

**Requires improvement****Alder Hey Children's NHS Foundation Trust**

# Specialist community mental health services for children and young people

## 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)
RBS25	Alder Hey Children's Hospital	Liverpool Fresh CAMHS	L12 2AP
RBS25	Alder Hey Children's Hospital	Sefton CAMHS	L22 0NY

This report describes our judgement of the quality of care provided within this core service by Alder Hey Children's 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 Alder Hey Children's NHS Foundation Trust and these are brought together to inform our overall judgement of Alder Hey Children's 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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated specialist community mental health services for children and young people as **requires improvement** overall because:

- The practices for lone working were not consistently implemented, so did not protect staff. There was no direct way of calling for urgent assistance from inside the therapy rooms.
- At Sefton CAMHS, confidential information about children and young people was left in an unlocked office on a corridor shared with a mixture of NHS and non-NHS businesses. This meant unauthorised people could potentially see patients' records.
- Morale among some staff was low.
- Some staff did not feel able to raise concerns.
- The service employed adequate numbers of staff, but there were staff shortages caused by staff absences which included long term sickness, maternity leave, and training.
- Risk assessments and care plans were not always clearly recorded, or easy to find in the care records.
- The service was provided from two office buildings, one in Liverpool and one in Sefton. There were therapy rooms on each site. They were not purpose-built and the décor was generally tired and worn. Attempts had been made to make them more child and young person friendly, particularly in the waiting areas. This had been designed with input from children and young people.
- There were internal waits for access to therapies and to see a consultant psychiatrist.
- There were a large amount of clinical records waiting to be scanned and archived. These were not for current patients, and the trust had implemented a plan to address this over time.

However:

- The service was provided by a multidisciplinary team of staff, who had training in working with children and young people. Across the service staff had

training and experience of a variety of psychological therapies. Staff had completed their mandatory training, received regular clinical supervision and had an annual appraisal.

- Children, young people and their parents were mostly positive about the service they received. Staff were caring and responsive to their needs. Children and young people and their families were able to raise their concerns. Complaints were responded to appropriately.
- Children and young people were involved in the development of the service. This was under the banner of "FRESH", which was used on the trust's website and in printed information. There were regular patients' forums and participation groups where developments of the service were discussed.
- At the last CQC inspection waiting lists were found to be over 18 weeks, and the trust did not monitor them effectively. At this inspection we found that the waiting lists and the time people wait had reduced. The waiting lists and times were monitored, and reviewed at a weekly meeting. Average waiting times were within the trust's target of 12 weeks from referral to treatment, and within 18 weeks from referral to treatment.
- The service followed best practice by using the choice and partnership approach, which emphasised collaborative working with children and young people and their families. The service had recently introduced the "THRIVE" model, which aims to provide better outcomes for children and young people, and reduce waiting times.
- All children and young people had an assessment carried out, and were offered choices about further partnership working with the child and adolescent service, signposted to other services, or given information and advice on self-help and care.
- Staff were knowledgeable in the assessment of capacity and consent, and how it applied to children and young people. Children and young people understood who their information was shared with.

# Summary of findings

- Incidents were reported, investigated, and action was taken to reduce the risk of them happening again.
- The service was part of a number of pilots and initiatives that aimed to improve access and outcomes for children, young people and their families. Many of these involved working with other organisations.

# Summary of findings

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

### Are services safe?

We rated **safe** as **requires improvement** because:

- The practices for lone working were not consistently implemented, so did not protect staff. There was no direct way of calling for urgent assistance from inside the therapy rooms.
- Confidential information about children and young people was left in an unlocked office on a corridor shared with non-NHS businesses. This meant unauthorised people could potentially see patients' records.
- The service employed adequate numbers of staff, but there were staff shortages caused by staff absences which included long term sickness, maternity leave, and training.
- Staff carried out risk assessments of all children and young people using the service, but it was not always clear from the records if these had been reviewed, and they were not always easy to find.
- Only sixty-seven percent of staff had completed level three safeguarding training.

However:

- Staff had a clear understanding of safeguarding, and how to respond to safeguarding concerns.
- Incidents were reported, investigated, and action was taken to reduce the risk of them happening again.
- Staff were aware of the duty of candour. There had been no incidents that met the criteria for the duty of candour.

**Requires improvement**



### Are services effective?

We rated **effective** as **good** because:

- The service followed best practice by using the choice and partnership approach, which emphasised collaborative working with children and young people and their families. The service had recently introduced the "THRIVE" model, which aims to provide better outcomes for children and young people, and reduce waiting times.

**Good**



# Summary of findings

- The service followed and monitored the use of guidance issued by the National Institute for Clinical Excellence. Children, young people and their families had access to psychological therapies. Staff used a number of rating scales and outcome measures, to provide a consistent measurement of progress.
- Clinical staff had training in working with children and young people. Across the service staff had training and experience of a variety of psychological therapies.
- All children and young people had an assessment carried out. They were offered choices about further partnership working with the child and adolescent service, signposted to other services, or given information and advice on self-help and care.
- Staff received regular clinical supervision and had an annual appraisal.
- The service comprised a range of professions which included nursing, psychiatry, psychology, therapy and social work.
- Staff were knowledgeable in the assessment of capacity and consent, and how it applied to children and young people.

However:

- Care plans and information about the child, young person or family's views were not always easy to find in the records, and were recorded in different ways.

## Are services caring?

We rated **caring** as **good** because:

- Children, young people and their parents were mostly positive about the service they received. Staff were caring and responsive to their needs.
- Children and young people were involved in the development of the service. This was under the banner of "FRESH", which was used on the trust's website and in printed information. There were regular patients' forums and participation groups where developments of the service were discussed.
- Children and young people understood who their information was shared with. If they did not want specific information shared with their parents, this was kept confidential, if staff deemed they were able to make this decision.
- Children and young people or their parents knew how to contact the service if they needed help quickly.

Good



# Summary of findings

- Feedback from the friends and family test found that the majority of patients would recommend the service to others.
- Children and young people were involved in the recruitment and training of staff. They were involved in the redesign and decorating of the waiting areas at both the Liverpool and Sefton sites.

However:

It was not always clear from records that children, young people and families had been involved in decisions about their own care.

## Are services responsive to people's needs?

We rated **responsive** as **good** because:

- At the last CQC inspection waiting lists were found to be over 18 weeks, and the trust did not monitor them effectively. At this inspection we found that the waiting lists and the time people wait had reduced. The waiting lists and times were monitored, and reviewed at a weekly meeting. Average waiting times were within the trust's target of 12 weeks from referral to treatment.
- The service was provided from two office buildings, one in Liverpool and one in Sefton. There were therapy rooms on each site, which were in frequent use. They were not purpose-built and the décor was generally tired and worn. Attempts had been made to make them more child and young person friendly, particularly in the waiting areas. This had been designed with input from children and young people.
- People who used a wheelchair could access the service.
- Children and young people and their families were able to raise their concerns. Complaints were made locally and through the Patient Advice and Liaison Service. Complaints were reviewed, monitored, investigated and responded to appropriately.
- Children and young people and their families had access to an interpreter when required.

However:

- There were internal waits for therapies, and this included waiting to see a consultant psychiatrist. The waiting lists and times were monitored.
- The service was provided from two office buildings, one in Liverpool and one in Sefton. There were therapy rooms on each site. They were not purpose-built and the décor was generally

Good





# Summary of findings

tired and worn. Attempts had been made to make them more child and young person friendly, particularly in the waiting areas. This had been designed with input from children and young people.

- Written information for people who did not read English was not easily available.

## Are services well-led?

We rated **well-led** as **requires improvement** because:

- Morale among some staff was low.
- Some staff did not feel able to raise concerns.
- There were a large amount of clinical records waiting to be scanned and archived. These were not for current patients, and the trust had implemented a plan to address this over time.

However:

- The quality of the service was monitored and reviewed locally by the child and adolescent mental health service managers. This fed into the clinical business unit the service was part of, and into the wider trust's governance processes.
- The service was part of a number of pilots and initiatives that aimed to improve access and outcomes for children, young people and their families. Many of these involved working with other organisations.
- Staff were aware of the values of the trust.
- The service had requested one and commissioned another independent review following concerns about the service, and poor staff morale in 2015. The service was still in the process of implementing the changes of these findings, and was in a process of transition. This included a revised leadership structure. The service had put strategies in place to address low staff morale.

**Requires improvement**



# Summary of findings

## Information about the service

Alder Hey Children's NHS Foundation Trust provides community mental health services for children and young people up to the age of 18.

The service has been reconfigured since our last inspection, and services are now provided from two geographically based sites:

- Liverpool FRESH CAMHS provides services for children and young people in Liverpool. It is also the base for the single point of access team. The single point of access team carry out assessments of all children referred to the service, including those from Sefton. The service is based in a standalone building in the grounds of Alder Hey Children's Hospital.
- Sefton CAMHS provides services for children and young people in the Sefton area. The service is based in an office building in Sefton that is shared with non-NHS businesses.

Within each geographical service, the teams were divided into primary mental health (typically for children and young people who needed relatively short-term work with one member of staff) and specialist child and adolescent mental health services (for children and young people who needed longer term support, usually with more than one member of staff). From the 1 April 2017 the service model changed, so that all the teams were integrated, and staff worked with children and young people with primary or specialist needs. Liverpool had four multidisciplinary teams, and Sefton had three. This change was still in transition at the time of our inspection.

## Our inspection team

The team that inspected the service comprised CQC inspection manager Lindsay Neil and two CQC inspectors.

## Why we carried out this inspection

We undertook this unannounced focused inspection to find out whether Alder Hey Children's 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 in June 2015.

When we last inspected the trust in June 2015, we rated specialist community mental health services for children and young people as requires improvement overall. We rated this core service as requires improvement for two domains, safe and responsive.

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 take action to improve the overall waiting time from referral to assessment to intervention and to ensure that there are effective systems in place to monitor the risk of people waiting to be seen.

We issued the trust with a requirement notice that affected specialist community mental health services for children and young people. This related to:

- Regulation 17: good governance

As the service was rated requires improvement in two of the five domains, we carried out a full comprehensive inspection of all five domains to fully understand whether the required improvements to the specialist community mental health services for children and young people had been made.

# Summary of findings

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- visited both community team bases, which were situated in the grounds of Alder Hey Children's Hospital in Liverpool, and in an office building in Sefton
- spoke with six children and young people, and six parents or carers
- spoke with the managers and senior manager in the service
- spoke with 19 other staff members including doctors, nurses, psychologists and support staff
- attended and observed an assessment, a young person's forum, and a multi-agency meeting
- looked at 17 treatment records of patients
- 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 with six children and young people and six carers.

All the patients and carers we spoke with were positive about the staff. They said they were treated with respect, and staff appeared caring and interested in their well-being. Patients and carers were positive about their experience, and the treatment they received. Patients and carers knew who their keyworker was, and said staff were responsive to their requests for information. When patients had not liked the staff they were working with, another member of staff had been allocated to them.

Children and young people were clear about who their information was shared with, and said this was explained to them. People told us that staff shared information with other organisations, such as their school, if this was appropriate. Children and young people were aware that staff shared information with their carers appropriately.

There were examples of patients not wanting specific information to be shared with their carers, and when the patient had been deemed to be able to make this decision the information had not been shared.

Children and young people, or their carers, knew what to do if they needed help quickly, and they knew how to contact staff at the service. People told us that when they visited the service, both at the Liverpool and Sefton sites, they felt safe.

The friends and family test for community child and adolescent mental health services showed that in the year to the end of March 2017 there had been 38 respondents. Of these, 29 people were extremely likely and two people were likely to recommend the service to their friends and family, with only one person unlikely to do so.

## Good practice

Children and young people were involved with the development of the service through the "FRESH" initiative. This involved children and young people in developing information such as posters, leaflets, and a website about the service, and mental health in general.

The FRESH logo, and the written materials associated with it, were in a clear but distinctive and recognisable design. The patients' forum had been used to lead developments in the service, which included the

# Summary of findings

decoration of the reception area in both services. Children and young people were involved in recruitment, and had participated in mental health awareness in schools. FRESH+ was a parents and carers group.

The service was involved in a number of initiatives and pilots which included the national child and adolescent mental health services currency project (a form of payment by results), and joint working with other organisations to support parents with children on the child protection register.

The service was part of a network of statutory and voluntary services. It was piloting ways to make it easier for people to contact services, so they could be either referred to the child and adolescent mental health services, or signposted elsewhere. This included accepting self-referrals from children and young people or their parents, and trialling visiting GP practices so that GPs did not have to make a written referral to the service.

## Areas for improvement

### Action the provider **MUST** take to improve

- The trust must ensure that lone working practices are implemented, to ensure the safety of staff and others.
- The trust must ensure that the confidentiality of patient information is maintained, and that patient records are only accessible to authorised staff.

### Action the provider **SHOULD** take to improve

- The trust should ensure that all risk assessments are routinely reviewed, and the outcome of these reviews is clearly documented.
- The trust should ensure that the environment, including furniture, is clean, well maintained, and in a good state of repair.

- The trust should ensure that the design and decoration of the environment is suitable for children and young people.
- The trust should ensure that all rooms are adequately soundproofed.
- The trust should ensure that people are provided with information in a language or format they understand.
- The trust should ensure that effective strategies are in place to improve morale.
- The trust should ensure that staff feel confident in raising concerns about the service.

Alder Hey Children's 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
Liverpool Fresh CAMHS	Alder Hey Children's Hospital
Sefton CAMHS	Alder Hey Children's Hospital

### Mental Health Act responsibilities

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

Few of the children and young people in the service were treated under the Mental Health Act. There were no patients currently receiving a service who were subject to community treatment orders under the Mental Health Act.

Staff received training on the Mental Health Act. Staff in the single point of access team, and the consultant psychiatrists, carried out assessments of patients who had been detained by the police under section 136 of the Mental Health Act.

The trust had implemented policies and procedures to ensure the Mental Health Act was applied appropriately.

### Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act only applies to people aged 16 years and over, so is only relevant to some of the children and young people who used the service. The trust had a

Mental Capacity Act and Deprivation of Liberty Safeguards policy for patients aged 16 and over, and a policy on capacity and consent for all children and young people who used the service.

# Detailed findings

The trust's consent policy was clear about the presumption of consent, and how this related to children and young people. It referred to the assessment of capacity, and to Gillick competence. Gillick competence is when a child or young person aged under 16 – who would not automatically be presumed to have capacity - is assessed as being able to understand and effectively consent to what is being proposed.

Staff understood the application of competence, capacity and consent. Several staff described examples of how they had worked with patients, mostly under 16, where there

were issues around capacity and consent. These showed an understanding of the issues of assessing the young person's competency and capacity to understand, and whether they were deemed able to make decisions for themselves. The outcomes included whether or not to involve carers and what information should be shared with them; and when to act in the person's best interests, which included under the Mental Capacity Act when a young person was over 16 years old.

CQC have made a public commitment to reviewing provider adherence to MCA and DoLS.

# 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

Alder Hey Children's Hospital NHS Foundation Trust only provided services for children and young people, or those transitioning from child to adult services. The Liverpool child and adolescent mental health service was in the grounds of Alder Hey Children's Hospital, so did not share access with any adult services. The Sefton child and adolescent mental health service was based in an office block, which was shared with a mixture of NHS and non-NHS businesses. The building had a shared reception desk, so children and young people shared access to the building with adults. There was a dedicated waiting room for children and young people using the Sefton service.

Staff knew what action to take in the event of a fire. They understood the need to sign in and out, where the fire exits were in the building, and where the fire assembly point was. Fire drills had been carried out at the Sefton service, which was situated over several floors.

Both Liverpool and Sefton services were in buildings that staff acknowledged were not ideal for their patients. The Liverpool service was temporarily based in a former outpatient department.

The décor in both buildings was tired, but generally clean. A meeting room in the Liverpool service had several chairs that were torn and in need of repair, which created a potential fire and infection control risk. There were also numerous marks/stains on the carpet.

There were no clinic rooms on either site, as physical observations were not carried out in the service.

### Safe staffing

For the year up to the end of March 2017 the service had a budget for 95.5 staff across the whole service. There were 94.8 staff in post. The manager told us that there were currently no vacancies in Liverpool and one in Sefton. However, there were a number of staff who had been recruited to posts but had not yet started, and staffing levels were impacted by long term sickness and the restructuring of the service. Staff told us that activities and appointments were never cancelled because there were not enough staff. However, workloads had been affected by

sickness, and this was shown by an increase in waiting times. The overall sickness rate for community children and adolescent mental health services was 8.28% for the period April 2016 to March 2017.

Staff turnover for the 12 months to the end of March 2017 was an average of 8.4%. This ranged from a monthly turnover of 4.4% in May 2016 to 12.2% in November 2016.

The service was in the process of moving from having two main divisions within services: primary mental health and specialist child and adolescent mental health, to staff having integrated caseloads. This transition started from the beginning of April 2017. At the time of our inspection there was a non-clinical band six operational manager at both the Liverpool and Sefton sites. However, this was due to change to a band seven locality manager for each service in Liverpool, Sefton and the single point of access teams. Liverpool and Sefton both had a band 8c clinical lead who was a psychologist. There were band 8b assistant clinical leads over each of the multidisciplinary teams, of which there were four in Liverpool, and three in Sefton. There was a vacancy for an assistant clinical lead in the Sefton service. The assistant clinical leads were from a variety of professional backgrounds. The multidisciplinary teams comprised a mixture of staff from band five to band 8a, which included psychologists, family therapists, nurses, mental health practitioners and social workers. Each child or young person was assigned a case manager from the multidisciplinary teams.

In addition to the operational/locality manager and the clinical leads, there were professional leads for nursing, mental health practitioners, psychiatry and psychology.

The director for child and adolescent mental health services was a social worker and psychotherapist. There were eleven consultant psychiatrists working in the service, which included their professional lead. A consultant psychiatrist was part of each of the multidisciplinary teams, though this was currently not the case for all teams in Sefton because of long term sickness and a vacancy. The service had had problems recruiting a locum but this had now been resolved.

There was a "consultant of the day" role, which covered the single point of access team and any emergency

# Are services safe?

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

assessments. Consultant psychiatrists from the Liverpool service currently covered this role on a rota. Consultant psychiatrists from the Sefton service did not cover the rota because of staff shortages there.

There was an impact on staffing levels because of absence. This included five staff on long term sick, two staff on maternity leave, and two staff on improving access to psychological therapies training. Managers told us that there was money available to cover the training, but it had been difficult to recruit to these temporary posts. In the Sefton service there were three agency staff covering mental health practitioner posts. The agency staff were recruited for several months at a time so they could provide meaningful and consistent support to children and young people.

Compliance with mandatory training for all staff in community child and adolescent mental health services was 78%.

The staff we spoke with told us they were up to date with their mandatory training, and that they received reminders from the training department when training was due. Mandatory training was provided through a mixture of workbooks and face-to-face sessions, which was dependent on the training. For example, staff had recently completed face-to-face training fire training and resuscitation.

The trust's safeguarding policy stated that all staff had to complete at least safeguarding level one training, including administration staff. Level three safeguarding training was mandatory for all clinical staff working in the child and adolescent mental health service. This constituted a three-hour face to face session, within 6 months of starting in post, and a level three update session every three years. Sixty-seven per cent of CAMHS staff have completed safeguarding level 3 training.

Recruitment checks were carried out by the human resources department before potential staff were offered a post. This included references and police checks.

## Assessing and managing risk to patients and staff

The trust had a policy for the assessment and management of risks across the organisation. This included a process for rating and reviewing risks. These were reviewed by the various governance groups and fed into the trust board and

the corporate risk register. Each clinical business unit had an action plan to reduce or eliminate risks for which there were not satisfactory controls. This included health and safety and other legislation such as manual handling.

There was a trust-wide lone working policy, and a specific policy for child and adolescent mental health services. This included that electronic diaries should be kept up to date and shared with colleagues and manager, and emphasised that staff should take responsibility for ensuring their own safety. However, this was not understood or applied consistently in practice. At the child and adolescent mental health service clinical governance meeting in February 2017 it was agreed that lone working should be added to the risk register.

The policy stated that if staff were working alone in the community a risk assessment should be completed. If staff were concerned they should visit with a colleague, take a mobile phone, and nominate a buddy to be aware of their movements, and take appropriate action if they were not contacted within a designated time period. This action may include trying to contact the person, escalating to a manager, or calling the police. The staff we spoke with did not feel there was an effective lone working policy in the service, and had a limited understanding of it. Most staff had a personal mobile phone, but some staff did not want to use this for work. The policy said there were work mobile phones available, but staff were not aware of these. Some staff had a buddy, and would go on joint visits if they had concerns. Staff said they maintained their calendars, but it was not clear who monitored this. Staff were not clear what action to take if a member of staff did not return from an appointment within a designated time period. Staff were not aware of any code words or signals that indicated they required assistance.

The use of alarms was included in the revised lone working policy for child and adolescent mental health services for the Liverpool site. At the Liverpool site, there were portable alarms but they did not work correctly so were not in use. A fault with the alarm system had been identified and reported on 9 March 2017, but had still not been fixed at the time of our inspection on 19 April 2017. Staff told us that they were unclear about who should respond to any alarms, and what action they should take. There were no alarms in the Sefton site.

Patient records were mainly electronic, and staff had their own login and passwords. Printed information was held



# Are services safe?

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

and scanned onto the system, though there were delays with this. Staff offices on the fourth floor at Sefton were at the end of a corridor shared with non-trust businesses. We found the offices on the fourth floor unlocked and the door open even though there were no staff in there, on three occasions. Staff told us that the office was only locked at the end of the day. Most records were held electronically, but there was confidential patient information on desks and in an unlocked filing cabinet. This was potentially accessible to staff and visitors of the other businesses with offices on the corridor.

The service monitored and reviewed waiting lists at weekly meetings to ensure that patients presenting with risks were seen within an appropriate timescale. However, appointment letters did not give advice on what patients or carers should do if risks increased before the appointment.

Staff told us that risk assessments were carried out by the single point of access team, and then reviewed at every session, although this would only be documented if there were changes. Some staff said that the risk assessment would be reviewed at the initial meeting after referral from the single point of access team. We reviewed 17 care records. Sixteen records contained an initial risk assessment and plan completed by the single point of access team, but the quality of these was variable. For example, one risk management plan stated 'refer to specialist CAMHS' but did not record whether any information was given to the parent about how to keep the child safe.

The trust did not have a policy for individual clinical risk assessment and review in child and adolescent mental health services. The trust was in the process of developing an operational guide, which was not fully implemented at the time of inspection. Staff who were not in the single point of access team had varied understandings of what was required, and recorded risk assessments, reviews and management plans in different ways. In 16 of the 17 records we reviewed we saw evidence that staff had considered risk either in their record of an individual appointment, in a clinical letter, in a risk assessment tool or in a separate crisis plan kept on a shared computer drive. We saw examples of staff acting appropriately and sharing information to help keep patients safe. However we had concerns that risk information would not be easy to find for staff who did not know the patient well.

Staff had a clear understanding of safeguarding and how to deal with safeguarding concerns. The trust had a safeguarding team based in the Rainbow Centre. Staff in the child and adolescent mental health service contacted staff at the Rainbow Centre if they had a safeguarding concern. Concerns were also discussed routinely in the multidisciplinary team meetings. Staff knew how to make a referral directly to children's social care, using an electronic form. Staff told us they would usually discuss any referrals with the child or young person and their family, unless there was a safety reason not to. When staff completed an electronic incident form, they were asked if there were any safeguarding concerns.

Medication was not dispensed or administered from the service, and there was no medication onsite. Doctors prescribed medication, and prescription pads were stored securely. Each doctor had an individual prescription pad, which was issued to them by the pharmacy department and a record kept of each individual prescription number. The pads were kept in lockable storage. An audit had been carried out, and found that the processes were mostly followed. In one case they had found a pad stored in a doctor's bag, which had been addressed. The service had a prescription printer on order, and had prepared a secure system and lockable storage for its arrival.

Staff were trained in basic life support. In the event of a medical emergency staff at the Sefton building or in the community called 999 to access the emergency services. In the event of a medical emergency in the Liverpool building staff called security who would alert the main hospital's crash team, and an ambulance. There were first aid boxes at both the Liverpool and Sefton sites.

## Track record on safety

There had been no serious incidents in the community child and adolescent mental health services in the last 12 months.

## Reporting incidents and learning from when things go wrong

In the year from 1 April 2016 to 31 March 2017 there were 46 incidents reported in community child and adolescent mental health services.

In the Liverpool service there were 37 incidents recorded. Of these eight incidents were rated as minor, seven were moderate and some had no severity recorded. There were

# Are services safe?

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

no clear themes, but the main causes of incidents were categorised by the trust as consent/communication/confidentiality, data protection, documentation, safeguarding, and transition (to other services) incidents.

In the Sefton service there were nine incidents. Of these three incidents were rated as minor, two were moderate, and some had no severity recorded. Again, there were no clear themes, but the trust identified data protection as the top cause of incidents.

Incidents were reported and recorded electronically on the trust's incident database. Staff knew how to report incidents. When incidents were reported, they were automatically shared with managers and the relevant leads across the trust. This included managers within the Liverpool and Sefton services, the director of child and adolescent mental health services, and the governance lead.

Incidents were investigated, and action was taken to prevent them happening again. The head of quality for community services compiled a monthly report of incidents. Each incident was discussed at multidisciplinary team meetings, management meetings, and the child and adolescent mental health board and governance meetings. More complex incidents included the involvement or joint investigation with other organisations and agencies.

Action was taken in response to incidents. For example, letters had been sent to the wrong address or organisation. In response to the findings of the investigation, standard operating procedures were updated, and all letters must now have the patient's Alder Hey identification number on them to ensure they relate to the correct person.

## Duty of candour

The trust told us that there had been no incidents within the community child and adolescent mental health services that met the criteria for duty of candour.

The trust's website provided information about the duty of candour, and the trust's commitment to it. When staff completed an electronic incident reporting form, they were asked if the duty of candour applied.

Staff were aware of the duty of candour, and its implications. They told us that they tried to be open and transparent with patients and carers. An example of this was of a patient's information being sent to the wrong place. The information was retrieved, and did not meet the criteria for duty of candour because there was no harm to the people involved. However, in the interests of openness and transparency staff informed the family.

# 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

We looked at 17 care records.

All children and young people who were referred to the service were assessed by the single point of access team. The single point of access team worked across Liverpool and Sefton, and carried out the initial 'choice' appointment with children and young people. This is part of a recognised way of working within child and adolescent mental health services, known as the choice and partnership approach. The initial 'choice' appointment is an opportunity for a collaborative discussion about the person's needs, where they can then be given choices about how to proceed. If the person chooses to continue working with the service, this then leads onto 'partnership' appointments, where staff, the child or young person, and their carers work together to address their problems and concerns.

Children and young people presenting at an emergency department following self-harm were triaged and assessed using a risk assessment tool. This was completed by emergency department staff, but considered the person's risk of harm, and whether they were known to or required assessment by the community child and adolescent mental health team.

Once a person had been accepted by the team, the level and detail of further assessment depended on the individual's needs, and what therapy they required. The quality of the care records was variable. They all contained an assessment and a plan of care, but not all were of good quality and not all were easy to find. The single point of access team completed a risk assessment as part of their initial assessment, but this was not always updated or referred to during further partnership meetings. Some records had care plans, but these were often brief, and the plan of care was often contained in letters, or summaries of care. All care records were stored electronically, but the information was stored in different places so was not always easy to find. Some records were very detailed, and risk assessments and care plans were clear, but others were not.

We observed an assessment. This gained the relevant information, and there was a clear plan for keeping the person safe agreed by staff, the child and their parent.

### Best practice in treatment and care

The service followed the choice and partnership approach to working with children and young people. This is a recognised approach, which emphasised collaborative working with the child or young person and their family. The initial or choice appointment is an assessment of needs, but aims to discuss with the family the options available to them so they can make choices about the next steps. The child or young person may be given the necessary skills and information at this appointment to be able to help themselves, and they may not need any further help or input from services. Alternatively the person may be signposted to other more suitable services, or may be accepted into the child and adolescent mental health service. If they continue in the service they will move onto partnership working. This is generally categorised into two main areas – primary, for people who work with one member of staff for a relatively short period of time, or specialist, for people who have input from more than one member of staff for an extended period.

Up until the end of March 2017 the service had separate teams for children and young people identified as needing a primary or a specialist service. From the 1 April 2017 the service started the move towards integrated teams, so staff would work with people identified as having primary or specialist needs. It was in transition at the time of our inspection. This integrated approach is based on the "THRIVE" model. This is a framework for providing child and adolescent mental health services developed by mental health organisations including NHS trusts. The central point of the model is to focus on ensuring that the children and young people it works with are 'thriving'. THRIVE also stands for the aims of the model which are that care should be timely, helpful, respectful, innovative, values-based and efficient. The model acknowledges that children and young people coming into services often have complex needs, and believes that all competent child and adolescent mental health staff should have the necessary skills to provide core care and treatment to all children and young people coming into the service.

Children and young people had access to psychological therapies. This included cognitive behavioural therapy, early years, systemic family therapy, dialectical behaviour therapy, eye movement desensitisation and reprocessing therapy, art therapy, cognitive analytic therapy and drama therapy. There was a non-violent resistance group, that supported parents of children who were aggressive or

# Are services effective?

Good 

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violent. Access to incredible years (for young children) and neurodevelopmental assessments (for autism and attention deficit hyperactivity disorder) was provided by other organisations and other parts of the trust.

The service used a number of rating scales and outcome measures, depending on the needs of the child or young person and the type of therapy provided. This included rating scales that monitored the severity of depression and anxiety symptoms, Score-15 (used in family therapy), strengths and difficulties questionnaire, and Conners behaviour rating scales.

The trust's clinical quality assurance committee monitored the implementation of National Institute for Health and Care Excellence guidance across the trust. This showed that that guidance was implemented and audited. For example, audits had been carried out of national guideline 43: transition from children's to adults' services for young people using health or social care services, quality standard 48: depression in children and young people, and clinical guideline 155: psychosis and schizophrenia in children and young people: recognition and management. The audits identified issues with consistent recording of relevant information. The staff we spoke with were familiar with the use of the guidelines within their service, particularly for the care and treatment of anxiety and depression.

## **Skilled staff to deliver care**

The service comprised staff with a mix of professional backgrounds and specialities. This included nurses, psychiatrists, psychologists, therapists and social workers. They provided a range of assessments and psychological therapies which included cognitive behaviour therapy, systemic family therapy, and psychotherapy.

All staff had had training in working with children and young people with mental health problems. There was a programme of core training for child and adolescent mental health. They used the choice and partnership approach model which all staff were part of. The service was part of NHS England's children and young people's improving access to psychological therapies programme. This included specific training for staff.

Staff had clinical supervision with their clinical leads. Staff told us they received regular clinical supervision, which typically occurred every four weeks.

There was no formal management supervision. Managers told us if there were non-clinical issues to discuss with staff, this would be addressed with individuals. Staff effectively had two managers. They had a professional lead, and the operational manager. Any disciplinary or management issues, such as sickness, would be led by the operational manager. Any clinical issues, such as caseload management or capability, would also involve the person's professional lead.

Staff had appraisals carried out jointly with the operational manager and their clinical lead. All staff in Liverpool had had an appraisal. Some staff appraisals in Sefton were overdue, but were scheduled to take place over the current quarter (April to June 2017). The proportion of community children and adolescent mental health service staff to have an appraisal in the period April 2016 to March 2017 was recorded as 75%. The trust had a human resources database for recording and monitoring appraisals.

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

There were weekly multidisciplinary meetings with each service.

The child and adolescent mental health services was part of Liverpool's "Children and Young People's Mental Health and Emotional Wellbeing Strategy 2014-2017" commissioned by the Liverpool Clinical Commissioning Group and Liverpool City Council. There were a number of provider agencies which included Alder Hey Children's NHS Foundation Trust, other NHS organisations, the local authority and independent/voluntary sector services.

The service was part of the child and adolescent mental health wellbeing network. This was chaired by the service, and co-chaired by the voluntary sector. It had a wide membership and remit, which included to share current issues in child and adolescent mental health services and identify training needs. Information was fed up to the steering group and then disseminated to its members. Current discussions included developing apps and websites for young people, and children and young people's involvement in services.

The service provided mental health awareness sessions to three Liverpool schools. This was presented by a member of staff and a young person who used the service. There was feedback from 74 young people who attended the session, and this was broadly positive.

# Are services effective?

Good 

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

Few of the children and young people in the service were treated under the Mental Health Act. There were no patients currently receiving a service who were subject to community treatment orders under the Mental Health Act.

Alder Hey Children's Hospital had a place of safety for under 16 year olds who were detained by the police under section 136 of the Mental Health Act. These patients would be assessed by consultant psychiatrists, and (within office hours) the single point of access team. Young people aged 16-17 detained by police under section 136 of the Mental Health Act would be taken to a place of safety at an alternative location, as Alder Hey hospital only admitted children aged 15 and under. If the patients were 16 or 17 years old, they would usually be assessed by staff from an NHS mental health trust that provided adult services.

Staff had had training on the Mental Health Act. Non-medical staff had some awareness of the Act, but rarely needed to put this into practice when working with patients. Staff knew where to go for advice when necessary.

The service had an agreement with a mental health trust for the provision and monitoring of the Mental Health Act. The service had a Mental Health Act administrator, and some of the non-executive directors had completed training to carry on the role of 'hospital manager' under the Act.

## Good practice in applying the Mental Capacity Act

The Mental Capacity Act only applies to people aged 16 years and over, so is only relevant to some of the children and young people who used the service. The trust had a Mental Capacity Act and Deprivation of Liberty Safeguards policy for patients aged 16 and over. This included general guidance on the key principles of the Act, and specific guidance on its application in practice. Figures provided by the trust showed that 90% of clinical staff in the children and adolescent mental health services had completed Mental Capacity Act training.

The trust's consent policy was clear about the presumption of consent, and how this related to children and young

people. It referred to the assessment of capacity, and briefly the Mental Capacity Act for young people aged over 16 years. It referred to Gillick competence, which is when a child under 16 – who would not automatically be presumed to have capacity - is assessed as being able to understand and effectively consent to what is being proposed.

Care records included assessments of a patient's capacity to provide informed consent about their care and treatment. An assessment of competence to make decisions was carried out for children and young people aged under 16 years. However there was no consent form or similar to clearly indicate who the child or young person wanted their clinical information to be shared with. Patients did sign consent forms, but only in relation to sharing questionnaire data with the improving access to psychological therapies for children and young people scheme.

Staff told us that capacity and consent was discussed at the beginning of each person's initial appointment. The service's young person-friendly "FRESH" website was clear about when carers will be provided with information. It clearly stated that if a young person was aged 16 years or older than it was their choice as to whether information was shared with their parents. Staff told us that it was not common for a person aged under 16 years to self-refer without their parents' involvement. However, when this did occur a discussion took place about contacting the person's parents.

Staff understood the application of competence, capacity and consent. Several staff described examples of how they had worked with patients, mostly under 16, where there were issues around capacity and consent. These showed an understanding of the issues of assessing the young person's competence and capacity to understand, and whether they were deemed able to make decisions for themselves. The outcomes included whether or not to involve parents and what information should be shared with them; and when to act in the person's best interests, which included under the Mental Capacity Act when a young person was over 16 years old.



# Are services caring?

Good 

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

## Our findings

### Kindness, dignity, respect and support

We spoke with six children and six carers.

All the children, young people and carers that we spoke with were positive about the staff. They said they were treated with respect, and staff appeared caring and interested in their well-being. They were positive about their experience, and the treatment they received. Children and young people knew who their keyworker was, and said staff were responsive to their requests for information. When children or young people had not liked the staff they were working with, another member of staff had been allocated to them.

Children and young people were clear about who their information was shared with, and said this was explained to them. Children and young people told us that staff shared information with other organisations, such as their school, if this was appropriate. Children and young people were aware that staff shared information with their carers appropriately. There were examples of young people not wanting specific information to be shared with their carers, and when the patient had been deemed to be able to make this decision the information had not been shared.

Children and young people, or their carers, knew what to do if they needed help quickly, and they knew how to contact staff at the service. Children, young people and their carers told us that when they visited the service, both at the Liverpool and Sefton sites, they felt safe.

The friends and family test for community child and adolescent mental health services showed that in the year to the end of March 2017 there had been 38 respondents. Of these, 29 people were extremely likely and two people were likely to recommend the service to their friends and family, with only one person unlikely to do so.

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

The service followed the choice and partnership approach to care. This emphasised a collaborative approach towards working with children, young people and their families. The children, young people and parents we spoke with were generally happy about the service. Children and young people were offered choices, but there was a mixed response as to how involved people felt they were in making decisions. The care records we looked at contained some references to the involvement of people using the service, but this was not always explicit.

Children and young people were involved with the development of the service through the “FRESH” initiative. This involved children and young people in developing information such as posters, leaflets, and the service’s website. The website contained information about how to access the service, self-help, and mental health in general. The FRESH logo, and the written materials associated with it, were in a clear but distinctive and recognisable design.

There were regular meetings of the patients’ forum/ participation group. The patients’ forum had been used to lead developments in the service, which included the decoration of the reception area in both services. Staff and young people discussed staff training and the forthcoming staff conference at the forum, and developed new information posters. Children and young people were involved in recruitment, and had co-presented mental health awareness sessions in schools.

There was a parents and carers participation group called FRESH+.

# 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

In the six months up to the end of March 2017, the service received 2128 referrals, of which 1220 were accepted for partnership working with the team. The number of referrals per month ranged from 169 referrals in October 2016 to 257 in March 2017. During the same period, there were 1522 completed or closed cases. This ranged from 236 in December 2016 to 272 in March 2017. Staff told us that if a child or young person's case had been closed, if they were referred back to the service within three months they would usually be seen by the same multidisciplinary team. If a child or young person was referred back to the service over three months from discharge they would be classed as a "new" referral.

All referrals went through the single point of access team, based in Liverpool. Children and young people were usually referred by their GP, a social worker, a hospital, or school. The service was piloting the use of self-referrals from children and young people or their carers. The information provided was triaged and prioritised, usually on the same day the referral was received, if on a weekday and within office hours.

All children and young people referred to the service were assessed by the single point of access team. At the initial or choice appointment staff discussed the problems and concerns with the child or young person and their parent or carer, and reached a joint decision about what they needed. This followed the choice and partnership approach. This was a recognised model of working in child and adolescent mental health services, that aimed to provide person centred care and reduce delays and waiting lists.

The single point of access team carried out assessments of children who had presented at the emergency department after self-harming. Emergency department staff carried out an assessment using a standardised assessment tool. If this scored over a certain level, the child was referred to the child and adolescent mental health service. When the child was medically fit, either in the emergency department or on a ward, the single point of access team carried out an assessment, and offered them an appointment within a

week to assess if they required input from the team, or needed signposting to other services. The assessments may be delayed if there was no family member available, but usually took place the day of the referral.

Any child or young person and/or their carer who was accepted for partnership working was sent a letter within two weeks offering them an opt-in appointment. Staff told us that before May 2016 they sent specific appointments, but found that people often rang to change dates or did not attend. The opt-in process had freed up administration time, and reduced the number of people who did not attend or missed appointments. In May 2016 the did not attend rate was 33%, but had reduced to 11% by September 2016.

The trust's target was for children and young people to be seen within six weeks from referral to assessment, and within six weeks from assessment to treatment. At our last inspection in June 2015 we found that there were waiting times for non-urgent referrals, with some patients waiting up to 21 weeks for an initial appointment, and there was no effective system in place to manage and monitor the risks of those waiting for treatment. At this inspection we found that the trust had taken action to address the waiting list. There were still some delays, but there was usually a reason for this (such as repeat cancelled appointments by the young person or carer), and most people were seen within the trust's 12 week target, and within 18 weeks. The trust had a robust system for monitoring waits, and had taken action to address this.

A weekly report was generated of waiting times for the whole clinical business unit, which included child and adolescent mental health services. This included waiting times, and the reasons for any outliers. The report was discussed at the weekly business meeting, which was attended by senior staff. The report also took account of events that may impact on waiting lists on the future, such as ongoing long term sickness, so action could be taken to address this. Several of the staff we spoke with were in teams that did not have a waiting list. Administration staff dealt with allocations, recorded choice appointments on the record system, and booked initial partnership appointments.

In the four months up to and including April 2017, in Liverpool the average waiting time from referral to treatment was from 8 weeks (in February and March) to 11 weeks (in January) for primary and from 11 weeks (in

# Are services responsive to people's needs?

Good 

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

January and March) to 13 weeks (in April) for specialist. In Sefton the average waiting time from referral to treatment was from 9 weeks (in March) to 12 weeks (in April) for primary and 9 weeks (in April) to 13 weeks (in March). Managers told us that the waiting lists had increased because of staff shortages, such as long term sickness and difficulties recruiting to posts.

The children, young people and parents we spoke with had typically waited a few weeks for an appointment. Most had thought this was tolerable, and some that it was shorter than they had expected. The people we spoke with said that appointment times were flexible. People had occasionally had an appointment rearranged, but this was not seen as a significant problem.

Staff told us that children and young people or their parents could contact the duty worker if they had concerns about the person's mental state. They said that many children and young people were already involved with other agencies (for example school, or social services) who provided support.

Every child or young person had a case manager, who was assigned to them when they were allocated to the team. The case manager was in addition to any staff they may see for specific therapies. Children and young people were referred for specific therapies within the team, and may be put on a waiting list for these therapies. The service recorded and monitored these 'internal waits' separately to the main waiting list.

There were also waiting lists for appointments with a consultant psychiatrist. Up to the end of April 2017 there were 18 children or young people waiting to see a psychiatrist, with the longest wait since January 2017. This had risen from 12-15 people from February to June 2016 to 29 people in September 2016 and 33 people in October 2016. It had peaked in February 2017 when there had been 49 people waiting. There was ongoing discussion within the service about the availability of psychiatry, which had been affected by long term sickness, staff leaving and retiring, and difficulties in filling a locum post. This was discussed in the child and adolescent mental health governance and board meetings, and was on the Sefton service risk register.

Up to the end of April 2017 there were a number of internal waiting lists for therapies. There were five children or young people waiting for cognitive analytical therapy, with the longest wait since February 2016. There were 14 children

and young people waiting for cognitive behavioural therapy, with the longest wait since October 2016. There were 12 families waiting for family therapy, with the longest wait since October 2016. The waits for cognitive behaviour therapy and family therapy were identified as particular issues that needed to be addressed, and they were due to be discussed at the next operational meeting. There were eight children and young people waiting for neuropsychology assessments, with the longest wait since November 2016. A member of staff was due to return from sickness which would reduce this list. There were four children and young people waiting for development disorder work, with the longest wait since September 2016. This had decreased from 10 people waiting in February 2017 and 11 people waiting in March 2017, and was partly attributed to staff sickness. The service was hoping to recruit a learning disability specialist in the future. There were 7 children and families waiting for theraplay (a type of child and family therapy), with the longest wait since November 2016. This had decreased from 10 children and families waiting in February 2017 and 11 waiting in March 2017. Managers identified that as this was a longer term therapy, it was not completed quickly so that other people could begin it. There was a plan to meet with the therapy team to review the waiting list. There were three young people waiting for psychotherapy, with the longest wait since September 2016. There was no waiting list for dialectical behavioural therapy.

The service had clear inclusion and exclusion criteria for the children and young people they worked with. This included definitions of when emergency and urgent assessments were required. Emergency assessments for 16 and 17 year olds were assessed by another NHS trust. Emergency assessments for under 16s, and urgent assessments for children and young people including 16 and 17 year olds were carried out by the child and adolescent mental health service within two weeks of referral.

There was a general trust-wide policy, and a child and adult mental health service specific policy regarding the transition of young people to adult service. The transition policy was last updated in March 2017. It acknowledged that transition arrangements can be complicated, and depended on the young person's age, where they lived, how long they had been receiving a service, how long they were likely to receive a service, and the complexity of their needs and service provided. The policy aimed to be clear



# Are services responsive to people's needs?

Good 

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

about who was responsible for specific patient groups, and when and how transition arrangements should be considered and made to minimise the impact of this change on patients. It was overseen by the director of child and adolescent mental health services and their equivalent in adult mental health services.

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

Services were provided from two sites, in Liverpool and Sefton. The Liverpool building had 15 individual therapy rooms. Seven of these had windows, but eight of them did not. There were two rooms with a one-way mirror for use in family therapy. The Sefton building had 10 therapy rooms where patients were seen. One room had a mirror for use in family therapy. There were no clinic rooms, and clinical examinations were not carried out in the service.

Staff told us that the administration team booked all the rooms. They acknowledged that not all rooms were fit for purpose, such as those without windows.

The service moved into the Liverpool building in March 2016. This was intended to be temporary, but had recently been extended to 2018. The building was formerly a paediatric cardiology outpatient department, and the décor was tired and had indications of its former occupants. For example there were blank noticeboards and marks on the wall from previous office equipment, such as empty picture hooks and wall plugs, and banks of electricity and communications points. There was old signage, such as a meeting room labelled "gait laboratory". Some of the furniture was very worn. For example, there was a meeting room with multiple stains on the floor, and torn chairs.

The Sefton service was based across several floors of a privately owned office block. There was a shared reception, with a dedicated waiting room on the ground floor. The therapy rooms were on the first floor. The fourth and fifth floors were shared with the landlords and other businesses, but were usually only used by staff.

Staff acknowledged that the buildings looked tired, although attempts had been made to make them more child friendly in some areas. The Liverpool building had a large open reception and waiting room, with a soft play area for younger children, television and information. There were murals and bright colours on the walls which incorporated the "FRESH" logo and design. The waiting

room in the Sefton building had been decorated to make it more attractive. Children and young people had been involved in the design of both waiting areas. There were child and young person friendly furniture, decoration and toys in some of the therapy rooms.

The therapy rooms were in use throughout our inspection so we were unable to test the quality of soundproofing throughout. It appeared to be generally adequate, though it was noted that sound carried through the walls of some of the rooms in the Sefton building.

On the Liverpool site there was an open staff office, with two individual offices directly off this. Staff told us that patients would sometimes be seen in the private offices, which meant they had to walk through the open office area. They told us that staff were very aware of privacy when this happened, and checked that confidential information was not on display.

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

Age-appropriate information was available for children and young people. Much of this had been developed with the involvement of children and young people, under the distinctive "FRESH" logo and design.

The Liverpool and Sefton sites were wheelchair accessible. The Liverpool service was on one floor. The Sefton service was on several floors, but patient areas were on the ground and first floors. All floors had lift access, and the doors between the lift and offices on the first floor were wheelchair accessible. There were disabled toilet facilities.

The trust had a policy on the use of interpreters and translation services. Face-to-face interpretation was the preferred option, and this included British Sign Language, but a telephone interpretation service was also available. The policy included guidance for staff on how to work with interpreters to make their interactions with patients and carers most effective.

There were no written materials available in other languages. The trust's policy stated that written material could be translated if requested by the patient or carer, and this was stated in multiple languages on the trust's main information leaflets. However, staff told us that although it was possible to get translations it was often impractical

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because of the length of time it took. We saw an example of an interpreter being used with a child or young person and their family, but the appointment and clinical letters were sent to them in English.

The sample of clinical records we saw for children with a learning disability, showed that staff had used a range of accessible communication materials to engage and support these children.

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

The service received two formal complaints in the six-month period from 1 October 2016 to the 27 April 2017. Both complaints were upheld. The trust's target was to resolve complaints within 25 days. One complaint met this target, and the other was two days over it. No complaints had been escalated to the Parliamentary and Health Service Ombudsman.

Staff told us that they tried to resolve complaints locally where possible. There had been six complaints in the four-

month period from December 2016 to March 2017. There were no particular themes for the formal or locally resolved complaints. Staff described a situation where there had been several informal complaints, where the initial appointment had not been what the family expected.

All complaints went through the patient advice and liaison service, commonly known as PALS. All complaints were reviewed at the child and adolescent mental health clinical governance, and child and adolescent mental health board meeting. Analysis of complaints was carried out by the head of quality for community services.

Most people we spoke with said they knew how to make a complaint, or could find out, and that they felt able to raise concerns. There was information about how to make a complaint onsite, and on the service's "FRESH" website. The website was young-person friendly, and provided phone numbers and email details of senior staff, and information about the patient advice and liaison service.

# Are services well-led?

**Requires improvement** 

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

## Our findings

### Vision and values

The trust's values were: respect, excellence, innovation, together and openness. Staff were aware of these, and they were printed on the lanyards staff wore around their necks that held their identity cards. Staff personal development review documents included questions on adherence to the values of the organisation.

Staff told us they knew who their senior managers were, and referred to local operational and clinical leads and the director of child and adolescent mental health services.

### Good governance

There was a local child and adolescent mental health service governance group and board, that each met once a month. This covered community and inpatient services, and fed into the governance arrangements of the clinical business unit they were part of, and into the trust-wide governance. At the local governance and board meetings issues affecting the service were discussed, and actions agreed and monitored. For example risks, incidents, and complaints were discussed at the governance meeting. Each clinical business unit had a governance lead who collated information about incidents and complaints, and identified themes. Vacancies, waiting lists and challenges to the service were discussed at the board meeting, in addition to what was working well in the service. There was an improvement group for Sefton and for Liverpool, that took action on improvements required in the service, and fed this back to the board meetings.

In 2015 the trust determined that the model of care it provided was not fit for purpose, and led to long waiting lists and poor staff morale, particularly amongst consultant psychiatrists. The trust invited the Royal College of Psychiatrists to carry out an independent review, and commissioned a review by an independent management consultant. The findings and recommendations from these reviews were used by the service to change the model of care, to improve outcomes for children and young people using the service, and increase staff morale.

The service was still in the process of transition to the new model. This centred on the "THRIVE" approach, which was a framework for providing child and adolescent mental health services developed by mental health organisations including NHS trusts. The central point of the model is that

it should focus on ensuring that the children and young people it works with are 'thriving', THRIVE also stands for the aims of the model which are that care should be timely, helpful, respectful, innovative, values-based and efficient. The model acknowledges that children and young people coming into services often have complex needs. A key part of the model is that all competent child and adolescent mental health staff should have the necessary skills to provide core care and treatment to all children and young people coming into the service. This means that teams should not be divided into primary mental health and specialist child and mental health services. The service was in the process of removing the boundaries between teams, so that all staff would be able to work with any child or young person, regardless of their identified level of need. It was anticipated that this would also help to reduce waiting times for children and young people who would otherwise have been seen by the specialist team.

The service had not completed a care record audit since December 2014. When we reviewed care records, we observed that staff were recording information in different places, which made it difficult to find. We also saw from incident reports from March and April 2017 that session notes and clinical letters were missing from some patients' files. The trust told us that the audit programme had been interrupted due to a rebuild of the electronic record system. The audit programme was due to start again in September 2017. There was an audit lead, who was preparing an audit cycle, and worked with the head of quality to prioritise the audit list. This was discussed and monitored in the child and adolescent mental health service governance meeting.

The risk register was discussed and reviewed in the child and adolescent mental health service governance meeting. Local risks fed into the trust's overarching risk register. The director of child and adolescent mental health services, and other managers and clinical leads, were able to add items to the register.

A joint inspection of children's services in Sefton by the Care Quality Commission and Ofsted in 2016 found large amounts of paper records waiting to be scanned. They raised concerns with the trust that staff may be unable to access up to date information about children and young people using the service. The trust told us that the paperwork was not related to children and young people who were currently being seen by the service. At this

# Are services well-led?

Requires improvement 

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inspection we were told that the paperwork that had been at Sefton had been moved to the Liverpool office. In the Liverpool service there were 18 boxes/crates of records in one room, and five laundry-type cages of records in another area. Staff told us that these were not for current patients, and were waiting to be scanned and archived. We looked at a small sample of records, and they were from 2010. Dedicated time has been allocated to the medical records department to scan and archive all the records.

## Leadership, morale and staff engagement

One of the findings of the independent reviews of the service requested by the trust in 2015 was a lack of clear leadership. The role of director of child and adolescent mental health services was established and recruited to in October 2016, and is held by a social worker and psychotherapist. There was a clinical lead and an operational manager at each site (Liverpool including the single point of access team, and Sefton), who shared line management of staff. There were professional leads for nursing, mental health practitioners, psychiatry and psychology. Assistant clinical leads managed each of the multidisciplinary teams, of which there are four in Liverpool and three in Sefton. All staff, including managers, had a job description which included their specific roles and responsibilities.

Managers at all levels told us they thought they were supported in their roles, and felt able to speak out and feed into the development of the service. They believed the transition and the impact of staff absences had impacted on staff morale, but this was being addressed.

The independent reviews identified poor staff morale as a problem in the service. There was a trust wide executive group that used “listening into action”, which works with the organisation to look at increasing engagement and improving morale, sickness rates and job satisfaction. Managers told us that they had implemented a staff morale strategy. This included a staff group that met monthly and aimed to improve morale, and a staff member who had dedicated time to work on staff morale issues. Managers acknowledge that the group had waned recently, so this was going to be reviewed at the service’s away day in May. There was a weekly multidisciplinary team meeting that all staff attended, and a monthly business meeting.

The staff we spoke with had mixed, often polarised views about the service. Many staff were very positive about the service, and said they enjoyed their jobs and felt supported

by managers. However, other staff were less positive about the service and the changes. Five of eight clinical staff told us that they would be reluctant to raise concerns or would raise them but felt these would be responded to negatively. Staff also had mixed views about the changes to the service. Staff working in the primary mental health teams tended to have higher caseloads than staff in the specialist child and adolescent mental health teams, because they worked with people for shorter periods. Staff’s main concern with the changes was that their caseloads would increase, and they would retain the higher caseloads of the primary mental health teams, but have more children and young people with “specialist” needs. There was evidence that the trust was responding to concerns raised by individuals and groups of staff.

## Commitment to quality improvement and innovation

The service was part of a number of initiatives and pilot programmes, both local and national.

The trust was selected as one of 16 NHS trusts that are part of NHS England’s global digital exemplar programme. The aim of the programme is to improve outcomes for people using services, by improving the use of information technology. In order to be selected trust had to demonstrate that they used electronic patient records effectively, shared information across local health and care teams, and had robust data security.

The service facilitated a non-violent resistance group for parents. This was an evidence-based intervention, that worked with parents about how to respond more effectively when their child was aggressive or violent.

The service was in phase two of a pilot for a national child and adolescent mental health services currency project, which is a form of payment by results. Payment by results is a national system for paying NHS trusts for the services they provide. Two staff had been trained in the process, and a third was needed so that they could train the rest of the staff to work with the system.

The service was in the early stages of a research project working with parents who have children on the child protection register. This was a joint project with a national centre for research, training and treatment of children and young people with mental health problems.

The service was piloting a way of working with GPs. Two clinicians went to two of the larger GP practices in some of

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the more deprived areas. This provided a face to face service for GPs, so they did not have to make a written referral. Staff completed a document called “My Plan” for the child or young person, which may give them information about CAMHS or, would signpost them to other services. The pilot was in the process of being audited for its effectiveness.

In September 2016 the service started accepting direct or self-referrals from children and young people or their carers. Staff told us that there was now enough information to analyse whether this had been successful, and whether it was a viable alternative or addition to a GP referral.

The service had a schedule of audits, the findings of which were reviewed in the governance meetings. This included a service evaluation of the effectiveness of the programme in managing anxiety in young children, an audit of letters and completion of routine outcome measures in Sefton, an evaluation of Alder Hey’s primary child and adolescent mental health services into schools, and a Liverpool and Sefton paediatric self-harm audit.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**How the regulation was not being met:**

Confidential information was not stored securely at all sites, and was potentially accessible by people outside the trust.

The trust had a lone working policy, but this was not all relevant to individual services, and was not fully implemented.

**This was a breach of regulation 17(2)(b) and (c)**