

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)
RW5HQ	Sceptre Point	Ellen House, Preston child and adolescent mental health services	PR1 7RH
RW5HQ	Sceptre Point	Westgate House, West Lancashire child and adolescent mental health services	WN8 6DS

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.

Summary of findings

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

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

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Lancashire Care NHS Foundation Trust specialist community child and adolescent mental health services as **good** because:

- All parents and young people said staff were welcoming, caring and respectful and listened to them. They found the service helpful and described positive change that had occurred after contact with the service. Parents could easily contact staff and found the teams responsive to their needs.
- Governance structures were in place to monitor performance targets and risk. Key performance indicators were used to assess the effectiveness of the service offered to young people. Most teams met the trusts target of 18 weeks waiting time from referral to assessment. Issues affecting waiting times such as staff performance, sickness and vacancies were monitored and addressed promptly.
- Staff employed by the service had good compliance with mandatory training, supervision and appraisals and had opportunities for specialist staff training and development. Child and adolescent mental health services had a range of suitably qualified staff who offered a choice of therapies to young people and their families.
- Staff had a clear understanding of the trusts safeguarding procedures. Safeguarding systems were in place to support staff in the safeguarding process and monitor safeguarding incidents across the trusts children and families network. Staff had a good understanding of issues of consent and Gillick competence in their work with young people.
- Staff had a good understanding of National Institute of Health and Care Excellence guidance and other national guidance. Nine evidence based care pathways had been developed and were in the process of being introduced across the service.
- Staff described effective communication and referrals between services, such as local schools, social workers, GPs and health visitors. Systems were in place to support young people transitioning to adult services. The effectiveness of these systems was subject to ongoing review.
- Information about how to complain was readily available to young people and their families. Complaints were dealt with promptly and monitored across the children's and families network. Parents, young people and staff were aware of the independent advocacy service. Child friendly posters and the trusts website gave comprehensive advice on how to access independent advocacy services.
- Staff felt valued and supported by their colleagues and were aware of the senior management team within the trust.

However:

- Not all young people had an up to date current risk assessment present in their care records. This meant young people were at risk of receiving care that did not take into account identified risks.
- The service did not collate quality measures in relation to primary reason for referral making it difficult to assess condition specific waiting times in line with National Institute of Health and Care Excellence guidance.

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:

- Not all young people accepted into the service had an up to date risk assessment present in their care records. This meant that patients were at risk of receiving care that did not take into account identified risks.

However:

- Risk monitoring systems were in place to assess risk for those young people on the waiting list and young people new to the service from April 2016.
- The service had good rates of compliance with mandatory training and staff felt supported to attend specialist training.
- Procedures were in place to support safeguarding and staff were clear about their safeguarding responsibilities. Good monitoring and review processes were in place to monitor safeguarding for children across the trust which complied with local safeguarding children board procedures and the Children's Act.
- All staff understood how to report incidents, serious incidents were reviewed in a timely manner and action planning was in place to reduce the likelihood of reoccurrence.
- Each location was clean and well maintained. Staff had systems in place to keep them safe such as alarms within the building to summon assistance, effective lone working practices were in place and staff had access to personal protective equipment.

Requires improvement



Are services effective?

We rated effective as good because:

- Staff had a good understanding of national guidance and had a National Institute of Health and Care Excellence champion who made sure their team was aware of and up to date with the latest guidance.
- Care pathways developed in line with national guidance had been identified and were being introduced across the child and adolescent mental health services service to ensure consistency of approach in clinical care.
- A range of therapies were offered and routine outcome measures were used to inform the effectiveness of the interventions offered to young people.

Good



Summary of findings

- Staff followed clear procedures for gaining consent to treatment and young people and their families' detailed good access to information to ensure they were well informed to make these decisions.
- There was a range of suitably qualified staff with the skills and experience to carry out their roles.
- The teams used a multidisciplinary and collaborative approach to caring for young people and had introduced new roles to support young people in the transition process to adult services.

Are services caring?

We rated caring as good because:

- All parents and young people said staff listened to them, were open and welcoming, positive and respectful. All young people and parents said they found the service helpful and described positive changes that the support and treatment they had received had brought about.
- Parents said they could easily contact staff and described staff as supportive of the whole family not just the young person receiving care.
- The trust routinely collected experience of service questionnaires from children, young people, parents and carers. A high number of these were returned, most of which had positive feedback.
- Young people could access support groups outside of their treatment and parents described being signposted to helpful local initiatives.
- Parents, young people and staff were aware of the independent advocacy service available, information on how to access this was available in waiting areas and on the trusts website.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- The service monitored target times of 18 weeks referral to assessment, when target times were falling below this standard action planning was put in place to address issues such as staff sickness and vacancies.
- Urgent referrals were prioritised and young people were seen in a timely manner.

Good



Summary of findings

- Child and adolescent mental health monitored the numbers of patients who did not attend appointments and employed strategies to reduce this. The number of appointments where patients did not attend was low.
- Appointment times were flexible and responsive in terms of urgency of need. Appointments ran on time and young people and families told us they were rarely kept waiting.
- Waiting rooms for young people and adolescents across both sites were comfortable and spacious.
- The service had undertaken measures to improve transition for young people into adult services.
- Young people and their carers were aware of the complaints process and information was available in child friendly formats and different languages.

However:

- The service did not collate quality measures in relation to primary reason for referral making it difficult to assess condition specific waiting times in line with National Institute for Health and Care Excellence guidance.

Are services well-led?

We rated well-led as good because:

- Staff said they enjoyed and felt proud to work for the organisation.
- Governance structures were in place to monitor performance targets and risk. Team leaders cascaded information to the teams and were active in subsequent action planning to improve .
- Key performance indicators were used to assess the effectiveness of the service offered to young people.
- The trust maintained good rates of staff compliance with mandatory training, supervision and annual appraisals.
- The services had low levels of staff turnover and good systems to monitor and respond to sickness and absence.
- Most staff said their colleagues and managers were supportive and that they felt valued.

Good



Summary of findings

Information about the service

Child and adolescent mental health services is a term used for all services that work with children and young people who have difficulties with their emotional or behavioural wellbeing. Child and adolescent mental health services deliver services in line with a four-tier strategic framework which is the basis for planning, commissioning and delivering services.

Tier 2 and 3 child and adolescent mental health services are multidisciplinary teams working in community mental health clinics. They provide specialised services for children and young people with severe, complex and persistent disorders.

Lancashire Care Foundation Trust community child and adolescent mental health services provided tier 2 and 3 services in Lancaster & Morecombe, Fylde and Wyre, Preston, Chorley South Ribble and West Lancashire.

Our inspection team

Our inspection team was led by:

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

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

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

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

Why we carried out this inspection

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

These services were last inspected between 28 and 30 April 2015. At the time of the last inspection these services were rated as requiring improvement.

We inspected the specialist community mental health services for children and young people using a comprehensive approach and rated this core service as requires improvement for safe responsive and well led.

Young people had long waits for appointments and transfer to adult mental health services was not working effectively. Neither teams visited had up to date

environmental risk assessments to ensure a safe environment for young people visiting the service. Too few staff had completed mandatory training and undertaken supervision and annual appraisal. Recording of risks to young people was undertaken inconsistently and staff were unaware of the trusts risk assessment policy.

Following the inspection in 2015 we issued three requirement notices, which related to good governance, staffing and safe care and treatment. The trust provided an action plan telling us how they would improve the issues identified and included an action plan to address them.

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?

Summary of findings

- Is it well-led?

During the inspection visit, the inspection team:

- visited two community teams at Preston and West Lancashire and looked at the quality of the environment and observed how staff were caring for patients
- spoke with 4 patients who were using the service and 10 parents/carers
- spoke with the managers or acting managers for each team

- spoke with 9 other staff members including nurses and social workers

- attended and observed one therapeutic meeting

We also:

- looked at 15 care and 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

All parents of the young people using the service we spoke with described how staff had helped them bring about positive change. They described the staff at the service as pleasant, helpful and accommodating to their needs. They praised the therapeutic input from staff and

described how staff had signposted them to other helpful resources and groups in their areas. Several parents described the staff as 'life savers' and commented on a 'wonderful' service despite economic pressures.

Good practice

Work had begun to introduce a more participative approach to care across all community teams. A well-established group of former patients and carers from tier 4 services called the CREW were instrumental in

developing a participation strategy across community services and involvement in engagement workshops to introduce the concept of what good participation looked like to staff at all levels.

Areas for improvement

Action the provider **MUST** take to improve

The trust must ensure risk assessments are completed for all young people utilising the service including young people who had been with the service prior to April 2016.

Action the provider **SHOULD** take to improve

The trust when collating quality measures should consider collating information in relation to the primary reason for referral to assess condition specific waiting times in line with national guidance.

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
Ellen House	Sceptre Point
Westgate House	Sceptre Point

Mental Health Act responsibilities

We did not inspect or report on Mental Health Act responsibilities. There were no young people, who were subject to a community treatment order.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental capacity is the ability to make an informed (having appropriate information) decision based on understanding a given situation, the options available, and the consequences of the decision. Just because someone is not able to make one decision, this does not mean they cannot make other decisions. People should always support a person to make their own decisions if they can do so.

The act does not apply to people under the age of 16. Gillick competence is the term used in British medical law to decide whether a child of 16 years or younger is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Children under 16 can consent to medical treatment if they understand what is being proposed. It is up to the doctor to decide

Detailed findings

whether the child has the maturity and intelligence to fully understand the nature of the treatment, the options, the risks involved and the benefits. A child who has such understanding is considered Gillick competent.

Children under 16 years who are not Gillick competent and very young children cannot either give or withhold consent. Those with parental responsibility need to make the decision on their behalf.

Children aged 16 and over were presumed to have capacity and able to consent or refuse to treatment in their own right. Most of the Act applies to young people aged between 16 and 17 years, who may lack capacity to make specific decisions.

People carrying out acts in connection with the care or treatment of a young person aged between 16 and 17 who lack capacity to consent should take reasonable steps to establish that the young person lacks capacity, reasonably believe that the young person lacks capacity and that the act is in the young person's best interests, and follows the act's principles.

When assessing the young person's best interests, the person providing care or treatment must consult those involved in the young person's care if practical to do so and anyone interested in their welfare. This may include the young person's parents.

Staff were able to access training in the Mental Capacity Act. Young people, parents and carers said staff asked for consent to treatment. The trust had a detailed consent to treatment policy and procedure that included guidance for clinicians on competence, consent, and refusal of treatment for children and young people; the procedure for obtaining consent for people aged 16 to 18 years; and the procedure for obtaining consent for people aged younger than 16.

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

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

We visited Ellen House in Preston and Westgate House. Interview rooms were fitted with alarms, which would alert staff should assistance be required. There were no designated clinic rooms at either service. However, there were facilities to measure the height and weight of the young people using the service.

The trust had effective lone working procedures in place. Staff told us there would always be someone else in the building when appointments were taking place. If they were visiting service users at home, they would alert the office when they were leaving the appointment.

Each location was clean and well maintained. An external provider carried out cleaning and maintenance. Maintenance logs showed that any repairs required were carried out within set timescales, which were dependent on the type of work required. All the necessary checks were carried out which included for example, legionella, fire extinguishers, fire alarms and gas.

Staff had access to personal protective equipment, which included gloves and anti-bacterial gel, although staff told us this equipment was very rarely needed.

Safe staffing

Staff at Ellen House and Westgate House used the six steps workforce planning model to estimate the number and grade of nurses required for each team.

Staffing establishment levels for Ellen House:

- Nurse Band 5: one
- Nurse Band 6: seven
- Nurse Band 7: one
- Family Therapist Band 7: one
- Occupational therapist Band 7: one

Staffing establishment levels for Westgate House:

- Nurse Band 5: two
- Nurse Band 6: six

- Nurse Band 7: one

Caseloads varied across each location, at Ellen House the largest caseload of 120 was managed by one whole time equivalent member of staff supported by two other part time members of staff. At Westgate House, the largest caseload of 87 was held by the consultant psychiatrist who was supported in case management by the team. The highest caseload held by a care co-ordinator was 82 who was supported by two other members of staff including a band 5 and a band 7 who was the attention deficit hyperactivity disorder lead.

Caseloads were managed and reassessed regularly by team leaders and discussed with staff at supervision, however two staff we spoke with at Preston child and adolescent mental health services felt their caseloads were high and due to sickness within the team supervision sessions had not always taken place.

Staff told us that when they were on annual leave service users and their parents would be advised of whom they should contact should they need assistance during that time. When absences occurred at short notice other members of the team would try to cover appointments. However, this was not always possible therefore appointments may have been cancelled.

The Preston child and adolescent mental health services team had 15 substantive staff with one leaver in the period previous 12 months from 30 April 2016, and the average permanent staff sickness was 0.8% for the same time period. The West Lancashire child and adolescent mental health team had eight substantive staff with three staff leavers in the 12 month period prior to 30 April 2016 with six percent sickness. All vacancies had since been filled.

The trust used agency staff at the one of locations we visited. This was a temporary measure whilst a vacant post was being filled. The agency staff was suitably qualified and able to provide cover for the period required. There was no psychiatrist cover out of hours for the community mental health services for children and young people. If service users needed urgent assistance out of hours, they would need to attend accident and emergency where there was an on call psychiatrist from the children and young people's inpatient services.

Are services safe?

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

Assessing and managing risk to patients and staff

We reviewed 12 care records at Ellen House and three care records at Westgate House. We found only three formal risk assessments at Ellen House and none at Westgate House. Staff told us the formal risk assessment had recently been introduced which was a paper document when once completed was scanned onto the electronic system. On the three records containing risk assessments, these were thorough and covered for example, risk to self, behavioural risks, risk to self-factors, family history, history of suicidal behaviour and risk to others. There was a detailed section, which included risk to self, risk to others, vulnerability, risk formulation and plan, other relevant information and a review date, which was the next appointment date. Staff told us it was their intention to complete these documents for all young people on their caseloads although currently they were only being completed for young people new to the service. This meant the majority of young people did not have a formal risk assessment. Staff told us that currently risks were contained within contact notes, which would mean staff unfamiliar with the young person, would need to read all the contact notes, which in some cases went back several years to fully understand the young person's risks. This meant that patients were at risk of receiving care that did not take into account identified risks.

With the exception of the three new records at Ellen House, we did not see crisis plans and advance decisions in the care records we reviewed. The new documentation covered crisis plans; however, this had not been completed for young people who had been with the service prior to April 2016.

Young people's physical health was monitored by their general practitioners. However, any concerns raised with staff would be referred on to general practitioners. Weight and height monitoring was carried out and recorded in young peoples' care records.

The community teams did not have an individual risk assessment process for those young people on the waiting list. However, following a serious incident a red, amber and green rating system had been put in place to review risk. A monthly case review was held with the multidisciplinary team to ascertain individual risk. Once on the waiting list a clinical assessment which included a formulation, risk assessment and initial outcome measure would be undertaken.

Staff we spoke with were very clear about their safeguarding responsibilities. There was a safeguarding children's and adults policy in place, which staff knew and understood. Staff told us they had a good relationship with the local authorities safeguarding unit and were involved with the safeguarding leads at local schools.

Mandatory training for staff across the specialist community mental health services for children and young people which were all at 73%. included:

- Conflict Resolution
- Equality & Diversity
- Fire Safety
- Health & Safety
- Infection Control
- Information Governance
- Manual Handling Level 1 2 and 3
- Resuscitation, Basic Life Support and Immediate Life Support
- Safeguarding Children Level 1, 2 and 3
- Safeguarding Vulnerable Adults Level 1

Most services had a high compliance level of mandatory training. However, Ellen House were below the trusts compliance level in fire safety, manual handling level 2, basic life support and safeguarding children level 3.

Track record on safety

We were advised of four serious incidents in the 12 months prior to our inspection. One incident related to a vulnerable child, two incidents were related incorrect data being entered on another patient' record and one related to information governance where a letter was sent to the wrong recipient detailing information about another patient. Action plans were in place to reduce the risk of these incidents reoccurring.

Reporting incidents and learning from when things go wrong

Staff we spoke with were able to describe the type of incidents they would need to record on the trust's electronic system in line with the trusts policies and procedures. Staff were confident that incidents that needed to be recorded were recorded.

Are services safe?

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

Staff used a system of grading incidents by severity, level one which was defined as insignificant, two as low, three as moderate, four as severe and level five which was catastrophic. Team leaders would conduct local investigations in incidents ranging from one to three, severe and catastrophic incidents would be investigated by managers and, if necessary, escalated to a serious incident review by a senior team.

A serious incident is an incident which may need further investigation, recommendations arise from these investigations which result in recommendations which improve practice and reduce the risk of the incident being repeated.

Lessons learnt from serious incidents were investigated and reported through the trusts governance structures and were communicated to staff in order to improve practice. Recommendations from serious incidents across the trust were cascaded through monthly governance meetings to team leaders. Information from reviews were included on the team information board and passed onto staff through supervision. Staff were able to provide good examples of changes in practice resulting from the recommendations

and actions made from serious incident reviews. Staff involved in serious incidents described being supported and debriefed after incidents; staff described good support from colleagues when incidents occur.

Staff could describe the principles of the duty of candour which is a responsibility to inform and apologise to patients when things go wrong and mistakes have been made in patient care that may have resulted in significant harm.

Duty of candour

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

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

Are services effective?

Good 

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

Our findings

Assessment of needs and planning of care

Staff carried out an assessment of young people and their families. A formulation of need would be undertaken on first contact with the service and any subsequent appointments required to complete this assessment. Following this baseline assessment, young people would be referred to the most appropriate practitioner skilled to meet their needs.

Risk based assessments were also undertaken in further specialist consultations such as cognitive behaviour therapy and family therapy. Care planning and treatment options would be discussed with the young person and (with consent) their family during these sessions. Risk issues would also be shared with the referrer and other appropriate people such as school staff.

Appointment notes and correspondence were stored in the electronic patient record system. We examined 15 care records and found that only some of the records were contemporary and up to date. It was difficult to ascertain whether the young people had been involved in any of the decision making processes from the electronic records although parents and young people we spoke with told us that they had involvement in the care planning process. Of the care plans we had sight of these had no set format and were of poor quality, seven parents we spoke with told us they did not have a copy of the care plan. Staff found the electronic system difficult to navigate and struggled to find documents on request. Information was stored in an electronic format and paper format. Paper records were scanned into the records system.

Best practice in treatment and care

At the previous inspection staff described only two care pathways which were those of learning disability and self-harm, meaning that there could have been inconsistencies in approach to clinical care across the service. After consultation with clinical staff and a review of the clinical data relating to the key presentations of young people being referred to child and adolescent mental health psychological services and other emotional health and wellbeing service; nine priority care pathways had since been identified. These were:

- Non Specific Emotional and Behavioural Difficulties
- Psychological Trauma and Attachment Difficulties

- Eating Disorder
- Autism Spectrum Disorder
- Depression for Children & Young People
- Anxiety for Children & Young People
- Anti-Social Behaviour and Conduct Disorder
- Psychological Adjustment to Physical Health
- Attention Deficit Hyperactivity Disorder

These pathways followed National Institute for Health and Care Excellence guidance and were being rolled out in a monthly phased approach across the service to enable any changes to be established and embedded in practice. Implementation was taking place from August 2016 to April 2017 the first two pathways were being utilised by teams at the end of September 2016. Monitoring of the actions plans for implementation was being undertaken and reflected in the governance reporting structures and the child and adolescent mental health services risk register.

Routine outcome measures included the revised child anxiety and depression scale and Child Outcome Rating Scales, Strengths and Difficulties Questionnaire, Outcome Rating Scale. These measures were used to inform the effectiveness of the interventions undertaken by the team and were undertaken pre and post treatment.

The service offered a range of therapies, group and individual to meet the young people's needs. We observed one dialectical behaviour therapy group session and were informed of others such as family therapy, cognitive behaviour therapy and video interactive guidance, parenting, play and art therapy.

The child and adolescent mental health services took part in two clinical audits in 2016. The service had a specialist multidisciplinary team working with children with diagnosed learning disability and challenging behaviour. The service was benchmarked against the National Institute for Health and Care Excellence guidance quality standard learning disabilities, challenging behaviour. The second audit was undertaken to raise awareness and support the implementation of the National Institute for Health and Care Excellence guidance on drug allergy, diagnosis and management.

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 undertook assessment of physical health and physical health plans were in place. Staff took basic measures of health such as height and weight. Any other physical healthcare need would be referred to the young person's GP.

Skilled staff to deliver care

The team included nursing staff, occupational therapist support, psychologist, transition worker, play art therapist, attention deficit hyperactivity disorder practitioner, and paediatric liaison family therapists and had access to a range of mental health disciplines required to care for young people including a participation lead. The Preston service had no dietetic input and was recruiting to this role. Nursing staff had completed role specific training and told us that training need was discussed regularly at appraisal and supervision.

Staff had the skills, experience and qualifications necessary to carry out their roles, two staff members were undertaking qualifications in the delivery of dialectic behaviour therapy. Most services had a high compliance level of mandatory training; those that were below the trusts compliance standards had plans in place to ensure full and timely compliance.

Most staff received regular supervision. Staff at Preston child and adolescent mental health services were 83% against a target of 100% compliance with monthly supervision and West Lancashire service were at 87%. All staff had a date scheduled for supervision to increase compliance with the trusts standards of 100% staff supervision

Multi-disciplinary and inter-agency team work

A multidisciplinary and collaborative approach was used when caring for young people and their families. Staff described effective referrals between services. The team described effective communication with other specialists on the team such as consultants, psychologists, social workers where advice and support could be accessed.

Monthly case review meetings with care coordinators were described by staff, these were held to review case load risk and determine changes in the young person's presentation. Records were kept of those at high risk.

Referral and discharge letters were scanned into the electronic records system; these included information about the care of the young person and were shared with

the referrer and the family. Good working links were described, with primary care, social services, and other teams external to the child and adolescent mental health services.

Transition is a purposeful and planned process of supporting young people to move from children's to adults' services. At the last inspection the trust did not have a protocol for staff to follow when young people moved from child and adolescent mental health services to adult services at 16 years of age. An audit was undertaken and a protocol was developed. Dedicated practitioners were in place who undertook the role of transition lead for their area.

The transition leads collected information from practitioners of those young people who may have required transition to adult services. Monthly meetings were held with adult teams to discuss those young people. We had sight of two shared transition plans that were scanned into the electronic care records.

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

Staff had access to Mental Health Act level 2. Staff had a good understanding of the Act and the guiding principles. West Lancashire child and adolescent mental health services had 100% attendance at level 1 training and 43% attendance at the Mental Health Act level 2 training. The Preston service had 70% attendance at the Mental Health Act training level 2. Staff were able to obtain advice on the Mental Health Act if needed, administrative support and legal advice was available.

Young people had access to independent mental health advocate services, we noted posters detailing access to this service in a child friendly format and staff were clear on how to access and support engagement. The independent mental health advocate is trained to work within the framework of the Mental Health Act 1983 to support people to understand their rights under the act and participate in decisions about their care and treatment.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act does not apply to people under the age of 16. Gillick competence is the term used in British medical law to decide whether a child of 16 years or younger is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Children under 16 can consent to medical

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.

treatment if they understand what is being proposed. Children aged 16 and over were presumed to have capacity and able to consent or refuse to treatment in their own right. Most of the act applies to young people aged 16–17 years, who may lack capacity to make specific decisions.

Staff training rates for the level 1 Mental Capacity Act were 100% for the West Lancashire service and 45% for the Preston service. Level 2 Mental Capacity Act training levels were low with Preston at 10% and West Lancashire at 43%.

A Mental Capacity Act policy was in place that staff could refer to. Staff had a good understanding of assessment of a

young person's competence and understanding to make decisions and had access to training in the Mental Capacity Act. Staff explained consent to young people and their families at their initial assessment and recorded this discussion in the electronic notes.

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

Are services caring?

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

Our findings

Kindness, dignity, respect and support

All young people accepted on referral were given a named care coordinator. Parents/carers and young people were very positive about the care they received from the community child and adolescent mental health teams. Parents and young people told us that all the staff they encountered were welcoming and respectful. The staff were described as really nice people and parents and young people felt listened to and supported by staff.

Parents and young people knew who to contact in an emergency if required, urgent referrals were dealt with promptly and parents/carers described timely interventions for young people who self-harmed or who had an eating disorder.

Staff were described as caring for the family as a whole not just the young person in need of support. Parents and young people described helpful and therapeutic relationships with staff. Parents and young people were aware of the limits of confidentiality.

Young people were offered the opportunity to complete an experience of service questionnaire. These were monitored on an on going basis. Results of these were largely positive. Young people and their families were encouraged to provide feedback about the service they received.

The friends and family test is a feedback tool for people who use NHS services working on the principle that all patients should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses.

Friends and family test returns were collected quarterly and were largely positive. Quarterly data collected in June 2016 showed that for the Preston team, of 63 returns 89% were positive and West Lancashire of 28 returns they were 93% positive.

However at Ellen House Preston, the height and weight facilities were stored and used in the corridor, which did not protect the privacy and dignity of the young people using the service, staff did relocate this equipment when this was discussed with them.

The involvement of people in the care that they receive

Staff sent a letter to the young person and family that summarised their assessment and outlined plans for care. It was difficult to ascertain from the electronic records system evidence of the young person's involvement in the care planning process. All but one of the parents we spoke with were unaware of the young person's care plans although when asked the young people were aware of their own care plans. Parents described good discussion about care and types of treatment available with staff and advice given about advocacy services. Parents felt that communication with staff was good and staff updated them regularly about the young person's care and treatment.

Information was available to young people and their carers in formats that met their communication needs. All young people and their families were aware of their rights and able to express their wishes. They understood the concept of confidentiality and information sharing and the consent frameworks for their age group including the nature of parental responsibility.

Young people and parents/carers were not involved in decisions about services or the recruitment of staff, however a participation plan and strategy was under development. A full time staff post dedicated to ensuring participation was in place and a series of staff engagement meetings/interactive workshops had taken place. Young people and their carers who had experience of community and inpatient services were involved in a participation group called the CREW. Members of this group had undertaken the training of staff and development of the participation strategy for tier 3 community services. These engagement meetings were aimed at all staff within community child and adolescent mental health services, children's learning disabilities, children's psychology and emotional health team. They focussed on the teams' culture in relation to engaging and involving young people and families in their own personal care planning

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

Referrals to the service were assessed at the point of referral and triaged by duty staff and young people were placed on a waiting list or seen urgently dependent on need. For non-urgent cases on the waiting list they were given a contact number of the team so that they were able to contact the duty worker if further help was required whilst they remained on the list. The urgency of contact with the team for those on the waiting list was regularly assessed by the duty worker.

If a team's waiting times increased and a young person's waiting time was extended, there would be a review with the team manager and clinical lead of the impact of the extended wait on the young person.

The teams worked with referrers to ensure the appropriateness of the referral. All young people that were accepted onto the waiting list were allocated a care co-ordinator at their first appointment.

Young people and families that required specialist input from other members of the multidisciplinary team such as a psychiatrist or specialist therapies as a part of their care plan could wait for these interventions. Data on waiting times for this type of therapeutic input was not collated; we were informed that waiting times were variable dependent on the type of intervention and the fluctuations within the service and that case managers would provide interventions whilst awaiting other specialist intervention.

The service did not collate quality measures in relation to primary reason for referral making it difficult to assess condition specific waiting times in line with National Institute for Health and Care Excellence guidance. For example the National Institute for Health and Care Excellence guidance recommend that children and young people who are referred with first episode psychosis should start assessment within two weeks. Starting assessment for a first episode of psychosis within two weeks can improve outcomes by reducing the duration of untreated psychosis, as longer periods of untreated psychosis are linked to worse outcomes. However the parents of young people we spoke with described timely and appropriate respite and treatment.

The target for waiting times was 18 weeks or under from acceptance into the service, all but one community team

were under the 18 weeks waiting time at the time of the inspection. Data provided by the trust showed that at the end of August 2016 there were 79 young people awaiting allocation to a care co-ordinator at Ellen House, with five young people waiting over the trust target of 18 weeks to be allocated. Westgate House information showed that there were 25 young people waiting to be allocated to a care-coordinator none of whom had been waiting over the trust target.

Waiting lists were monitored through the governance structure using a patient targeted list. Actions were in place to reduce these waiting times such as recruitment to vacant posts and appointments made for all young people waiting over the 18 weeks date. From March to August 2016, the number of young people on the waiting list for Preston child and adolescent mental health services ranged from 79 to 108, of those an average of 6 young people had waited up to 24 weeks, 6 weeks over the 18 week standard. Between March and August 2016 West Lancashire services had an average of 100 young people on their waiting list; the longest wait was 17 weeks.

Appointment times were flexible and we were told by families that staff were flexible and responsive in terms of appointment times and urgency of need. Appointments ran on time and young people and families told us they were rarely kept waiting.

Appointments that were cancelled were routinely rearranged to suit the circumstances of the young people and their families. Information was routinely collated on young people who did not attend appointments, all effort was made to engage these young people and their families and systems were in place to engage those that were hard to reach. Young people who did not attend appointments were offered a new appointment if they continued to fail to engage they would be informed that the service was disengaging and would be referred back to the initial referrer dependent on risk.

The facilities promote recovery, comfort, dignity and confidentiality

Both locations inspected had a full range of interview and therapy rooms. Rooms were well furnished and suitable for purpose. Conversations taking place in interview and therapy rooms could not be overheard by anyone passing.

Are services responsive to people's needs?

Good 

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

There was a range of information available in the reception areas of Preston and West Lancashire community and mental health services for children and young people. This included information on treatment options and information on how to complain.

Meeting the needs of all people who use the service

The premises housing the tier 2 and 3 teams at Preston and West Lancashire were on two floors. No lift was available for disabled access to the upper floor although arrangements were in place for young people and their carers to be seen on the ground floor if necessary.

Information leaflets in different languages, access to interpreters or those who required sign language was available for those who required them.

Listening to and learning from concerns and complaints

All young people and their families we spoke with knew how to make a complaint to the service, a policy was in place and information on how to make a complaint was readily available. The Trust website provided a link to the 'contact us' page from which patients, families and carers could access information on how to raise a concern or

make a complaint. There was information available on notice boards on how to make a complaint. A 'you said we did' system was in place and information produced was displayed within the service.

A quality and safety report was produced monthly which highlighted learning from complaints, serious investigations and action plans were discussed in local governance meetings with team leaders and cascaded to each teams through the team meeting and supervision process.

The service received 30 complaints with two complaints being withdrawn, four were not upheld, seven were partially upheld, 16 were upheld and one was unknown during the period 1 April 2015 to 31 March 2016. No complaints were referred to the ombudsman. The child and adolescent mental health services Tier 2 and 3 Chorley and South Ribble team received the most number of complaints with 13.

The service also received 93 compliments during the previous twelve months with the child and adolescent mental health services Tier 2 and 3 Fylde and Wyre at Whitegate Health Centre, receiving the most with 70 compliments.

Are services well-led?

Good 

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

Our findings

Vision and values

The values of the trust were on display throughout the service. These values were teamwork, compassion, integrity, respect, excellence and accountability.

Staff were able to describe these values and team briefings were held regularly where the trusts visions and values were reinforced. The two community teams we visited demonstrated the trusts visions and values in their interactions with parents and young people.

All staff we spoke with knew of the senior management team within the organisation and described occasional contact with visits from the senior management team.

Good governance

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

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

Child and adolescent mental health services community performance and capacity reports; quality and safety information and safeguarding reports were produced monthly. An overview of lessons learnt and any subsequent action plans were discussed within the trust governance structure and disseminated through local governance meetings with team leaders. Information was shared with the staff teams at staff meetings, clinical supervision and information was placed on team information boards.

Mandatory training appraisal and supervision were in place although Preston staff compliance rates were low due to sickness within the team, dates had been scheduled and plans were in place to ensure compliance with trust standards were addressed.

Key performance indicators were used to assess the effectiveness of the service offered to young people. Waiting times, outcomes, activity, vulnerable and transitioning children figures were collated monthly. Senior managers met regularly with the wider integrated children and families' network to discuss issues of performance, workforce issues, risks, incidents and quality issues

Leadership, morale and staff engagement

Staff we spoke with were aware of the whistleblowing procedures, they told us that they felt able to raise concerns with senior managers. Staff generally talked positively about their roles although staff did feel some pressure with their caseloads and waiting lists.

There were no members of staff in either team who were undergoing formal disciplinary investigation. There had been no formal grievances or investigations in the teams we visited in the previous six months prior to inspection related to bullying and harassment.

Sickness and absence rates for the Preston child and adolescent mental health services was low at 0.8%, and higher than the trust average at six percent for the West Lancs child and adolescent mental health services. West Lancashire also had higher staff turnover. Managers were monitoring sickness and absence and supporting staff back into work.

Staff told us they had opportunities for personal development and were informed of service developments within meetings, supervision and from newsletters produced by the trust. A monthly communication to all staff was sent out in a document called the PULSE. This included support documentation and information on roadshows and workshops throughout the trust. Additional guidance documents, such as quick step by step guides were uploaded to a SharePoint internet site of which all staff had access.

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

Are services well-led?

Good 

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

All but one member of staff told us they valued their colleagues and felt they were part of well-functioning, reflective teams. Staff described their colleagues as friendly, hard-working and caring. Staff said they felt listened to and supported.

Commitment to quality improvement and innovation

The child and adolescent mental health services had systems in place to monitor the quality of services. They participated in audits and initiated action plans and monitoring systems to improve services.

Recent initiatives had been introduced to improve the young person's experience. Care pathways had recently been put in place. The plan was to implement one care pathway per month, with ongoing review. At the time of the

inspection two of the nine care pathways had been rolled out across the service. The implementation plan included data analysis, case audit, use of routine outcome measures and young person's experience measures and variance analysis to measure the effectiveness of the pathways. Variance analysis is used to measure what happens to the young person on the pathway and whether there is a deviation from the expected pathway and if so, for what reasons.

The teams had been engaged in the national Improving Access to Psychological Therapies programme since 2012; this provides therapeutic training for staff and supports wider service transformation in relation to participation, use of standardised outcome measures and local partnership working.

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

Accommodation for persons who require nursing or personal care

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation

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

We found that risk assessments were in place only for new referrals to the service from April 2016.

This is a breach of regulation 12 (2) (a)