Requires improvement

Bolton NHS Foundation Trust

Specialist community mental health services for children and young people

Quality Report

Royal Bolton Hospital
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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)
RMC01	Royal Bolton Hospital	Child and adolescent mental health services	BL4 0JR

This report describes our judgement of the quality of care provided within this core service by Bolton 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 Bolton NHS Foundation Trust and these are brought together to inform our overall judgement of Bolton 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?	**Requires improvement** 
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:

- The trust did not provide eligible staff with mandatory training in safeguarding vulnerable children at level three. NHS England identified that this training is essential for the role of a community CAMHS practitioner.
- The trust did not provide eligible staff with mandatory training in the Mental Health Act (MHA), MHA Code of Practice (2015), Mental Capacity Act or legal frameworks specific to children and young people aged below 16 years, such as the Children's Act (2004).
- The trust had a MHA policy in place. However, staff did not always follow the MHA Code of Practice (2015).
- CAMHS had a lone working policy in place. However, staff did not always follow this in practice.
- Once assessed by the single point of access team (SPoA), children and young people had to wait approximately 23 weeks to receive active treatment from a CAMHS practitioner.
- Children and young people's care plans did not always capture their views.
- The local population comprised of approximately 30% of people who identified as black or a minority ethnicity (BME). CAMHS received very few referrals from children and young people who identified as a BME.
- Outcome measures to monitor the progress children and young people were making whilst receiving treatment were not routinely completed.
- In some key areas, CAMHS were not working proactively with other teams within Bolton NHS Foundation Trust to improve the service they delivered to children and young people.
- During inspection, we found a sharps box (a box used to dispose of contaminated items such as used needles and syringes) that had not been disposed of since 2014. This increased the risk of the spread of infection within the service.
- The main units clinic room did not have a mixed water tap.The Department of Health guidelines (Infection control in the built environment 2013) states that mixed water taps are essential for reducing the risk of scalding to people using the facility.

However;

- Staff completed comprehensive risk assessments for every child and young person that used the service, and these were regularly reviewed. There was an effective on-call system to respond to any emergencies within the service.
- Staff were effective in the prescribing and monitoring of children and young people on medications.
- Staff were well qualified to perform their role.
- CAMHS had improved its working relationship with other agencies, external to the trust, that were also involved with children and young people using the service. This included delivering training to local primary and secondary schools to raise mental health awareness.
- Staff treated children, young people and their parents/carers with kindness, dignity and respect.
- Children, young people and their parents/carers had produced short films for the CAMHS website to raise awareness of what it was like to access CAMHS and the different kinds of support they offered.
- The service demonstrated a commitment to quality improvement and innovation. The patient participation group had successfully secured funding from the Health Education Innovation England Fund (2015/16) to develop a self-help mobile phone application.

Summary of findings

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

Are services safe?

Requires improvement

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

- During inspection, we saw that some staff did not follow the lone worker policy and take alarms into rooms where they had contact with a child or young person. Alarms are sometimes used to alert other staff members in emergency situations. This is to minimise the risk of harm to staff, parents and the young person.
- Although the service were trying to recruit into vacant posts, they had difficulty recruiting staff to the service.
- The trust did not provide level three safeguarding children and vulnerable adult's' training. This training is essential for the role of a CAMHS practitioner.
- We found a sharps box that had not been disposed of as per trust policy. The sharps box was dated as being full in 2014.
- The wash-basin tap in the clinic room did not meet Department of Health guidelines (Infection control in the built environment 2013). This was not a mixed tap; the main CAMHS unit's clinic room had a wash-basin fitted with separate taps for hot and cold water. This had recently been installed and had not been identified as a safety issue beforehand.

However:

- In December 2015, all CAMHS staff had completed the trust's mandatory training programme. This included safeguarding vulnerable children at level 2.
- There were good systems in place to monitor the risk of children and young people placed on the CAMHS waiting list. Staff completed a comprehensive risk assessment for every child and young person on referral to the service. Staff reviewed risk assessments on a regular basis.
- The service employed two nurse prescribers. The service followed safe medicines management practice, including the prescribing of medications and adequate monitoring for any side effects.

Are services effective?

Requires improvement

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

- The trust did not provide mandatory training in the Mental Health Act (MHA) or Mental Capacity Act (MCA).

Summary of findings

- The trust had a service level agreement in place for MHA provision. This was provided by another NHS Trust. The trust had policies in place to support the proper use of the MHA, however, staff did not always follow these in practice.
- Staff did not always follow the MHA Code of Practice (2015). This included not filing copies of MHA detention paper work in children and young people's care records.
- Care plans were not always person centred and did not capture the views of the child or young person using the service.
- There were not always effective handovers between services within the trust who were involved in the care and treatment of children and young people.

However:

- Five staff members were trained in children and young person's improving access to psychological therapies (CYP-IAPT). Staff were well qualified to perform their role. Some staff held a specialist diploma in CAMHS nursing in addition to other professional qualifications.
- The service had improved their working relationship with other agencies to improve the service they provided. This included the local council, schools and voluntary organisations.

Are services caring?

Good

We rated caring as **good** because:

- We observed that staff treated children and young people with kindness, dignity and respect.
- Patients we spoke with told us that staff knew their individual needs and included them in decisions regarding their care and treatment.
- Staff maintained children and young people's confidentiality and only shared information regarding their care and treatment where appropriate.
- The service employed a patient participation lead who was implementing new ways in which children, young people and carers could be involved in the running of the service.
- The service had a well-established patient participation group. Young people within the group had successfully placed a bid to NHS England to secure funding for a self-help mobile phone application.
- The service had an established parent and carers' forum. Parents and carers had co-produced a film for the CAMHS website. This was to explain to parents of newly referred children what to expect from the service.

Summary of findings

- Parents and carers sat on interview panels to recruit new staff to the service.
- Children and young people were able to give feed-back on the care they received and we saw that the service responded appropriately to this. For example, children and young people said that the waiting area needed to be more welcoming and appropriate to their needs. They had since led a service 'take-over' day where they re-designed the waiting area to meet their preferences.

Are services responsive to people's needs?

Requires improvement

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

- Following an initial assessment by the single point of access team, children and young people had to wait approximately 23 weeks to receive treatment from a CAMHS practitioner.
- The services' therapy building was not well maintained. The décor was tired which meant that the environment did not promote the recovery of children and young people.
- Approximately 30% of Bolton's population was representative of people from black and minority ethnic groups. However, CAMHS did not receive many referrals from these groups. CAMHS were starting to think about ways in which they could promote their service to different ethnic groups within the local community.

However:

- There was an effective on-call rota so that a CAMHS practitioner could see a child or young person who presented as high-risk within an acceptable time-frame.
- The service had a low did not attend rate. The service had introduced an appointment alert system on their computer database system, IAPTUS. This automatically reminded carers, parents, children and young people of their scheduled appointment two days before via text message.
- The service were working with local schools to raise awareness of what CAMHS provides. This was, in part, introduced to reduce the number of inappropriate referrals to the service.
- The service had an agreement with the local clinical commissioning group to provide training in raising mental health awareness, including self-harm in children and young people, to primary and high schools within the local area.

Are services well-led?

Requires improvement

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

Summary of findings

- The trust did not provide all the mandatory training to CAMHS staff that was essential for their role.
- There was a lack of effective information sharing with other services responsible for the care of children and young people within Bolton NHS Foundation Trust. This meant that when there was an incident, this was not always shared so that learning could take place to prevent it from happening again.
- Staff submitted items to the trust risk register where appropriate. However, difficulties in recruiting staff had been added to the register in October 2015 and had not been adequately resolved at the time of our inspection. This effected waiting times to receive active treatment.

However:

- All staff had received an annual appraisal. The service had a low sickness and absence rate; between April 2015 and December 2015 this averaged at 2%.
- Staff told us that morale had improved over the past few months. Staff were supportive of each other and all were passionate about improving the service they provided to children and young people with a mental health need.
- The service had been successful in securing funding to develop a self-help mobile phone application for children and young people with a mental health difficulty. The service had plans in place to share this application with other CAMHS teams nationally.

Summary of findings

Information about the service

The community child and adolescent mental health service (CAMHS) sits within the families division of Bolton NHS Foundation Trust.

CAMHS is registered with the Care Quality Commission to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

The CAMHS service operates from self-contained buildings on the Royal Bolton Hospital site. It provides outpatient support, including an extended assessment day for children who may have neuro-developmental problems, for 1694 referrals (2014-2015) of children and young people aged from five to 17 experiencing mental health difficulties.

The service employs staff from a range of disciplines including psychiatry, clinical psychology, nursing, social work, youth worker, therapies and dieticians.

The service is divided into three teams. The single point of access team triages referrals, completes choice and risk sessions and provides on call cover during working hours. The early intervention and prevention team focuses on children and young people with limited history of CAMHS. The intervention and recovery team focus on people with previous CAMHS interventions and potentially long-term problems. The service is a collaborative partner in NHS England's CYP-IAPT programme (Children and Young People – Improving Access to Psychological Therapies).

The service has not previously been inspected by the Care Quality Commission.

Our inspection team

The team was led by:

Chair: Paula Head

Head of Inspection: Ann Ford, Head of North West Acute Hospital Inspections, Care Quality Commission.

Team Leader: Sarah Dunnett, Inspection Manager, Care Quality Commission.

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of findings

Before the inspection visit, we reviewed information that we held about this service and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the main child and adolescent mental health services (CAMHS) unit and therapy building at the Royal Bolton Hospital site;
- looked at the quality of the environments and observed how staff were caring for children and young people;
- spoke with four young people who were using the service;
- spoke with five carers and parents of children and young people using the service;
- spoke with the divisional manager with responsibility for this service;
- spoke with the clinical lead psychologist;
- spoke with the specialist safeguarding lead nurse for CAMHS;
- spoke with nine other staff members including a consultant psychiatrist, nurses, psychologists, administration and a patient participation lead;
- spoke with three members of the local authority who worked with CAMHS;
- spoke with one member of a learning disability service who worked with CAMHS;
- attended and observed three multi-disciplinary meetings;
- attended and observed one patient participation group;
- looked at 13 patient care records;
- looked at three medication treatment records of patients; and

looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with four young people who used the service. They were all positive about the care and treatment they had received. They told us that staff had a good understanding of their individual needs, and that they genuinely cared about their well-being. They also told us that staff encouraged them to share their ideas regarding the development of the service, including identifying what they wanted from it and what was not working so well.

We spoke with five parents of children and young people using the service. They were mostly positive about the care and treatment they had received from CAMHS. They told us that they felt involved in decisions regarding their child's care and treatment, and that they had no difficulties in accessing the service in an emergency situation. Some parents commented that the wait for active treatment was in excess of 20 weeks. They said that this wait could be frustrating, however they complimented the service once treatment had started.

Good practice

Areas for improvement

Action the provider MUST take to improve

Action the provider SHOULD take to improve

Bolton 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
Child and adolescent mental health services	Royal Bolton Hospital

Mental Health Act responsibilities

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

- The trust had a service level agreement (SLA) in place with a local NHS trust. An SLA is a written agreement between a provider of a service and the commissioner of that service setting out the range and level of services to be provided, the responsibilities and priorities and the fees. The local NHS trust's MHA office provided Bolton NHS Foundation Trust with support with the administration of the MHA and legal advice on the implementation of the MHA and MHA Code of Practice 2015 (MHA CoP).
- The trust did not provide mandatory training in the MHA or the revised MHA CoP 2015 to all eligible CAMHS staff.
- We looked at care records for two young people who staff had told us had been detained under the MHA on the trust's paediatric ward by a CAMHS practitioner. Although we saw copies of the detention paper work in one young person's paediatric care records, there were no copies of the detention papers in the young person's mental health care records. Staff told us that MHA paperwork was stored by the trust who provided MHA support. This was not in line within the MHA CoP that states that copies of MHA detention paper work should be filed in all patient care records.
- One young person was detained on a paediatric ward at the Royal Bolton Hospital. The young person was open to CAMHS and had been detained by a responsible clinician who was part of the CAMHS team. The young person was allowed to leave the ward without relevant permission from the responsible clinician.

Detailed findings

- Where a child or young person was detained under the MHA, staff did explain their rights. However, we found that staff did not always accurately capture these discussions in their care records. There was no record of a discussion with the young person's next of kin.
- None of the children and young people detained under the MHA on the trust's paediatric ward had care plans in place to address their mental health needs.
- The trust did not undertake any regular audits to ensure that the MHA was being applied correctly.

We presented these concerns regarding the proper use of the MHA to the trust during our inspection. The trust responded promptly to address these concerns. For example, the trust had actively worked with other NHS trust's to devise a care plan template specifically for detained patients. This was currently awaiting ratification by the patient advisory group in April 2016. A local NHS trust had also agreed to provide a training package in the MHA to senior management teams within the trust. A formal checklist to identify that the correct procedures for implementing the MHA was also being drawn up with a local NHS trust (for patients over the age of 16) and CAMHS (for under 16's).

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Deprivation of Liberty Safeguards (DoLS) do not apply to people under the age of 18 years. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. These would include the existing powers of the court, particularly those under s25 of the Children Act, or use of the Mental Health Act. Eligible CAMHS staff received training in legislation relevant to children and young people, such as the Children's Act (2004), within level two safeguarding children's training. This included training in the Gillick Competence Framework. All eligible staff had completed this training.
- The Mental Capacity Act does apply to young people aged 16 and 17 and mental capacity assessments should be carried out to make sure the patient has the capacity to give consent. The Mental Capacity Act does not apply to children and young people below the age of 16. It does apply to young people aged 16 and over. The trust did not provide mandatory training in the Mental Capacity Act (MCA) for young people aged 16 or above. MCA principles were covered within a safeguarding vulnerable adult's course provided by the trust. All eligible CAMHS staff had completed this course.
- The Mental Capacity Act (MCA) act does not apply to young people aged 16 or under. For children under the age of 16, the young persons' decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves. We only found one occasion where a young person aged below 16 had not been assessed under the Gillick Competence Framework as appropriate. The young person had been detained under the MHA and there was no documentation to evidence that those with parental responsibility had been informed of their detention. If the young person had been assessed as being Gillick Competent and had identified that they did not want to their parent/s to be informed, this should have been recorded in the young person's care records. However, care records did not identify that this assessment had taken place as appropriate. Therefore, there was no information available to identify whether the young person.

Requires improvement

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

- None of the interview rooms in the main child and adolescent mental health services (CAMHS) unit or therapy building were fitted with alarms. The therapy building was a separate building next to the CAMHS unit, a short walk away. Within mental health settings, alarms are used to alert other staff members in emergency situations. For example, if a child or young person becomes distressed during a meeting with a professional. We reviewed a summary of incidents that CAMHS staff had submitted to the trust's incident report system between January 2015 and December 2015. We found that four reports related to incidents where a child or young person had become distressed and physically and verbally aggressive towards their carer during a professional meeting. When the incidents occurred, risk had been adequately mitigated because the professional had alerted other staff members for assistance using a personal alarm. However, whilst inspecting the CAMHS unit, we found that staff did not always follow their own policy and take personal alarms with them into meetings with a child or young person. This meant that if a child or young person became distressed, the professional would have difficulty alerting staff promptly for assistance.
- The main CAMHS unit's clinic room had a wash-basin fitted with separate taps for hot and cold water. This had recently been installed and had not been identified as a safety issue prior to installation. Department of Health guidelines (Infection control in the built environment 2013) recommend the use of a mixer tap as high water temperatures can be difficult to control. This could increase the risk of staff scalding themselves when washing their hands. However, alcohol gel dispensers were located throughout all corridors.
- In the medical device storage room, we found one sharps box that staff had sealed in 2014. Clinical staff use a sharps box to dispose of used sharps items, such as needles and syringes. This had not been removed from the building within an appropriate time-frame as per trust policy.
- The main CAMHS unit was modern, clean and well maintained. It was accessed by a ramp that led out onto hospital parking facilities. The ramp complied with regulations as outlined under the Equality Act (2010) for safe disabled accessed.
- The therapy building was located opposite to the main CAMHS unit. It was also accessed by a ramp that complied with the Equality Act (2010).At the time of our inspection, it was in the early stages of refurbishment by the trust's estates department. The trust provided us with documentation relating to the re-design and modernisation of the therapy building.

Safe staffing

Key Staffing Indicators

Establishment levels: qualified nurses

(WTE): 20

Establishment levels: nursing assistants (WTE): two

Number of vacancies: qualified nurses (WTE): two

Number of vacancies: nursing assistants (WTE): 0

Staff sickness rate (%) in 12 month period: 2%

Staff turnover rate (%) in 12 month period:

10%

- At the time of our inspection, the service did not have a CAMHS manager in post. The post had been vacant since January 2016. A candidate had been successfully recruited to post and had an identified start date in April 2016.
- Since the establishment of a new service model in January 2016, some staff had voluntarily left employment with the CAMHS team. All staff had to re-apply for their position, and all staff that did apply were successful in securing employment in the service. Current staff we spoke with told us that they had been well supported through the transition by senior management, and that they felt skilled and confident to meet the demands of their new role effectively. The current vacancies were, in part, accounted for by staff

who did not reapply for their position during the introduction of the new service model. The trust were actively recruiting to these roles but had not been able to identify any suitable candidates.

- The service employed two full time consultant psychiatrists at the time of our inspection. There was one vacant post for the position of consultant psychiatrist for the early intervention team. The post had been vacant since January 2016 and was currently being covered by a locum psychiatrist. Although the trust had advertised the vacancy, senior management told us that they had not received any applications for the post.
- Between April 2015 and December 2015, CAMHS used a small number of bank or agency staff to cover staffing shortfalls. This averaged at 31 hours per calendar month. Between October 2015 and December 2015, CAMHS had not used any bank or agency to cover staffing shortfalls.
- The average case-load of practitioners was variable and was influenced by the number of referrals to the team they worked in. Case-loads of practitioners within the single point of access team were highest, averaging between 50 and 60. However, the function of this team was to risk assess and screen patients for the care pathway they were most suited to (early intervention or the intervention and recovery pathway). Therefore, practitioners in the single point of access team referred cases on once this brief intervention was completed, or discharged them if they were not appropriate for further intervention. Case-loads of practitioners within the other two teams averaged between 35 and 50.
- The trust provided us with data to demonstrate that in December 2015, 89% of staff had completed mandatory training. Staff who were not up to date with mandatory training were booked on the relevant course to attend in the next two months.

Assessing and managing risk to patients and staff

- The single point of access (SPoA) team was responsible for screening all new referrals to the service for risk. There was a rota of two practitioners per day who triaged referrals immediately upon receipt. We reviewed 13 care records of children and young people using the service. All had a comprehensive risk assessment that was completed on referral to the service and regularly reviewed thereafter.
- A rota to assess all emergency referrals to the service was in place that covered the hours between 9am and 5pm, Monday to Friday. Senior practitioners from the single point of access team were responsible for covering this rota. Outside of these hours, emergency cover for young people aged 16 and over was provided by the Rapid Assessment, Interface and Discharge team (RAID). The RAID team was provided by another local health NHS trust, and based at the Royal Bolton Hospital. Children and young people aged below 16 years were seen by an on-call consultant psychiatrist. This was provided on an out of hour's rota by another local NHS trust.
- All children and young people had a crisis management plan in place. Parents, children and young people had copies of these. Details within the plan included who to contact and where to go in an emergency situation.
- The service monitored children and young people placed on waiting lists for an increase in risk. The SPoA team provided an in-reach service to those identified at increased risk whilst waiting to be seen by a practitioner from early intervention and the intervention and recovery teams. This was called an extended SPoA service. There was a weekly multi-disciplinary team meeting where practitioners from all three teams attended to discuss case-loads, including concerns regarding elevated risk to children and young people.
- The trust did not provide level three safeguarding of children and young people training to clinical staff employed by CAMHS. We found that all eligible staff had completed training at level two. However, NHS England safeguarding policy (2015) states that all clinical staff working with children, young people and who could potentially contribute to assessing, planning, intervening and evaluation of their needs, including responsibility for making safeguarding referrals, should complete training at level three.
- However, the trust did provide us with details of eligible staff who had been booked to attend level three training in April and May 2016. Eligible staff accounted for 18 of the 33 staff employed by CAMHS. To date, the

safeguarding team had delivered specialist courses in domestic abuse (young people) and safety planning to eligible CAMHS staff. Eligible staff had also attended a conference hosted by the Safeguarding Children's Board. This was to explore effective interagency working with other services involved in the safeguarding of children and young people, such as the local authority and the police. This meant that although no staff had fully completed safeguarding training at the appropriate level, they did complete courses that enhanced their skills and knowledge base in safeguarding concerns specific to their role.

- We spoke with the lead safeguarding nurse for CAMHS.The safeguarding team had access to CAMHS' electronic incident reporting system, IAPTUS. They could identify and escalate any safeguarding concerns following review of this system. The team also provided two drop-in sessions per month. CAMHS staff could attend to discuss any safeguarding concerns and access specialist support and advice. The safeguarding team told us that CAMHS staff made appropriate and timely safeguarding referrals. Records reviewed confirmed this. We also attended and observed two multi-disciplinary team meetings. We saw that staff were aware of their role and responsibilities in relation to identifying, raising and acting on safeguarding concerns.
- The trust had a lone-working policy in place. Staff did not have regular clinical contact with children, young people and their families in their own homes. Staff saw them on-site or within other community locations such as children's centres and GP practices. However, there was no local procedure in place to advise staff how they should keep themselves safe when working as a lone practitioner off-site. Furthermore, staff did not always use personal alarms as appropriate when working on-site.
- An independent trainer called Team Teach provided eligible CAMHS staff with training in approved physical interventions and de-escalation techniques. Team Teach training is affiliated to the General Services Association. Its courses have been accredited (2006, 2009, 2012) by the British Institute of Learning Disabilities and the Institute of Conflict Management (2015). We found that all eligible staff had completed the Team Teach foundation programme and had completed a yearly fresher course thereafter. Intervention and techniques taught within the programme were suitable for use with children and young people of all ages that used the service.
- CAMHS employed two senior nurses as non-medical prescribers. This meant that there were more practitioners available to prescribe medications and monitor their effects for children and young people using the service. Consultant psychiatrists provided regular supervision to non-medical prescribers. This included observing and reviewing their prescribing practice using a formal non-medical prescriber assessment tool called DOPE (direct observation of prescribing event). This assessment was completed five times a year as per trust policy. CAMHS also held a monthly psycho-pharmacology meeting. This provided an opportunity for staff to discuss and reflect on the effects prescribed medications may have on a child or young person's mental state and behaviour, and to review prescribing practice in line with National Institute for Health and Clinical Excellence guidelines.
- Prescribers used prescription pads called FP10s and outpatient prescription charts. Some medicines were dispensed from the pharmacy based at the Royal Bolton Hospital (RBH) site. Prescribers also used FP10's to prescribe medications at off-site clinics. This meant that children, young people and their parents could also collect medicines from a high street pharmacist more local to them if required. Prescription pads were stored securely. At the time of our inspection, there were no audits conducted by a pharmacy team to monitor safe medicines management practices.

Track record on safety

- Between January 2015 and December 2016, CAMHS reported no serious incidents requiring investigation.
- Between January 2015 and December 2015, CAMHS reported four incidents that related to a child or young person becoming distressed and verbally or physically aggressive towards their parents or carers during a professional meeting. Staff used de-escalation techniques and approved physical interventions to successfully reduce the child and young person's distress.

Reporting incidents and learning from when things go wrong

Requires improvement

Are services safe?

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

- Staff used the trust's incident reporting system to report incidents as appropriate.
- We saw that CAMHS staff explained to parents, children and young people when something had gone wrong with regard to their care in treatment. This included providing them with additional support to address any outstanding concerns and a written and verbal apology. This meant that the service complied with their regulatory duties under the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Feedback following investigation of incidents (both internal and external to the service) was a standing agenda item within weekly pathway team meetings. CAMHS also met with the Rapid Access, Intervention and Discharge (RAID) team every six weeks to discuss, review and address any concerns regarding the risk management of young people aged 16-18 years.
- However, we did find that where some incidents had been reported, there was limited evidence that learning and positive change had occurred as a consequence. This included a lack of shared learning with other services involved in the care of child or young people. For example, on three occasions between January 2015 and December 2015, CAMHS had reported that the Royal Bolton Hospital's accident and emergency department had failed to follow trust policy. This specifically involved discharging children or young people who had taken an overdose of medication. Trust policy states that under these circumstances, the service must make a referral to inpatient paediatric services for further medical review, and also request a mental health assessment from the CAMHS team. We did not find that either service had worked together to address the issue. This may have prevented such incidents from occurring again.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- We reviewed 13 patient care records for children and young people using CAMHS. All care records demonstrated that children and young people received a comprehensive assessment of their needs. Staff used the CAPA (the choice and partnership approach) model to explore the child or young person's current difficulties, the severity of risk with which they presented and establish treatment goals. CAPA is a service delivery model recommended by NHS England's improving access to psychological therapies. The model promotes a collaborative and shared decision-making approach to treatment between professionals, parents, children and young people.
- However, none of the care records we reviewed demonstrated that a formal template had been used to capture the child or young person's plan of care following initial assessment. CAMHS sent a letter to the child and young person's GP to briefly identify what their plan of care was. Although the child, or young person, and their parent/carer received a copy of this letter, there was no evidence that they had been involved in deciding what their plan of care might include.
- Staff used the quantative behaviour test (Qb) to assess whether a patient had attention deficit and hyperactivity disorder (ADHD). Current research, conducted by a leading UK University, identified that the Qb test was effective in reaching an accurate diagnosis and more effective prescribing of medications for children and young people diagnosed with ADHD. Several staff were trained to facilitate this.
- All patient care records were in paper-format. All clinical staff had an i-pad that was used to access the trust's incident reporting system, IAPTUS. This meant that information regarding a child or young person's level of risk was accessible to practitioners in emergency situations when working off-site.

Best practice in treatment and care

- We reviewed three medication records for children and young people who had been prescribed medication by a CAMHS practitioner. The trust monitored children and young people's physical health well. Prescribers followed National Institute for Care and Excellence guidance and conducted all the necessary physical health checks before prescribing medication. Prescribers continued to routinely monitor children and young people for any side-effects and made further interventions where appropriate.
- The service was a collaborative partner in NHS England's CYP-IAPT programme (children and young people – improving access to psychological therapies). Five staff members had been trained to deliver CYP-IAPT. Staff delivered evidence-based psychological therapies such as cognitive behavioural therapy and functional family therapy.
- The service also offered evidence based therapies for parents/carers, such as VIG (video interactive guidance) and PCG (parent and child game). VIG is an intervention through which a practitioner uses video clips of real situations to promote communication within relationships. PCG is used to support parents in their development of positive child-centred strategies to influence their child's behaviour. This approach combines live parent skills training work, which is undertaken during ten minute play sessions, with other interventions using a range of therapeutic methods. This included behaviour management advice and supportive counselling.
- The service also provided an evidence-based psycho-therapeutic approach to children and young people who had experienced significant trauma; eye movement and desensitization and reprocessing (EMDR). The service also ran a once weekly day service for children and young people with complex neurodevelopmental disorders.
- A range of outcome measures were used to rate the severity of children and young people's condition, and any outcomes of treatment, throughout their engagement with the service. Outcomes measures included the Spence children's anxiety scale (SCAS), the revised children's anxiety and depression scale (RCADS) and the children's global assessment scale (CGAS). However, we found that although the range of outcome measures used by practitioners was extensive, they were not always completed. To address this concern, the CAMHS clinical audit lead had added improving staff compliance in completing outcomes measures as a standing agenda item within weekly pathway team

Are services effective?

Requires improvement

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.

meetings. However, staff we spoke with told us that the reason they had difficulties completing all the outcomes measures was because there were too many. In total, staff were expected to complete five outcome measures with the child or young person during consultation. Staff told us that this took time away from providing the child or young person with the opportunity to openly discuss their difficulties during face-to-face contact.

Skilled staff to deliver care

- The CAMHS team comprised a variety of professionals. This included psychologists, psychiatrists, junior doctors, mental health nurses, support workers, administrators, a part-time dietician and a social worker. In addition to a professional qualification in mental health nursing, two staff members held a specialist diploma in child and adolescent mental health. One staff member also worked with the National Institute of Care and Excellence to provide guidance on the care of children and young people diagnosed with attention deficit and hyperactivity disorder.
- Figures provided by the trust identified that as of 31 March 2016, all CAMHS staff had received an appraisal of their work performance. All staff received weekly group supervision within a weekly pathway team meeting. Staff were able to discuss complex cases and receive professional advice and support from their peers and line manager. However, some staff we spoke with said that they would benefit from individual supervision with their line management. Staff said that there were some professional and personal concerns they would feel more comfortable addressing on an individual basis with line management. However, all staff we spoke with said that senior management were mostly approachable and accessible should they require individual support.

Multi-disciplinary and inter-agency team work

- All staff attended and participated in regular multi-disciplinary meetings to review case-loads, discuss new referrals and address other standing agenda items such as clinical audit and incident reviews. We attended and observed three multi-disciplinary team meetings. Staff respected different professionals input, and all worked together to address any concerns and identify effective ways of working with children and young people. Staff had developed a supportive working culture but were able to challenge differing professionals opinions where appropriate.
- We found that there was not always effective working with other services within the trust that were involved in the care and treatment of children and young people. This was particularly in relation to Royal Bolton Hospital's accident and emergency department. There was not always an effective handover when children and young people were seen by one service. They sometimes failed to notify the other service that they had been seen. This meant that services did not have all the information available to them regarding a child or young person's contact with services.
- We found some evidence that the trust were acting to improve working relationships between CAMHS and other services within the trust. For example, in June 2014 an item was added to the family care divisional care risk register. This identified the lack of appropriate therapeutic intervention for children and young people with mental health difficulties based on acute paediatric wards whilst awaiting transfer to tier four inpatient mental health services. As an action, the risk register identified that CAMHS staff were to supply mental health awareness training and supervision to paediatric services. However, an update to the risk register later identified that there were not enough CAMHS staff to facilitate this training and supervision.
- The CAMHS team were working to improve links with other organisations that were also involved in the care of children and young people. CAMHS had worked with the local clinical commissioning group (CCG) to provide a 'core service offer' to local primary and secondary schools. This involved CAMHS staff providing schools with specialist training in how to identify and support a child or young person with a mental health difficulty. The training mainly focused on supporting people who engaged in self-harming behaviours, as schools had identified this was an increasing problem. Young people from the CAMHS participation group, together with young people from the local authorities Bolton youth council, had produced an emotional health toolkit. This had been successfully embedded in local schools'

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personal health and social education lessons. CAMHS also provided advice on the referral criteria that children and young people must meet to qualify for intervention by CAMHS.

- We spoke with three members of staff employed by the local authority, including schools. All said that they valued the expertise of CAMHS staff, and that the referral process had become clearer and more accessible since the core service offer had been instated. CAMHS were also receptive to the specific needs of individual schools with regard to what they would find helpful for their students' emotional health and learning capacity. CAMHS were working with a local school to deliver a training package on challenging behaviour and how it could affect learning.
- CAMHS had established a good working relationship with another NHS trust who provided an inpatient mental health service for young people.This meant that CAMHS were referring young people who required more intensive support within an inpatient setting in a timely and appropriate way.CAMHS also maintained regular contact with inpatient services throughout the young person's inpatient admission.This ensured continuity of care and adequate information sharing to help facilitate a smooth discharge back into community services when appropriate.

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

- The trust had a service level agreement (SLA) in place with a local NHS trust. An SLA is a written agreement between a provider of a service and the commissioner of that service setting out the range and level of services to be provided, the responsibilities and priorities and the fees. The local NHS trust's MHA office provided Bolton NHS Foundation Trust with support with the administration of the MHA and legal advice on the implementation of the MHA and MHA Code of Practice 2015 (MHA CoP). The trust's met on a three monthly basis to discuss and review any concerns or developments in relation to the SLA.
- The trust did not provide mandatory training in the MHA or the revised MHA CoP 2015 to CAMHS staff. Only doctors who were approved under section 12 of the MHA had received up to date training in the MHA and MHA CoP. This accounted for two consultant psychiatrists within CAMHS. A doctor who is approved under Section 12 of the MHA is approved on behalf of the Secretary of State as having special expertise in the diagnosis and treatment of mental disorders. Section 12 approved doctors have a role in deciding whether someone should be detained in hospital under Section 2 and Section 3 of the MHA.
- We looked at care records for two young people who staff told us had been detained under the MHA on the trust's paediatric ward by a CAMHS practitioner. Although we saw copies of the detention paper work in one young person's paediatric care records, there were no copies in the young person's CAMHS care records. This was not in line with the MHA CoP that states that copies of MHA detention paper work should be filed in all patient care records. There was no record that the young person's next of kin had been consulted There was no copy of the approved mental health practitioner's recommendation in either the paediatric records or the CAMHS records.This was a risk because CAMHS staff did not keep a comprehensive record of a young person's legal status, which could potentially affect their care and treatment.
- One young person was detained on a paediatric ward at the Royal Bolton Hospital and allowed to leave without an authorised section 17 leave form. The young person was open to CAMHS and had been detained by a responsible clinician who was part of the CAMHS team. If someone is detained in hospital under the MHA, they are not allowed leave without specific permission granted by the responsible clinician. When people are detained in hospital under sections 2, 3 and 37, they may be given a time-limited leave of absence. This means they can leave the hospital grounds with permission – to visit their family, for example, or for a trial visit home prior to discharge. Sometimes, a member of staff might escort a patient on leave. The responsible clinician must authorise leave under section 17. This meant that the young person was allowed to leave the ward without the relevant legal authority.
- Where a child or young person was detained under the MHA, staff did explain their rights. However, we found that staff did not always accurately capture these discussions in their care records. For example, staff did not specifically identify what the patient had

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understood and how they had determined that the young person understood their rights. There was also no evidence to demonstrate that they been provided with a written copy of their rights. The MHA CoP 2015 states that all patients detained under the MHA must have information presented to them (regarding their rights) verbally and in written form.

- None of the children and young people detained under the MHA on the trust's paediatric ward had care plans in place to address their mental health needs. This meant that staff caring for them lacked guidance regarding how to care for a child or young person with a mental health need. It also meant that children and young people's preferences and concerns regarding their mental health were not formally captured within their care records.
- A local NHS trust was responsible for conducting audits to ensure the proper use of the MHA within CAMHS.However, at the time of our inspection, audits had yet to be completed.
- We presented these concerns regarding the proper use of the MHA to the trust during our inspection. The trust responded promptly to address these concerns. For example, the trust had actively worked with other NHS trust's to devise a care plan template specifically for detained patients. This was currently awaiting ratification by the patient advisory group in April 2016. A local NHS trust had also agreed to provide a training package in the MHA to senior management teams within the trust. MHA audits were also due to be completed. Plans were in place to continually revisit the auditing of the MHA to maintain a consistent oversight of how it was being implemented so that improvements could be made. A formal checklist to identify that the correct procedures for implementing the MHA was also being drawn up with a local NHS trust (for patients over the age of 16) and CAMHS (for under 16's).
- There was no commissioned service to provide children and young people detained under the MHA with an independent mental health advocate (IMHA).Where children and young people had been detained under the MHA, staff did not refer them to IMHA services for additional advice and support.However, children and young people detained under the MHA were quickly assessed and transferred to a local NHS trust's inpatient mental health unit where they could be referred to IMHA services.

Good practice in applying the Mental Capacity Act

- The trust did not provide mandatory training in the Mental Capacity Act (MCA) for young people aged 16 or above. MCA principles were covered within a safeguarding vulnerable adult's course provided by the trust. All eligible CAMHS staff had completed this course. The Mental Capacity Act does not apply to children and young people below the age of 16. Eligible CAMHS staff received training in legislation relevant to children and young people, such as the Children's Act (2004), within level two safeguarding children's training. This included training in the Gillick Competence Framework. All eligible staff had completed this training.
- We only found one occasion where a young person aged below 16 had not been assessed under the Gillick Competence Framework as appropriate. The young person had been detained under the MHA and there was no documentation to evidence that those with parental responsibility had been informed of their detention. If the young person had been assessed as being Gillick Competent and had identified that they did not want their parents to be informed, this should have been recorded in the young person's care records. However, care records did not identify that this assessment had taken place.
- For young people aged above 16 years, staff could access advice regarding the correct implementation of the MCA from the trust's adult safeguarding team.There was also a trust policy in place regarding the proper use of the MCA in clinical practice

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We attended and observed one patient participation group led by CAMHS staff. Staff respected young people's points of view and were sensitive to their individual needs. Young people we spoke with told us that staff were generally interested in their well-being. One young person said that their "confidence had improved" since being in the service, and another said "staff really understand what I need but also listen to what I think is right for me".
- We attended and observed two multi-disciplinary meetings where staff discussed patient care. Staff demonstrated a thorough understanding of individual children and young people's needs. Some children and young people had previously been seen by another CAMHS practitioner. In these instances, we saw that practitioners worked together to form a comprehensive assessment of the child or young person's needs. This helped practitioners achieve a better understanding of individual children and young people's case histories, so that they could better understand their current needs.
- Staff respected children and young people's right to confidentiality. We saw that practitioners sought permission from children, young people and their carer's, where appropriate, before sharing personal information with other organisations such as their school.
- Some parents we spoke with identified that their child had waited a long time to receive treatment once the initial assessment had been completed. They told us that waiting times to receive treatment could be in excess of 20 weeks. They said that although the service had provided information on how to receive help in emergency situations, they felt the waiting time had a negative impact on the child's mental well-being. However, parents we spoke with complimented the effectiveness of treatment once it had started.

The involvement of people in the care that they receive

- We reviewed 13 care records for children and young people. We found that children and young people were actively involved in the initial assessment process, and were encouraged to identify goals that they would like to work towards during their treatment. However, patient care plans did not capture the child or young person's point of view. Care plans took the form of a letter that was sent to the child or young person's GP, identifying what their current difficulties where and what interventions the service was going to provide. A copy of this letter was then sent to the child, young person and their parents. These were all written from the practitioner's perspective. However, we spoke with five carers and four young people using the service. They all told us that they had a good understanding of what their plan of care was and felt they were listened to when planning and delivering their care and treatment.
- The service employed a participation co-ordinator who was responsible for increasing patient and carer involvement in the service. The young people we spoke with said they were given opportunities to provide feedback to change how the service was delivered. This included a patient participation group, 'young voices', that ran fortnightly. The young voices group had successfully placed a bid to NHS England to secure funding for a self-help mobile phone application. Children and young people had been supported to work with a professional software company to develop the application. They had also been involved in a 'take over day' where children and young people were invited to re-decorate the main CAMHS unit's waiting area. This included producing a CAMHS mission statement that all staff were pledged to sign. The mission statement identified that all CAMHS staff would strive to continually involve children, young people and their relatives in all decisions regarding their care and treatment.
- Children and young people had also been involved in producing short films for the CAMHS website blog. Short films covered topics that the children and young people using the service had identified as being important to them, such as what to expect when coming to CAMHS, a young person's perspective on how schools handle mental health and self-harm. Children and young people wanted to raise public awareness of the services CAMHS offered, and also to make children new to the service feel more confident and comfortable in accessing the service.

Good

Are services caring?

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

- The service had an established parent and carer's participation group. The group had produced short films for the CAMHS internet blog to help explain to parents of newly referred children what they could expect from the service. The group also participated in a parent and carer transformation project that was part of NHS England's improving access to psychological therapies initiative. This was an established partnership between Bolton CAMHS and Bolton children's services. Parents and carers had identified that the CAMHS profile needed to be raised in the local community. They were working to develop literature that could be distributed within health centres, GP surgeries and hospitals to improve awareness of CAMHS so that more parents and carers could access the service if required. Parents of children and young people who had the used service were also recruited as volunteers to co-facilitate the group. Volunteers could empathise with the concerns of parents attending the group as they had first-hand experience of what it was like to care for child with a mental health difficulty.
- Parents, carers, children and young people also sat on interview panels to recruit new members of staff. They had also helped re-design the staff induction booklet and CAMHS mission statement to identify what qualities and values a CAMHS practitioner should possess.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- Referrals to the service could be completed and made directly by a child or young person's GP, school nurse, social worker, paediatrician or another CAMHS service. CAMHS provided a consultation telephone service where professionals could speak with a CAMHS practitioner regarding the appropriateness of a potential referral.
- Children, young people or their carers could not self-refer into the service. This was because they were not commissioned to do so. However, the service had been successful in securing funding for the CYP-IAPT accelerating service transformation fund to introduce a self-referral process. This idea had been put forward by parents of children and young people who used the service within the parents' participation group.
- The average waiting time from referral to triage was one week.The average waiting time from referral to assessment for all routine cases was three weeks.
- An on-call practitioner from the SPoA team screened all emergency referrals to the service for their level of risk between 9am and 5pm, Monday – Friday. Emergency referrals were seen on the same day. Referrals identified as non-urgent were discussed within the weekly SPoA team meeting and allocated to a practitioner for initial assessment. The CAMHS local target was to assess all routine, non-urgent referrals within four weeks. Between April 2015 and December 2015, the average waiting time to be assessed by the SPoA team was three weeks. Between October and December 2015, all routine referrals were assessed within two weeks.
- Following initial assessment by the SPoA team, the waiting time for active treatment from a CAMHS practitioner was approximately 23 weeks for the early intervention team, and 20 weeks for the intervention and recovery team. The senior management team had put new systems in place to try and address these waiting times. This included advertising staff vacancies via a new, online recruitment system, TRAC jobs, and reorganising the service delivery model. Although this had been effective in reducing waiting times to active treatment, children and young people still had to wait in excess of 20 weeks.
- The service used the children's global assessment scale (CGAS) which is a global rating of functioning aimed at children and young people aged 6-17 years. Patients were assessed against different levels of functioning from 0, needs constant supervision, to 100, superior functioning in all areas. The child or young person must fall below a certain level of functioning to meet the criteria for referral into the service. The criteria was clearly identified in the CGAS assessment.
- Children and young people assessed by CAMHS as not meeting the criterion for service intervention were referred to other teams and organisations for further support. This included 'Think Positive', a team that was part of adult mental health services. The team delivered evidenced based psychological therapies, such as cognitive behavioural therapy, to young people and adults aged above 16 years. Many referrals were also made to external organisations that provided specialist support to children and young people with gender-identification difficulties.
- In the care records we reviewed, we found that staff consistently tried to engage children and young people who were reluctant to access the service. This included offering to change the child or young person's care co-ordinator to explore whether another practitioner may form a more effective therapeutic relationship. Staff also offered children and young people appointments in different locations according to individual preference, such as children's centres and satellite clinics.
- The service had set a local target of keeping 'did not attend' (DNA) rates for appointments below 8% for initial assessments. Between April 2015 and December 2015, the service had a DNA rate between 3% and 10% for initial assessment appointments. The DNA rate was higher for children or young people accessing follow-up appointments within the early intervention and intervention and recovery teams. Between April 2015 and December 2015, the DNA rate ranged between 3% and 12%.Between October 2015 and December 2015, this had decreased to an average DNA rate of 6%.Two days before all appointments were scheduled, the services' electronic database system, IAPTUS, sent an automated text message to young people and their parents as an appointment reminder. This system had been effective in reducing the number of missed appointments within 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.

- The service had a local target to keep cancelled appointments (by the service) below a rate of 2%. Between April 2015 and December 2015, the average cancellation rate was 2%. The service only cancelled appointments due to emergency situations. This included another child or young person requiring immediate support by their named practitioner, or staff sickness. We saw that where appointments had been cancelled, staff offered children or young people alternative appointments within one week of cancellation, as per trust policy.

The facilities promote recovery, comfort, dignity and confidentiality

- The main CAMHS unit was modern and well maintained. Children, young people and carers had decorated the fences leading to the main CAMHS therapy unit with knitting work that had been co-produced within a local inter-generational knitting group project. However, most appointments took place in the services' therapy building. This was not welcoming to children and young people accessing the service. Although it was in the very early stages of being refurbished, the décor was tired and did not promote an environment that facilitated recovery. Therapy rooms were mostly bare, although some rooms and waiting areas did contain toys that were age appropriate to children.Information leaflets regarding the service and different treatments were available in waiting areas.Some of these were written in a child friendly way.This ensured that people of all ages using the service could gain an understanding of what the service provided.
- The main CAMHS units' waiting room had recently been refurbished. Children and young people had led a re-design of the waiting area, identifying what they would like it to look like and include. This included pictures of all staff working within the unit, with an accompanying participation mission statement that staff had signed to agree to promote it within their professional practice. The CAMHS' participation mission statement had been co-produced by children, young people and staff. It emphasised the need to prioritise children and young people's view in all decisions regarding their care and treatment.
- A 'you said, we did' notice board was also displayed within the waiting area. This included information regarding areas that children, young people and carers had asked the service to improve, and what the service had done to address this. Such improvements included modernisation of the waiting area and a review the staff induction pack. Information regarding how to make a complaint, independent advocacy services and other support agencies were also available. A confidential suggestions box was available for children, young people and carers to provide feedback regarding CAMHS. They also had access to a wide range of age appropriate toys and magazine.

Meeting the needs of all people who use the service

- The main CAMHS unit and therapy buildings were both based on one ground floor level. Ramps leading to both buildings complied with regulations as set out in the Equality Act (2010).
- The service used the mental health learning data set (MHLDS) to capture the ethnicity of children and young people accessing the service. Despite approximately 30% of the local population deriving from black or minority ethnic groups (BME), the total number of referrals into the service from this sector of the population was low. The diversity of the ethnicity of staff employed by CAMHS did also not reflect that of the local population. Most staff employed by the service identified as white British.
- We reviewed a recent participation action plan that had been produced by the Bolton CAMHS' children and young people, improving access to psychological therapies lead co-ordinator (CYP-IAPT). This had been developed to improve engagement with the local community, including children and young people within the BME group. The over-arching drive behind the plan was to raise awareness of what CAMHS provided so that they could seek referral into the service where appropriate. So far, actions that had been initiated included making contact with local mosques to increase CAMHS awareness within the Muslim community.
- We found that for those children and young people who accessed the service that spoke a different language, interpreters to support appointments and translators to translate any correspondence, were requested and used

Are services responsive to people's needs?

Requires improvement

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as appropriate. CAMHS were working with the Bolton Youth Council to gain a wider perspective of what children and young people within the local community wanted from the service.

Listening to and learning from concerns and complaints

- Between January 2015 and December 2015, the service received five complaints.Only one of these was upheld.Within this time period, no complaints had been referred to the Ombudsman.
- During our inspection, we reviewed three complaints made to the service between December 2015 and March 2016. We found that all three complaints had been responded to appropriately, in accordance with trust policy. The staff we spoke with demonstrated that they knew how to handle a complaint appropriately. Patients and carers we spoke with said they knew how to make a complaint, and were provided with a complaints leaflet (which included details of the patient advice and liaison service (PALS)), when referred to the service. Parents and carers told us that where they had raised concerns, staff dealt with these immediately. Therefore, in most cases, complaints were resolved on a local level without requiring escalation to the PALS team.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- The trust promoted four key values that all employees should hold and demonstrate within their work at Bolton NHS Foundation Trust. This included putting patients and staff at the heart of everything they do, to be respected, valued and proud. Staff we spoke with demonstrated a limited awareness of these values. However, they were more aware of the local values the team had recently created in partnership with children and young people. This included a mission statement, displayed in the CAMHS units waiting area, where all staff had pledged to promote patient and carer participation in all the work they undertook with children, young people and carers using the service.
- Staff we spoke with said that the organisation's senior management team visited their service occasionally. On a local level, staff told us that the senior management within the Family's Directorate were approachable and mostly listened to their ideas and concerns regarding the service.

Good governance

- Staff did not receive mandatory training in safeguarding vulnerable children at level three, which is deemed essential for their role. They also did not receive training in the Mental Health Act or Mental Capacity Act for children aged 16 or above. However, when we raised these concerns with the trust during inspection, they responded immediately and demonstrated that plans had been put in place to offer this training to all eligible staff over the next two months.
- Inadequate staffing, and the impact this had on waiting times to receive treatment by a CAMHS practitioner, was added to the divisional risk register in October 2015. The cause of inadequate staffing was identified as a delay to recruitment into vacancies. Although the trust had advertised these vacancies, the trust had not been able to recruit at the time of our inspection. The trust received very few applicants, and where senior management had interviewed applicants, they had not been recruited to post. This was because they were identified as not being sufficiently experienced or suitable for the role. The directorates risk register also identified that where staff had been recruited, there was limited capacity to conduct occupational health screening as part of the pre-employment checks. This meant that new employees start dates were unnecessarily delayed. Collectively, this meant that the waiting time for children and young people to receive active treatment by a CAMHS practitioner remained above 23 weeks.
- Within CAMHS, we found that lessons were mostly shared, reflected upon and adequately addressed following any incidents that had occurred. There was an established CAMHS quality forum and lead clinicians meeting. This occurred monthly and was attended by senior management within the family care division of the trust. Standing agenda items included a review of the CAMHS dashboard. The CAMHS dashboard captured service performance in relation to key performance indicators and goals, including staff training compliance, complaints, incident reports, referrals and waiting times. However, we found limited evidence to suggest that incidents that occurred within the wider trust were adequately shared and addressed. This was because there was limited communication and effective working between CAMHS and other teams within the trust that were also responsible for the care and treatment of children and young people. This included services outside of the family care division, such as Accident and Emergency.
- Although staff engaged in clinical audit and used a wide range of outcome measures to measure children and young people's progress in the service, the services' audit lead identified that outcome measures were not consistently being completed. Despite this being a standing agenda item within weekly pathway team meetings, audits identified that staff completion of outcome measures continued to be low. For example, the global assessment scale outcome measure (CGAS) identified that between October 2015 and December 2015, the proportion of children and young people who had scored a ten point improvement in their functioning was between 35% - 45%. This fell below the local target of an improvement above 50%. The reason the improvement score was lower than target was because staff were not consistently completing the outcome measure with children and young people during appointments.

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.

- The trust had appointed a new CAMHS service manager to post. They had an identified start date in April 2016.
- An administrative team provided good support to CAMHS senior management and practitioners. They attended weekly multi-disciplinary team meetings and sent correspondence, including appointment letters, to children, young people and their carers within locally identified target times.

Leadership, morale and staff engagement

- No local staff surveys were available regarding CAMHS.
- The service had a low sickness and absence rate. Between January 2015 and December 2016, the rate was recorded at 2%. No bullying or harassment cases had been reported by staff that worked within CAMHS.
- During our inspection, we observed staff interaction that included the senior management team. We found that staff displayed confidence in asserting their professional opinions and were open to receiving constructive and appropriate challenge where necessary. Staff told us that they felt comfortable in raising concerns regarding the service without fear of this having negative consequences. Some staff told us that they would welcome the opportunity to have formal supervision individually, in addition to peer supervision sessions. This is because they would not feel comfortable discussing some issues within a group setting. However, staff said that senior management were accessible on an informal basis should they have any concerns.
- Most staff told us that they had a good degree of job satisfaction and that they were provided with opportunities to develop their career. This included five staff who were currently being trained in NHS England's children and young people's improving access to psychological therapies project. However, some staff told us that since the service model had been changed over the past few months, development opportunities were more limited. Staff said this was because there was not enough practice time available to allow them to engage in further study and training. Staff told us that they thought this would improve now that the new service model was becoming more embedded and staff had adjusted to their new roles.
- Mutual staff support within CAMHS was high. Staff we spoke with told us that this is what they were most proud of within their work as a CAMHS practitioner.

Commitment to quality improvement and innovation

- CAMHS had secured funding from NHS England's innovation fund 2015/16. This was to develop a net-safety in your pocket mobile phone application. The safety in your pocket is a targeted intervention aimed at improving the personal safety management of young people by giving them access to interactive safety management plans on their own mobile device. It's aim is to reduce the risk of self-harm, suicide and frequency of repeated need for urgent care in a crisis. It would be shared by a school nurse or CAMHS worker at first presentation of self-harm.

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	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (2) (a) Staffing How the regulation was not being met; Staff were not adequately trained in some elements of care that were essential to their role as a CAMHS practitioner. • Eligible staff did not receive level three safeguarding vulnerable children and adults training. NHS England has identified this training as essential for the role of community CAMHS practitioner. • Eligible staff did not receive training in the Mental Health Act (MHA) or revised MHA Code or Practice (MHA CoP) 2015. Staff did not always follow trust policy or the MHA CoP 2015 when using the MHA. This was a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(2)(a) and (c) Good governance How this regulation was not being met; We found that there were not always effective systems and processes in place to assess, monitor and improve the quality and safety of the services provided. We also found that some patient care records did not contain all the necessary information regarding their care and treatment.

This section is primarily information for the provider

Requirement notices

- There was no effective system in place to monitor the services' compliance with the Mental Health Act Code of Practice (2015).
- In patient care records, there were no copies of detention paper work for children and young people who had been detained under the MHA.

This was a breach of regulation 17(2)(a) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(b)(d) and (h) Safe care and treatment How this regulation was not being met; We found that the service was not taking all reasonably practicable steps to mitigate certain risks to provide safe care and treatment. We also found that the service was not always adequately assessing the risk of, and preventing, detecting and controlling the spread of infections. • Staff did not always take alarms into clinical areas where clinical contact with a child or young person took place. There had been reported incidents where a child or young person had become distressed and verbally or physically aggressive during an appointment. This put people at risk, as alarms can be used to alert other staff for assistance in an emergency situation. • There was no local procedure in place to advise staff how they should keep themselves safe when working as a lone practitioner off-site. • The CAMHS clinic room did not have a mixer tap. This had recently been installed and had not been identified as a safety issue.

This section is primarily information for the provider

Requirement notices

- We found a sharps box that had not been disposed of since 2014. This could contribute to the spread of infection.

This was a breach of regulation 12(b)(d) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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.