November 2017

Inquiry into the Emotional and Mental Health of Children

Work undertaken

2009

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). 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 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.

2013

3. In 2013 HIW and the Wales Audit Office published a follow-up review which aimed to establish whether the Welsh Government and health boards had fully addressed the issues that were highlighted in 2009 as putting children and young people at risk.

4. This review concluded that although there had been some progress by the Welsh Government and health boards in addressing the safety issues highlighted in our 2009 report, children and young people continued 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.

Since 2013

5. There are three in-patient CAMHS units in Wales. Two of these are NHS Units: Ty Llidiard in Cwm Taf University Health Board, and the North Wales Adolescent Unit in Betsi Cadwaladr University Health Board. The third unit is Regis Healthcare Hospital and is managed by an independent provider Regis Healthcare Ltd.

Ty Llidiard

6. HIW published the report on its latest inspection of Ty Llidiard in June 2017 http://hiw.org.uk/find-service/service-index/tyllidiard?lang=en

7. This report highlights a number of positive features including the standard of care and treatment plans and positive behaviours in the treatment of patients and also between multi-disciplinary team members and management.

8. It also identified a number of areas in which the service could be improved. For example:

- Record keeping**:** it was noted there was evidence of poor record-keeping in a number of areas including poorly organised patient records; incomplete Mental Health Act documentation and patient observation records; and poor completion of Medication Administration Records.
- There was a lack of robustness to some safety procedures such as medication administration and management, timely access to the on-call manager, and access to emergency equipment
- Compliance of staff with mandatory training such as child protection needed
- Completion of additional specific training to help support and care for patients, including Maudsley training for eating disorders, meal support, nasogastric feeding, suicide and self harm reduction and internet addiction training.

9. Of particular interest to the Committee may be the issues highlighted relating to wider pressures within the system. Our report states

> At the time of our inspection Ty Llidiard was commissioned as a 15 bed hospital. The hospital had a total of 19 bedrooms, 14 bedrooms on Enfys Ward and five bedrooms on Seren Ward. During the inspection there were 18 patients being cared for at the hospital.

We were informed that due to the current levels of demand on the in-patient service, Ty Llidiard was regularly providing care for more patients than the 15 bedded services which it was commissioned and staffed to provide. Therefore, additional staff via the bank system or agency were required.

We were also informed that at times during 2016, patients had been placed 'out-of-area' due to lack of patient beds in Ty Llidiard.

10. We recommended that the Health Board should review CAMHS provision in South Wales to ensure there is sufficient capacity.

11. We identified the impact these pressures were having on staff.

It was evident that the service was under significant pressure to provide care for more patients than the number it was commissioned for. This impacted upon staff's ability to consistently provide high quality, safe and reliable patient-centred care.

12. We also highlighted the impact that pressures and recent vacancies had on the ability of staff to complete their mandatory and update training.

North Wales Adolescent Unit, Abergele Hospital

13. HIW currently expects to visit this Unit at some point during 2018.

Regis Healthcare

14. HIW published the report on its latest inspection of Regis Healthcare Hospital in February 2017 http://hiw.org.uk/find-service/service-index/regishealthcare89?lang=en .

15. Overall this was a generally positive inspection which highlighted a number of areas in which progress had been made since our previous inspection in 2015.

Broader perspectives

Youth Offending Teams

16. HIW also takes part in joint inspections of Youth Offending Teams in Wales. These reviews are led by Her Majesty's Inspectorate of Probation and also involve representatives from CSSIW and Estyn. The latest report to be published in July 2017 was a Full Joint Inspection of Youth Offending Work in Cwm Taf

https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2017/07/Cwm-Taf-FJI-report.pdf . This report concluded that

> *"There was some good partnership working, but the provision of services by Child and Adolescent Mental Health Services was poor."*

17. Further detail in the body of the report highlights some positive movement in spite of continuing problems

> *"1.7 There was also evidence of good Health Board … and Youth Offending Service collaborative working, such as the new development service[1]. This initiative had a positive impact in terms of reducing waiting times for children and young people to access health services."*

> *"2.17 The lack of access to CAMHS was a significant issue despite the tenacious efforts of YOS staff. The transition of children and young people from youth to adult services was problematic and we saw limited involvement from CAMHS. YOS staff did report that the service was better for children and young people known to the YOS who had a dual diagnosis"*

Intelligence

18. We use a range of intelligence to help us decide where to focus our work. This includes concerns raised by staff, patients or relatives. The volume of concerns relating to specialist CAMHS units is not large and over the past two years we have received only ten concerns covering both the NHS and independent sectors.

[1] The initiative was announced in 2015 and was funded by the Welsh Government to reduce waiting times in specialist CAMHS

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our Priorities

Through our work we aim to:

Provide assurance:

Provide an independent view on the quality of care.

Promote improvement:

Encourage improvement through reporting and sharing of good practice.

Influence policy and standards:

Use what we find to influence policy, standards and practice.

Our Responsibilities

Our work delivers activities in three key areas:

- regulation of independent healthcare
- inspecting the NHS
- mental health.

<u>Regulation of independent healthcare</u>

Registration, inspection and enforcement action are the methods through which HIW regulates the independent health sector in Wales in accordance with the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011; the Independent Health Care (Fees) (Wales) Regulations 2011 and other legislation (see Annex B).

We regulate and inspect a broad range of independent healthcare providers ranging from those who use lasers to full private hospitals. Our core activities are listed below.

- Registration and inspection of independent clinics, hospitals and medical agencies.

- Registration of independent mental health and learning disability establishments.
- Registration and inspection of premises using class 3B or 4 laser or intense pulse light machines.
- Pursuit of enforcement action when regulatory breaches are identified in a registered setting.
- Identifying and dealing with potential unregistered providers.

Inspecting the NHS

HIW inspects services provided by the NHS across Wales to test whether care is provided in accordance with the Health & Care Standards. Many of HIW inspections are unannounced although for practical reasons this is not always possible. We have published a statement setting out the rationale for whether our inspections are unannounced or announced. We also undertake a proportion of our visits outside of office hours.

Inspections test care against three specific domains:

- quality of patient experience.
- delivery of safe and effective care.
- quality of leadership and management.

Mental Health

The focus of this work area is to ensure the most vulnerable individuals in society are protected, cared for and treated appropriately in environments conducive to their recovery. HIW visits hospitals in both the NHS and the independent sector as part of our work programme. We also visit services provided in the community to review Community Treatment Orders.

Our core activities are listed below.

- Inspection of NHS and independent mental health and learning disability establishments with appropriate follow-up activity.
- Provision of the Mental Health Review Service and processing requests for Second Opinion Appointed Doctors (SOADs).
- Monitoring the implementation of the Mental Health Measure.
- Monitoring the implementation of the Deprivation of Liberty Safeguards (DOLS).
- Monitoring the use of the Mental Health Act.