WHSSC Specialised Services consultation

Stakeholder Response Proforma

Policy Title	In-patient Child and Adolescent Mental Health Services (CAMHS): General Adolescent Unit (GAU) and High-Dependency Unit (HDU)
Policy Reference Number	CP150
Deadline for comments	Please complete and return your completed form by e-mail to CTT_WHSSC_Consultation@wales.nhs.uk by **17:00** on **18th October 2019**

Respondent's Name	Siân Harrop-Griffiths
Respondent's Job Title	Director of Strategy
Replying on behalf of organisation?	Swansea Bay University Health Board
Name of Respondent's organisation	Swansea Bay University Health Board

Declaration: Before completing this proforma you must declare any financial or other interests in relation to any specialised services directly relevant to this commissioning policy. [Please refer to the WHSSC 'Standards of Behaviour' policy]
No interests to be declared

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Comment Number	Page Number	Line Number	Section	Comment [Insert each comment in a new row]
1.	General			Language needs to change throughout, avoid patient and say CYP.
2.	General			Is there going to be a service user friendly version of this document?
3.	General			PBS and pro-active approaches need to be fully embedded throughout
4.	General			The service user does not feel central to much of this document. There needs to be much clearer discussion about partnership, co-production, collaborative decision making and capturing, reflecting and acting on feedback.
5.	6	22	Tier 1- Universal Services	The School Nursing Service needs to be added here.
6.	7	12 & 21		These lines are effectively describing the same services yet they are in different tiers. This is inherently confusing.
7.	8	34 -37		The intention to provide mental health assessment and treatment for 12 to 18 year olds that cannot safely have their needs met in a community setting is warmly welcomed as it removes the need for under 18s to be admitted to adult mental health wards.
8.	11	32, 33, 34, 35	Access Criteria	It is good to see that Learning Disabilities is included as these patients do require specialist support which is currently limited within South Wales. This may not provide an equity of care to all patients with issues, but will address the high level cases. IQ is not the only measure of learning disability and is often unreliable. Many CYP may not have had an IQ

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				assessment and the level of learning disability is understood by functional skills/adaptive behaviour. IQ should not form part of access criteria access for those with learning disabilities and should be based on individual presentation and level of assessed need.
9.	12	4	Exclusion criteria	As above
10.	12	6,7.8, & 9	Exclusion criteria	The exclusion of chronic high risk cases not fitting the admission criteria leaves the Health Board with children and young people who are displaying risky behaviour still spending extended periods on the Health Board's paediatric ward. Making a statement that this is social care to sort is difficult as there are not the placements available, this does leave CYP with risky behaviour in an environment that is not suitable for their needs. A primary mental disorder may be a precipitating factor in high levels of risk or "placement breakdown" and to say that a young person's needs "will" be better met by social services is a very large assumption. It should be decided in partnership through multiagency assessment and in the meantime the person should be safeguarded in the best manner available in an emergency situation.
11.	12	16	Exclusion criteria	How recently does the formulation need to have taken place to exclude access?
12.	12	20	Exclusion criteria	Is there signposting to appropriate alternative?
13.	12	23	Exclusion criteria	Where the statement: 'the decision about the priority of presenting needs……..' this could be a standard statement introducing the inclusion and exclusion criteria, or should be added to the end of each of the complex exclusion

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				points to ensure that individuals needs are fully understood before being excluded from the service.
14.	11 & 12			Where is the young persons voice in this, how will they be involved in decisions about what their needs are in relation to assessment.
15.	12	32	Exclusion criteria	Do these specialist services exist?
16.	12	37	Exclusion criteria	Is this legal? The Equality Act (2010) says reasonable adjustments must be made by organisations to meet needs. If a child is born deaf and has a primary diagnosis of Mental Disorder is there not an obligation to provide further assessment and appropriate care and treatment?
17.	12	39,40	Exclusion criteria	Where are the appropriate services for these individuals to avoid secure services- future likelihood of criminal justice/Prison. Is there a duty to signpost within this document?
18.	13	6&7	Exclusion criteria	Does this mean potentially CYP with ASD would be able to access the service if the in-patients CAMHS GAU or HDU MDT feel they are best able to meet needs?
19.	13	9	Exclusion criteria	This needs to come across in a much stronger way, the document has numerous exclusion criteria making it seem like an inaccessible service. If this statement was set ahead of the exclusion criteria (also see comment 9 & 10) it might feel more positive, recognising the individualised approaches that the service will take.
20.				The language doesn't feel right. Where else do we talk of referrals to inpatient care? We have referrals for assessment of needs and a decision about the best manner of meeting that need which may be hospital care. CCAMHS services should also operate in this way, seamlessly, for the wellbeing of children. There are surely no

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				inappropriate referrals just professional or clinical disagreements about needs or the way to best meet a child's needs.
21.	13	20	Referrals	'responsibility for the care….' This could be reworded: The Young person will need to continue to access the support from the referring service until they are admitted, it may be necessary to provide ongoing input to support step down and timely discharge/transfer of care'
22.	13	25	Referrals	Instead of setting a minimum standard, why not set a gold standard? The referral form will need to capture the young persons views/goals about/for the admission
23.	13, 14	general		There is a mismatch between the timeframe for undertaking assessments which are urgent and the intention of the specification to provide inpatient care for children who cannot safely have their needs met in community settings. If a person is identified as requiring inpatient care by a CAMHS consultant and the maximum timeframe for admission can be up to 38 hours following this or (even 24 hours) then you are effectively saying that a child may have to remain in an unsafe situation whilst admission is facilitated. What is the justification for this? Furthermore if it is anticipated that the current questionable practice of temporarily admitting a child to an adult psychiatric setting would still be expected to continue after commissioning a GAU for children then this would be absolutely unacceptable in terms of the care available for vulnerable children. This is an opportunity to effectively commission the right services for children that ensure they receive the care that they deserve.

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24.	15	19		The young person and their family should be informed….. this needs to be earlier in the paragraph, this does not feel like the YP and their family will be involved in or central to the decision making. Ideally the YP and their family will be involved.
25.	15	25	Admission	Why these timescales? Is 7am better than 6am? The most important thing is that admissions take place when they are necessary for the child and that the service makes adjustments to ensure that this is safe ad well managed. Why not say ideally the admission will take place during day time hours in a calm and well managed way, admissions during the evening and early hours should be avoided to reduce the distress and disorientation that may occur as a result for the YP and those already in the unit however there are occasions where this is unavoidable to best meet a child's needs.
26.	15	40	Admission	Information about their condition?
27.	16	38	Facilities	An activities of daily living kitchen Occupational Therapy space Therapy room for 1:1 sessions Outdoor space/Garden areas A range of freely accessible snacks and drinks A feedback mechanism- ideas board/box Augmented communication systems
28.	18	20	Staffing and training	Speech and language therapy
29.	18	41 & 42	Staffing & Training	Needs to be explicit that these teachers must have received appropriate level of MH awareness training

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30.	19	22	Staffing and training	& Values Based Approaches: Positive Behaviour Support Understanding of ACEs Trauma Informed Functional assessment?
31.	19	37	Assessment	Routine enquiry?
32.	19	37	Assessment	Outcome measures? Baseline assessments? Quality of life indicators?
33.	20	15		Great to see that the formulation will be shared with the YP and their family.
34.	21	18	Therapeutic interventions and clinical progress	The service endeavours- again, this should be a gold standard statement: the service **must** provide sufficient notice, where this is not possible a variation/exception must be reported
35.	22	29	Education	Re-order statements, YP receive an assessment within one week- move to the top.
36.	24	1	Risk management	The unit will adopt a positive approach to risk taking, least restrictive approaches will be promoted and CYP will be involved in the development of their individualised, person centred risk assessment.
37.	24	17	Risk management	'With' each YP
38.	24 & 25	44, 45 & 1	RRP	CYP rather than pt Staff need to be aware of the broad range of practice that can be restrictive, regular opportunities for reflection on practice and group supervision to discuss least restrictive approaches

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39.	25 20	11 20	Enhanced Observation	Consider renaming: 'Safe and supportive observation' Engage with the YP where possible to agree the levels of observation that they feel they need and staff assess as appropriate.
40.	25	29	Restraint	May be used……only as a last resort, when all pro-active approaches have failed.
41.	25 26	37 & 38 6	Restraint	Good description in terms of development, is there scope to reflect past trauma and advance planning in partnership with the individual e.g. if seated restraint is a preferable option? What about space for de-brief, reflection on incident including the individual, those around them and the team supporting.
42.	27	20	Community leave	Cancellation must be avoided at all costs
43.	27	32	Discharge	Planning for discharge should be considered from admission, expectation for recovery and transition to home setting should be clearly communicated
44.	37	all	Raising a concern	The language needs to be CYP rather than pt throughout this document

Insert extra rows as needed

Instructions for submitting comments

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- Include page, line and section number of the text each comment is referring to.
- If you wish to make a comment on the whole document please insert 'general' in the page number and section column.
- Submit this template as a Word document (not a PDF).
- Combine all comments from your organisation into one response. We cannot accept more than one response from each organisation.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use.
- For copyright reasons, comment forms must not include attachments such as research articles, letters or leaflets.
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Responses to consultations may be made public – on the internet or in a report. If you would prefer your response to be kept confidential, please enter YES in the box	