Child and Adolescent Mental Health Services: Follow-up Review of Safety Issues

11 December 2013

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales
hiw

This report has been prepared jointly by Healthcare Inspectorate Wales and the Wales Audit Office, and is presented by the Auditor General for Wales to the National Assembly under the Government of Wales Acts 1998 and 2006.

Further information on the roles of Healthcare Inspectorate Wales and the Wales Audit Office is given in Appendix 2 of this report.

The images used throughout this report have been selected from material produced by children and young people who took part in group work sessions as part of the consultation undertaken in the original joint review of child and adolescent mental health services.

Contents

Summary and recommendations

About our review

1 In November 2009, Healthcare Inspectorate Wales (HIW), the Wales Audit Office, Estyn, and the Care and Social Services Inspectorate Wales (CSSIW) published a report of a joint review of Child and Adolescent Mental Health Services (CAMHS)[1]. The review examined a broad range of services for children and young people with emotional and mental health problems across health, social services and education, and set out to establish whether services were adequately meeting the mental health needs of children and young people in Wales. The overall conclusion was that despite some improvements in recent years, services were still failing many children and young people, reflecting a number of key barriers to improvement.

2 The report was considered by the Public Accounts Committee of the National Assembly in sessions in December 2009 and January 2010. Our recommendation that the Welsh Government produce an action plan to address the broad range of issues raised in the joint report, was endorsed by the Public Accounts Committee. The Welsh Government acted upon this recommendation by issuing in May 2010, *Breaking the Barriers: Meeting the Challenges*[2], which set out the actions that the NHS and local authorities needed to take.

3 The November 2009 joint report identified a number of safety concerns that arose from practices, largely within the NHS. Given the risks that these practices posed to the safety of children and young people, HIW requested that local action plans be immediately developed by health boards whilst the broader Welsh Government action plan was being developed. This follow-up review focuses on the Welsh Government's and health boards' responses to the safety issues identified in our 2009 report. These were:

- the inappropriate admission of children and young people to adult mental health wards;
- health staff not understanding and/or not acting upon their safeguarding responsibilities;
- health professionals not sharing information regarding individual children with other practitioners; and
- the closing of cases or discharge of patients following non-attendance at appointments.

1 *Services for children and young people with emotional and mental health needs,* Wales Audit Office, Healthcare Inspectorate Wales Estyn, Care and Social Services Inspectorate Wales, November 2009

2 *Breaking the Barriers: Meeting the Challenges, Better Support for Children and Young People with Emotional Well-being and Mental Health Needs, An Action Plan for Wales,* May 2010

4 The objective of this follow-up review was to establish whether the Welsh Government and health boards have fully addressed the issues that were highlighted in 2009 as putting children and young people at risk. Details of how we undertook the review can be found in Appendix 1. During the course of the review we have kept the Welsh Government and health boards informed of our emerging findings so that they could be fed into local and national improvement initiatives. Such initiatives include the implementation plan[3] developed to support the revised mental health strategy that was issued in October 2012[4].

Main conclusions

5 Our overall conclusion is that whilst there has been some progress by the Welsh Government and health boards in addressing the safety issues highlighted in our 2009 report, children and young people continue to be put at risk due to inappropriate admissions to adult mental health wards, problems with sharing information and acting upon safeguarding duties, and unsafe discharge practices.

Admitting young people inappropriately to adult mental health wards

6 Inappropriate admissions of young people to adult mental health wards continue. Health boards are not reporting all such admissions to the Welsh Government as required, and when they do so, the reasons for the admission and the steps taken to minimise risks are not always clear. Betsi Cadwaladr University Health Board produces an annual report detailing each admission, but this level of detail is not reported by other health boards.

7 There is a divergence between the Welsh Government's policy on inappropriate admissions to adult mental health wards and how young people presenting in crisis who are in need of an initial assessment are being dealt with. In the absence of comprehensive services in the community, young people in crisis are being admitted to adult mental health or paediatric wards for an assessment. This is because the alternative of admitting to a CAMHS inpatient unit is deemed by clinicians in the units to be inappropriate.

8 Although steps have been taken to ensure that in an emergency young people can be safely cared for on an adult mental health ward, such measures have not been completely successful. We found that it was common practice for health boards to have identified a specific (designated) adult ward with an appropriate environment to which young people could be admitted, and for increased (one-to-one) staffing to be provided when such an admission takes place. However, some young people are still being placed on non-designated adult wards; the adequacy of at least one designated ward is of concern; and, following a change of use, another designated ward is no longer available to young people but no replacement facility is planned.

9 Intensive community support services, which are aimed at reducing the need for admission, have been expanded since our 2009 report. However, although there are plans to develop these services further, they will still not be universally provided across Wales.

10 Quantifying the capacity of the two CAMHS units is a complex exercise, which needs to take into account a number of factors including case mix, staffing levels and skills and the number of patients on home leave. There are plans to improve the way the capacity of the two CAMHS units is monitored. However, the planned numbers of emergency beds in both CAMHS units have not been delivered, in part as a result of using some of the funding that had been allocated to the units to develop intensive community support services. The limited capacity of the two units has resulted in significant numbers of out-of-area placements. Between June 2011 and April 2012, 21 patients who were discharged from an out-of-area placement had been originally

3 *Together for Mental Health Delivery Plan: 2012-16,* Welsh Government

4 *Together for Mental Health, A Strategy for Mental Health And Wellbeing in Wales,* October 2012

referred out of area due to the limited capacity of the CAMHS units in Wales. These placements cost a total of more than £1.5 million. It is likely that the lack of capacity in the two CAMHS units is also leading to some inappropriate placements on adult mental health and paediatric wards, but the extent of this has not been quantified. Although Welsh Health Specialised Services told us that it is continuing to work with both CAMHS units to increase capacity, through increased beds and intensive community support, there has been limited progress since our 2009 report.

Safeguarding and information sharing

11 Health boards have introduced revised policies and procedures relating to safeguarding and information sharing, and have strengthened training provision. However, there is clear evidence that these changes are not leading to the desired changes to practice on the ground. Problems persist with information sharing and the approach taken by staff when safeguarding issues are identified.

12 Health boards have not ensured that all clinical staff working in CAMHS have a Disclosure and Barring Services (DBS) check (formerly called a Criminal Records Bureau or CRB check) renewed every three years. It remains common practice that only staff who join a health board or who move posts are subject to a DBS check.

Discharge practices

13 The response to missed appointments continues to be problematic. Children and young people continue to be routinely discharged if there is no response by a set date from the family or carer to a letter sent following a missed appointment. Where this happens, there is little evidence that the risks to the young person or others have been assessed before discharge, or that clear communication routinely takes place with other agencies involved in the care of the individual.

14 The Welsh Government has developed a national 'was not brought' protocol, to ensure improved attendance and consistent and safe discharge practices, and expects all health boards to comply with the 11 key steps identified in the protocol. The impact of the protocol in changing practices on the ground will need to be monitored.

Recommendations

a There is a divergence between Welsh Government policy on reducing inappropriate admissions to adult mental health wards and the way young people in crisis that are in need of an assessment and emergency care are being dealt with. **We recommend that:**

- **i The Welsh Government confirms with health boards and Welsh Health Specialised Services the extent to which the two specialist CAMHS inpatient units should provide initial assessment, emergency and crisis support.**

b The continued lack of reliable data on admissions to adult mental health wards is a concern. Betsi Cadwaladr University Health Board's mechanisms for the reporting of admissions of young people to adult wards is a notable exception, and should be used as the benchmark by all health boards. **We recommend that the Welsh Government:**

- **i confirms in writing the need for health boards to report to it all admissions of young people under the age of 18 to an adult mental health ward, identifying those admissions that are inappropriate and the steps taken to minimise risks;**
- **ii requires health boards to validate that they are accurately reporting the number of under 18 year olds admitted to adult mental health wards, by periodically comparing the number of these admissions reported to the Welsh Government with the number registered on patient admission systems; and**

iii **clarifies, by providing a range of detailed examples, what constitutes an inappropriate admission of a young person to an adult mental health ward;**

c Although there are now more designated adult wards with environments appropriate for the care of young people, we have identified a number of concerns about how they are used. **We recommend that the Welsh Government:**

i **requires health boards to regularly report the number of designated wards, the appropriateness of their environments, and the number of admissions to designated and non-designated wards.**

d There has been limited progress in increasing capacity at the two CAMHS units. The lack of capacity has led to significant numbers of out-of-area placements and is also likely to have resulted in some inappropriate use of adult mental health and paediatric wards. The planned numbers of emergency beds at both CAMHS units have not been delivered. **We recommend that the Welsh Government:**

i **makes clear whether or not one of its aims is that out-of-area placements and admissions to adult mental health or paediatric wards should not occur due to a lack of capacity in the two CAMHS units, and, if so, sets a deadline by which the aim should be achieved;**

ii **requires Welsh Health Specialised Services to routinely report the number and cost of out-of-area placements that result from a lack of capacity in the two CAMHS units; and**

iii **requires Welsh Health Specialised Services and health boards to establish mechanisms for identifying and reporting admissions to adult mental health or paediatric wards that result from a lack of capacity in the two CAMHS units.**

e We found that revised policies and procedures, and strengthened training, are not leading to the desired change in practices in relation to safeguarding, information sharing and discharge practices. **We recommend that:**

i **the Welsh Government agrees with health boards systems for routine monitoring to check, at least annually, on compliance by service provider staff with their safeguarding and information sharing responsibilities, and with the all-Wales 'was not brought' protocol.**

f Health boards have made little progress in ensuring that all CAMHS staff have up-to-date DBS checks. **We recommend that:**

i **the Welsh Government sets a deadline for health boards to arrange DBS checks on all staff working in CAMHS, and requires that the checks are updated at least every three years.**

Placing young people inappropriately on adult mental health wards

Why this issue is important

1.1 The Mental Health Act 2008 required that age-appropriate services be put in place by April 2010, and that patients aged under 18 with a mental health problem requiring admission to hospital are accommodated in an environment that is suitable for their age.

1.2 It can be appropriate for a young person with mental health problems to be admitted to an adult ward due to their maturity, but for many young people admission to adult mental health wards would be inappropriate because:

- the wards may be mixed sex and lack privacy, stimulation and educational opportunities;
- there may be inadequate access to specialist CAMHS support and advice;
- staff are not trained to support young people with mental health problems, and are not aware of relevant child protection requirements; and
- staff are not trained in appropriate restraint techniques.

What we said in our 2009 report

Significant numbers of children and young people are being placed, or kept, inappropriately on paediatric or adult mental health wards, giving rise to concerns about the effectiveness and safety of the care provided. Reasons for inappropriate use of paediatric or adult mental health beds include insufficient CAMHS inpatient beds, especially emergency beds, and inadequate access to a CAMHS assessment, particularly out of hours. The improved availability of emergency beds may help to reduce the inappropriate use of adult mental health and paediatric wards.

What we recommended

The Assembly Government, in collaboration with health boards, should take steps to ensure children and young people are not placed inappropriately on adult mental health wards. Until the issue is resolved, the Assembly Government and health boards should monitor the numbers of inappropriate placements.

The Welsh Government response

The *Breaking the Barriers: Meeting the Challenges* action plan reconfirmed that health boards were required to ensure that children and young people were placed in appropriate accommodation and that inappropriate admissions to adult mental health wards were stopped. Health boards were expected to report all admissions of under 18s to an adult mental health ward to the Assembly Government as serious incidents, and the Delivery Assurance Group[5] was to monitor the numbers of these admissions.

5 The Delivery Assurance Group monitors and oversees the delivery of the *Breaking the Barriers: Meeting the Challenges* action plan on behalf of relevant directors general within the Welsh Government and the ministers they serve. Membership comprises senior policy officials drawn from relevant Assembly Government departments, and senior representatives of the health, local government, education and third sectors.

Follow-up review findings

Welsh Government policy developments

1.3 The Welsh Government's policy on inappropriate admissions was reaffirmed in the *Together for Mental Health* strategy, which clarified that 'children and young people should not be admitted to adult wards except in the most exceptional circumstances. Where such an admission is unavoidable, it should be reported to the Welsh Government as a serious incident.' However, the strategy did not make it clear what constitutes 'exceptional circumstances'.

1.4 The delivery plan that supports the *Together for Mental Health* strategy contains a number of actions that are intended to reduce the risks faced by children and young people when placed on adult mental health wards. These include requirements for health boards to:

- reduce the number of inappropriate admissions of those under 18 years of age to adult wards;
- designate by December 2012 an adult ward(s) to which unavoidable emergency admissions could be made, with the staff on such wards being required to have appropriate training and safeguarding checks; and
- ensure that by June 2013 staff on designated wards had completed formal training on the needs of young people.

1.5 There is a divergence between the Welsh Government's policy on inappropriate admissions to adult mental health wards and how young people presenting in crisis who are in need of an initial assessment are being dealt with. As far as possible, young people presenting in crisis should be assessed by CAMHS in the community, at which point the appropriate care and support can be considered, including whether there is need for admission to a CAMHS inpatient unit. However, in the absence of comprehensive services in the community, young people in crisis are being admitted to adult mental health or paediatric wards for an assessment. The alternative of admitting to a CAMHS inpatient unit is deemed by clinicians in the units to be inappropriate. This is because:

- admitting to a paediatric ward, rather than a CAMHS unit, is less traumatic and avoids the stigma of the child or young person being labelled as having a mental health problem;
- travelling distances to the two CAMHS units can be impractical, and using paediatric or designated adult mental health beds keeps young people as close as possible to their own homes; and
- there are risks that young people get 'stuck' in the CAMHS unit as some local community services may be reluctant to take the young person back.

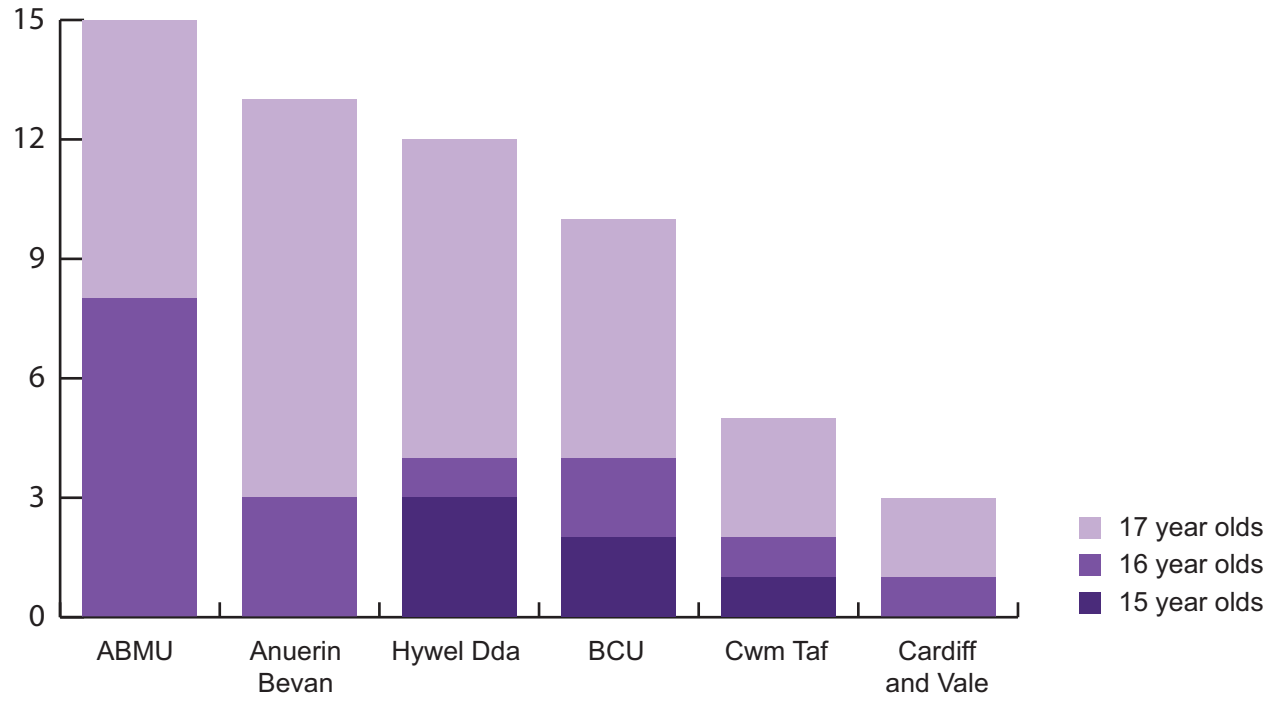
Placements onto adult mental health wards

1.6 Significant numbers of young people under 18 years of age are still being admitted to adult mental health wards. Data from health board patient administration systems identified 58 such admissions between July 2011 and June 2012 (Figure 1).

1.7 The *Breaking the Barriers: Meeting the Challenges* action plan set a target date of the end of March 2012 for specialist CAMHS to cover all young people up to their 18th birthday. Previously some 16 and 17 year olds (those attending college or no longer in education) were the responsibility of adult mental health services. The period covered by our data request (July 2011 to June 2012) overlapped the period of transition to these new arrangements.

1.8 Ensuring that all young people under 18 are the responsibility of specialist CAMHS should reduce the number of admissions to an adult mental health ward. However, admissions data does not suggest that this occurred in the period immediately after the end of March 2012 target date had passed – the average number of admissions of under 18 year olds to adult mental health wards between April and June 2012 (4.3 per month) was not significantly lower than the average between July 2011 and March 2012 (4.6 per month).

Figure 1 – Admissions of patients aged under 18 by health board (1 July 2011 to 30 June 2012)



Note

No data shown for Powys as admissions are adult services run by neighbouring health boards.

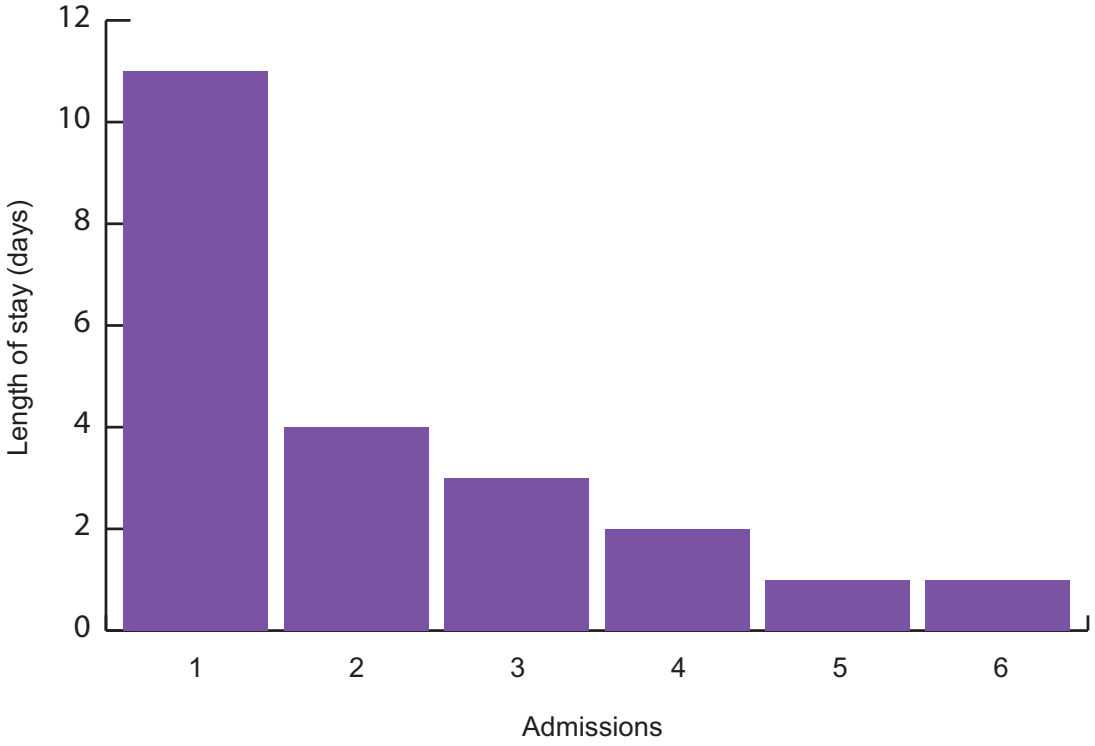
Source: Health board data request, September 2012

1.9 Health boards do not routinely record whether the admission of someone under 18 to an adult ward was appropriate on the grounds of the individual's maturity. As a result, an assessment of the extent to which such admissions are appropriate or inappropriate cannot be made. However, the data we collected from health boards indicates that significant numbers of inappropriate admissions are being made, as between July 2011 and June 2012:

- three health boards admitted young people who were only 15 years old and all health boards admitted at least one 16 year old; and
- in total, six young people aged 15 and a further 16 young people aged 16 were admitted to adult wards.

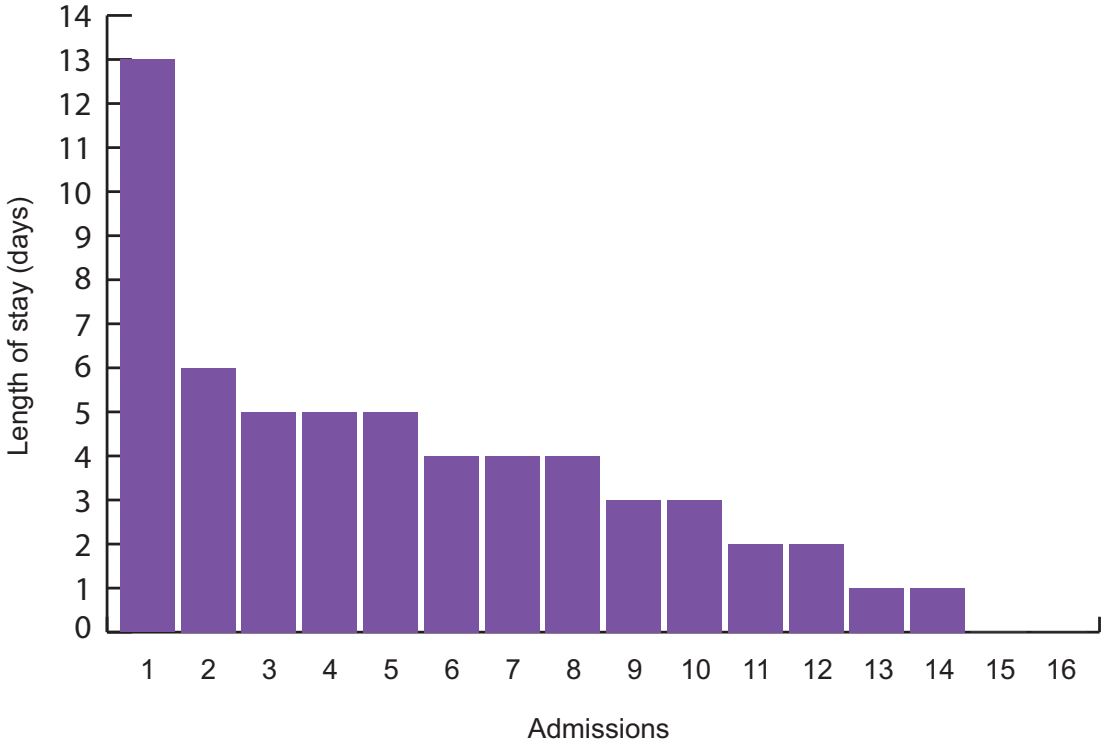
1.10 Most 15 and 16 year olds admitted to an adult ward between July 2011 and June 2012 had a length of stay of four days or less (Figure 2 and 3). Two of the six 15 year olds admitted during the period stayed for one day. Of the 16 year olds admitted during the period two stayed for one day, and a further two were admitted and discharged within a day. However, one 15 year old remained on the adult mental health ward for 11 days, and one 16 year old for 13 days.

Figure 2 – Length of stay for admissions of 15 year olds to adult mental health wards (1 July 2011 to 30 June 2012)



Source: Health board data request, September 2012

Figure 3 – Length of stay for admissions of 16 year olds to adult mental health wards (1 July 2011 to 30 June 2012)



Source: Health board data request, September 2012

Reporting of admissions to adult mental health wards

1.11 The Welsh Government requires health boards to report to it all admissions of young people under 18 years of age to adult mental health wards. However, health boards are underreporting the number of these admissions. Between July 2011 and June 2012, only eight admissions were reported to the Welsh Government compared to the 58 identified by our analysis of health board patient administration systems. The annual number of admissions reported by health boards between 2009 and 2012 has varied between nine and 16, with 14 reported during 2013 (to September 2013).

1.12 The figures reported to the Welsh Government have been used when reporting progress, such as in the annual report on the *Breaking the Barriers: Meeting the Challenges* action plan[6], and give false assurance to health boards and the Welsh Government. Our discussions with health boards identified a number of factors that help explain the underreporting, including:

- some adult wards may only be reporting those cases which they see as being inappropriate rather than all admissions of young people under 18 years of age;
- admissions resulting in a short stay of one or two days may not be felt to be worth reporting; and
- problems in ensuring consistent application of the reporting requirement across the large number of adult mental health wards that admit young people.

1.13 When health boards do report such admissions to the Welsh Government, the quality of the information provided is often inadequate. Our review of the information provided to the Welsh Government supporting the admission of young people to adult mental health wards included only brief details of the reasons for admission and the actions taken to minimise risk.

1.14 The reporting by Betsi Cadwaladr University Health Board of admissions of young people to adult mental health wards is a notable exception. The health board produces an annual report, which includes details of each individual admission, the adult mental health ward to which the young person was admitted, the age and gender of the person admitted, detailed reasons for the admission, the length of stay, and details of where the person was discharged to and the post-discharge care and support provided. These should be the minimum reporting requirements set for all health boards.

1.15 The Welsh Government told us that during its regular meetings with health boards it has reinforced the need to reduce the number of inappropriate admissions and to ensure that those that do occur are reported. This message was also relayed during a meeting between the Minister for Health and Social Services and the vice chairs of health boards in July 2013. The Welsh Government also told us that, during the last 12 months, its mental health team has followed up individual incidents that have been reported by health boards, to understand why they occurred and raise any issues of concern with health board nurse leads for mental health and directors or nursing.

Adult mental health ward environments

1.16 The action plans developed by four of the seven health boards in response to our 2009 review referred to improved training for those staff on adult mental health wards that had been designated as suitable for admitting young people. The action plans for three of these health boards also made reference to improved or amended admissions policies for young people placed on adult mental health wards. Two health boards provided us with a copy of their admissions policy, but both were out of date and in need of review and revision.

6 *Breaking the Barriers, Annual Report,* December 2011, Welsh Government

1.17 The requirements of the Mental Health Act 2008 and additional Welsh Government funding have been the stimulus for ensuring that, in the exceptional circumstances that children and young people are admitted to an adult mental health ward, they are admitted to a ward that has an appropriate environment. It is usual now for health boards to have one or more named adult wards with an appropriate environment, and with increased (one-to-one observation) staffing when required. The number of designated wards reflects the differing health board populations and geography. Health boards have put in place audit and accreditation processes for the designated adult wards. However:

- Some young people are being placed onto non-designated adult mental health wards, and Mental Health Act monitoring reports indicate that some of these wards are unsuitable for people under 18 years old due to a lack of privacy and gender separation and an inappropriate case mix.
- In Abertawe Bro Morgannwg University Health Board, one of the designated adult wards was assessed by HIW as not being able to provide the requisite care for young people. The health board subsequently developed an action plan to address the issues raised by HIW and the ward continues to be used for the admission of young people.

Specialist CAMHS community services

1.18 There have been some developments in specialist CAMHS community services since our 2009 report. A new Community Intensive Therapy and Treatment service is now in place in Abertawe Bro Morgannwg University Health Board. The service has been funded through decommissioning a day unit and other service reorganisations. Hywel Dda Health Board has developed a service specification for a Community Intensive Therapy and Treatment service, although funding for this service development has not yet been secured. In North Wales, an Intensive Community Support Team is expected to be operational from November 2013. Health boards expect that these services, when fully developed, will lead to reduced admissions to CAMHS inpatient beds.

1.19 However, intensive community support services are still not universally provided across Wales. As a result, some parts of Wales are more dependent upon inpatient services than others.

1.20 Different clinical opinions have also resulted in a different service model being pursued in the north and south. In the south, the intensive community support service (where available) is able to take on cases that are referred by CAMHS teams. In the north, the equivalent service will work alongside CAMHS teams but will not take on the case. The Intensive Community Support Team in the north will work into the evenings and weekend sessions, whereas the teams in the south work normal office hours. Finally, the intensive community support service in the north, on a pilot 12-month basis, will have built-in education provision through access to the education facility in the CAMHS unit. There is no such provision in the south.

1.21 The impact on admissions of the service model in the north will only be known when the service is up and running. It will also be some time before an assessment can be undertaken of how effective both service models are in reducing admissions.

Specialist CAMHS inpatient services

1.22 There are two specialist CAMHS inpatient units in Wales. Ty Llidiard in Bridgend covers South Wales and South Powys, and the North Wales Adolescent Service in Abergele Hospital covers North Wales and North Powys. In our 2009 report, we highlighted that 16 to 18 year olds who were not in education were the responsibility of adult mental health services. This has now been addressed and both CAMHS units now take all young people up to the age of 18 years of age regardless of whether they are in education or not.

1.23 A shortage of capacity in the two CAMHS units will result in out-of-area placements and admissions to adult mental health or paediatric wards. However, quantifying the capacity of the two CAMHS units is a complex issue involving a number of factors. When running at full capacity the beds in a unit may not be full due to, amongst other things:

- a complex case mix placing greater demands upon staff;
- limitations in staffing levels and skills; and
- the number of patients on home leave.

1.24 Welsh Health Specialised Services is responsible for commissioning tertiary CAMHS services on behalf of health boards, including services provided by the inpatient units and any out-of-area specialist placements. To better assess the capacity in the CAMHS units Welsh Health Specialised Services, with support from Public Health Wales, plans to implement a common system for assessing the dependency of patients.

1.25 The new unit in the north, which opened in July 2009, went through a troubled start. On opening, the new unit was staffed either by nurses from the former unit or by newly qualified nurses, both of whom lacked experience of dealing with seriously ill young people. The clinical lead for the unit told us of occasions when the unit was looking after young people with very challenging behaviours, such as violence and extreme self-harm. Together, these two factors resulted in the unit being unable to accept further admissions even though a bed was available. This was compounded by a high level of staff turnover, and resulted in increased numbers of young people being placed in out-of-area facilities. At the time of our follow-up visit in October 2012, the unit was still not able to take all appropriate cases, even when a bed was available. The new unit now caters for more seriously ill young people than the former unit, and the health board told us that as staff skills have been developed the number of out-of-area placements has fallen.

1.26 The business cases for each of the CAMHS inpatient units included provision for five emergency/acute beds. However, the emergency/acute beds have not been put in place. In the north, the funding is being used instead to develop community services that are designed to reduce the level of admissions. In the south, the CAMHS unit told us that the level of funding was not sufficient to provide adequately for the planned mix of emergency and general beds. Emergency admissions do take place in both units when a bed is available and, in the north, when case mix and staffing levels allow. However, both units have less capacity to deal with emergency admissions than originally planned. Welsh Health Specialised Services told us that few out-of-area placements relate to emergency cases. However, the extent to which a lack of capacity in the two CAMHS units leads to emergency cases being admitted to an adult mental health or paediatric ward is not routinely monitored and is not known.

1.27 In October 2013, the Welsh Government announced annual funding of £250,000 to improve specialist services for children and young people with complex eating disorders in South Wales. The Welsh Government anticipates that one outcome of this additional funding will be to release CAMHS staff to provide more support for emergency and crisis admissions for young people with more complex needs.

1.28 Inpatient staff at both units are supporting young people in the community. This is particularly the case in the south, where an outreach service was provided by inpatient staff for young people on short and long-term leave from the unit. The outreach service has now been replaced with a discharge liaison service providing input for up to four weeks. At the time of our fieldwork in the north, outreach and educational support was being provided to keep a small number of young people out of a hospital bed. The CAMHS unit told us that this type of intervention is no longer being provided, although it remains part of a 'menu' of interventions that can be called upon if required.

1.29 There is a potential trade-off between using inpatient staff to provide outreach services and thereby reducing the demand on inpatient beds, and the reduced capacity of these staff to support inpatient beds. Potentially, this could lead to fewer young people being supported as inpatients in the unit, and increase the risk of admissions to adult mental health or paediatric wards or out-of-area placements. The overall impact on bed use of deploying finite inpatient staff resources in this way is unclear.

1.30 Welsh Health Specialised Services maintains an out-of-area placements database with more detailed information being available from individual patient files. At the time of our fieldwork, the database did not hold information on the reasons for out-of-area placements, and could only provide an approximate cost of each placement 'with some caution' as not all extensions to treatment and placements had necessarily been collated together. Welsh Health Specialised Services told us that these issues have now been resolved, and confirmed that since September 2013 the reason for each placement (such as need of the patient, or a lack of capacity in Welsh CAMHS inpatient units) has been recorded on the database.

1.31 In 2013, Welsh Health Specialised Services undertook an audit of out-of-area placements covering current patients and a cohort of patients that had been discharged from out-of-area placements. The audit focused upon the rationale for placement, diagnosis information and length of stay. The audit found that all of the 10 inpatients who were in out-of-area placements at the time of the audit were placed due to need rather than capacity issues in the units in Wales. However, 21 of 41 patients who had been discharged between June 2011 and April 2013 had been originally referred out of area due to the limited capacity of the CAMHS units in Wales. The cost of these 21 placements was not established as part of the audit although, following our request, Welsh Health Specialised Services has undertaken a further analysis and has estimated the cost to be £1.584 million. Although Welsh Health Specialised Services told us that it is continuing to work with both CAMHS units to increase capacity, through increasing the number of beds and the extent of intensive community support, the progress made since our 2009 report has been limited.

1.32 There is out-of-hours telephone consultation and support from CAMHS consultants to adult mental health and paediatric consultants across North Wales. However, there are no out-of-hours admissions to the CAMHS unit in the north due to the lack of any out-of-hours junior doctor cover. In the south, out-of-hours admissions do occur, although not from across the whole catchment area as there is no on-call psychiatrist in either Hywel Dda or Powys health boards. This increases the risk of admissions to adult mental health and paediatric wards.

In conclusion

1.33 Our conclusions are that:

- inappropriate admissions to adult mental health wards continue, health boards are not reporting all such admissions, and, where reported, the reasons for admission and the steps taken to minimise risks are not always clear;
- there is a divergence between the Welsh Government's policy on inappropriate admissions to adult mental health wards and the use of these wards for young people presenting in crisis who are in need of an initial assessment;
- although steps have been taken to ensure that adult mental health wards that provide a safe and appropriate environment for young people are available, such measures have not been completely successful;
- intensive community support services are still not universally provided across Wales, and as a result, some parts of Wales are more dependent upon inpatient services than others;
- there are plans to improve the way the capacity of the two CAMHS units is monitored;

- the planned numbers of emergency beds in both CAMHS units have not been delivered, in part as a result of using funding to develop community services, and an overall lack of capacity in the two units has resulted in significant numbers of out-of-area placements; and
- the extent to which a lack of capacity for both emergency and general care in the two CAMHS units is leading to placements on adult mental health and paediatric wards is unclear.

Safeguarding and information sharing

Why this issue is important

2.1 Safeguarding is a term that describes the process of identifying children and young people who have suffered or who are likely to suffer significant harm, and taking the appropriate action to keep them safe.

2.2 A number of high-profile reviews of deaths and other serious incidents involving children and young people in England and Wales have identified the inadequate sharing of information between responsible agencies as a key factor that led to the inadequate identification and management of safeguarding issues. A report on the Confidential Enquiry into Maternal and Child Health, *Why Children Die: A Pilot Study 2006*[7], identified the lack of information sharing as an avoidable factor in child deaths. Failures to act on safeguarding issues often involve information not being shared appropriately.

What we said in our 2009 report

In some parts of Wales, professionals in different organisations are not appropriately sharing information on individual cases, putting children and young people at further risk and undermining child protection arrangements.

What we recommended

Health boards and local authorities should ensure that all staff working with children and young people understand their safeguarding responsibilities, as set out in Welsh Assembly guidance *Safeguarding Children: Working Together Under the Children Act 2004*.

Health boards and local authorities, in collaboration with the Assembly Government, should ensure that all staff working with children understand their responsibilities for sharing information on individual children and young people.

The Welsh Government response

The *Breaking the Barriers: Meeting the Challenges* action plan stated that all organisations were to ensure that they implemented the national safeguarding guidance, and that staff were trained in its requirements. The action plan also tasked the specialist CAMHS planning networks, on behalf of health boards, with ensuring that appropriate arrangements were in place to share information between relevant professionals; and with developing a model information sharing protocol and guidance.

7 Pearson, G A (Ed) *Why Children Die: A Pilot Study 2006*; England (South West, North East and West Midlands), Wales and Northern Ireland. London: CEMACH. 2008

Follow-up review findings

Policy and protocols

2.3 There is no specific mention in the *Breaking the Barriers, Annual Report* for 2011[8] of safeguarding issues. However, a CAMHS information sharing protocol for use by NHS staff has been developed and piloted in North Wales by the North Wales CAMHS Planning Network and Betsi Cadwaladr University Health Board. In June 2013, the Welsh Government issued CAMHS specialist advice for service planners that included information sharing requirements. The advice, which is non-prescriptive, was developed by the National Expert Reference Group[9]. It details that providers need to have robust information sharing arrangements between services and across agencies that ensure risk and safeguarding issues are assured. It includes the Betsi Cadwaladr University Health Board information sharing protocol as a model for other services to consider.

2.4 The Betsi Cadwaladr University Health Board information sharing protocol applies only to NHS staff, although it covers sharing of information within the NHS and by the NHS with local authority and voluntary sector partners. The health board is planning to develop the protocol to cover the sharing of information by all partners, including local authorities. Health board staff told us that they expected this next stage to be more challenging and, given the number of organisations involved, it is likely to take a considerable time to agree.

Training and organisational arrangements

2.5 In their action plan updates, all health boards referred to having comprehensive safeguarding training in place, and to arrangements whereby staff understanding and compliance with the training is monitored through appraisal and development processes. In addition, four health boards referred to having specific training in place on the sharing of information.

2.6 Health boards confirmed in their updates the links that exist between CAMHS and local safeguarding boards, and between CAMHS and individual health board governance structures. Cwm Taf Health Board, which provides CAMHS to three health board areas, has developed a database for monitoring all safeguarding activity within CAMHS. The database includes details of the safeguarding referrals made by CAMHS and of the follow-up and feedback from children's services.

2.7 Disclosure and Barring Service checks on CAMHS staff and those working on designated adult wards remain an area of concern across Wales. Common practice in all health boards continues to be that only new staff or those moving post are subject to DBS checks. This means that the majority of staff have not been subject to a DBS check. The Cwm Taf service, which provides CAMHS across two other health board areas in South Wales, has failed to implement a target in its safety action plan, drawn up in response to our joint review, that all clinical staff in CAMHS have a DBS check that is renewed every three years. Three of the other four health board action plan updates did not refer to any actions planned or taken in relation to DBS checks.

2.8 One health board told us that legal advice to the NHS was that existing staff did not require a DBS check. However, as a matter of good governance it is reasonable to expect that all staff working with such vulnerable young people should have a DBS check. The Director

8 Since 2011, the Welsh Government's annual report on progress in implementing the *Breaking the Barriers: Meeting the Challenges* action plan has been superseded by reports against the *Together for Mental Health Delivery Plan: 2012-16*, which covers all ages.

9 The National Expert Reference Group is a multiagency group providing professional support, expert advice and the delivery of specific objectives in the CAMHS action plan for the Delivery Assurance Group. Membership comprises service users, practitioners, professionals (drawn from education, health, social care and the third sector), academics, service planners and service managers associated and involved in service delivery in the field, either directly or indirectly, in support of the CAMHS agenda.

of Workforce at the Welsh Government wrote to health boards in August 2013 reiterating that they should comply with the requirements of the Welsh Government guidance *Safeguarding Children: Working Together Under the Children Act 2004*. This guidance states that both new and existing employees should have a DBS check which should be repeated at regular intervals of no more than three years.

2.9 In June 2013, the DBS launched a new service that keeps an individual's DBS check automatically up to date. Currently the individual, rather than their employer, can subscribe to the update service at a cost of £13 per year. Once subscribed this allows the employee to 'take their DBS with them' from role to role within the same workforce or when changing employers where the same type and level of check is required. If an individual subscribes to the update service, with his or her consent their employer can go online and carry out a free, instant check to find out if the DBS check is current and up to date. This service, particularly if it is extended to allow employers to subscribe, could make it easier for health boards to administer DBS checks.

Professional practices

2.10 As part of its review of how prepared CAMHS were for the care and treatment planning requirements of the Mental Health (Wales) Measure 2010, the Delivery Support Unit[10] carried out case file reviews. These case file reviews identified similar concerns to those highlighted in our 2009 report in terms of staff exercising their safeguarding responsibilities effectively and sharing information. For example, the Delivery Support Unit found that some case notes had indicated that the child or young person was at risk of self-harm or violence, but there was no agreed plan in place to address the risk.

2.11 Children and young people with emotional or mental health problems should be assessed in relation to the risks of self-harm, harm to others and vulnerability (including risk of being harmed by others). However, the Delivery Support Unit review of 45 case files found that:

- very few case files included a risk assessment (only six out of 45) or a comprehensive risk management plan (only one case);
- no standardised risk assessment processes were in place;
- relevant staff had not been trained in risk assessment and management; and
- consent to share information with other professionals was not being routinely recorded or evidenced.

2.12 There has been no audit or monitoring by health boards to ensure that safeguarding training and information sharing requirements are being applied in practice. However, in its action plan update in March 2012, Cwm Taf Health Board stated that in future information sharing will form part of the regular medical records audit that is carried out within CAMHS.

In conclusion

2.13 Our conclusions on the progress made with safeguarding and information sharing are:

- revised policies and procedures and strengthened training are not leading to the desired changes in practice on the ground – problems persist both with information sharing and with staff acting upon their safeguarding responsibilities; and
- health boards have not ensured that all clinical staff working in CAMHS or on designated adult mental health wards have a DBS check that has been renewed within the last three years.

10 The Welsh Government established the Delivery Support Unit to assist NHS Wales in delivering key targets and levels of service expected. The Delivery Support Unit is part of the Welsh Government's Department of Health and Social Services.

Discharge practices

Why this issue is important

3.1 The report by the Confidential Enquiry into Maternal and Child Health, *Why Children Die: A Pilot Study 2006*, published in 2008, is highly critical of both the practice of closing cases due to missed appointments and the lack of routine follow-up where appointments have been missed. The report highlights missed CAMHS appointments as a particular area of concern and notes that a failure to attend can be an indicator of a family's vulnerability, potentially placing the child's welfare in jeopardy. Also, missed appointments may be due to the parents' or guardians' competing commitments, or other family problems. The report concludes that 'Whilst there may be policies in which adults are not sent repeat appointments, this will rarely be appropriate practice with children' and that 'Child and Adolescent Mental Health Services should proactively follow up children who do not attend their appointments'.

What we said in our 2009 report

Children and young people who miss appointments are, as a consequence, 'discharged' by specialist CAMHS teams in many areas, and a lack of routine follow-up of missed appointments can put children at risk.

What we recommended

Health boards and local authorities, in collaboration with the Assembly Government, should ensure that cases are not routinely closed due to non-attendance at appointments, and that safe and effective routine follow-up occurs when appointments are missed.

The Welsh Government response

The *Breaking the Barriers: Meeting the Challenges* action plan stated that locally agreed protocols were already in place across Wales setting out how to deal with cases where a child or young person does not attend an appointment; with patients who do not attend being contacted by telephone, then by letter if necessary; and with the referrer always being contacted where the service user does not engage. Only actions relating to monitoring and reducing non-attendance rates were included in Breaking the Barriers.

Follow-up review findings

3.2 With the exception of Aneurin Bevan Health Board, all health boards provided us with a copy of their protocol for managing children and young people who do not attend an appointment. Protocols can cover just CAMHS staff or can cover all health professionals who work with young people under 18 in inpatient, outpatient or community settings. All protocols had been updated following the publication of our 2009 report, and they outline the need for follow-up action if someone does not attend an appointment and for risks to be assessed prior to discharge.

3.3 An all-Wales 'was not brought' protocol has been agreed by the Welsh Government's Delivery Assurance Group and the National Expert Reference Group. The two-page protocol sets out 11 key steps that should be taken by health board staff when a child or young person does not attend an appointment. The Welsh Government expects all health boards to comply with the all-Wales protocol and that local protocols will be reviewed to ensure they follow the 11 key steps.

3.4 National monitoring of rates of non-attendance has highlighted that, on average across Wales, 13 per cent of CAMHS appointments are missed, but in some areas the rate is as high as one in five cases. Health boards have put various initiatives in place to reduce non-attendance rates. For example, Betsi Cadwaladr University Health Board has undertaken an audit of patients who did not engage following referral to CAMHS to ascertain the reasons for this and to look at how engagement can be improved.

3.5 The Delivery Support Unit's review of CAMHS case files identified a number of issues in relation to 'discharges'. They found that children and young people were routinely being discharged if there was no response by a set date from the family or carer to a letter sent following non-attendance at an outpatient appointment. The Delivery Support Unit found little evidence of risk assessments being undertaken prior to discharge, and concluded that children and young people were being discharged without the 'requisite attention to the risks involved'. In addition, they found that:

- discharges were usually agreed and confirmed by the clinician caring for the child or young person, rather than by a CAMHS multidisciplinary team;
- there was no standardised process to confirm that a discharge had occurred, and that the relevant people within the NHS and other agencies had been informed; and
- actions required of other agencies were not being communicated or documented in case files.

3.6 The new procedures for dealing with non-attendance put in place by health boards since 2009 have not been subject to audit or other checks to ensure that they are being followed by staff. Also, health boards have not introduced any audit or other checks of the safety of their discharge procedures.

3.7 The Welsh Government has told us that following the findings of the Delivery Support Unit's review it wrote to health boards in February 2013 asking them to work with partner local authorities and the third sector to ensure evidenced-based risk assessment training is provided for CAMHS staff. The Welsh Government also informed us that it had requested, and was about to receive, an update from health boards on their progress with providing risk assessment training and on their implementation of the 'was not brought' protocol.

In conclusion

3.8 Our conclusions on the discharge practices of health boards as a result of children and young people missing CAMHS appointments are:

- safe and effective practices are still not in place for young people who miss appointments, with patients being discharged without sufficient attention to the risks involved;
- health boards have not developed arrangements for auditing or checking the safety of their discharge procedures; and
- although a national 'was not brought' protocol has been developed, its impact on the safety of discharges will need to be monitored.

Appendix 1 - How the follow-up review was undertaken

The follow-up was undertaken jointly by HIW and the Wales Audit Office, and involved gathering evidence using a number of methods.

Updated safety action plans

We requested from each health board progress updates, as at March 2012, on the original safety action plan. All health boards responded and included in their returns various levels of supporting policies and documents.

Review of HIW reports

We reviewed the evidence relating to the safety issues gathered since 2009 by HIW as part of its routine Mental Health Act visits. These visits focus on young people detained under the Mental Health Act.

Document review

We collated and reviewed relevant reports, policies and protocols produced by the Welsh Government and health boards including the Welsh Government's action plan drawn up in response to our 2009 report and annual reports by the Welsh Government on progress with implementing the action plan. We also reviewed the March 2012 Delivery Support Unit report into how well prepared CAMHS was for implementing Part 2 of the Mental Health Measure (Wales) 2010.

Data request

We gathered data from health board patient information systems relating to individuals under 18 years of age who had been admitted to an adult mental health ward between July 2011 and June 2012.

Interviews

We interviewed a range of staff from the Welsh Government, the three CAMHS planning networks, health boards, the Delivery Support Unit, and the Welsh Health Specialised Services who are responsible for commissioning inpatient services for children and young people. These interviews were undertaken between October and November 2012.

Appendix 2 - Audit and inspection bodies undertaking this review

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales is the independent inspectorate and regulator of all healthcare in Wales. Healthcare Inspectorate Wales' primary focus is on:

- making a significant contribution to improving the safety and quality of healthcare services in Wales;
- improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee;
- strengthening the voice of patients and the public in the way health services are reviewed; and
- ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

Healthcare Inspectorate Wales' core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Government and healthcare providers that services are safe and good quality. Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work, HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. We also protect the interests of people whose rights are restricted under the Mental Health Act. In addition, HIW is the regulator of independent healthcare providers in Wales and is the local supervising authority for the statutory supervision of midwives.

Healthcare Inspectorate Wales carries out its functions on behalf of Welsh Ministers and, although part of the Welsh Government, protocols have been established to safeguard its operational autonomy. Healthcare Inspectorate Wales' main functions and responsibilities are drawn from the following legislation:

- Health and Social Care (Community Health and Standards) Act 2003;
- Care Standards Act 2000 and associated regulations;
- Mental Health Act 1983 and the Mental Health Act 2007;
- Statutory Supervision of Midwives as set out in Articles 42 and 43 of the Nursing and Midwifery Order 2001; and
- Ionising Radiation (Medical Exposure) Regulations 2000 and Amendment Regulations 2006.

Healthcare Inspectorate Wales works closely with other inspectorates and regulators in carrying out cross-sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.

Wales Audit Office

The Auditor General is totally independent of the National Assembly and the Welsh Government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies in Wales. He also has the statutory power to report to the National Assembly on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also appoints auditors to local government bodies in Wales, conducts and promotes value for money studies in the local government sector and inspects for compliance with best value requirements under the Wales Programme for Improvement. However, in order to protect the constitutional position of local government, he does not report to the National Assembly specifically on such local government work, except where required to do so by statute.

The Wales Audit Office mission is to promote improvement, so that people in Wales benefit from accountable, well-managed public services that offer the best possible value for money. It is also committed to identifying and spreading good practice across the Welsh public sector.