

Lancashire Care 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)
Lancaster and Morecambe CAMHS	Sceptre Point	RW5HQ	LA4 5LE
Chorley and South Ribble CAMHS	Sceptre Point	RW5HQ	PR25 3ED

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Requires improvement



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 because:

- Children and adolescents had to long waits for appointments. For example, Chorley and South Ribble CAMHS had a waiting time of 29 weeks from referral to assessment for non-urgent cases. Following the initial assessment by staff, young people had to wait 24 weeks to see a psychiatrist, 18 weeks to see a psychologist, 10 weeks for family therapy and 54 weeks for an autistic spectrum disorder assessment.
- We found that the transfer of young people to adult mental health services was not working effectively. There was no current protocol for staff to follow and inconsistency in practice.
- Neither of the CAMHS teams had an up-to-date environmental risk assessment to ensure the environments posed no potential risks to young people or children.
- Too few staff had completed mandatory training, which had the potential to put young people at risk. Also, Lancaster CAMHS had only completed 50% of staff appraisals, and the trust could not give figures for the Chorley and South Ribble service.
- CAMHS staff were unavailable outside of normal working hours, to assess young people with mental health problems at Lancaster, Blackpool and West Lancashire A&E departments as this is not currently commissioned to be provided by Lancashire Care. This meant that young people might wait as long as three days to be seen by a specialist at a weekend.
- Team leaders had no consistent system to monitor the uptake of clinical and management supervision of staff. Evidence of a monitoring system was provided by the Lancaster and Morecambe team, however there was no evidence available for Chorley and South Ribble team. Clinical supervision is an important tool for checking that young people have received the appropriate care and treatment.
- Staff assessed, managed, and reviewed risks to young people daily but recorded information inconsistently. They did not know the trust's risk assessment policy. This meant staff might have difficulty when reviewing the records, to locate and identify potential risks.

Although we found inconsistencies in approaches to service provision, newly appointed managers had made changes to improve services. For example:

- The trust significantly changed the management structure in the three months before the inspection. It had brought in new staff to introduce systems to monitor compliance and improve services; and employed four new staff to reduce waiting lists.
- The trust used comprehensive performance monitoring and risk registers, to identify and respond to organisational risks. Staff had the ability to submit items to the risk register. The trust had systems in place to monitor the quality of the services and drive improvements.
- Staff understood processes to safeguard young people, reported incidents and investigated them. Team leaders told staff about outcomes and learning from incidents.
- Staff delivered care and treatment based on young people's needs. Staff understood and addressed the type of problems presented by the young person and their families. They worked collaboratively with the young person and their family and always sought their agreement.
- Staff had a good knowledge of the Mental Capacity and Mental Health Act.
- The clinical staff had participated in clinical audits, to look at whether the services had met National Institute for Health and Care Excellence (NICE) guidelines in December 2014 for depression and attention deficit hyperactivity disorder.
- Staff felt well supported by the team leaders. Staff followed the trust's values of teamwork, compassion, integrity, respect, and intelligence when carrying out their work.
- Professionals involved in the clinical care of young people held case review meetings when they felt it was necessary to discuss and explore the options for care and treatment.
- Young people and families knew how to make a complaint or raise a concern about the service and staff had responded to these.

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:-

- too few staff had completed mandatory training to the expected standard.
- neither service had an up-to-date environmental risk assessment to assess environmental risks to young people or children.
- although premises appeared suitable, clean and safe, the most recent infection and control audit to protect against infections spreading at Chorley and South Ribble CAMHS was July 2011.
- staff used different ways to record information, about risks, and were unaware of the trust's risk assessment policy (so may struggle, when reviewing records, to find and identify risks).

However we also found areas of good practice and improvements. The trust had:-

- planned and reviewed staff numbers to respond to increased waiting lists.
- a safeguarding performance framework that allowed senior managers to oversee staff engagements, which allowed them to monitor and review resources.

And staff:-

- assessed, managed, and reviewed risks to young people daily.
- knew the processes to safeguard young people.
- knew how to report incidents, and when incidents occurred investigated them.
- Lancaster and Morecambe and Chorley and South Ribble CAMHS had weekly team meetings where lessons learned from incidents were cascaded to staff. However, three staff at Chorley and South Ribble CAMHS reported that they had not had any recent feedback about incidents.

Requires improvement



Are services effective?

We rated effective as good because staff had:-

- understood and addressed the problems presented by the young person and their families.
- mostly completed comprehensive and timely assessment of young people's needs.
- completed care records that were personalised, holistic and recovery focused.
- delivered care and treatment based on the young people's needs.

Good



Summary of findings

- assessed young people and referred them to specialist services.
- participated in clinical audits, to look at whether the services had met National Institute for Health and Care Excellence (NICE) guidelines in December 2014, for depression and attention deficit hyperactivity disorder.
- held case review meetings as and when they felt it was necessary to discuss and explore the options for care and treatment.
- had a good knowledge of the Mental Capacity and Mental Health act.

However we also found that improvements should be made because:-

- the staff followed only two care pathways. A care pathway is, the anticipated care placed in an appropriate time frame, written and agreed by a multidisciplinary team. Clinicians agree the pathways based on clinical evidence. They help to inform the patient, with a specific condition or diagnosis and staff of the expected progression through the clinical experience.
- team leaders had no consistent system to monitor the uptake of clinical and management supervision of staff. Evidence of a monitoring system was provided by the Lancaster and Morecambe team. However, there was no evidence available for Chorley and South Ribble. Clinical supervision is an important tool for checking that Young people have received the appropriate care and treatment,
- compliance with staff's annual appraisals was poor. At Lancaster CAMHS only 50% of staff had completed appraisal, and the trust could not give figures for the Chorley and South Ribble service.

Are services caring?

We rated caring as good because:

Staff:-

- treated young people with kindness, dignity, and respect by staff support.
- worked in partnership with young people and their families.
- sent letters to inform young people about care and treatment.

The trust:-

- implemented the friends and family questionnaire to provide young people with the opportunity to share their experience of the services,

Good



Summary of findings

- provided verbal and written information that enabled young people to understand their care was available to meet their specific communication needs.

Are services responsive to people's needs?

We rated responsive as requires improvement because:

- children and adolescents had long waits for appointments. For example, Chorley and South Ribble CAMHS had a waiting time of 29 weeks from referral to assessment for non-urgent cases. Following the initial assessment by staff, young people had to wait 24 weeks to see a psychiatrist, 18 weeks to see a psychologist, 10 weeks for family therapy and 54 weeks for an autistic spectrum disorder assessment.
- the trust did not have a current protocol for staff to follow when young people moved from CAMHS services to adult mental health services at 16 years. This meant that young people may have had an inconsistent approach to their care and treatment.
- CAMHS staff were unavailable outside of normal working hours, to assess young people with mental health problems at Lancaster, Blackpool and West Lancashire A&E departments as this is not currently commissioned to be provided by Lancashire Care. This meant that young people might wait as long as three days to be seen by a specialist at a weekend.

However we also found areas of improvements and good practices. For example:-

- the trust had identified a need to improve the transition of young people to adult mental health services and had responded to this by the provision of training.
- at both services, the facilities promoted the comfort, recovery, dignity, and confidentiality of the young people.
- young people and families knew how to make a complaint or raise a concern about the service and these had been responded to

Requires improvement



Are services well-led?

We rated well led as requires improvement because:

- compliance with mandatory training was below expected levels.
- neither service had an up-to-date environmental risk assessment. Chorley and South Ribble CAMHS did not have an up-to-date infection control audit.
- staff were unaware of the trust's risk assessment policy and used different ways to record information about risks.

Requires improvement



Summary of findings

However

The trust had:-

- in response to issues identified, made significant changes to the management structure of CAMHS in the three months prior to the inspection,
- used comprehensive reviews of the performance monitoring and risk register, to identify and respond to organisational risks. Staff had the ability to submit items to the ward risk register.

Staff :

- felt well supported by the team leaders
- had identified issues and put new systems in place to monitor compliance and improve services. The changes were new and staff had not fully embedded them in their practices.

Summary of findings

Information about the service

Child and adolescent mental health services (CAMHS) deliver services in line with a four-tier strategic framework, which is nationally accepted as the basis for planning, commissioning, and delivering services. This report is relevant to tier 2 and 3 services.

Tier 2 – Consists of CAMHS specialists working in community and primary care settings. Practitioners offer consultations to identify severe or complex needs which require more specialist interventions and assessment.

Tier 3 – Consists of a community mental health team or clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders.

Lancashire Care Foundation trust community CAMHS had tier 2 and 3 services at five locations:-

- Chorley and South Ribble CAMHS,
- Lancaster & Morecambe ,
- Preston CAMHS,
- West Lancashire CAMHS,
- Fylde & Wyre CAMHS.

The trust provided a service for children and young people aged 5-16 who have a range of mental health, emotional and behavioural difficulties.

A CQC inspection had not previously been carried out at these locations

Our inspection team

Our inspection team was led by:-

Chair: Peter Molyneux: Chair of South West London and St George's Mental Health NHS Trust.

Team Leader: Sharon Marston, Inspection Manager, Care Quality Commission (CQC).

Head of Inspection: Jenny Wilkes, Head of Inspection for Mental Health, Care Quality Commission (CQC).

The team that inspected this core service comprised CQC inspectors; a consultant psychiatrist, a Mental Health Act reviewer and three nurse specialists in CAMHS services.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of 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 a range of information we held about the child and adolescent mental health services and asked other organisations to share what they knew. During the inspection, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, and therapists.

We carried out the following announced visits:-

To Chorley and South Ribble CAMHS on the 28, 30 April and 12 May 2015.

Summary of findings

To Lancaster and Morecambe CAMHS on the 29 April and 12 May 2015.

During the inspection, the inspection team:

- spoke with 24 young people and their families, who shared their views and experiences of the services we visited,
- spoke with 25 members of staff, including, consultant psychiatrists, psychologists, service managers, team leaders, and nurses,

- with the young person's and families permission observed eight consultations in the services and in schools,
 - looked at 25 young peoples and children's 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 observed eight consultations and spoke with 24 young people and families. During the consultations, we saw staff treated the young person with compassion and respect and built a rapport with them. They listened to the young person and their family and offered appropriate practical and emotional support.

Young people and families we spoke with made very positive comments about the staff. They described the staff as “fantastic”, “listened to [them]”, “made a difference”, “responsive”, “flexible” and “interested in welfare”.

However, eight families commented on the long wait to access CAMHS.

Areas for improvement

Action the provider **MUST** take to improve

The trust must ensure that:-

- staff complete environmental risk assessments, to minimise risks to young people, children, or staff.
- staff complete mandatory training. Young people could be at risk because the number of staff who had completed training was below expected standards at both CAMHS. For example conflict resolution was below 70%, and resuscitation (basic life support) 50%.
- there is a protocol in place for the transfer of young people from CAMHS to adult mental health services and that this is fully adhered to by staff to ensure the health, safety and welfare of young people.

Action the provider **SHOULD** take to improve

The trust should make sure that staff:-

- make better use of care pathways. This is so senior managers could ensure there was a consistent approach to treatment and care; and young people had a coherent journey from referral to receiving a timely and relevant service.

- have a system in place to monitor the uptake of clinical and management supervision of staff. Clinical supervision is an important tool for checking that young people have received the appropriate care and treatment.
- have an annual appraisal. This is because annual appraisal enables the managers to review staff performance, to check their competency, and develop a training plan to ensure they update or develop their skills.
- continue to address the initial and internal waiting times for young people at Chorley and South Ribble CAMHS.
- young people who present at the A&E department at Lancaster, Blackpool and West Lancashire hospitals, CAMHS with self-harm or acute mental health problems receive a prompt assessment of their mental health needs.

Lancashire Care 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
Chorley and South Ribble CAMHS	Sceptre Point
Lancaster and Morecambe CAMHS	Sceptre Point

Mental Health Act responsibilities

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

At the inspection, no young people or children were subject to community treatment orders (CTO).

If a person has been detained in hospital under the Mental Health Act, the responsible clinician (the person who is in charge of the person's care, usually the psychiatrist) can arrange for the person to have a community treatment order (CTO). This means that the person will have supervised treatment when they leave hospital.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act does not apply to young people below the age of 16. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have a sufficient level of

maturity to make some decisions themselves. Consequently, when working with children, staff should be assessing whether or not a child has a sufficient level of understanding to make decisions

Detailed findings

At the CAMHS services, we observed staff informed, agreed, and explained consent during the initial assessment with the young person and their family and recorded this in the young person's records.

Generally, families were involved in the consultations and the young people agreed to their involvement. The families' involvement and understanding was necessary to safeguard the young people when they went home.

However, staff explained where the young person had decided they did not want their families to be involved; staff used Gillick competence test and an assessment of risk to ensure the safety of the young person.

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

Summary of findings

We rated safe as requires improvement because:

- too few staff had completed mandatory training to the expected standard.
- neither service had an up-to-date environmental risk assessment to assess environmental risks to young people or children.
- although premises appeared suitable, clean and safe, the most recent infection and control audit to protect against infections spreading at Chorley and South Ribble CAMHS was July 2011.
- staff used different ways to record information, about risks, and were unaware of the trust's risk assessment policy (so may struggle, when reviewing records, to find and identify risks).

However we also found areas of good practice and improvements. The trust had:-

- planned and reviewed staff numbers to respond to increased waiting lists.
- a safeguarding performance framework that allowed senior managers to oversee staff engagements, which allowed them to monitor and review resources.

And staff:-

- assessed, managed, and reviewed risks to young people daily.
- knew the processes to safeguard young people.
- knew how to report incidents, and when incidents occurred investigated them.
- Lancaster and Chorley and South Ribble CAMHS had weekly team meetings where lessons learned from incidents were cascaded to staff. However, three staff at Chorley and South Ribble CAMHS reported that they had not had any recent feedback about incidents.'

Our findings

Safe and clean environment

The premises appeared suitable, clean, and safe.

However, the trust informed us that neither CAMHS had an up to date environmental risk assessment to ensure the environments posed no potential risks to young people or children. In addition, the most recent infection and control audit to protect against the spread of infections at Chorley and South Ribble CAMHS was July 2011.

Staff saw young people and their families in suitable premises. Chorley and South Ribble CAMHS had alarms in the consultation rooms and systems in place to alert other staff should anyone be at risk. Lancaster CAMHS did not have alarms in the interview rooms, but staff used the ground floor rooms next to reception to interview young people and families unknown to the service. So reception staff could provide assistance if needed.

Chorley and South Ribble CAMHS had a clinic room that was only equipped to check young people's height and weight. Lancaster CAMHS did not have a clinic room but checked young people's height and weight in the consultation rooms. Neither team carried out full physical examinations or dispensed medication to young people.

Both teams had defibrillators on the premises, which staff checked daily. The teams did not hold full resuscitation equipment. In a physical emergency staff called the emergency services.

Safe staffing

Information reviewed indicated that Chorley and South Ribble CAMHS had an establishment of 13.5 full time clinicians. This consisted of a team leader, qualified nurses, social workers, occupational, family, and play therapists, clinical psychologists and cognitive behaviour therapists.

Staff sickness rate in the last 12 months for clinicians was low at 6.3%, which aligned exactly with the trust overall figure for sickness.

Young people had to wait up to 29 weeks for an initial appointment because of insufficient appointments and an

Are services safe?

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

increase in referrals. In response to this, as a temporary measure, the trust had employed an additional four clinicians to help reduce the waiting lists and had plans to introduce evening clinics.

In addition, Chorley and South Ribble CAMHS had an establishment of one full time and one part time (three days) consultant psychiatrist. However thirty two young people were waiting to see a consultant psychiatrist. The clinical and business service manager for CAMHS told us plans were in place to ensure these waiting times were reduced.

Lancaster CAMHS had an establishment of eight full time clinicians. This consisted of a team leader, qualified nurses, occupation and play therapists and primary care workers and a consultant psychiatrist for three and half days a week. A psychologist who worked for four days a week. Staff sickness was low at 3.4% in the previous 12 months. Young people did not have to wait to see a consultant psychiatrist.

Staff had low levels of compliance with mandatory training, which could compromise the safety of young people and staff. For example at Lancaster CAMHS out of 15 staff:

- ten had completed conflict resolution training,
- nine had completed fire safety and infection control training,
- eight had completed resuscitation (basic life support) training.

Out of ten staff at Chorley and South Ribble CAMHS:-

- six had completed conflict resolution,
- five had completed resuscitation (basic life support) training.

At Chorley and South Ribble CAMHS, the team's caseloads ranged from 25 to 81. The complexity of young people's cases influenced how many cases staff held. For example, staff acted as a care coordinator where the young person was waiting for an autistic spectrum disorder assessment, so little if any casework was required. In addition, less experienced nurses, did not hold caseloads but provided support to other team members with high caseloads.

At Lancaster CAMHS, the caseloads ranged from eight to 30 for staff working full time, and were dependant on other demands of their role and the complexity of the cases. The team's managers reviewed the caseloads during clinical and management supervision, to assess the complexity

and number of cases held by staff. When sick leave or annual leave occurred the team managers reviewed caseloads to ensure cover arrangements were in place. Once the CAMHS teams had accepted the young person or child referral, staff allocated a care co-ordinator.

The children and families senior management network meetings reviewed staffing establishments to ensure safety. For example, the children and families risk register reviewed on 2 February 2015, included how the attention deficit hyperactivity disorder (ADHD) staff vacancy was affecting the service and how this was to be managed in the interim until the vacancy was filled. In addition, it included a concern from West Lancashire CAMHS team that anticipated reduced staffing could compromise patient care and the action plan in response. This demonstrated that the senior managers reviewed the numbers of staff to make sure the services were safe.

Assessing and managing risk to patients and staff

The CAMHS teams had a duty system in place. The duty staff triaged the referrals, reviewed the information and prioritised referrals according to potential risk.

The staff carried out a thorough risk assessment at the young person's first appointment. This included the risk to self and others and the identification of harm and risk indicators. However, in the 23 records we looked at we found that staff used an inconsistent approach when recording the risks. In addition, staff were unaware of relevant policies. These included the trust's clinical risk assessment and management in mental health policy and the CAMHS standard operating policy. The aim of these two documents was to ensure a consistent and thorough approach to assessment and management of clinical risk in the trust. The different approaches to recording information about risks meant staff might have difficulty when reviewing the records to identify potential risks. We discussed our findings with the clinical and business service managers who recognised the need for a consistent approach to recording risk across all CAMHS teams.

At both teams, the team leaders told us how they monitored waiting lists to make sure they identified any risks to the young people. Staff discussed with young people and their families how to make contact with CAMHS if a young person's mental health worsened. In addition, during clinical and management supervision, team leaders reviewed with staff the young people's cases following a traffic light system to identify any further risks.

Are services safe?

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

When young people did not attend their appointment, staff followed up with a telephone call and letter to make sure they no longer required the service. Staff also referred to the standard operating procedure for failed contacts and family disengagement. This provided staff with clear guidelines and a consistent approach to follow should young people not attend appointments.

Staff knew how to recognise safeguarding concerns and was aware of the trust's protecting and safeguarding children policy. The safeguarding children team provided frontline staff with advice and support from the concept of early help to the protection of children at significant risk of harm.

All Lancaster CAMHS staff had completed children's safeguarding training level one and 13 out of 15 staff had completed level two. At Chorley and South Ribble CAMHS nine out of ten had completed children's safeguarding training level one and eight out of ten had completed level two. Also, both teams had staff that had completed more in depth training safeguarding courses about families and children. Staff reported that Lancaster CAMHS held monthly group safeguarding meetings where they discussed issues and any lessons learnt from incidents.

Lone working procedures were in place. The teams had developed systems and processes to make sure that staff were safe when visiting families and young people in the community.

Staff did not store or dispense medication at the services. In the event of a medical emergency staff contacted the emergency services.

Track record on safety

The trust had a safeguarding performance framework, designed to support and provide evidence of engagement with safeguarding processes. This provided an overview of the training and safeguarding engagement by staff for senior management to monitor and review. The report for 1 January to 31 March 2015, showed Chorley and South Ribble CAMHS staff were involved in 75 cases that also involved the Lancashire Multi Agency Safeguarding Hub (MASH).

The trust's safeguarding annual report for 2013/2014 stated the trust had contributed to eight children serious case Reviews (SCR).

From May 2014 to March 2015, Chorley and South Ribble CAMHS had reported one serious incident and Lancaster CAMHS reported no serious incidents. A serious incident is an event where the potential for learning was so great, or the consequences to patients, families and carers, staff or organisations was so significant, that they require a comprehensive investigation and response.

Reporting incidents and learning from when things go wrong

Staff reported any incidents using the electronic data system. Staff graded the incidents by the level of severity grade from one to five. Team leaders were responsible for conducting local investigation reviews for levels one to three incidents within seven working days. For level four and five incidents, managers completed an investigation within three days and reviewed by the executive serious incident review panel, so it could be determined if further investigation was necessary. This was to identify learning and to make changes in service and care delivery.

Data provided by the trust showed that staff had reported incidents using the electronic system. For example, Chorley and South Ribble CAMHS reported 27 incidents between 1 October 2014 and 15 January 2015. Lancaster CAMHS reported 10 incidents between the 1 January and 31 March 2015. The types of incidents involved governance or patient safety.

Lancaster and Chorley and South Ribble CAMHS had a weekly team meeting where lessons learned from incidents were cascaded to staff. However, three staff at Chorley CAMHS reported that they had not had any recent feedback about incidents.

Staff had an awareness of the duty of candour. Information about duty of candour had been cascaded to team leaders in governance meetings. The team talk also provided staff with learning from incidents and transparency. In January 2013, learning from an inquiry at another trust was included in the team talk. The team talk was a trust news bulletin for staff. The duty of candour is a legal duty on hospital, mental health and community trusts to inform and apologise to patients if there have been mistakes in their care that might have led to significant harm.

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.

Summary of findings

We rated effective as good because staff had:-

- understood and addressed the problems presented by the young person and their families.
- mostly completed comprehensive and timely assessment of young people's needs.
- completed care records that were personalised, holistic and recovery focused.
- delivered care and treatment based on the young people's needs.
- assessed young people and referred them to specialist services.
- participated in clinical audits, to look at whether the services had met National Institute for Health and Care Excellence (NICE) guidelines in December 2014, for depression and attention deficit hyperactivity disorder.
- held case review meetings as and when they felt it was necessary to discuss and explore the options for care and treatment.
- had a good knowledge of the Mental Capacity and Mental Health act.

However we also found that improvements should be made because:-

- the staff followed only two care pathways. A care pathway is, the anticipated care placed in an appropriate time frame, written and agreed by a multidisciplinary team. Clinicians agree the pathways based on clinical evidence. They help to inform the patient, with a specific condition or diagnosis and staff of the expected progression through the clinical experience.
- Team leaders had no consistent system to monitor the uptake of clinical and management supervision of staff. Evidence of a monitoring system was provided by the Lancaster and Morecambe team. However, there was no evidence available for Chorley and South Ribble team. Clinical supervision is an important tool for checking that Young people have received the appropriate care and treatment.
- compliance with staff's annual appraisals was poor. At Lancaster CAMHS only 50% of staff had completed appraisal, and the trust could not give figures for the Chorley and South Ribble service.

Our findings

Assessment of needs and planning of care

We looked at 23 young people's assessments, which had been undertaken when they began using the service, and observed staff carrying out eight consultations. We saw staff assessed young people, children's and family's mental health needs sympathetically and thoroughly. Staff carried out timely and comprehensive assessment at the young people's and family's pace. If unable to complete the assessment during the initial consultation, staff offered further meetings. Staff planned for care and treatment during the meetings and agreed any further actions with the young person and their family.

At the initial assessment, staff referred young people to other practitioners in the team where they required specific interventions. Examples of specialist interventions were family therapy, cognitive behaviour therapy and play therapy.

To ensure the young person's safety, staff shared the information of risk and actions taken, by letter, with the young person's GP or school if appropriate. Administration staff monitored the mailing of the letters to make sure the letters went out promptly.

Staff kept detailed records of the consultations on the electronic system. All of the information needed to deliver care was stored securely and was available to staff in an accessible form. However, we observed that staff found the electronic system difficult to navigate when locating scanned information. In addition, the electronic system was not shared with the adult mental health services. This meant when a young person transferred to adult services, staff from adult services may have found it difficult to access information easily.

Best practice in treatment and care

The CAMHS teams delivered care and treatment based on the young people's needs. During the initial assessment, staff planned and agreed young people's care and treatment. We observed staff during consultations understood, addressed, and articulated the type of problems presenting by the young person and their families.

Staff described two types of care pathway, learning disability and self-harm. However, staff said they did not

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.

follow any other care pathways. This meant that the senior managers could not always ensure there was a consistent approach to treatment and care of young people who had other mental illnesses.

CAMHS services had high intensity workers or psychological wellbeing practitioners, who provided psychological therapies to young people, such as cognitive behaviour therapy

We observed the staff carrying out routine outcome measures (ROMS) with young people. ROMS measure the severity of the young person's mental illness. ROMS were questions that can be completed by the young person, the carer or the clinician, at the beginning and end or during the interventions by staff. The trust informed us that staff always uses ROMS in their clinical practice. Information showed that the trust was working towards meeting a national target of 90% for the child and young person's improving access to psychological therapies (IAPT), which was measured by a minimum of two paired ROMS. The service was under target and had reported 48% compliance of paired ROMS in April 2015, which was below the trusts own target of 60%.

In response, the trust had implemented actions to improve this. Also, at Lancaster CAMHS in October 2014 the consultant psychiatrist had carried out a clinical audit of the use of ROMS at Lancaster CAMHS. The use of outcome measures helps the staff to review young peoples progress and assists the clinicians by helping them recognise if young peoples treatments are working.

The service offered a range of groups and specialist clinics to meet young people's needs. These included incredible years, eating disorders play therapy and family therapy.

In December the clinical staff had participated in clinical audits, to look at whether the services had met National institute for health and care excellence guidelines for depression and attention deficit hyperactivity disorder.

Skilled staff to deliver care

Staff had the qualifications and skills they needed to carry out their roles effectively. However there were gaps in mandatory training uptake.

Staff we spoke with were mostly positive, motivated and passionate to provide good quality care. We observed seven consultations and found the staff were skilled and motivated.

The team included a range of mental health disciplines required to care for the young people and their families. These included; consultant psychiatrists, social workers, teachers, nurses, occupational therapists, and a transition worker.

Nursing staff had completed role specific training such as management training, self-harm, route cause analysis, and ROMS.

33% of staff had trained as high intensity workers or psychological wellbeing practitioners. At Lancaster CAMHS three staff had trained in cognitive behavioural therapy and one in parenting. At Chorley and South Ribble CAMHS one had completed cognitive behaviour therapy and one parenting.

Staff reported having received management and clinical supervision suitable to their work. Team leaders had no consistent system to monitor the uptake of clinical and management supervision of staff.

Evidence of a monitoring system was provided by the Lancaster and Morecambe team. However there was no evidence available for Chorley and South Ribble. Clinical supervision is an important tool for checking that young people have received the appropriate care and treatment.

The trust provided information to demonstrate that all of the consultant psychiatrists had completed revalidation to ensure they were skilled at their roles.

Figures provided by the trust identified gaps in staff having received an annual appraisal. As of the 15th of May 2015, Lancaster CAMHS had only completed 50% of staff appraisal, and the trust was unable to provide us with any statistics for the Chorley and South Ribble service. The overall compliance for the children's and families network was 25%. Annual appraisal enables the managers to review the staff's performance, to ensure their competency and develop a training plan to ensure they update or develop their skills.

Multi-disciplinary and inter-agency team work (MDT)

A multi-disciplinary team (MDT) is a group of health care and social care professionals who provide different services for patients in a coordinated way. Members of the team may vary and will depend on the patients needs and the condition or disorder being treated.

Are services effective?

Good 

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

Staff described a multi-disciplinary and collaborative approach to care and treatment. Staff said they would discuss cases and would seek out and ask advice from the specialists in the team. The teams included consultant psychiatrists, consultant psychologists, junior doctors, social workers, nurses, and occupational therapists.

We found there was an inconsistent approach in determining the regularity of MDTs. The trust provided us with the tier three RAG rating standard operating procedure (a traffic light system). The CAMHS services introduced the procedure when they identified from incidents that a regular multi-disciplinary review of cases was necessary for the care co-ordination, care planning and management of risk for young people and their families. Using a traffic light system, it recommended how often the staff should review cases and how to document the reviews. For example, it recommended staff discussed and reviewed high-risk 'red' cases monthly or more regularly if required.

However, we found that the Chorley and South Ribble team did not hold a regular MDT meeting or discussed the use of the RAG rating procedure to schedule case reviews. Instead, staff in Chorley and South Ribble team described holding meetings between professionals involved in the clinical care of young people, as and when they felt it was necessary to discuss and explore the options for care and treatment. Lancaster and Morecambe team have a weekly MDT meeting. These are called case review meetings and each child discussed has a record documented.

In young people's records, we saw examples of referral and discharge letters, which informed the receiver about the young person's care and their changing needs. For example, letters to GP's, school nurses and the local authority.

We were told there was a good working relationship with the transition team. The transition team helped young people who had received assistance from CAMHS and reached the age of 16, to move on to and get the support they needed from Adult Mental Health Services.

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

Staff reported they had regularly up dated Mental Health Act 1983 and Code of Practice training. Data provided by the trust showed the compliance levels with training were 85% for Lancaster CAMHS and 66% for Chorley and South Ribble CAMHS.

At our inspection, no young people were subject to a community treatment order.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act does not apply to young people aged 16 and under. For children under the age of 16, staff decided upon their decisions making ability using the Gillick competence test. The concept of Gillick competence recognises that some children may have a sufficient level of maturity to make some decisions themselves. Consequently, when working with children, staff should be assessing whether or not a child has a sufficient level of understanding to make decisions.

All of the staff had received training in the Mental Capacity Act.

At the CAMHS services, we observed staff informed, agreed, and explained consent during the initial assessment with the young person and their families and staff recorded in the consultation notes.

Generally, families were involved in the consultations and the young people agreed to their involvement. The families' involvement and understanding was necessary to safeguard the young people when they went home. However, staff explained where the young person had decided they did not want their families to be involved; staff used Gillick competence test and an assessment of risk to ensure the safety of the young person.

Are services caring?

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

Summary of findings

We rated caring as good because:

Staff:-

- treated young people with kindness, dignity, and respect by staff support.
- worked in partnership with young people and their families.
- sent letters to inform young people about care and treatment.

The trust:-

- implemented the friends and family questionnaire to provide young people with the opportunity to share their experience of the services,
- provided verbal and written information that enabled young people to understand their care was available to meet their specific communication needs.

Our findings

Kindness, dignity, respect and support

We observed eight consultations and spoke with 24 young people and families. During the consultations, we saw staff treated young people with compassion and respect, and built a rapport with the young people. They listened to the young people and their families and offered appropriate practical and emotional support.

The young people and families we spoke with made very positive comments about the staff. They described the staff as being “fantastic”, they “listened to [them]”, “made a difference”, “were responsive”, “flexible” and “interested in their welfare”

The involvement of people in the care that they receive

Staff involved young people and their families as partners in their care and in making decisions. We observed that staff sought young people’s agreement throughout the consultation. Young people and families told us that staff shared information with them about their care and treatment and fully consulted them about any decisions made. We saw there was active involvement and participation in planning their care and treatment and agreeing the potential risks. Young people said they had received letters to inform them about care and treatment

Verbal and written information that enabled young people to understand their care was available to meet their specific communication needs. This included the provision of written information in different formats and interpreting services.

Young people and families had a variety of ways to provide feedback about the service. The teams had suggestion boxes in reception so young people could raise any issues about the service. The routine outcomes measures also ask the young people and families about their experience of the service.

Are services responsive to people's needs?

Requires improvement 

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

Summary of findings

We rated responsive as requires improvement because:

- children and adolescents had long waits for appointments. For example, Chorley and South Ribble CAMHS had a waiting time of 29 weeks from referral to assessment for non-urgent cases. Following the initial assessment by staff, young people had to wait 24 weeks to see a psychiatrist, 18 weeks to see a psychologist, 10 weeks for family therapy and 54 weeks for an autistic spectrum disorder assessment.
- the trust did not have a current protocol for staff to follow when young people moved from CAMHS services to adult mental health services at 16 years. This meant that young people may have had an inconsistent approach to their care and treatment.
- CAMHS staff were unavailable outside of normal working hours, to assess young people with mental health problems at Lancaster, Blackpool and West Lancashire A&E departments as this is not currently commissioned to be provided by Lancashire Care. This meant that young people might wait as long as three days to be seen by a specialist at a weekend.

However we also found areas of improvements and good practices. For example:-

- the trust had identified a need to improve the transition of young people to adult mental health services and had responded to this by the provision of training.
- at both services, the facilities promoted the comfort, recovery, dignity, and confidentiality of the young people.
- young people and families knew how to make a complaint or raise a concern about the service and these had been responded to.

Our findings

Access and discharge

When young people presented at accident and emergency department with mental health problems, the A&E staff

admitted them to a children's ward, for a place of safety and for an assessment of their mental health needs. From Monday to Friday, the CAMHS staff would see young people within 24 hours.

At Preston hospital, CAMHS services were available out of hours to make sure CAMHS staff assessed young people promptly. The local clinical commissioning group (CCG) commissioned this service, as the provision of out of hours support was not included in the trusts normal contract.

The local CCG had not commissioned this service therefore at Lancaster, Blackpool and West Lancashire hospitals, CAMHS staff were not available out of normal working hours. Therefore, if a young person presented at A&E department on a Friday at 6 pm, CAMHS staff would not assess them until Monday morning at the earliest. This could be longer during bank holidays. This meant a young person admitted to the children's ward for assessment due to self-harm or acute mental health problems, may put themselves and others at risk due to lack of a mental health assessment and the inappropriate environment.

The CAMHS teams operated a duty system. The duty staff triaged the referrals, reviewed the information, and prioritised the referrals according to potential risks. They signposted young people to other services or made an appointment for an initial assessment. When staff assessed young people as high risk, they saw them within the next seven days.

For the first three months in 2015 Lancaster CAMHS received an average of 50 referrals each month and accepted more than 50%. For example in March 2015, staff accepted 29 out of 55 young people referred to the service. For the first three months in 2015 Chorley CAMHS received an average of 100 referrals each month and accepted between 70% and 80%. For example in March 2015, staff accepted 95 out of 117 young people referred to the service.

The clinical service manager and team leaders explained they had found Chorley CAMHS, team were operating a lower threshold for accepting patients into the tier three services. In addition, the team accepted referrals for young people and children for autistic spectrum disorder (ASD) assessments. The clinical service and team leader acknowledged this had affected the waiting lists at the Chorley and South Ribble service. In response to ensure a consistent approach and adherence to the specific

Are services responsive to people's needs?

Requires improvement 

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

requirements to access the service, the team leader reviewed all of the referrals each day. The clinical and business service managers were also in discussions with the local commissioners to ensure adequate funding for the ASD assessments.

In January 2015, staff at the Chorley and South Ribble service saw 82% of young people referred to the service within 18 weeks. At Lancaster CAMHS staff saw 97%. At our inspection visit Chorley and South Ribble CAMHS had a waiting time of 29 weeks from referral for non-urgent cases for initial assessment. In response, during the inspection, the trust had recruited a new team manager to review the service, and recruited four new staff to reduce the waiting lists. They also planned to commence overtime clinics for two evening a week to reduce the waiting times. In addition, they planned to speak with all of the young people and families on the waiting list to check whether they still required their appointment.

Some young people received the treatment they needed during the initial assessments. Where young people needed more specialised treatments, staff referred them to specialist staff working in the service. At Lancaster CAMHS, the team leader operated a system to make sure a young person, following an initial assessment, did not have a further wait for specialist treatments. However, in Chorley and South Ribble CAMHS following the 29-week wait for the assessment young people had to wait longer to access specific treatments. For example:-

- Young people with an autistic spectrum disorder (ASD) had to wait 54 weeks for an ASD assessment, and 107 young people were on the waiting list. All would have an allocated case coordinator from the CAMHS team until referred to the specialist team for assessment and treatment. However, without this assessment the child may not have been able to access the help they needed in education.
- For family therapy, families had to wait 11 weeks. Six families were on the waiting list at the time of our inspection.
- Young people had to wait 24 weeks to see the consultant psychiatrist, and 32 were on the waiting list. The waiting list included young people who were waiting for a diagnosis of ADHD from the psychiatrist so they could access other agencies and services.

- Eight families told us they had to wait to access the services. They did not tell us the exact waiting time.

We reviewed four young people's records and found these demonstrated that CAMHS staff had liaised with adult mental health service staff when young people transferred. The transition officer and clinical service manager explained Lancashire Care Foundation Trust CAMHS operated a service for children aged five to 16 years. The trusts policy was that young people transferred to adult mental health services at the age of 16, regardless of whether or not they had completed year 11 at school (final year of GCSE). The exception was of young people with a learning disability who transferred at 18 years of age.

This sometimes meant the adult mental health services refused a service to young people. This was because of the different threshold for accepting patients referred to adult mental health services. For example, the adult mental health service did not accept referrals for young people whose only mental health issue was autism. In addition, when they assessed the risk and severity of depression they did not include the consideration of the impulsivity of the young person.

Managers explained that the trust had identified the issues with the transition pathway, and in response, incorporated a review of transition in their local performance targets, (Commission for quality and innovation payment framework). This had resulted in providing staff with training and the allocation of current staff as young people's champions within each adult mental health team.

When we reviewed the protocol that describes how staff should transfer a young person to adult services we found this document was out of date and did not reflect current practices. A protocol provides staff with a consistent approach to follow, and if it is not current, young people may be provided with an inconsistent approach to their care and treatment. In addition, the trust did not monitor how many young people who were referred from CAMHS to adult mental health services had been refused a service, as a means to identify any need for further improvements. This meant the trust had no means of knowing what happened to their patients once discharged from CAMHS, with on going mental health issues.

Both teams reported the services core hours were from 9 am to 5 pm Monday to Friday. However the service also

Are services responsive to people's needs?

Requires improvement 

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

operates regular evening clinics to ensure flexible service delivery. Most young people would visit the service. However, staff also arranged to see young people at home or at school.

The facilities promote recovery, comfort, dignity and confidentiality

At both services, we found the facilities promoted the comfort, recovery, dignity, and confidentiality of the young people. The reception areas contained play equipment and information to inform young people about the CAMHS. Rooms were available for individual consultations, play therapy, group therapy and video assessments.

Meeting the needs of all people who use the service

There was access to an interpretation service where the young person's first language was not English.

Listening to and learning from concerns and complaints

From the evidence we reviewed we concluded that staff listened to the concerns and complaints of young people and their families. The trust had a complaints procedure that was summarised in leaflets and on their website. The information was available in easy read format and other languages, such as Urdu, Polish, Gujarati. Both services had a suggestion/complaints box in reception. Young people and their families also told us they knew how to make a complaint.

Staff responded to complaints with the assistance of the customer care department, whose role was to process and manage complaints, concerns, and compliments. The customer care team worked with the investigation leads to improve quality and to review investigations on request. Team and clinical managers carried out the investigations into the complaints.

Where young people and families had raised concerns, the managers had responded and changes were made to the service. For example, information provided by the trust showed that Lancaster CAMHS had received two complaints between March 2014 and February 2015. The trust had upheld one of the complaints regarding the services response to an urgent referral. This had resulted in the service commencing a duty system to ensure staff responded to all urgent referrals. Chorley and South Ribble CAMHS had received four complaints and the trust had upheld all of the complaints. Of these families one family had complained following transition to adult mental health services, where the young person's needs had not been met and others had complained about waiting times. The trust had recently taken action to reduce the waiting lists.

At Lancaster CAMHS, the team leaders had informed staff about any lessons learnt from complaints at the team meeting. However, at Chorley and South Ribble CAMHS, three staff said they felt uninformed about the responses to complaints.

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.

Summary of findings

We rated well led as requires improvement because:

- compliance with mandatory training was below expected levels.
- neither service had an up-to-date environmental risk assessment. Chorley CAMHS did not have an up-to-date infection control audit.
- staff were unaware of the trust's risk assessment policy and used different ways to record information about risks.

However

The trust had:-

- in response to issues identified, made significant changes to the management structure of CAMHS in the three months prior to the inspection,
- used comprehensive reviews of the performance monitoring and risk register, to identify and respond to organisational risks. Staff had the ability to submit items to the ward risk register.

Staff :

- felt well supported by the team leaders
- had identified issues and put new systems in place to monitor compliance and improve services. The changes were new and staff had not fully embedded them in their practices.

Our findings

Vision and values

We talked with 25 staff. Most did not comment about the trust's vision and values, or about their communication with the senior managers. However, we observed that staff followed the trust values of teamwork, compassion, integrity, respect, and intelligence when carrying out their work.

Staff we spoke with were motivated and dedicated to give the best care and treatment they could to young people and children.

Staff knew who the senior managers in the organisation were and commented about the presence of the service managers within the services.

Good governance

The governance systems informed senior managers of any issues or risk of poor performance. The team leaders reported to the tier three governance meeting. This fed into the overall CAMHS governance meeting, and this reported to the child and families' network board, chaired by the director. The meetings reviewed the teams' monthly performance and risk registers.

The trust provided a comprehensive performance monitoring report for March 2015. This showed that the trust had developed actions to improve all of the issues identified. Staff had the ability to submit items to the ward risk register. The children and families' network risk register identified the waiting lists and the poor compliance with mandatory training.

The trust had made significant changes to the management structure of CAMHS in the three months prior to the inspection. The trust had recently appointed the clinical business manager, whose role was to streamline systems and processes to ensure a consistent approach throughout CAMHS. At Chorley CAMHS the team leader started work during the week of the inspection. On our return to the service, the team leader had identified areas where they acknowledged improvements needed to be made and had taken action. For example, they had implemented the employment of four new staff and overtime clinics to reduce waiting lists. Also, they were monitoring the referrals to ensure they met the services criteria.

Young people said they would recommend the service and they were actively participating in decisions about their care and treatment. Safeguarding young people was a priority and incidents reported and investigated. Learning from incidents was evident. Staff had listened to complaints, responded and made improvements to services.

However, whilst we recognised that new staff had identified issues and put new systems in place, to improve services. These had not had the time to embed and there were underlying problems. At the time of our inspection, the compliance with mandatory training and annual appraisal was poor. The waiting times for appointments were sometimes long for young people. Staff were not aware of, or had not adhered to, the risk assessment and transition protocols which could have led to an inconsistent approach by staff. Environmental and infection control

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.

audits were not in place. In addition, young people admitted to an A&E department could have to wait a considerable time before staff assessed their mental health needs.

Leadership, morale and staff engagement

There had been recent changes to the leadership and staff we spoke with talked very positively about the changes and developments. Staff did not mention low morale or lack of job satisfaction. However, some felt pressured by the waiting lists, and the trust's slow response to their concerns about them. Although we heard about some frustrations, we did not hear from staff that they felt harassed or bullied in the work place and many at Chorley and South Ribble CAMHS were positive about the changes. All the staff felt able to raise concerns without fear of victimisation.

The sickness and absence rates were low - 3.4% at Lancaster CAMHS and 6.4% at Chorley and South Ribble CAMHS. Team leaders explained this often equated to one member of staff on long-term sick leave. Both teams reported that they worked well together and had support from their colleagues.

The trust had introduced 'Dear Derek', an online form on the trust's internet to enable any member of staff to raise a concern quickly, effectively and in confidence to the trust's chairman about any wrongdoing or poor practice they had seen.

Staff confirmed they had the opportunities for development such as the CAMHS diploma and the IAPT training.

The staff were kept informed of developments; they had team meetings weekly and the trust cascaded information using a weekly document called pulse and a magazine called insight.

Commitment to quality improvement and innovation

We found that the trust had systems in place to monitor the quality of the services. For example:-

- The childrens and families' network had a specific operational plan for 2015 to 2016 for CAMHS. This included a review of the weakness, strengths, opportunities, and threats of the CAMHS tier three and four services.
- There was evidence of the trust managing the performance and quality of the service. This included the monthly performance report that included the information about waiting times to access services. In addition, the trust had recently introduced the quality, safety, experience, effectiveness, and leadership (SEEL) to monitor the trusts compliance with CQC outcomes.
- Staff had carried out clinical audits to drive improvements.

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

Neither CAMHS had an up to date environmental risk assessment to ensure the environments posed no potential risks to young people or children.

This is a breach of Regulation 17 (2) (b).

To ensure the environments posed no potential risks to young people, children, or staff, the trust must ensure that environmental risk assessments are completed at Chorley and South Ribble and Lancaster CAMHS.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Young people could be at risk because the number of staff that had completed training was below expected standards at both Chorley and South Ribble and Lancaster CAMHS.

This is a breach of Regulation 18 (2)(a)

The trust must ensure that all staff working in Chorley and Lancaster specialist community health services for children and young people have completed the necessary training to enable them to perform their work safely

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

We found that the transfer of young people to adult mental health services was not working effectively. There was no current protocol for staff to follow and inconsistency in practice.

This is a breach of Regulation 12 (2) (i).

The trust must ensure that there is a protocol in place for the transfer of young people from CAMHS to adult mental health services and that this is fully adhered to by staff to ensure the health, safety and welfare of service users.