappointed that the plans for the move could have been more participative.

## **Commitment to quality improvement and innovation**

The trust had systems in place to monitor quality issues within child and adolescent mental health service inpatient services. There was a clear commitment for continuous improvement with the involvement of young people and their families. Clinicians were committed to improving the experience of young people and all staff we spoke with, in all the teams, had a focus on improving services.

The service fulfilled their requirements of local and national reporting standards and actively took part in audits of quality of the services available to young people and their families.

The Junction and the Platform participated in the Royal College of Psychiatrist's quality network for inpatients. The quality network aimed to demonstrate and improve the quality of inpatient child and adolescent psychiatric inpatient care through a system of review against the quality network service standards. This process follows a clinical audit cycle with self-review and peer-review.