Good

Cheshire and Wirral Partnership NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

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Date of inspection visit: 10 October 2016
Date of publication: 03/02/2017

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Trust Headquarters, Redesmere	RXAX2	West Cheshire Tier 2 Child and Adolescent Mental Health Service West Cheshire Tier 3 Child and Adolescent Mental Health Service	CH1 3DY
Trust Headquarters, Redesmere	RXAX2	Vale Royal Tier 2 Child and Adolescent Mental Health Service	CW7 1AS

Summary of findings

Vale Royal Tier 3 Child and Adolescent Mental Health Service

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	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 have rated specialist community mental health services for children and young people as good overall because:

- Following our inspection in June 2015, we rated the service as 'good' for effective, caring, responsive and well-led. Since that inspection, we have received no information that would cause us to re-inspect these key questions or change the ratings.
- We re-rated the safe question from requires improvement to good following this inspection. This was because the provider had taken action to make improvements. We found that staff followed the trust and local lone working procedures, that the environment at the team bases were safe and that team managers monitored waiting lists.
- We also found that patients' risk assessment and management plans were up to date and completed to a high standard. Safeguarding procedures were followed. Serious incidents were reported and investigated.

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:

- Clinic environments at both team bases were safe and clean.
- There were enough staff to provide a safe service for patients.
- Staff were able to respond quickly to deterioration in patients' mental health.
- Staff compliance with mandatory training was high.
- Patients' risk assessments and management plans were up to date and completed to a high standard.
- Information about risk had, where appropriate, been shared with families and other people who could help to keep the child safe.
- Staff followed the trust's safeguarding procedures.
- Team managers monitored waiting lists.
- Staff followed the trust and local lone working procedures.
- There was evidence of safe prescribing practice.
- Serious incidents were reported and investigated.
- Teams discussed and learned from incidents.

Are services effective?

Good

At the last inspection in June 2015 we rated effective as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services caring?

Good

At the last inspection in June 2015 we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive to people's needs?

Good

At the last inspection in June 2015 we rated responsive as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services well-led?

Good

At the last inspection in June 2015 we rated well-led as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Summary of findings

Information about the service

Child and adolescent mental health services in the geographical area covered by Cheshire and Wirral Partnership NHS Foundation Trust are provided within a four tier strategic framework. The four tier framework is nationally accepted as the basis for planning, commissioning and delivering of services to children and young people with mental health needs.

Tier one is provided in universal services by practitioners who are not mental health specialists. These practitioners include GPs, health visitors, school nurses and teachers. Cheshire and Wirral Partnership NHS Foundation Trust provides services from tier two to four for children and young people aged five to 19 years. Tier two consists of brief interventions at a lower level of need (for example, therapeutic groups). Tier three support can be longer term and might include input from several different mental health specialists. Tier four consists of highly specialised services, including inpatient services.

The child and adolescent mental health community teams at Cheshire and Wirral Partnership NHS Foundation Trust are multi-disciplinary. They include nurses, psychiatrists, clinical psychologists, psychotherapists, occupational therapists, speech and language therapists, social workers and support workers. Their aim is to reduce children and young people's distress by changing the environment or system that is maintaining a problem, and/or helping them cope more effectively when situations cannot be changed.

Cheshire and Wirral Partnership NHS Foundation Trust includes five tier three child and adolescent mental health teams, plus a number of additional targeted teams. We visited tier two and tier three services in West Cheshire and in Vale Royal. They provided a service for children aged up to 16. There was a separate service for children aged 16 and over, which was not inspected on this occasion.

Our inspection team

Our inspection team was led by:

Team Leader: Lindsay Neil, Inspection Manager, Care Quality Commission.

The team that inspected specialist community mental health services for children and young people comprised one inspection manager and one inspector.

Why we carried out this inspection

We undertook this inspection to find out whether Cheshire and Wirral Partnership NHS Foundation Trust had made improvements to their specialist community mental health services for children and young people since our last comprehensive inspection of the trust on 24 June 2015.

When we last inspected the trust in June 2015, we rated specialist community mental health services for children and young people as good overall. We rated the core service as requires improvement for the safe key question and good for the effective, caring, responsive and well-led key questions.

Following the June 2015 inspection we told the trust that it must take the following actions to improve specialist community mental health services for children and young people:

- The trust must ensure that all young people using the service have a completed comprehensive individual risk assessment.

We also told the trust that it should take the following actions to improve:

- The trust should ensure that there is an effective system in place to keep staff safe when visiting people in the community including increased understanding and compliance with the lone worker policy.

Summary of findings

- The trust should complete an environmental risk assessment of Hawthorn Centre to identify risks and how they will be mitigated
- The trust should review the collation of the waiting list to ensure effective measures are in place to monitor the risk of people waiting to be seen. Including enabling team managers to access the waiting list to ascertain the number of young people waiting and how long they have been waiting.

We issued the trust with one requirement notice that affected specialist community mental health services for children and young people. This related to Regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How we carried out this inspection

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

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

Before the inspection, we reviewed information that we held about specialist community mental health services for children and young people, and requested information from the trust. This information suggested that the ratings of good for effective, caring, responsive and well led, that we made following our June 2015 inspection, were still valid. Therefore, during this inspection, we focused on those issues that had caused us to rate the service as requires improvement for safe.

This inspection was unannounced, which meant the service did not know that we would be visiting.

During the inspection visit, the inspection team:

- visited four of the specialist community health teams for children and young people and looked at the quality of the clinic environment
- spoke with four carers and one child who were using the service
- spoke with the managers or acting managers for both teams
- spoke with eight other staff members including doctors, mental health practitioners and therapists.
- looked at 13 patient care 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

We spoke to four carers and one patient. We only asked questions about whether the service was safe. All of the carers and the patient told us that they had been able to contact their worker when they needed help. Those who needed to be seen urgently had had appointments brought forward. All were positive about their experience of using the service.

Good practice

Child and adolescent mental health services had worked with children, young people and with the acute trust to develop 'passports' for patients who might present at other services (including accident and emergency departments). The passport included information about consent, how the patient would like to be supported in difficult circumstances (for example, after harming

themselves), 'treatment dos and don'ts' and key contact numbers. This meant that patients could communicate their key needs effectively to unfamiliar staff at a time of distress.

Cheshire and Wirral Partnership 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
West Cheshire Tier 2 Child and Adolescent Mental Health Service West Cheshire Tier 3 Child and Adolescent Mental Health Service Vale Royal Tier 2 Child and Adolescent Mental Health Service Vale Royal Tier 3 Child and Adolescent Mental Health Service	Trust Headquarters, Redesmere

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.

We did not review the Mental Health Act at this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the Mental Capacity Act or Deprivation of Liberty Safeguards at this inspection.

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

Clinic environments at Marsden House (West Cheshire) and the Hawthorn Centre (Vale Royal) child and adolescent mental health services were safe and clean. The Vale Royal team had refurbished and improved their use of accommodation since our last inspection. Environmental risk assessments were complete and up to date. This meant that environmental risks had been identified and reduced. Reception areas in both clinics were close to the entrance. Both waiting rooms were bright, spacious and visible from the administrative office.

Team bases had integrated alarm systems. Personal alarms were available to staff from the central office. If staff used the alarm while in the building, an electronic device in the main area would show their specific location. Administrative staff would then approach the location to investigate, and seek assistance from other staff and/or police if necessary. All except one of the staff that we spoke to were aware of this system. The staff member who was unaware had only recently joined the team.

Neither of the team bases had a clinic room with all of the necessary equipment to carry out physical examinations. However, staff were able to take height, weight and blood pressure readings on site. This allowed them to safely monitor some medications' side effects and some aspects of risk for children at a low weight. The scales and blood pressure monitors were calibrated regularly to ensure they were accurate. Services had agreements in place with local paediatricians and general practitioners for children who needed full physical examination and monitoring (for example, blood tests).

The team bases were cleaned every weekday. We checked all communal areas, including toilets, and saw that they were clean. Soap and alcohol gel dispensers were available to staff and visitors, along with prompts for thorough handwashing.

Fire wardens and first-aiders were identified at each base. Fire logs were up to date and fire evacuation practices took place every six months. Fire plans, including maps of the building, exit points and assembly points, were visible to staff and patients inside both buildings.

Safe staffing

The following staffing figures were provided by the trust as correct at the time of inspection:

- West Cheshire tier 2 child and adolescent mental health service: 5.3 whole time equivalent staff; 0 vacancies.
- West Cheshire tier 3 child and adolescent mental health service: 20.0 whole time equivalent staff; 0.2 whole time equivalent vacancy.
- Vale Royal tier 2 child and adolescent mental health service: 0.6 whole time equivalent staff; 0.04 whole time equivalent vacancy.
- Vale Royal tier 3 child and adolescent mental health service: 10.7 whole time equivalent staff; 0.7 whole time equivalent vacancy.

All staff had received appropriate pre-employment checks, including Disclosure and Barring Service checks and references covering the previous three years. This helped to ensure that staff were safe to work with children and vulnerable people.

Staffing numbers and grades were estimated using the 'choice and partnership approach', which is a nationally recognised service transformation model. The average number of cases open to the teams between April and September 2016 was 392 in West Cheshire and 188 in Vale Royal child and adolescent mental health services. Staff caseloads varied depending on the type of work that was being provided (for example, weekly therapy or less frequent monitoring and support). Staff told us that their caseloads were manageable. They discussed their caseloads regularly in supervision and team meetings. Managers were able to offer additional hours to substantive staff when needed. Services did not use any bank or agency staff.

Sickness rates were 3.7% for West Cheshire tier 2, 5.0% for West Cheshire tier 3, 0% for Vale Royal tier 2 and 9.1% for Vale Royal tier 3 child and adolescent mental health

Good

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services. Vale Royal tier 3 child and adolescent mental health service's sickness absence was higher than the 5.0% average for NHS mental health and learning disability trusts. Managers told us that they arranged cover within the teams when staff were sick, in order to minimise impact on patients.

Staff were able to respond quickly to deterioration in patients' mental health. There was a member of staff on duty each weekday between 9am and 5pm to provide urgent assessment to children (aged up to 16 years) presenting at local hospitals with self-harm and/or suicidal ideation. Outside these hours, a child and adolescent consultant psychiatrist was on call to give advice to hospital staff, to help them care for the patient on a paediatric ward until the patient could be seen by a child and adolescent mental health specialist.

Staff were also able to offer urgent appointments at their bases where needed. The three carers and one patient that we spoke to told us that they were able to contact their worker easily when they needed help. Two of the carers said that they had been able to get appointments brought forward when they were worried about their child.

There was a consultant psychiatrist based in each of the services. Consultants kept one free urgent appointment per week, which meant that they were quickly able to see children who were presenting with increased levels of risk. Staff told us that consultants were also available to offer advice. If consultants were on leave, then cover was provided from one of the other teams.

There were 28 different mandatory training topics for child and adolescent mental health service staff. These included basic life support, infection prevention and control, and safeguarding children level three. Average staff compliance with mandatory training was 86% across the two locations. In West Cheshire child and adolescent mental health services, staff compliance was below 75% in five topics: dementia awareness (63%), effective care planning and risk (69%), workshop to raise awareness of prevent (61%), critical updates in health, safety, equality and diversity (69%) and physical health in mental health (25%). Although compliance with physical health in mental health training was particularly low, we did not find any evidence of negative impact on patients.

Assessing and managing risk to patients and staff

When we last inspected in June 2015, we reviewed 23 care records. Fifteen did not have an up-to-date risk assessment. At this inspection, we reviewed 13 care records. All had standard risk assessments completed in line with trust policy. Risk assessments had been reviewed and updated for patients who had been using the service for longer than six months. This meant that any member of staff working with patients would be able to easily access up-to-date information about risk. All 13 care records also included a risk management plan either within the risk assessment document or as part of a clinical letter. In all except one case, clinical letters were sent to the child and/or family as well as the GP and referrer. In the one case where this had not happened, the clinical letter contained sensitive information and there was evidence in the file that staff had verbally discussed risk with the family. This meant that for all 13 patients, risks and management plans had been shared with the people outside the service who would be able to help to keep the patient safe. Records also showed that carers had been advised to remove access to family medications when a patient had taken an overdose. This is in line with the National Institute for Health and Care Excellence guideline CG16:Self-harm in over 8s: short-term management and prevention of recurrence.

The trust had a lead safeguarding nurse practitioner. There were clear safeguarding policies and procedures to protect children and young people from abuse. All of the staff that we spoke to knew how to make a safeguarding alert. The electronic care record system included a 'red alert' for patients who were also open to children's social care. We looked in more detail at the care record for a patient who was on a child protection plan. We could see that the child and adolescent mental health practitioner and the local authority social worker were working together to share and manage risks. All child protection referrals and child protection conference reports generated by child and adolescent mental health services were quality assured by the trust's safeguarding team.

When we last inspected in June 2015, we identified that team managers did not have the information they needed to be able to monitor waiting lists. We saw improvements at this inspection. Managers were able to generate reports showing how many appointments were available, how many patients were waiting and how long patients had been waiting. Teams sent standard letters at least once

Good

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every two months to patients and/or carers on the waiting list. The letter explained that the patient or carer could contact the service if their situation had changed. Two of the carers we spoke to had requested and been able to access urgent appointments for their children.

Both services had clear lone working procedures in place. Some staff worked longer hours (8am to 6pm) but were never left in the buildings on their own. The West Cheshire base had a whiteboard and the Vale Royal base had a book for staff to sign in and out. Staff seeing patients in their own homes or in another location knew to ring administrative colleagues to confirm that they were safe after the appointment. We spoke to administrative staff, who explained the process they would follow if the member of staff failed to ring in. All of the staff we spoke to were able to describe the procedure and tell us the 'code word' they would use to alert colleagues if needed.

There was evidence of safe prescribing practice. Consultant psychiatrists prescribed medication according to individual needs. Consultants completed prescription monitoring sheets quarterly, which were returned to and checked by the trust's pharmacy department. Consultants also met regularly to reflect on their prescribing. Minutes of one meeting showed that consultants had discussed the use of anti-depressants for young people with a diagnosis of autism, and a number of other issues. The services did not dispense medication, which meant that drugs were not stored at the team bases. There were no nurse prescribers or junior doctors in either service at the time of inspection.

Track record on safety

Child and adolescent mental health services across the whole trust had reported seven serious incidents between October 2015 and October 2016. There had been four unexpected deaths and three incidents of severe harm involving children or young people who were using or had recently used services. Investigations were either ongoing or completed.

Reporting incidents and learning from when things go wrong

Staff told us, and we confirmed from team meeting minutes, that they had discussed lessons learned from a recent local safeguarding children board serious case review (for example, ways to meet needs of young people who are unable to engage with talking therapy). The senior safeguarding nurse practitioner and the clinical service manager led this discussion.

All of the staff we spoke to knew how to report incidents using the electronic system, and could give examples of the kinds of things that should be reported. We saw that a range of non-serious incidents had been appropriately reported through the trust's electronic system between October 2015 and October 2016.

Minutes of governance meetings showed that managers encouraged staff to report and discussed and acted on reports where appropriate. For example staff at West Cheshire child and adolescent mental health service had reported that the clinic environment was uncomfortably hot for staff and patients. Managers agreed a number of actions, including the purchase of new fans and identification of other venues for seeing patients.

'Learning from experience' or 'serious incidents/learning' were standing agenda items in teams' governance or business meetings. For example, in August 2016 the West Cheshire child and adolescent mental health team were reminded to record all safeguarding information in the relevant section of the electronic care record. It was also clear from the minutes that staff had planned how to improve following the previous CQC inspection.

Child and adolescent mental health services were able to add items to the trust's risk register.

Duty of Candour

Duty of candour is the requirement for providers of healthcare services to be open and honest with patients and other 'relevant persons' (for example, carers) when things go wrong with care and treatment. Staff had not had training on duty of candour, but they told us that if something went wrong they would give patients and carers support, truthful information and an apology. Duty of candour was covered in the trust's policy for the recording, investigation and management of complaints, concerns and compliments.

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

At the last inspection in June 2015 we rated effective as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Good

Are services caring?

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

Our findings

At the last inspection in June 2015 we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

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

At the last inspection in June 2015 we rated responsive as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

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

At the last inspection in June 2015 we rated well-led as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.