GIG CYMRU NHS WALES | Delivery Unit Uned Gyflawni

All Wales Assurance Review of Primary Care Child and Adolescent Mental Health Services (CAMHS)

The Review of Primary Care CAMHS Abertawe Bro Morgannwg University Health Board

June 2019

Introduction and rationale for the Delivery Unit DU assurance review.

Meeting the emotional and mental health needs of children and young people enables them to develop resilience, to grow and develop to their full potential.

Most frequently these needs are met within the family, by education and youth services. However, where children and young people experience more profound emotional or mental health problems they may require more specialist child and adolescent mental health services (CAMHS). Early intervention from these services increases the potential for recovery limiting the impact of these problems on the young person's development.

A number of reports and inquiries into CAMHS in Wales have however, demonstrated shortcomings in the accessibility of these services. These deficiencies have been identified by children and young people themselves, by their family members, carers, G.P.s, other stakeholders and by the services themselves.

In order to improve the delivery of mental health services to people of all ages Welsh Government introduced Wales specific legislation; the Mental Health (Wales) Measure 2010 (the Measure). This legislation included the development of local primary mental health support services (LPMHSS) including services to people under the age of 18.

As a result of Welsh Government (WG) concerns about CAMHS performance significant additional revenue investment has been made into CAMHS since the commencement of the Measure. The investment has been directed at both primary care and specialist CAMHs with the aim of increasing the capacity and capability of CAMHS to deliver timely assessment and interventions. A separate CAMHS strand of the Together for Mental Health strategy has been developed, entitled Together for Children and Young people. This was established to drive the pace and scale of change and to improve the reach and quality of these services.

The DU Assurance review was commissioned by Welsh Government to analyse the impact these initiatives have had on improving primary care mental health services for people under the age of 18

Background

Part 1 of the Measure requires the LPMHSS to deliver the following 5 functions:

- Comprehensive assessment
- Treatment interventions
- Provision of information, advice and signposting
- Support and advice to GPs and other primary care workers
- Supporting onward referral and coordination of next steps with secondary care mental health services

Activity data reports are required by WG on the first two of these functions which are the subject of time bound targets. Assessments are required to be undertaken within 28 days of referral and intervention is required to commence 28 days after assessment. Assessments under Part 1 can only be undertaken by registrants from within designated professional groups.

The DU routinely monitors local primary care mental health support services' activity and performance data including those for people under 18.

CAMHS' across Wales have reported lower rates of compliance with these targets than their counterparts delivering services to working age and older adults frequently missing these national performance targets for the timely delivery of both assessments and interventions. These performance issues are leading to some children experiencing long waits for assessment and intervention.

Consideration of these performance concerns is central to the DU assurance review which will be undertaken in primary care CAMHS in each of the Health Boards in Wales.

The review of primary care CAMHS in Abertawe Bro Morgannwg University Health Board (ABMUHB) took place between 14th – 25th Jan 2019. Verbal feedback was provided to the Health Board Directorate on the final day of the visit.

The Aim and Objectives of the Assurance review

Aim

To analyse primary care CAMHS data and engage CAMHS staff and stakeholders to gather enumerative and qualitative data allowing a reliable evaluation of primary care CAMHS capability and capacity to meet presenting demand. The assurance review uses an appreciative inquiry approach seeking to provide a constructive approach to impact positively on service provision.

Objectives

- To determine the level of growth achieved in the under 18s LPMHSS, PCAMHS and SCAMHS workforce following commencement of the Measure and the additional WG investment in these services.
- To evaluate whether there is evidence to suggest a demand and capacity mismatch in primary care CAMHS.
- To determine whether any variance exists between primary care CAMHS services and service performance in Wales? If such variation does exist what is the degree of variation and what are the implications of any such variation on, for example, waiting times in primary care CAMHS and flow into and from SCAMHS?
- To produce high quality reports including recommendations to HBs and Welsh Government on the assurance review findings.

Key Findings

- ***The PCAMHS teams that were interviewed demonstrated a passion and commitment to their work with children and young people and described receiving support from their manager and from each other. The manager of PCAMHS in ABMU has responsibility for managerial tasks alone and does not carry out clinical work.***

- ***PCAMHS teams have developed good links with education & offer support within schools.***
- ***The commissioning arrangements within ABMUHB have improved in recent years enabling better oversight and a more strategic approach to developing CAMHS services to the ABMUHB population. Formal meetings are held with staff from ABMUHB and CTUHB to jointly plan developments using resources such as ICF and to oversee changes such as the forthcoming transfer of NHS services in Bridgend to the newly formed CTMUHB.***
- ***The PCAMHS service lacks critical mass. Staffing numbers are low with additional strain on the system resulting from staff vacancies. At the time of the review the Swansea team had only one agency member of staff in post. The lack of critical mass impacts upon the ability for staff to receive training.***
- ***The pathway between PCAMHS & SCAMHS is unclear. Evidence was found of poor communication between teams and referrals that have "bounced" between teams. Some cases audited demonstrated similar levels of risk and or need in PCAMHS and SCAMHS.***
- ***PCAMHS lack the necessary IT and mobile communications to fully enable mobile working. The lack of access to suitable IT requires staff to carry paper files between locations. This practice risks a data breach should files be lost or stolen in transit.***
- ***It was unclear to the review team which process is used to assess risk, vulnerability and safeguards within PCAMHS, many case notes audited had blank sections on risk.***
- ***The audit of case notes was difficult with inconsistent recording and gaps in notes.***
- ***A practice of keeping separate and incomplete records on some children where the referral or enquiry has been received from a school was reported by staff, due to concerns about future career prospects of the children. This practice is considered unsafe by the DU review team.***
- ***The case notes record evidence of the use of therapeutic skills including Cognitive Behavioural Therapy. However, the service lacks a consistent therapeutic modality and a minority of staff have received formal therapeutic training.***
- ***The review team found little use of outcome measures to inform clinical decision making.***
- ***Many GPs responding to the DU questionnaire described an unresponsive service citing a lack of acceptance of referrals and poor communication of the outcome of assessments. Emphasis was placed on the need for a 7 day helpline and E-advice.***
- ***Letters primarily prepared for GPs were comprehensive but may include other recipients including the patient and their family. The terminology used within letters made it unclear to the review team who was the intended principal recipient.***
- ***PCAMHS lacks outcome options in some areas leading to a reliance on PCAMHS to provide follow up, the extent of this varied between local authority areas.***
- ***A good network of clinics exists across three localities. However, PCAMHS staff report difficulty in accessing rooms which can be prioritised for SCAMHS use.***

Recommendations

1. **SBUHB and CTMUHB should review its PCAMHS workforce in order to ensure that the service has critical mass and is capable of delivering all five functions required by Part 1 of the Measure and that the service has training capability. Particular attention should be paid to the reliance on agency staffing and contingencies considered in the event that ICF funding is withdrawn.**

2. **CTMUHB should develop guidance on record keeping linking this to its electronic record, ensuring that all contacts and enquiries are properly recorded. Records should be routinely audited with an emphasis on person centeredness, risk management and wider safeguarding.**

3. **The pathway between PCAMHS & SCAMHS should be reviewed ensuring that a single whole system approach is delivered. This should include the receipt of referrals, the undertaking of assessments and interventions with flow through the service.**

4. **A review of the availability of IT and mobile communications should be undertaken ensuring that mobile working is effective and that the potential for a data breach is mitigated.**

5. **SBUHB and CTMUHB should work with representatives of General Practice in Swansea and Neath Port Talbot to ensure that thresholds for PCAMHS together with referral requirements are clearly communicated, understood and followed by staff in PCAMHS and General Practice. Particular attention should be paid to meeting the needs of C&YP in a crisis and to the potential to offer GPs provision of E-advice.**

Methodology

Data Gathering and analysis

The review team were provided with information by the HB on the organisation of their CAMHS and in particular the primary care services for under 18s. This included; the Part 1 scheme, relevant operational policies and procedures, pathways, algorithms, workforce and activity data in both specialist and primary care CAMHS. The DU also analysed publicised National Office for Statistics (NOS) data on the ABMUHB under 18 population and levels of deprivation by LA area.

The data were used to build a picture of the current service model and its staffing, together with the position shortly after commencement of the Measure.

Fieldwork

Fieldwork within ABMUHB consisted of; an introductory interview with the managers of CAMHS, a meeting with primary care practitioners, administrative staff and their manager during which they described their process for prioritising and allocating referrals.

A case note audit was undertaken of a random sample of 84 current and recent referrals to PCAMHS and 30 cases of children and young people open to SCAMHS who had not been afforded relevant patient status. The audit analysed the assessment of the referrals and the outcome of these assessments, using a bespoke audit tool.

A GP questionnaire was distributed via practice managers in each G.P. practice within the HB using DOO Poll an electronic questionnaire.

In parallel to the work undertaken by the DU, the CAMHS/Eating Disorder Network undertook work with primary care CAMHS stakeholders (other than G.P.s) including children, young people, their families and referring agencies. This work was undertaken by means of questionnaires and the running of focus groups.

Reporting.

Initial, verbal feedback was provided to the management of the service prior to the production of this report and the report has been subject to scrutiny by the management team to ensure factual accuracy. The CAMHS/ED Network analysis of stakeholder views will be reported separately.

Primary Care CAMHS in ABMUHB

In Wales primary care services for under 18s may be provided by three service components; the Local Primary Mental Health Support Service (LPMHSS), other primary care CAMHS sometimes referred to as PCAMHS and in some cases members of specialist CAMHS (SCAMHS) may offer primary care assessments and interventions to under 18s accepted into SCAMHS but who are not afforded relevant patient status under Part 2 of the Measure.

The rationale for primary care mental health services being provided to under 18s from these three potential services components are:

- LPMHSS are only statutorily required to receive referrals from G.P.s. in order to fulfil their duties under Part 1 of the Measure.
- Referrals from other sources such as schools, and third sector services may therefore be assessed by other primary care CAMHS.
- Some under 18s having been accepted into SCAMHS are not afforded “relevant patient” status and therefore remain primary care patients within the Measure definitions.

These service components may be provided by a single staff delivering both specialist and primary care CAMHS, alternatively primary care CAMHS may be provided by a discreet team.

CAMHS services in ABMU are provided by the CAMHS network hosted in Cwm Taf University Health Board (CTUHB). CAMHS staff are employed by CTUHB and all operational and strategic management of CAMHS services delivered within ABMUHB are the responsibility of CTUHB. ABMUHB and its partner LAs are however responsible for the commissioning and oversight of services provided to its children and young people (C&YP).

Primary Care CAMHS are provided by dedicated teams which are separate from the LPMHSS for adults. A primary care CAMHS team has been established in each of the LA localities of ABMUHB.

PCAMHS managerial arrangements

The ABMUHB PCAMHS teams are managed by the Primary Mental Health Specialist who reports to the CTUHB Deputy Head of Nursing for Children and Young People and CAMHS. The Primary Mental Health Specialist undertakes only managerial and clinical supervisory work, holding no clinical caseload. The post holder forms part of the locality management team serving the Bridgend, Neath Port Talbot and Swansea localities. Beyond the locality management structure, line management is delivered by the CTUHB CAMHS management.

A dual accountability exists to the CTUHB operational line management and to the ABMUHB commissioners.

An organogram setting out the managerial arrangements for CAMHS within both CTUHB and ABMUHB was provided to the DU team. Whilst the managerial arrangements described were broadly consistent with the arrangements set out in the organogram. The distance of the service in its operation from the operational line management appeared to the review team to create an impediment to the line of sight from the CTUHB management to the ABMUHB PCAMHS in its operation.

The fact that ABMUHB SCAMHS is structured around the same localities as PCAMHS offers the opportunity for local connectivity of PCAMHS and SCAMHS. In practice the degree to which this connectivity is achieved varies between localities.

Commissioning arrangements

In order to provide oversight and assurance to commissioners responsible for CAMHS in ABMUHB, monthly meetings are held to discuss the delivery and performance of CAMHS services including PCAMHS provision. The meeting is provided with a performance report which includes any existing staff vacancies as workforce is viewed as critical to performance.

The meeting provides briefing on CAMHS performance to the Board of ABMUHB. Meetings include CAMHS managers from both ABMUHB and CTUHB together with LA and finance staff.

The monthly commissioning meeting progressed from its position of three years ago at which time the focus was described as overly focussed on performance metrics. The

meeting is now much more strategic in its approach and seeks to provide a partnership approach between the commissioners and the service provider. However, it was reported that a lack of planning and strategy capability within the CTUHB management structure has caused challenges.

Waiting list initiatives are developed through the group as are the use of additional resources such as the integrated care funding (ICF). The current provision of CAMHS were described in the DU review management meeting as not providing a sustainable approach and that CAMHS have not reached a point where pathways are “smooth”.

Planning is underway to consolidate CAMHS into a single team delivering primary & secondary care, covering all of Swansea and Neath Port Talbot. Resources available from the ICF have been prioritised for the Western Bay. This resource will be used to develop liaison workers from within Social Services offering consultation and advice functions.

The specification within the primary care scheme developed by ABMUHB and its partner LAs was reviewed in October 2016. The last scheme update was in 2018 but CYP were not involved in this review which has not been agreed by the Regional Planning Board or the Western Bay Partnership Board.

Discussions have taken place at executive level within ABMUHB concerning the repatriation of the service to direct management by ABMUHB. The review team were however advised that this has not been progressed because ABMUHB favours restructuring the service within existing arrangements.

The Board prioritises achieving the WG targets under Parts 1 and 2 of the Measure. In its analysis of the PCAMHS data, managers seek to clarify the different targets for primary and secondary care, emphasising that the Part 1 target does not function in the same manner as standard RTT targets. This difference can lead to confusion and difficulty in attacking the waiting list in a coherent manner.

GP clusters are also being engaged to determine a better means of delivering services. The Cwm Tawe cluster will be introducing a counsellor for C&YP. They have also offered room space for CAMHS clinics.

Those working within the commissioning group believe that significant improvement has been made since the current PCAMHS manager was appointed as a result of a more mature commissioning approach.

The improvements include the general direction the service is taking with improved linkage to GPs and an improved focus on the broader needs of children, young people and their families. There is also an improved relationship between CTUHB and ABMUHB with a more appropriate shared understanding of the problems faced and a willingness to work together to solve these problems. It was noted that in terms of meeting Part 1 targets progress made via waiting list initiatives has been diminished as a result of a significant increase in referrals since the WLIs were introduced.

A planning group for the emotional wellbeing of children and young people and a children and young people strategy group have been established for the Western Bay. These groups have good strategic "buy in" and have improved planning but have not made the same degree of progress in improving operational systems.

Findings

The distance of the service in its operation from the operational line management, appeared to the review team to create an impediment to the line of sight from the CTUHB management to the ABMUHB PCAMHS in its operation.

The commissioning arrangements within ABMUHB have improved in recent years enabling better oversight and a more strategic approach to developing CAMHS services to the ABMUHB population. Formal meetings are held with staff from ABMUHB and CTUHB to jointly plan developments using resources such as ICF and to oversee changes such as the forthcoming transfer of NHS services in Bridgend to the newly formed CTMUHB.

The Location of PCAMHS

The Bridgend PCAMHS is based in the Tier 4 CAMHS unit Ty Llidiard at the Princess of Wales Hospital, the Neath Port Talbot team is based at Neath Port Talbot Hospital on the same site, but not in the same building as SCAMHS, and the Swansea team is based in Trehafod.

Clinics are delivered in locations away from the PCAMHS bases. These include the ARC in Bridgend at which the adult LPMHSS is based. Access to rooms within the ARC was described as good. The Bridgend team also use Hartshorn House. One concern raised by staff of the facilities at the ARC and Hartshorn House is the fact that at both settings adult service users attend the same location which diminishes the child friendly nature of these settings.

The Neath Port Talbot team use clinical rooms in the SCAMHS base but stated that access can be restricted with SCAMHS taking priority in room bookings. All teams undertake domiciliary visits and will see children and young people in school and will undertake joint visits with other disciplines such as the Educational Welfare Officer.

Staff raised concerns that access to suitable clinical environments is problematic as is the suitability of the PCAMHS office base which is cramped and requires desk sharing. Access to IT and mobile working was also raised as a concern.

ABMUHB has a clear vison to provide more suitable accommodation which will allow staff teams to unite and enable the delivery of a stepped care approach. It is proposed that staff will move to an office base in Neath Port Talbot Hospital from April 2019.

Staffing

The overall PCAMHS staff is small. The small scale of the service is exacerbated by staff vacancies. At the time of the review Swansea had lost all of its substantive staffing with only one agency member of staff formally covering the Swansea locality.

The PCAMHS workforce data provided to the DU are contained in table 1 below.

	Core		**ICF**	
	Establishment WTE	**Vacancies**	**Establishment WTE**	**Vacancies**
Swansea	2 WTE	2 WTE (1 appointed to start soon)	1 WTE	1 WTE (covered by agency presently)
NPT	1 WTE 0.4 WTE (upped to 0.6 WTE to cover secondment) 0.5 WTE (But seconded to Cardiff)		1 WTE	
Bridgend	0.6 WTE 0.6 WTE (currently upped to 1 WTE, but the additional 0.4 WTE is to do WLI and may cover SCAMHS)		1 WTE	1 WTE (covered by agency presently)

Table 1

These workforce data identify a total of approximately 6 whole time equivalent (WTE) staff making up the PCAMHS workforce. The manager does not hold a caseload but does also manage the SCAMHS service. It is noteworthy that as a result of the funding arrangements for some posts it was not possible for the review team to establish a definitive position on the PCAMHS workforce.

Of the WTE staffing, the Swansea team had consisted of three part time staff however at the time of the review these staff had left the service. Neath Port Talbot and Bridgend have four part time staff per team. In addition to these staff an additional three ICF posts have been created, but the funding for these staff is only committed on an annual basis.

One member of the PCAMHS in Bridgend has been based in the Social Services led multi-agency Safeguarding hub (MASH) using ICF. It took a year to recruit into the post. The MASH post holder transferred from PCAMHS and has been back filled using a long term agency member of staff. This link with MASH was viewed positively as it has improved collaborative working.

All current PCAMHS nursing staff are RMNs. In the past one RGN was working in PCAMHS undertaking interventions. This member of staff has subsequently commenced work in one of the three ICF posts. Two staff are “retire and return”. In the future further retirements will likely impact on service capacity.

Vacancies within PCAMHS have been a significant problem. It was reported to the DU that for long periods of time teams have consisted of a single staff member. The use of agency staff has been used as a remedy but this appeared to the DU team to have led to something of a dependency on agency nursing staff. One member of staff has remained working as an agency member of staff for a year. The use of agency staffing can have a destabilising effect on a team because these staff can leave at short notice impacting on the ability to avoid long term vacancies due to a lack of a period of notice.

Whilst additional investment into CAMH services is welcomed it was reported that additional investment and the additional employment opportunities it affords can lead to internal “churn” and turnover with staff moving into new posts. This can lead to vacancies because additional staff are frequently not available. This was also reported as having a destabilising effect on services.

Staff reported that should changes be introduced concerning the staff permitted to undertake PCAMHS functions, this would increase the pool of staff from which PCAMHS can recruit which may ease the current vacancy difficulties. Likewise an imaginative approach to the use of non-registrant staff may assist staffing up PCAMHS.

The scale of the service and current vacancies make it difficult to fulfil all of the five Part 1 Measure functions. Currently staff do not have formal job plans, but clear expectations regarding the work expected to be undertaken each week are clear and administrative staff address this by booking slots in staff diaries.

Some staff suggested that they would like to see a broadening of the skill mix within the service which could include the recruitment of social work staff. They suggested that the use of support workers and therapists would be useful additions if more staffing were feasible in PCAMHS.

In the future administration staff covering Bridgend will be based in Tonteg Hospital as part of wider service reconfiguration arrangements. This was perceived to be a retrograde step by Bridgend staff who perceived that it will add to difficulties already experienced in completing administrative processes.

Findings

The PCAMHS service lacks critical mass. Staffing numbers are low with additional strain on the system resulting from staff vacancies. At the time of the review the Swansea team had only one agency member of staff in post. The lack of critical mass impacts upon the ability for staff to receive training.

Due to short term ICF funding arrangements for some posts and current vacancies it was not possible for the review team to establish a definitive position on extant PCAMHS workforce.

The Interface with SCAMHS

In all three of the localities within ABMUHB, PCAMHS and SCAMHS are located on the same site. In Bridgend the services are located within the same building, in Neath Port Talbot they are based on the same site but not in the same building and in Swansea the services are based at Trehafod.

Teams described differing levels of co-operation between PCAMHS and SCAMHS. Whilst staff reported having a good relationship with SCAMHS none of the localities described a fully effective interface with SCAMHS within a single service system. This lack of a fully functioning interface impacts negatively on the ease of onward referral from PCAMHS to SCAMHS where complexity or duration requires such a transfer. This was reported to be due to service pressures in SCAMHS.

The introduction of choice and partnership approach (CAPA) within SCAMHS was reported to have worsened this position due to a perceived lack of flexibility within the CAPA process.

Systems to appropriately allocate cases to PCAMHS and SCAMHS are underdeveloped. Current referral and allocation processes do not ensure that complexity of need and risk are the determining factors. This can be particularly problematic for the PCAMHS service given the volume of demand it faces and the duration of intervention required in more complex and higher risk cases. Staff reported that SCAMHS use PCAMHS to undertake initial assessment work and that a large proportion of referrals received from SCAMHS need to be redirected. PCAMHS cases may require onward referral following initial intervention but onward referral to SCAMHS was highlighted as being a challenge.

Staff stated that thresholds for SCAMHS have increased stating that “the goalposts have moved”. Cases now accepted by PCAMHS, would previously have received a service from SCAMHS. Some staff described a lack of trust in decision making between the teams, this was said to be especially the case in Swansea.

A daily SCAMHS referral meeting is held in each locality which PCAMHS try to attend. However, attendance is not consistent due to pressure of work, some staff have never attended and others described monthly attendance.

It was identified that currently referral to CAMHS can be considered as a default position especially where a young person has, or is suspected of having self-harmed “All roads lead to CAMHS”.

The majority of staff interviewed within the review had previously worked in SCAMHS. Their view is that the PCAMHS approach used is less paternalistic than in SCAMHS creating less dependency and enabling families to retain responsibility. They described PCAMHS as recovery focused with an emphasis on prevention. Many said they would not wish to return

to SCAMHS because they value the PCAMHS methods and approach and the fact that PCAMHS is not a clinic based service. However, some PCAMHS staff described feeling that as a team they are not taken seriously or treated as a priority. This can lead to difficulties in accessing SCAMHS rooms which has led to appointment cancellations. Staff said that they "feel at the bottom of the pile" suggesting that PCAMHS lacks status and that improved access to training and closer working with SCAMHS could improve the status of PCAMHS.

PCAMHS staff expressed frustration that some administrative staff are based in SCAMHS and due to administrative staff sickness delays of months can occur in letters being dispatched.

Staff stated that in the last 12 months a manager has been appointed with responsibility for both primary & secondary care CAMHS. This has improved relationships and is leading to a more rational approach to allocation and integrated working. The manager reported undertaking considerable work "pulling the teams together" and seeking to establish an approach in which the services think as one. An example cited in improving integration is the use of the same paperwork for assessment in both services. This is assisting the development of a smooth pathway between the services. Nevertheless some difficulties continue particularly in the Swansea locality.

Findings

The pathway between PCAMHS & SCAMHS is unclear.

Evidence was found of poor communication between teams and referrals that have "bounced" between teams.

Some cases audited demonstrated similar levels of risk and or need in PCAMHS and SCAMHS.

A manager has recently been appointed with responsibility for both primary & secondary care CAMHS. This has improved relationships and is leading to a more rational approach to allocation and integrated working.

Locality Data

Key indicators of potential demand for CAMHS are contained within the demographic makeup of the HBs population, in particular; the proportion of the population under the age of 18, the distribution of this population and the levels of deprivation within the local authorities. These data provide useful predictive information on potential demand.

The under 18 populations and the deprivation indices within the three local authority areas comprising the HB were therefore considered within the DU analysis of the distribution of presenting demand and the deployment of the PCAMHS workforce.

Geographical area

The geographical area covered by each Local Authority is detailed in table 2 below.

Local Authority Area	Area Size
Bridgend	246 km²
Neath Port Talbot	442 km²
Swansea	380 km²
ABMU	**1071 km²**
Wales	**20,780km²**

Table 2

Population Age Profile

Published data are available reflecting different age groups within local authority populations. However, there is inconsistency within the data for children and young people. Data are presented in different data sets for under 16s, under 18s, or under19s. As a result no consistent measure exists for the child and adolescent population. The data available do nevertheless provide a useful indicator & comparator.

Overall, ABMUHB's under 18 population is comparable with the national average, with 20% of the total population in both Bridgend and Neath Port Talbot being under the age of 18, and 19% in Swansea. This compares to the national average of 20% see table 3 below.

	<18s	All ages	% under 18s
Bridgend	29217	144288	20%
Neath Port Talbot	27891	142090	20%
Swansea	47272	245480	19%
ABMU	**104380**	**531858**	**20%**
All Wales	**628289**	**3125165**	**20%**

Table 3

The population of children aged 16 is distributed as pictured below throughout the HB (figure 1).

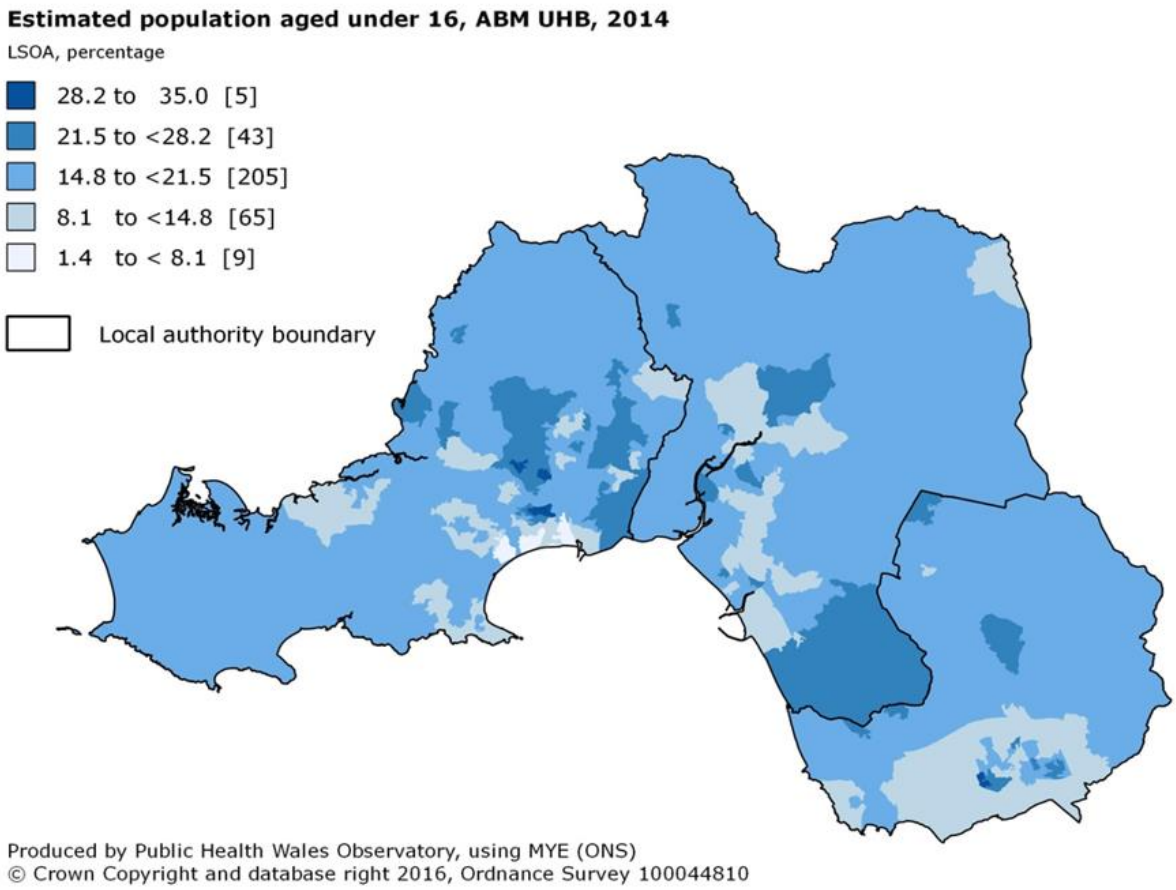

Figure 1

Deprivation

The average number of children (under 19 years) living in income deprivation is evenly distributed between Swansea and Bridgend at 25%, with Neath Port Talbot higher at 28%. All LAs have higher income deprivation than the Welsh average of 24% (table 4).

% of the population of children in income deprivation by local authority area

	0 - 18
Bridgend	25%
Neath Port Talbot	28%
Swansea	25%
All Wales	**24%**

WIMD 2014 Table 4

Income deprivation consists of a single composite indicator calculated from the following elements:

a. Income-Related Benefit claimants
b. Certain Tax Credit recipients
c. Supported Asylum Seekers
d. Certain Universal Credit claimants

Source: StatsWales

A broader measure of deprivation, the Welsh Index of Multiple Deprivation, includes; income, employment, health, education, access to services, community safety, physical environment and housing. Figure 2 below depicts whole population levels of multiple

deprivation, with the highest levels in Neath Port Talbot. It demonstrates a similar pattern to the distribution of child income deprivation. The increased levels of deprivation in the Valleys is clearly depicted. Each LA area has clear divides between districts with significant differences in levels of deprivation.

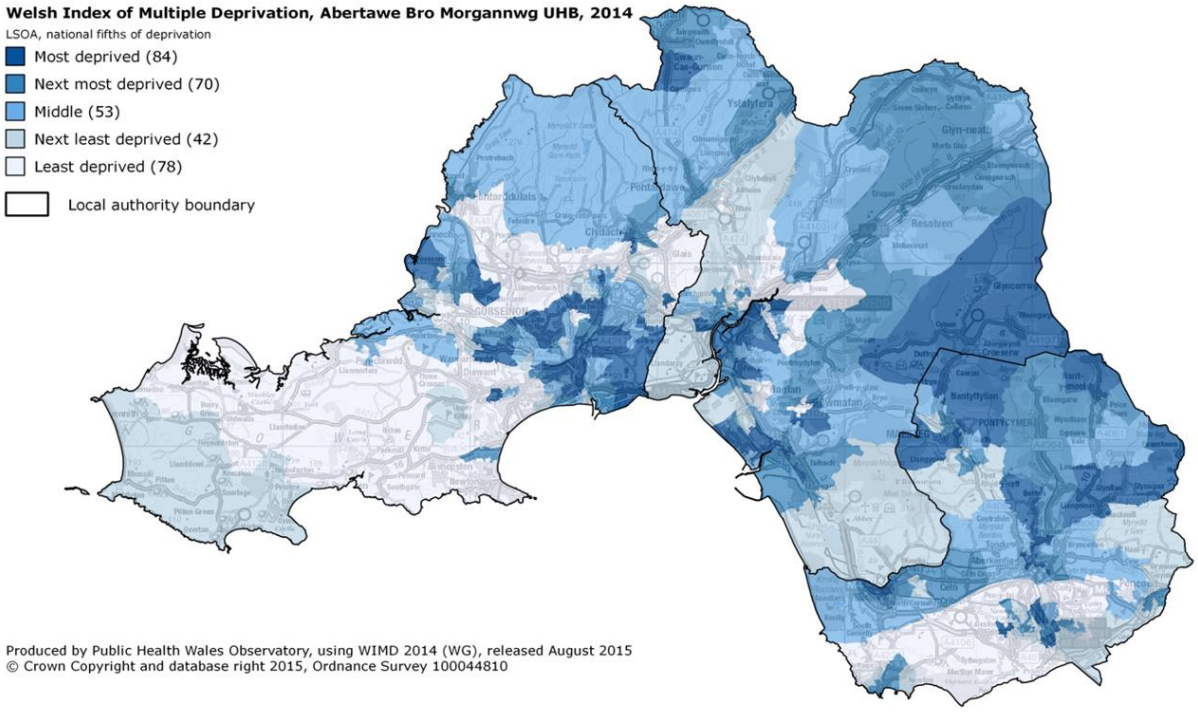

Figure 2

Based on the distribution of the under 18 population and levels of deprivation it would be reasonable to anticipate that staffing is distributed in such a way as to match service capacity to anticipated demand.

Table 5 below briefly summarises the differences in demography and deprivation. These could assist in predicting demand and the allocation of workforce by Local Authority. However, the small scale of the service, the current level of vacancies and absences and the required critical mass to run a service make the distribution of workforce to meet anticipated demand a challenge.

	Lowest	**Highest**
Number of children under 18	Neath Port Talbot	Swansea
% of children under 18	Swansea	Neath Port Talbot/Bridgend
Income deprivation	Swansea/Bridgend	Neath Port Talbot
Multiple deprivation	Swansea	Neath Port Talbot
Size of geographical area	Bridgend	Neath Port Talbot

Table 5

Findings

The factors which may affect demand in each local authority area differ, and the capacity directed to meet demand should acknowledge and reflect this. However, the scale of the service and the required critical mass do not currently allow the service to be structured in line with population and deprivation indices.

Service Demand and activity

Referrals, Assessments & Interventions

The data represented on the delivery of Local Primary Mental Health Support Services to under 18s is made up of the work undertaken by the PCAMHS but may also include work undertaken by the adult LPMHSS who may see 17 year olds but will report this activity as under 18 year old work.

Figure 3 below demonstrates that for a considerable period no activity was reported to WG on assessment and intervention activity.

From discussions with the service in the past, and at the time of the review, it is clear that this has been the consequence of a failure to report activity rather than a lack of any activity. The graph also demonstrates that the waiting list initiatives (WLI) undertaken in 2017-18 had a significant impact on the levels of assessment and intervention activity. However, it is also evident that due to a significant increase in the rate of referrals to PCAMHS that once the WLIs ceased activity fell below the rate of referrals received. This mismatch will lead to further backlog of assessment and intervention work if left unchecked.

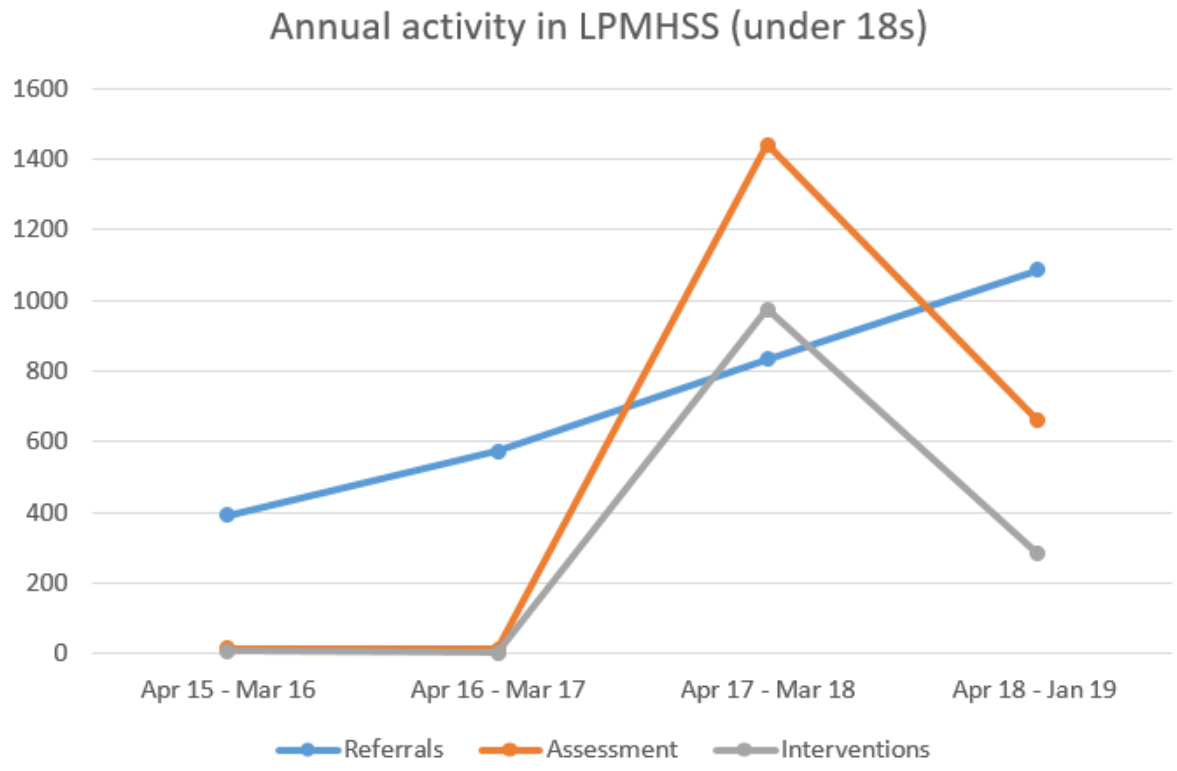

Figure 3

Referrals

The referral data submitted to the DU for the purpose of the review are detailed in table 6 below. These data illustrate the number of referrals received for the PCAMHS between July 2017 and June 2018. Activity was analysed and is presented in three ways; the total number of referrals received, the number per 1000 of the under 18 population and the rate per WTE practitioner as per establishment figures not by staff in post.

This does not therefore reflect the work actually undertaken by the current staff establishment.

As no staff were substantively in post in Swansea it is not possible to represent the data by local authority. Bridgend has the highest referral rate per 1000 of under 18 population, being almost double the rate for Swansea. However, if the service was fully staffed the staffing establishment would be fairly evenly distributed to meet this variation in demand.

	Bridgend	NPT	Swansea	ABM total
Referrals (July 2017 – June 2018)	369	267	333	**969**
Referrals per 1000 under 18 population	**13**	**10**	**7**	**9**
Referrals per WTE practitioner	**168**	**141**	**167**	**159**

Table 6

These data demonstrate that of the total number of referrals received during 2017 – 2018, there were 9 referrals per 1000 population. This equates to a range from 141 to 168 referrals per WTE per year with an average of 159 across the entire service.

The ABMUHB primary care CAMHS service has two formal referral routes. Direct referrals are accepted from General Practitioners (GPs) by means of secure email and referrals are accepted from SCAMHS following screening and redirection to Primary care CAMHS.

Referral Source	Number	% total
GP	77	92%
Paediatrician	3	4%
GP-redirected from SCAMHS	1	1%
SCAMHS	1	1%
(blank)	2	2%
Grand Total	**84**	**100%**

Table 7

The audit of case notes found that 92% of the referrals were received form GPs, and 4% were referrals received from a Paediatrician.

Whilst the service does not formally accept referrals from schools, schools counsellors or other non GP community services, staff commented that they will use their judgement on the suitability of referrals received from a school source. Staff stated that ordinarily a referral from a school will be provided with information and advice to refer via the GP. Data are collected on referrals accepted for assessment regardless of their source but only direct GP referrals are reported to WG.

Staff stated that once referrals have been received cases are treated in turn. Cases referred under Part 1 of the Measure will receive an assessment and are subject to an opt-in process. They added that cases are not always allocated to a member of staff matching needs to a staff member's skill set due to resource constraints, but will do so where possible. This was reported to have been more common practice when there were Social Workers in the team due to a broader skill mix.

In welcoming the review staff stated that the PCAMHS had not historically received the attention necessary. They believed that the increase in referrals represents the feeling they have had that they have become "responsible" for more C&YP. They felt that they were required to move from working with up to 16 year olds to cover those up to 18 and that this change, plus the additional requirements of the Measure, had been placed on PCAMHS with no additional investment.

They also stated that as the service was established to address mild to moderate need, which is greater in volume than those with severe or more complex need, that PCAMHS has the least capacity to undertake a greater volume of work. Furthermore PCAMHS work reported is not truly illustrative of the work undertaken or of the work that could be undertaken if they had more capacity.

Some staff stated that they are not comfortable with the definitions within the Measure most notably addressing the needs of those with stable, severe disorders. They feel that this does not apply to C&YP and is a concept from adult services.

Staff stated that a lack of clear referral to treatment data reporting requirements has impacted on consistent reporting both internally and to WG.

Staff reported that the quality of referrals varies. They identified that frequently children with problems not addressed by PCAMHS are nevertheless referred. These problems include C&YP with behavioural problems of a social nature, neurodevelopmental disorders (NDD) and epilepsy. The Neath Port Talbot Team reported that a considerable number of referrals on children with autistic spectrum disorders are received. They believe that this is in part due to the fact that a waiting list of some 700 children exists for children on the autistic pathway and a paucity of services available locally for children with NDDs.

Findings

WLIs undertaken in 2017-18 had a significant impact on the levels of assessment and intervention activity. However, a significant increase in the rate of referrals to PCAMHS eroded the impact of the WLIs. The mismatch between demand and capacity will lead to further backlog of assessment and intervention work accruing if left unchecked.

The review team found some discrepancies between what were stated as the formal referral protocols and that which happens in practice. This variation may account for discrepancies in the reported data and the actual workload reported by the service.

Assessments

In total 762 of the 969 referrals received were assessed by PCAMHS. Ranging from 230 in Swansea to 369 in Bridgend. This would equate to an average of 125 assessments per WTE assuming the teams were fully staffed.

	Bridgend	NPT	Swansea	ABM total
Assessments (July 2017 – June 2018)	369	354	230	**762**
Assessments per 1000 under 18 population	**6**	**13**	**5**	**7**
Assessments per WTE practitioner	**81**	**186**	**115**	**125**

Table 8

Assessment performance & waiting lists

Despite a lack of historical data a snapshot of waiting times was undertaken in August 2018. The snap shot demonstrates that at that point in time some 166 children were awaiting assessment and that 74 of them had been waiting in excess of 28 days, 48 had been waiting in excess of 57 days of which 4 had been waiting in excess of 85 days.

These data reflect those children waiting for the PCAMHS team, and not all under 18s some of whom could be waiting for assessment by the adult LPMHSS). Waiting list snapshot data are set out in table 9 below.

Assessment waiting list snapshot 23/08/18	Bridgend	NPT	Swansea	ABMU
0 - 28 days	35	28	29	92
29 - 56 days	8	20	22	50
57 - 84 days	2	2	18	22
85 - 180 days			2	2
181 - 365 days				
366 days+				
Total waiting for assessment	**45**	**50**	**71**	**166**
Per 1000 population	**1.54**	**1.79**	**1.50**	**1.64**
Per WTE staff establishment	20	26	36	27

Table 9

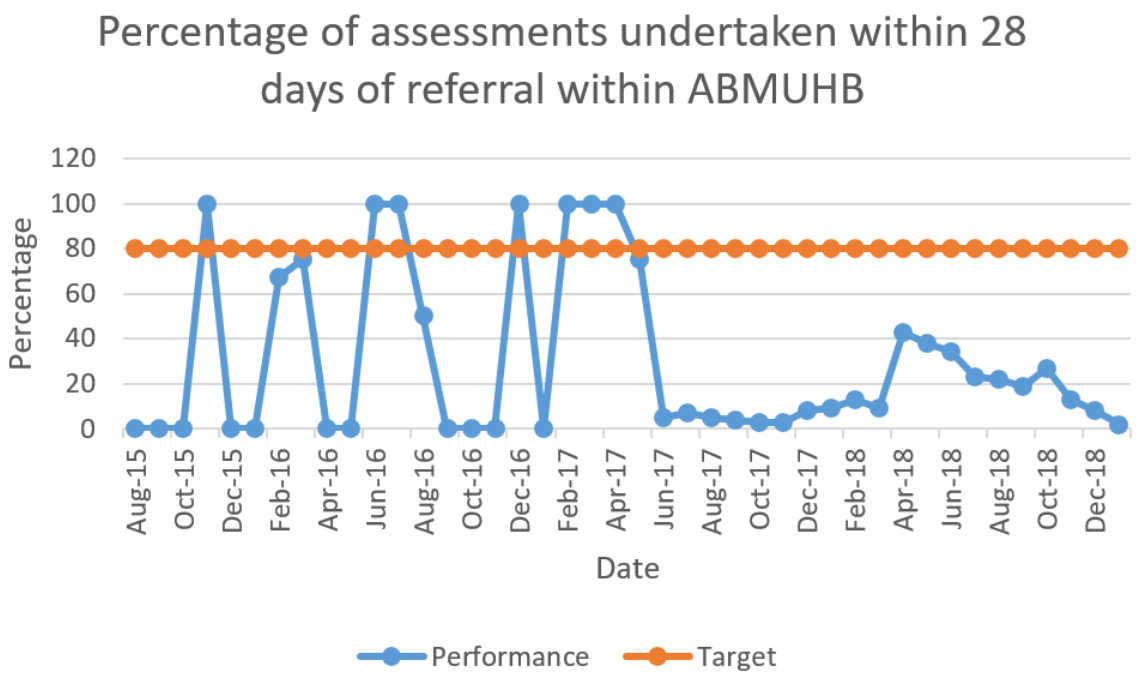

Figure 4

The DU review team were informed that for some time data were not routinely reported on assessment performance. As a result where 0% assessment activity is reflected in figure 4 above this represents no data reported rather than 0% of assessments undertaken within 28 days. As a result of missing data it is not possible for this report to illustrate assessment performance over time nor to comment on the frequency that the ABMUHB PCAMHS achieved target. Moreover because of data reporting issues it cannot be assumed that where 100% compliance is reflected that this was actually achieved.

Data reporting practice has improved more recently. Both the SBUHB as the commissioner of the service and CTMUHB should continue to ensure that data reporting takes place and is accurate and should track these data to understand compliance with WG targets.

The mangers reported that the service is currently targeting the waiting list tail which they have managed to reduce to approximately 10-11 weeks across the 3 LA areas. In order to achieve this with vacancies in some areas staff work ABMU wide if necessary.

Despite these challenges staff described being proud of their work and the amount of work they get through especially the volume of assessment work undertaken compared to the volume of assessment work in SCAMHS. They described SCAMHS assessing one new patient a week whereas PCAMHS will assess four new cases in a day.

An issue that can impact with compliance is the rate of C&YP who cannot or do not attend appointments. Staff reported the use of an “opt in” process whereby an offer to intervene is sent to the child, young person or their family. If there is no response to this offer the case is closed. Staff will speak to parents if a child doesn’t want to engage with PCAMHS. Because frequently concerns will be raised by family members rather than the child or young person some very challenging situations can arise regarding engagement.

It was reported that once engaged C&YP are offered two appointments which if they do not keep them they will be discharged. One member of staff stated that if no explanation is given and there are no safeguarding issues then discharge, this may occur after the offer of one appointment.

The recording of assessments

In order to fully analyse the functioning of PCAMHS a case note audit of primary care referrals, assessments, and outcomes was undertaken. This consisted of cases in each local authority area. The case note audit recorded the date the referral was received, the date that the assessment was undertaken as logged on the assessment pro-forma and the date that initial intervention commenced.

The National Service Model states that the purpose of a primary mental health assessment is to consider an individual's mental health and to identify the local primary mental health treatment (if any) and other services which might improve or prevent a deterioration in that person's mental health. The National Service Model further states that all assessments will cover need and risk, including suicide risk where relevant, and the national curriculum for primary mental health support workers states that risk in a primary mental health setting must include vulnerability factors and safeguarding.

The case note audit analysed the quality of the information contained within the assessment record. This included the assessment of risk, consideration of safeguarding and whether the assessment had considered the views of the young person.

A standard pro forma is used to record the assessment of children and young people, this is recorded manually and held within the case file.

An assessment pro forma was found in 76 (90%) of the cases audited. However, many of the assessments were considered brief and contained little detail or information; a number of assessment documents included sections of the pro forma that had been left blank.

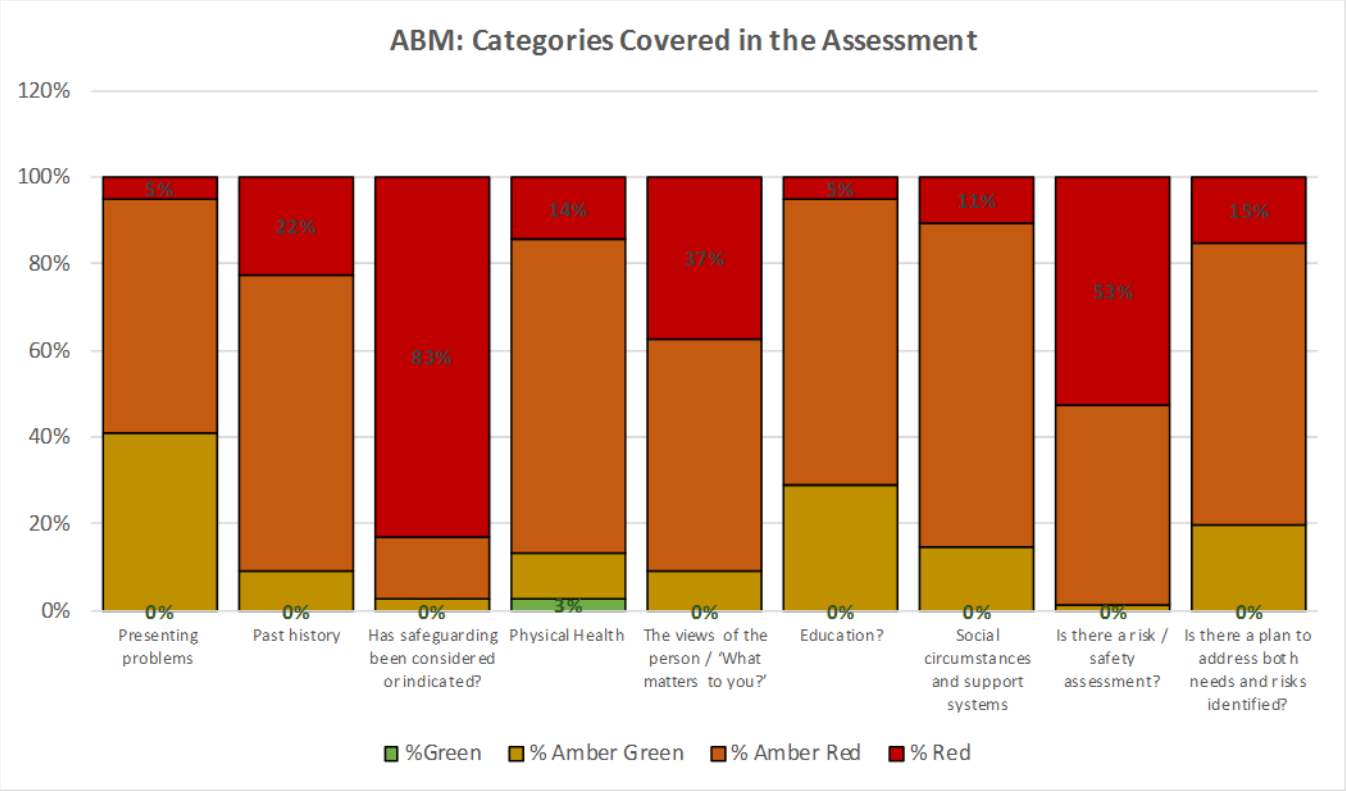

Figure 5

The majority of cases were rated red or amber red across the categories considered within the assessment.

The standard of assessment required by the HB in respect of recording an assessment was unclear to the DU review team. Where assessments had been undertaken, the case note audit found that there was variance in the information being recorded between practitioners. The case note review found that the assessment pro forma was not completed consistently across the teams. However, the reviewers also noted that many assessments were recorded in a letter back to the referrer. Some of this correspondence provided assessment detail and a summary of outcomes, however, this was not consistently applied.

Another issue noted was that the letters were often copied to the young person or there families, however appeared to use formal language that was not always considered to be person centred. There were also copies of letters in some case notes that appeared to have been copied form a previous template, creating a risk of breeching GDPR.

An Issue emerged during the visit that raised concern for the review team. This was the practice of staff not creating files for children where there may have been a formal consultation or enquiry. The practice was explained as avoiding the creation of a mental health service history that may have employment implications later in life for example the person being prevented from joining the armed forces.

This practice is considered to be potentially unsafe because it limits the ability to link multiple contacts or a referral to previous contact history which is vital in the case of emerging risk or safeguarding issues.

In terms of undertaking and recording risk assessment and formulation the team reported that they do not always use WARRN and rely on choice paperwork to pick up on risk and safeguarding issues. It was stated that whilst WARRN is rarely used it may be in the case of more complex cases.

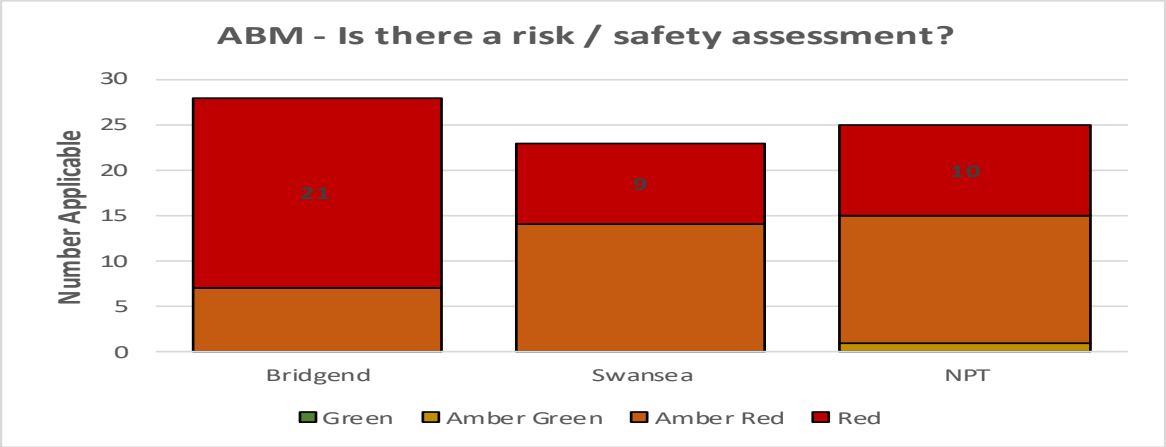

Figure 6

Not all cases evidenced that a risk assessment had been completed and of those that did a significant proportion were considered to be red in terms of recorded detail and information.

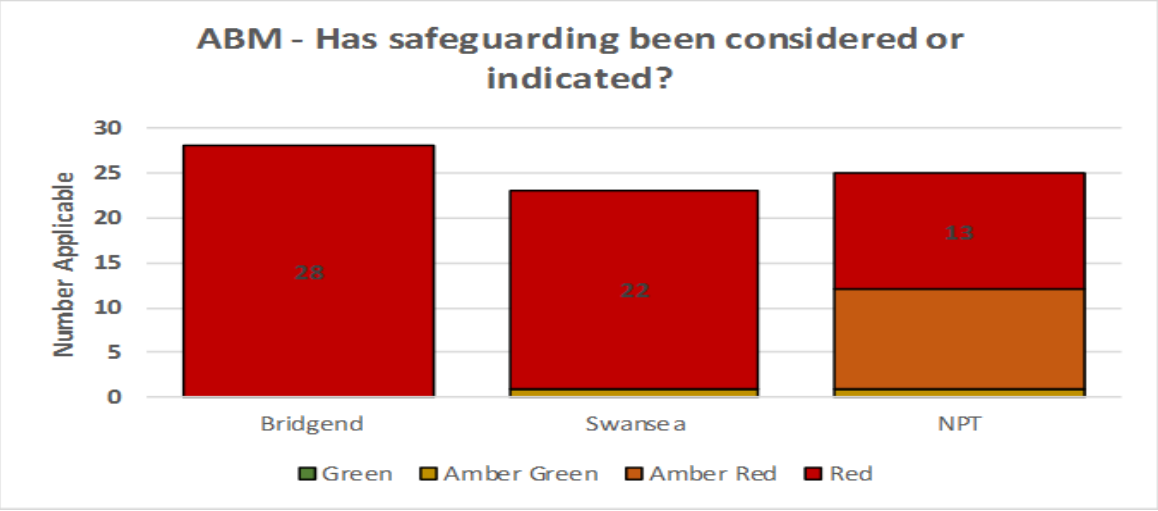

Figure 7

Evidence that safeguarding issues had been considered or indicated was lacking in the cases reviewed. All cases in the Bridgend team were rated as red against this criteria.

Some cases had been referred for safeguarding reasons, mostly historical cases, and the team can highlight issues to the SPOC.

Where safeguarding issues arise they may see C&YP separately to family members to ask questions and evaluate safeguarding issues. When staff were asked how they recorded

safeguarding as part of the risk assessment process they appeared not to understand the question.

One member of staff will assess & intervene in schools but using different paperwork than PCAMHS as such data on this work is not captured.

Outcome of Assessment:

In 44 (52%) cases the outcome of the assessment was for further intervention from the PCAMHS. 12 (14%) cases were offered information and advice and 12 (14%) were signposted to other services. Two (2.3%) of the cases were referred to SCAMHS following an assessment by the primary care team.

	Bridgend	Swansea	NPT	Grand Total
Intervention from LPMHSS	17	15	12	44
Back to referrer (patient declined / unavailable)			5	5
Provision of information and advice	2	7	3	12
Referral to secondary care	1		1	2
Referred/signposted to other services	8	1	3	12
Other (state in comments)			1	1
(blank)	2	3	3	8
Grand Total	**30**	**26**	**28**	**84**

Table 10

Findings

The lack of historical data made it impossible for the review team to analyse compliance with WG targets on the provision of assessments.

A practice of keeping separate and incomplete records on some children where the referral or enquiry has been received from a school was reported by staff, due to concerns about future career prospects of the children. This practice is considered unsafe by the DU review team.

It was unclear to the review team which process is used to assess risk, vulnerability and safeguards within PCAMHS, many case notes audited had blank sections on risk.

The audit of case notes was difficult with inconsistent recording and gaps in notes.

Interventions

Practitioners record all activity that is not an assessment as an intervention. This is standard practice for PCAMHS throughout Wales. The data relate to the number of interventions started per child, not the number of individual sessions delivered. Therefore the data cannot differentiate between a child seen for 1 intervention appointment, 6 appointments or more than 6.

Both the duration and frequency of treatment, the "dosage", and the amount of time staff spend on assessments, will impact on the time available to deliver interventions. The data contained in table 11 below do not therefore entirely demonstrate the potential demand for interventions that may be present without these confounding factors.

Data available for 2017-18 demonstrate that the rate of interventions per WTE practitioner varied across the three localities from 30 in Bridgend to 52 in Swansea. The rate of intervention per 1000 of the under 18 population showed little variation ranging from 2-3.

	Bridgend	NPT	Swansea	ABM total
Interventions (July 2017 – June 2018)	67	96	103	**266**
Interventions per 1000 under 18 population	**2**	**3**	**2**	**3**
Interventions per WTE practitioner	**30**	**51**	**52**	**44**

Table 11

Intervention Performance & Waiting List

The National Service Model states that the assessment process must identify needs in a timely fashion, to ensure a balance of time and activity for the other functions of the local primary mental health service, and specifically the delivery of the mental health interventions intended to support the individual.

Practitioners record all activity that is not an assessment as an intervention. This is standard practice for PCAMHS throughout Wales. The data relate to the number of interventions started per child, not the number of individual sessions delivered. Therefore the data cannot differentiate between a child seen for 1 intervention appointment, 6 appointments or more than 6.

As with performance data on assessment the missing data for intervention compliance means that it is not possible for this report to illustrate intervention performance over time nor to comment on the frequency that the ABMUHB PCAMS achieved target.

Figure 8 below presents performance against the assessment target as reported to WG. Due to incomplete data reports the reflection in the graph of 0% compliance with e 28 day target is the result of no data having been reported rather than a 0% level of compliance with the WG performance target for delivering interventions. Neither can it be assumed that where 100% compliance is reflected that this was actually achieved.

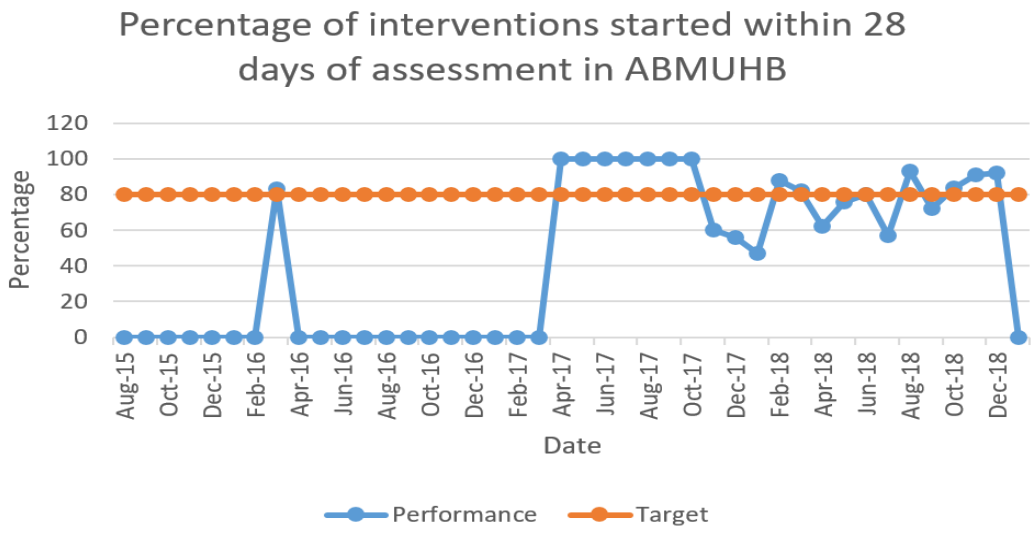

Figure 8

Despite a lack of historical data a snapshot of waiting times was undertaken in August 2018.

The snapshot illustrated that at the 23rd August 2018 24 C&YP were awaiting intervention of which 10 had been waiting in excess of 28 days two of whom had been waiting in excess of 57 days these data are set out in table 12 below.

Intervention waiting list snapshot 23/08/18	Bridgend	NPT	Swansea	ABMU
0 - 28 days	6	3	10	19
29 - 56 days	1		3	4
57 - 84 days			1	1
85 - 180 days				
181 - 365 days				
366 days+				
Total waiting for intervention	**7**	**3**	**14**	**24**
Per 1000 population	**0.24**	**0.11**	**0.30**	**0.24**
Per WTE staff establishment	3	2	7	4

Table 12

Intervention Modalities

Currently interventions are nurse led and delivered in house by PCAMHS. Staff will try to match CYP needs to staff with particular intervention skills if possible but this is not always feasible due to service demand.

The interventions available are therefore limited to those deliverable within the skillset and availability of current staff.

Variance exists in the skill set for intervention among the team. One member of staff informed the review team that they hold a Masters degree in counselling and CBT and a certificate in education, whereas other staff have no formal training in specific modalities.

A broader range of staff with therapy qualifications would enable greater availability of interventions that the service would wish to see provided, including family therapy and more frequent use of CBT. The team also stated that it would help to offer interventions from non-registrant staff who have specific therapeutic skills. This would enable registrant staff time to deliver more assessments and interventions.

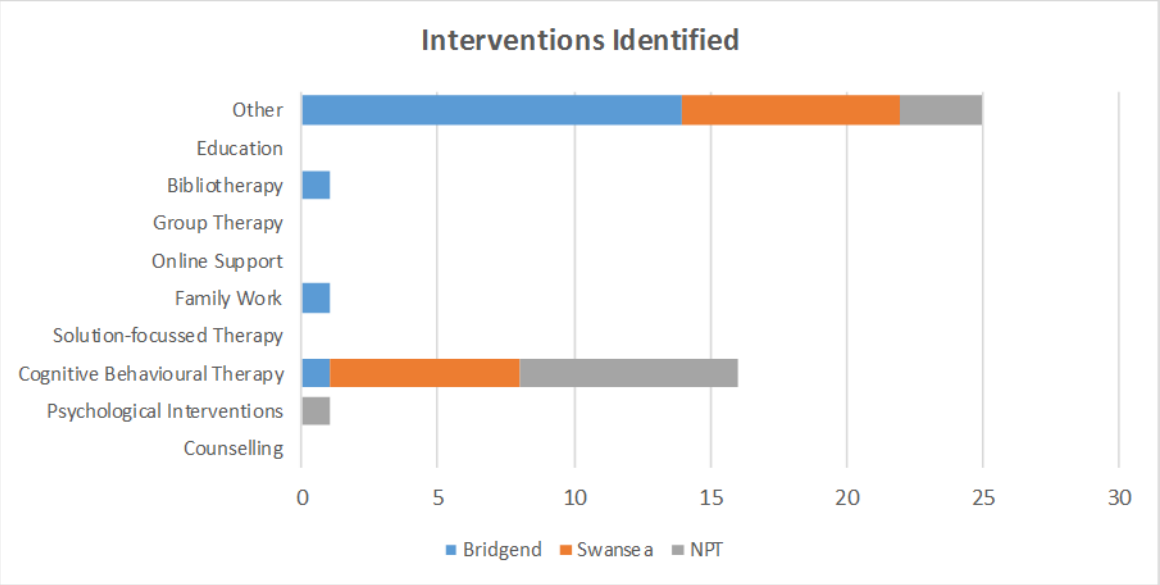

Figure 9

Of the 44 children and young people who were offered an intervention, 16 were offered CBT and in 25 cases intervention was described as other. Interventions that were considered as “other” were predominantly anxiety management. However, in a number of cases the review team were unable to ascertain the specific interventions that were offered.

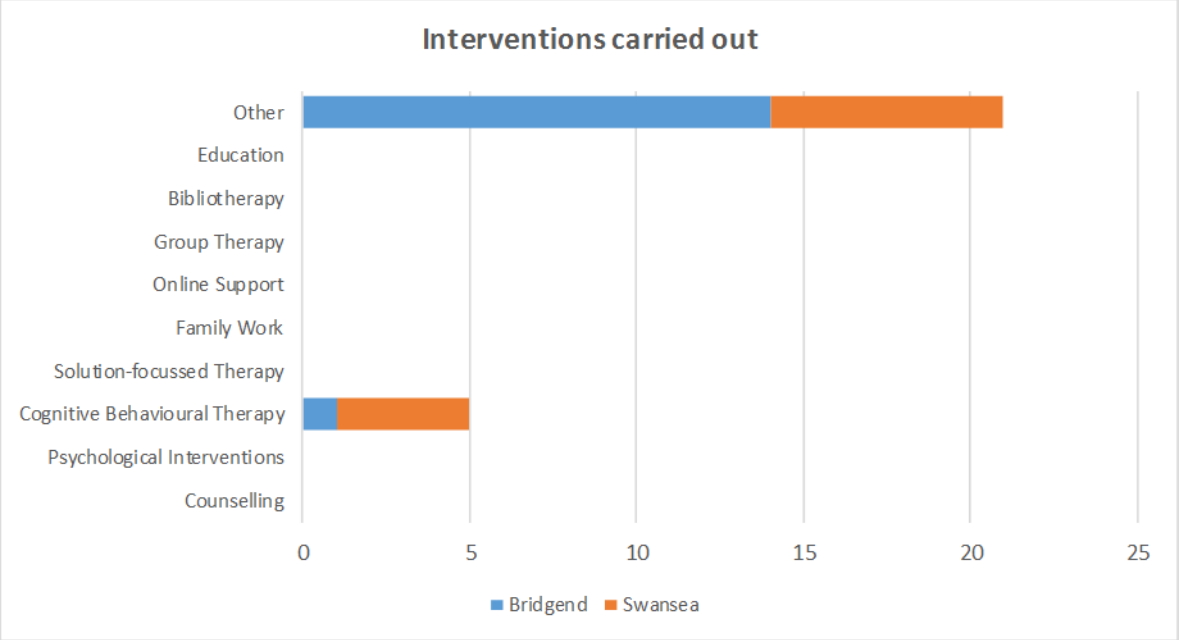

Figure 10

The case notes evidenced that of the 44 C&YP who were offered intervention 38 (86%) had been commenced; however, there was no evidence of interventions being commenced in the Swansea locality.

The duration and frequency of interventions varied between team members with no consistency of approach within the team.

One member of the team reported that they offer interventions with three initial sessions followed by a review, a further three sessions and further review. Using this approach the staff member reported providing between nine and 12 sessions. Stating that it is rare to deliver 12 and that C&YP are normally offered between 3 and 12 sessions depending on need. The frequency of sessions could be weekly or fortnightly depending on the child.

Another staff member stated that they will see a child or young person up to 3 times and will refer to SCAMHS or the child therapy service after this. Another stated that they would generally offer 4-6 sessions.

The team stated that they would like to deliver groups but can't do so due to a lack of resources. They also said that they have an interest in the use of self-help "tier 0" approaches but whilst they have held discussions about their use nothing is currently in place.

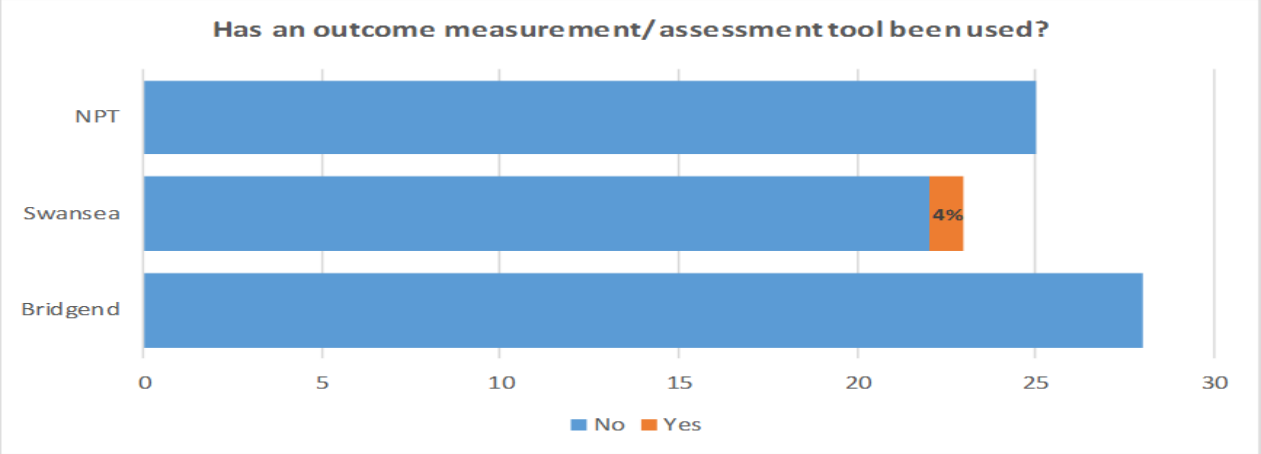

Figure 11

The case not review found little evidence that outcome measurement is routinely applied. Only 4% of cases demonstrated that an outcome measurement tool had been used. Where a tool had been used, it was a mood and feelings questionnaire.

July 2017 – June 2018	Referrals	Assessments	Interventions
Per WG Submission	996	1439	923
Per DU submission	969	762	266

Table 13

Findings

The lack of historical data made it impossible for the review team to analyse compliance with WG targets on the provision of interventions.

The data reported to WG and to the DU varied considerably. This may be due to data "cleansing" post submission of data to WG or anomalies in data collection systems.

The case notes record evidence of the use of therapeutic skills including Cognitive Behavioural Therapy. However, the service lacks a consistent therapeutic modality and a minority of staff have received formal therapeutic training.

A broader skill mix would be likely to expand the range of therapies on offer to C&YP enabling therapy to be more frequently matched to client need.

The review team found little use of outcome measures to inform clinical decision making.

The Recording of Discharge

The staff said that they are proud of the way in which care is delivered with a recovery focussed approach using relationships with C&YP and their families. Recovery enables C&YP to get better allowing them to be discharged.

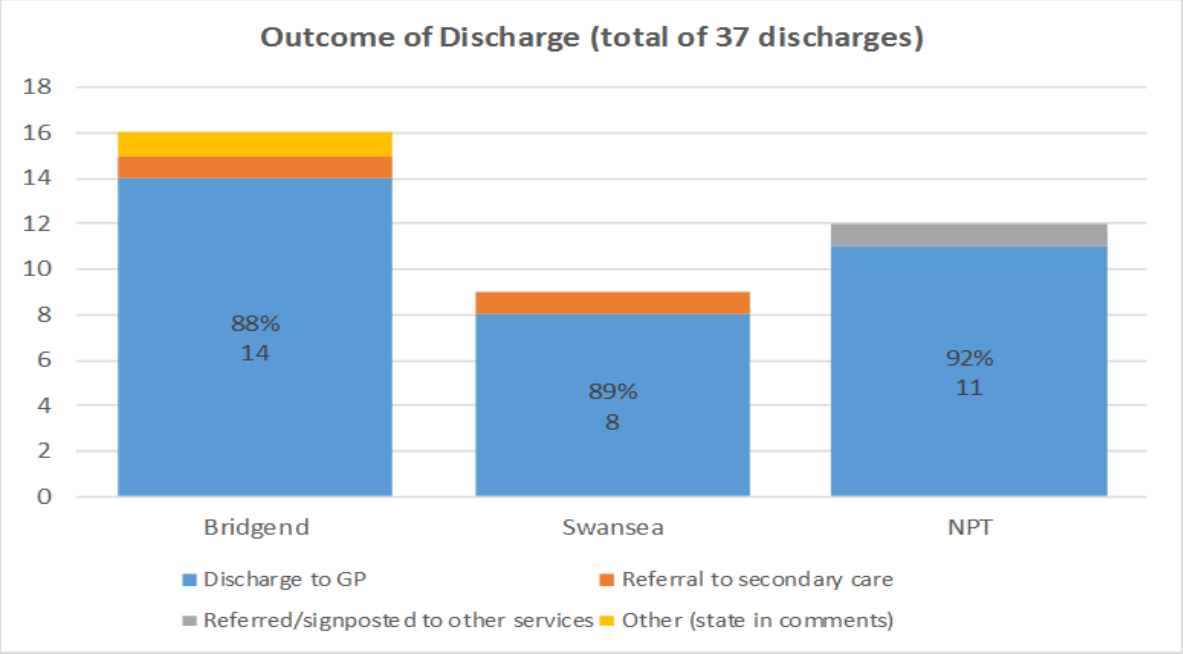

Figure 12

The case note review included 37 children and young people who had been discharged following PCAMHS intervention. Of those discharged 33 (89%) were discharged back to their GP and two were referred on to SCAMHS. There were six cases where the child or young person had been discharged form PACMHS following "was not brought".

Findings

Letters primarily prepared for GPs were comprehensive but may include other recipients including the patient and their family. The terminology used within letters made it unclear to the review team who was the intended principal recipient.

PCAMHS lacks outcome options in some areas leading to a reliance on PCAMHS to provide follow up, the extent of this varied between local authority areas.

Audit of SCAMHS

A sample of 30 cases open to SCAMHS but which had not been afforded relevant patient stats, were audited. This was intended as a comparison of the needs of children open to PCAMHS and SCAMHS and to give a brief analysis of the determinants leading to input by SCAMHS, but at the primary care level.

Of the 30 cases reviewed, 21 (70%) had been referred by the GP, other referral sources included three from educational psychology and one from the liaison team. There were five cases where the source of referral was not recorded.

There were 26 cases where the primary reason for the referral had been recorded. The primary reasons for referral included nine cases (35%) referred for anxiety, six (23%) ASD or ADHD and four (15%) for depression. There were also four cases (15%) where the primary reason for referral were concerns of suicide.

Interventions provided by the SACMHs team included medication prescription and management, psychological therapies such as CBT and work with families. The range of professionals involved included psychiatrists, nursing, therapists and psychology.

Findings

There is greater diversity of professionals involved in SCMAHS cases than in PCAMHS

The main interventions recorded were medication and psychological therapies.

Anxiety and ASD or ADHD were the most common primary reasons for referral

Signposting

In addition to undertaking assessments and interventions the Measure requires that LPMHSS staff signpost C&YP to other services and liaise with agencies to provide support in meeting need.

The PCAMHS service do signpost onto child and youth agencies and staff said they are proud of good collaborative working. Staff stated that Mental Health Matters and BAVO offer some support services and that a good selection of third sector services exists but that access to some services is inconsistent and some have waiting lists.

CAMHS has a service level agreement with Cruse Cymru for bereavement work with children but staff stated that in practice this service may not be as well linked as it should be to PCAMHS. Staff also stated that Cruse Cymru only provide group work which may not always be suitable. In some cases GP referrals may be redirected to this service in order to avoid a 10 week wait for assessment with PCAMHS.

Historically schools counselling offered an excellent service in Bridgend with a clear pathway for both primary and secondary schools. However, funding was removed as was the services management which was moved into MASH.

As a result of these changes staff reported that whilst lots of C&YP continue to be seen in schools counselling it is not as effective as it was, especially for issues with neurodevelopmental disorders and working with children with learning disabilities.

An early intervention (EI) panel has been established by the Social Services Department offering a single point of contact (SPOC). A PCAMHS representative is a member of the panel and the service can refer via the SPOC.

PCAMHS staff reported that they can't access other services unless through the SPOC. They added that historically, a number services were curtailed by the Social Services Department to fund the team around the family service (TAF). TAF then became bottlenecked and the SPOC took over to manage demand and ration services in an attempt to reduce the bottleneck. However staff stated that as families can self-refer to the SPOC which can lead to a persistence of the bottleneck and therefore delays.

The data provided to the DU review team suggests that signposting activity has remained reasonably stable between 2015 and 2019. The exception in activity is 2017-18 when activity rose including two significant spikes in activity during that year.

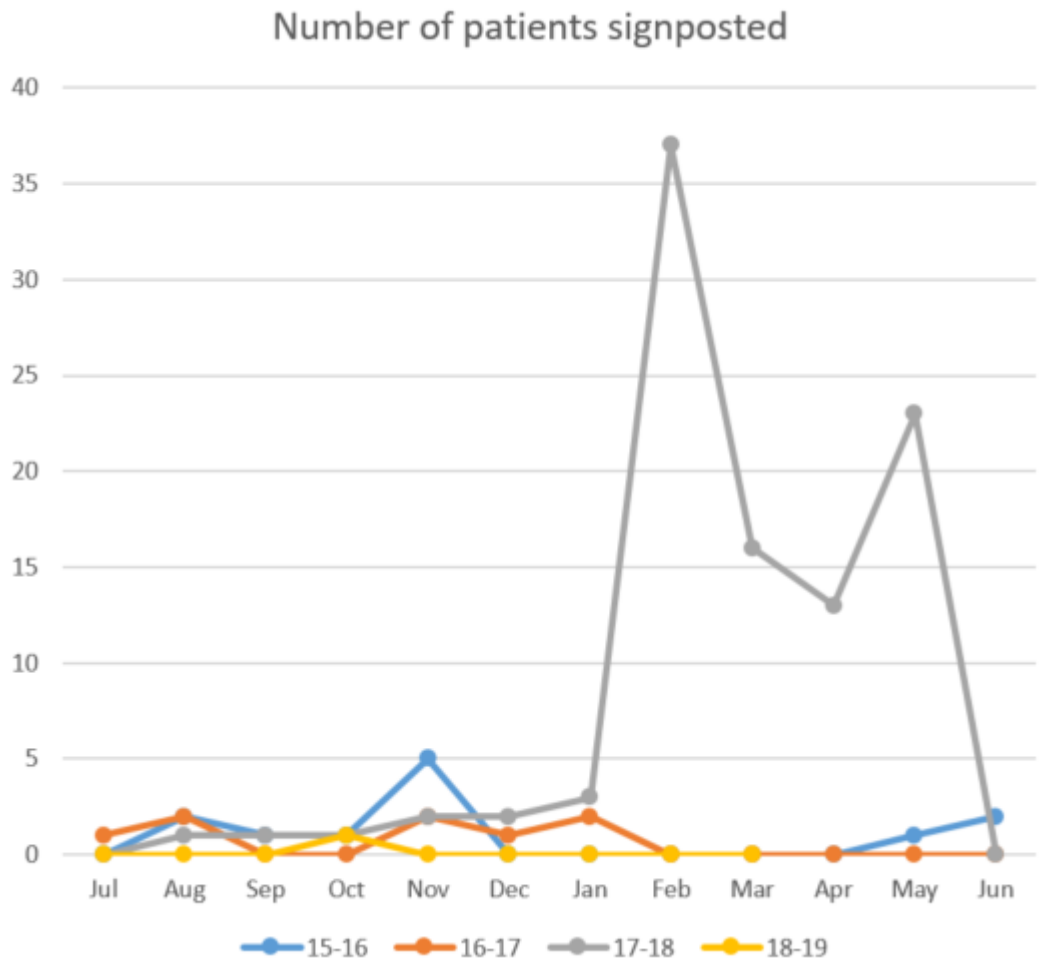

Figure 13

Findings

Whilst data on signposting were limited it was evident to the review team that signposting takes place as a routine outcome of PCAMHS intervention.

Signposting has been impacted upon by the availability of services to which the team can direct C&YP and their families.

Information & advice

One of the functions for primary care mental health services set out within Part 1 of the Measure is the provision of information and advice. This should be directed not only to children and their families but also to schools, General Practice, and other statutory and non-statutory child and family services engaged in meeting the needs of C&YP experiencing emotional and mental health problems.

Staff reported that whilst there is a clear expectation that addressing assessment and intervention work is prioritised and other "Measure functions" are given less priority. They stated that it is vital to speak to schools and to advocate for children but they feel that they are not able to undertake as much of this work as they would prefer due to demand and service capacity issues.

The provision of advice and information can assist other agencies to increase their confidence and competence in meeting the needs of children and their families.

PCAMHS staff reported that existing staff do "liaison" work, mostly with schools, upskilling Special Education Needs Coordinators and others.

Staff who are new to PCAMHS begin by undertaking "Part 1 work", when more experienced they will participate in the telephone consultation service and finally onto working in schools and other agencies.

Where work outside of assessment and intervention is undertaken this is recorded and captured within an excel spreadsheet. One member of staff reported undertaking approximately 40% of non-Part 1 assessment work the majority of which is liaison work. The DU did not have sight of these data. Other accounts provided by staff suggested the proportion of work spent on advice and liaison was greater than this account would suggest.

Where PCAMHS staff undertake joint visits with other agencies this work is not included within assessments or intervention performance data. The purpose of this work is to skill up other professional staff.

Schools have a tendency to automatically refer cases where safeguarding issues are identified or if there is an incident. They will tend to push the work out to CAMHS.

A member of PCAMHS is actively working to try to help schools to manage appropriate cases within the school through advice and liaison. This includes work with school refusers, the recognition of ASD. They stated that class sizes can be too large for teachers to understand children well enough to offer support in both primary & secondary schools. The knowledge of attachment and trauma issues differs between schools and SCAMHS don't see trauma as core business. As a result much of this work is left to PCAMHS.

School counsellors can call the PCAMHS telephone consultation line, but ordinarily can't refer. The protocol for liaison was written years ago and has never really worked. However, the new head of the school counselling service is more willing to joint work.

Managerial staff attend the LMC on a regular basis to discuss issues and develop clinical partnerships. A regular issue raised by LMC membership is access to CAMHS, as is a lack of clarity for GPs of the CAMHS pathways & eligibility criteria. The HB has been distributing information to GPs to improve a shared understanding of the current system. This approach is seeking to improve GP trust in the service and to improve the quality of referrals from GPs. Current systems allow analysis of extracted data to review referral rates from each GP and acceptance rates by the service. The use of these data can assist familiarisation of GPs to prepare more useful referrals.

It is recognised that ensuring timely access to appropriate support requires partnerships broader than with the CAMHS system. Work is taking place with the LAs to improve access to counselling and other children and family services by PCAMHS staff.

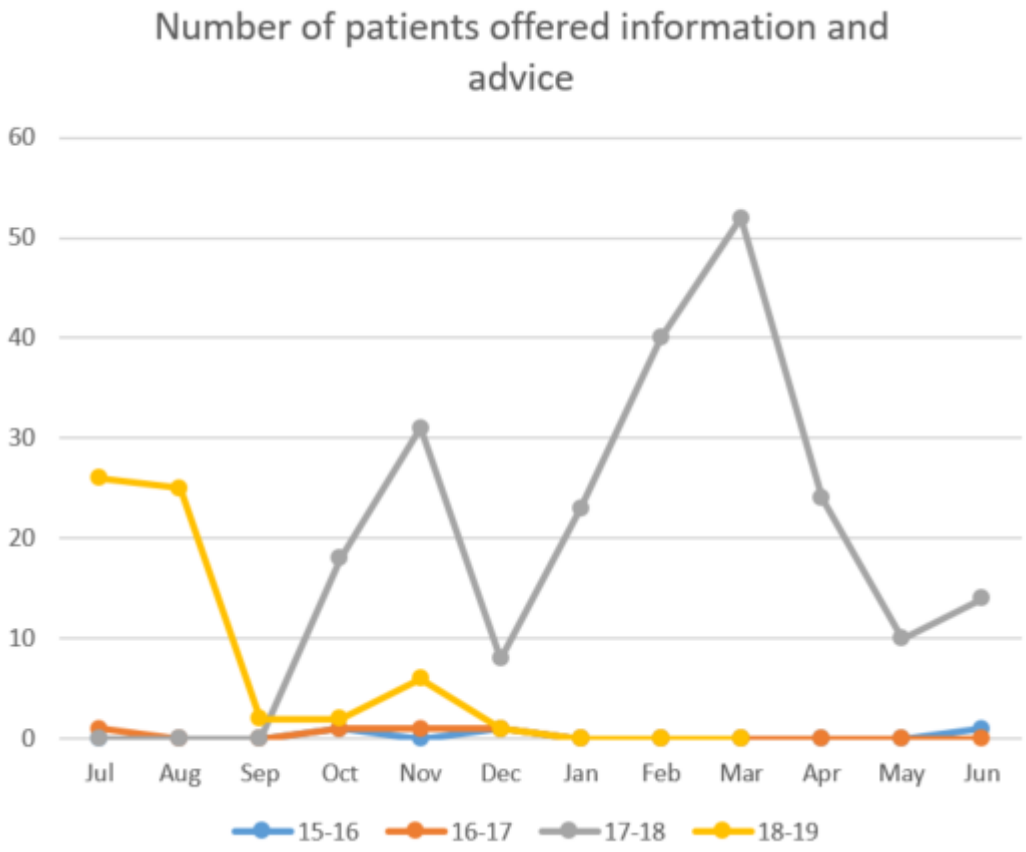

Figure 14

The data provided to the DU identifies that between 2015 and 2019 advice and information to patients was rarely being reported as an outcome following assessment. It has increased in frequency from October 2017 and reduced back to rarely being reported from September 2018.

Findings

Whilst data on the provision of liaison and advice were limited it was evident to the review team that the provision this support does take place as a routine outcome of PCAMHS intervention.

Staff reported that would wish to spend more time offering advice and working in liaison with other agencies but the amount of the work that they are able to undertake is restricted due to a lack of capacity.

Peer Support and Supervision

The PCAMHS team described working well together. There have been issues with colleagues in the past but the team is now more cohesive. Support networks exist with good peer support.

Team meetings are held every Tuesday afternoon allowing PCAMHS staff to meet across the three locality areas. The meetings allow staff to discuss issues they are confronting and to provide peer supervision to each other.

The PCAMHS meetings are separate from the adult LPMHSS meetings with whom the team described having good links in spite of this.

The team receive managerial supervision and can choose their clinical supervisor. They described the support from the CAMHS manager as good. Supervision and training address safeguarding issues. The team has access to the safeguarding office in Princess of Wales Hospital but these links are not frequently used.

Some team members described the team as loyal and hard working. Staff don't worry about the targets, they are passionate about the work and focus on the C&YP.

PCAMHS Training

Staff described training as being provided in house, with additional external training. CAMHS staff recently received training on anxiety but not all PCAMHS staff knew that the training was available.

In-house training provide by SCAMHS has included sessions on systemic therapy and Cognitive Behavioural therapy (CBT). SCAMHS have requested brief therapy training from PCAMHS staff.

The review team were advised that away days and training days are held for the whole service on a six monthly basis and that tutorials are available for new starters on Monday mornings.

One member of the PCAMHS team is undertaking systemic psychotherapy which commenced when based in SCAMHS. Staff reported an appetite for formal CBT & Eye Movement Desensitisation and Reprocessing (EMDR) training but this is not currently taking place.

The staff described the CAMHS manager as supporting access to training requests by PCAMHS staff but that there are issues with capacity to undertake training due to a lack of time. This is particularly problematic for part time staff.

In terms of risk assessment and risk formulation training, one member of staff had previously worked in liaison psychiatry and had undertaken Wales Applied Risk Research Network (WARRN) and Becks training. However not all PCAMHS staff are WARRN trained.

IT & Mobile Working Arrangements

A number of factors have led to errors in data collection and under reporting within the electronic recording system these include; difficulties with information technology (IT),the lack of consistent administrative staff and staff not understanding the need to log work undertaken under Part 1 of the Measure within the IT system.

One particular IT issue was reported as having been placed on the ABMUHB risk register. This concerns the use of two different Myrddin systems, one used by CTUHB and one by ABMUHB. Where a child or young person presents at the ED in ABMU staff cannot access the child's CAMHS record because this will be contained within the CAMHS record held within the CTUHB Myrddin system which is not accessible by ED staff in ABMU.

The Wales Community Care Information System (WCCIS) may offer solutions to some of these IT problems when it is fully rolled out and functioning. Swansea LA has recently taken steps to introduce the WCCIS system whereas Bridgend County Borough Council are already using it.

In the absence of a functioning electronic record system PCAMHS staff are frequently continuing to rely on paper case files which have to be moved between bases in order to conduct clinical work and record when in clinical settings. Some PCAMHS staff have laptop computers and some have blackberries allowing some portability of information but some staff lack computers and only have basic mobile telephones.

Managerial and other issues

Both managers and staff identified a number of core issues that they would wish to see improved these include:

- The availability of appropriate clinical environments in which to engage C&YP with ease of access to a suitable environment. Less cramped office space in which staff can have their own desk and seat with bespoke, collocated administrative staff.
- Access to mobile telephones and IT is currently poor. Adult LPMHSS use IT to record but PCAMHS use paper files which they have to transport which is a GDPR risk if lost or stolen. The lack of appropriate IT also makes it difficult to validate the accuracy of data.
- Better links with other agencies including SCAMHS and LA Social Services Departments.
- The correct staffing to cover all aspects of PCAMHS with social workers and RMN's, a better skill mix was viewed as enabling the delivery of more appropriate interventions and the potential to improve work to children in the looked after system, those in foster care and specific approaches to C&YP with a disability. In the past one member of staff undertook interventions for people with anxiety and ASD. However they joined MASH and the loss of this member of staff has impacted on the team's capability to continue this work.

Findings

The use of two different Myrddin systems, one used by CTUHB and one by ABMUHB restrict staff access to the CAMHS record held within the CTUHB Myrddin system.

PCAMHS lack the necessary IT and mobile communications to fully enable mobile working. The lack of access to suitable IT requires staff to carry paper files between locations. This practice risks a data breach should files be lost or stolen in transit.

A good network of clinics exists across three localities. However, PCAMHS staff report difficulty in accessing rooms which can be prioritised for SCAMHS use.

Access to training requests by PCAMHS staff are supported. However, the capacity to undertake training is restricted due to a lack of time. This is particularly problematic for part time staff.

The Views of General Practice

An important component of the DU review of ABMUHB PCAMHS was to elicit the views of GPs within the HB. In order to achieve this a questionnaire was sent to GPs via their Practice Managers.

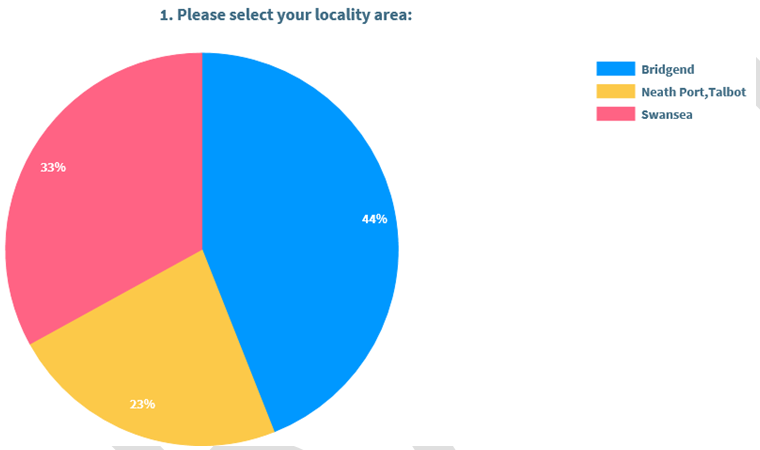

Figure 15

A total of 30 responses were received, the majority of which were received from the Bridgend locality

The Frequency of GP Referrals

GPs were asked on average how often they make a referral to PCAMHS.

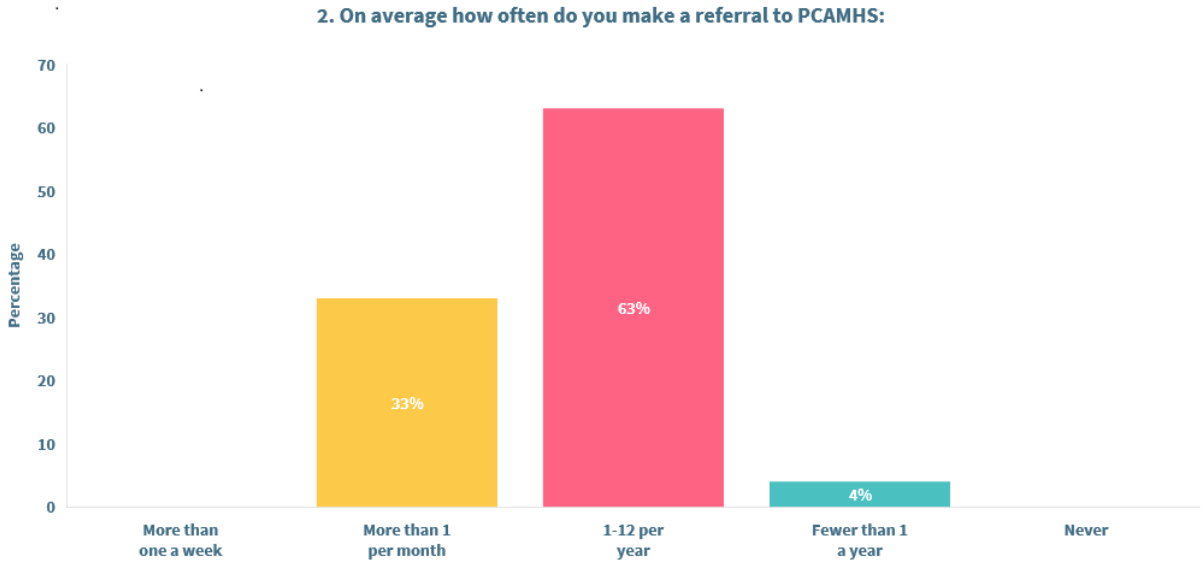

Figure 16

Comments:

The majority of respondents reported they make between 1 and 12 referrals per year, 33% reported making more than one referral per month. Some comments suggested that GPs do not make referrals as they anticipate a slow response or that patients will not be seen.

'I'm aware that referrals for problems interfering with school are via school itself as are referrals for ADHD. As such there is not a lot of pathology that comes to see me looking for further advice and I don't refer on much. Some of this is because of limited demand presenting to me, but some is also my perception that patients won't be seen. There is a significant disconnect between primary and secondary CAMHS which acts as a barrier to referral.'

'Sometimes because the service has a reputation for being slow and resistant to offering help to patients, their families and GPs, I encourage my patients to seek help privately. Cost usually limits engagement then.'

The Reason for GPs making Referrals

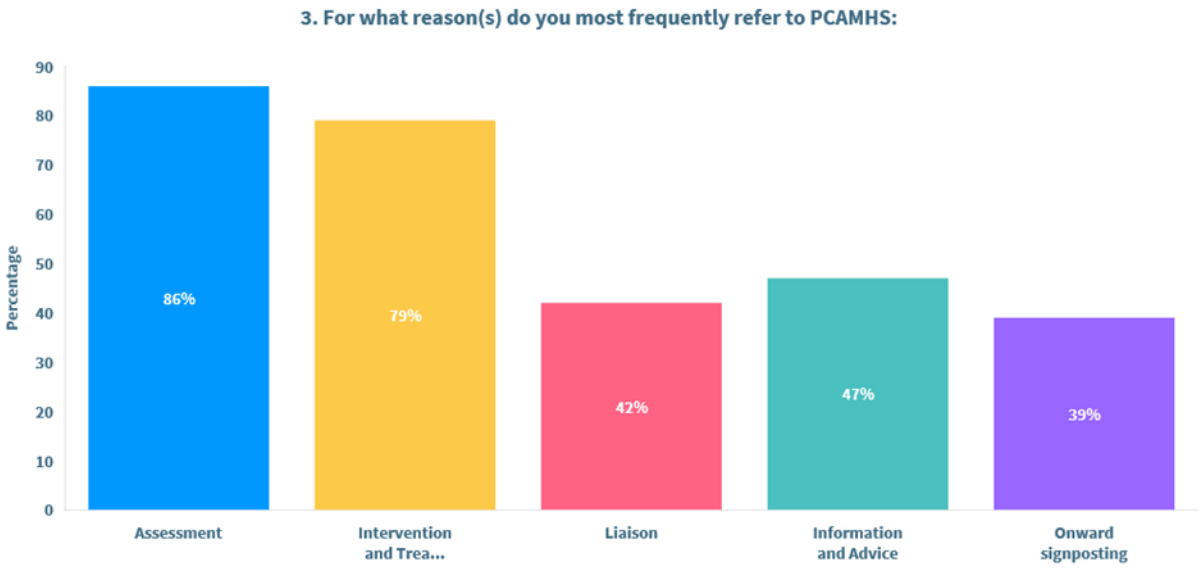

Figure 17

Assessment and Intervention were the main reasons for making a referral and signposting the least reported reason.

> *'For assessment and intervention, including psychological support and medication initiation where appropriate'*
>
> *'For further assessment and provision of further care and management.'*
>
> *'For help accessing appropriate therapies'*
>
> *'For conditions or services- that I am not able to manage or for services I have no access to'*

Some respondents made reference to risk of self-harm and suicide as the primary reason for referral.

> *'Most of the time patients or their families are at their wits end. They have experienced self-harm, or negative black thoughts. They are asking for specialist help'.*
>
> *'When I refer children it is because I think they are at risk of self-harm / suicide. I try to use specialist CAMHS carefully and for seriously ill children. Unfortunately, some of these patients would not have been so serious if I had a PRIMARY CAMHS team. Prevention is always better than cure. I think a lot of my colleagues can't / don't differentiate between the 2 services.'*

The Outcome of Referrals

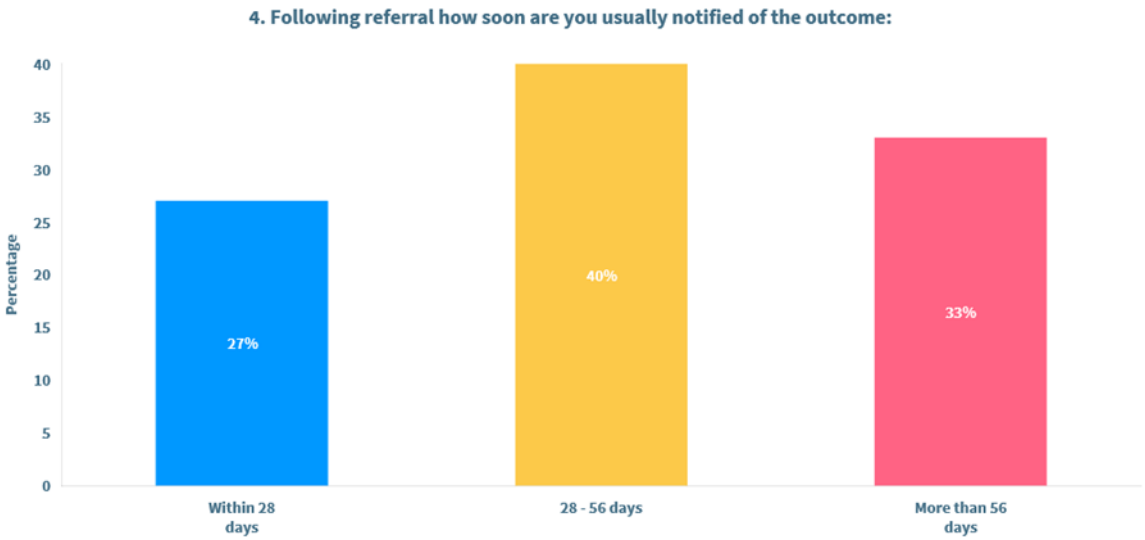

Figure 18

The majority of respondents reported that they are notified of the outcome more than 28 days after making a referral, the majority of which reported receiving notification between 28 and 56 days. A number of respondents commented that notification is often to say that the referral has not been accepted.

'Sometimes can be couple of months.'

'Clearly this depends on the nature of the referral. With some there is rapid feedback but for others where there is either no appointment deemed necessary, or else a routine appointment, then this can seemingly take ages, leaving patient/families and us in limbo.'

'Usually I get a referral bounced back to this or that help group, or support number within a week or two if CAMHS see then can be 4-8 weeks before any letter is back'

'Sometimes we receive no information or very little unhelpful information'

'The service is atrocious they always reject the referrals, leaving parents bewildered isolated and feeling there is no help'

Satisfaction with PCAMHS

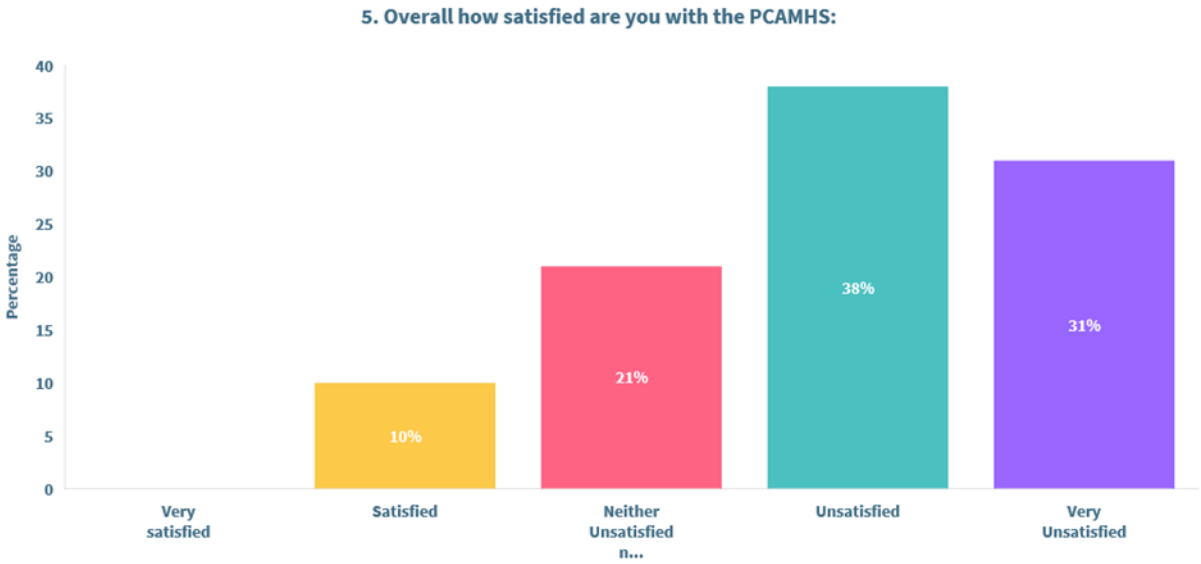

Figure 19

The majority of respondents reported either being unsatisfied or very unsatisfied with the service. Many of the comments referred to accessibility, waiting times and the "bounce back" of referrals, including how this may impact upon young people and families. One unsatisfied respondent's comments related to the telephone advice service.

'A lot of referrals get returned, despite there not being a clear alternative place to refer young people to. Waiting lists are very long.'

'CAMHS need a robust prompt service for those GP's are concerned about, even if most do not need ongoing CAMHS support. The school pathways are slow remote cumbersome and frankly exhaust parent's patience. When such a parent sees the GP for help, the GP needs to have fast access to an assessment. Just because in 90% nil ongoing care is needed, does not negate the stress and family turmoil often present for months before CAMHS see child and reassure'

'Not very satisfied as some referral are sent back with other advice instead of child being seen and assessed-Most of the times once GP has seen and referred I feel the child should at least be seen by CAMHS.'

'Often my referrals regarding children I am very worried about are returned and the child is not seen. This is very unsafe and concerning.'

'The waiting time for assessment has improved recently (previously every patient referred had a wait of at least 6 months before assessment). I have tried on occasions to use the telephone advice service that is promoted in the pCAMHS paperwork and have had great difficulty getting through to speak to anyone at the designated times for the advice service to be used. This has put me off using the advice telephone line, as I do not have time in a working day to keep phoning back to see if anyone is there to speak to me.'

Improvements

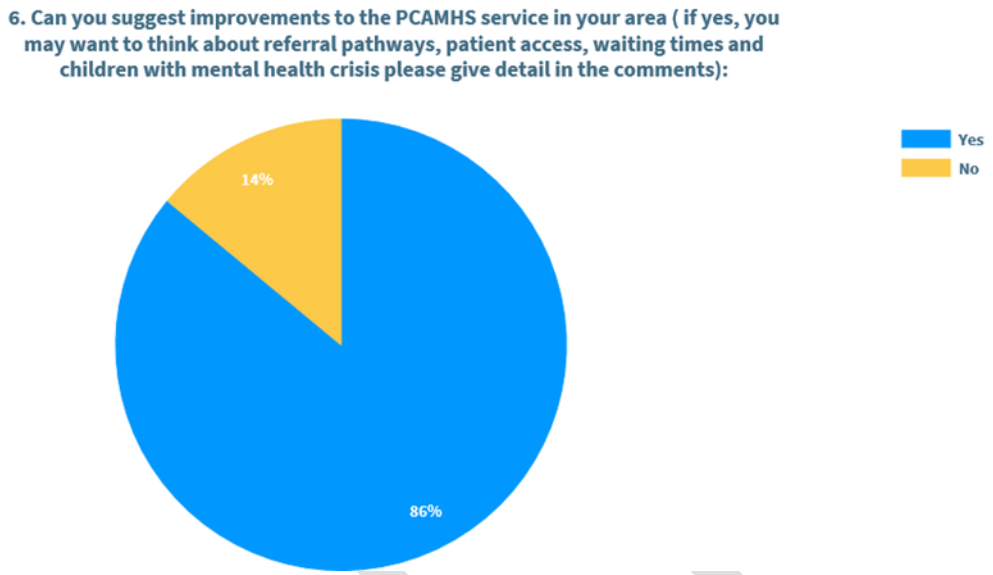

Figure 20

Overall 86% of respondents suggested improvements that could be made to the service. A number of comments suggested that the telephone advice line should be available all week, and that email advice should be available. Other comments suggested that there should be a telephone advice line for patients who have been referred.

'Tel advice line for patients who have been referred for them to be told directly the state of the referral'

'Early contact by telephone to families to make initial assessment and offer crisis support while awaiting face to face appointments'

'The advice line to be available all week'

'On call service for advice, Email advice line'

'*Email advice line could be useful'*

'Would an email advice line be possible rather than the telephone advice line?'

'Waiting times, especially for urgent referrals'

'We need more rapid access to assessment. If the specialist opinion is that the young person either isn't at risk or doesn't need intervention then that's fine but it's difficult for us to decide that.'

'If a GP is concerned about a child then they should be seen urgently - please stop trying to screen referral and see all of them. If the resources are not currently present to achieve this then they need to be found'

'It is almost impossible to get children seen in a timely fashion even when in crisis or with serious indicators of mental health issues. Better access and an option for dialogue (rather than an enforced no dialogue fax referral and only nurse triage) would be helpful for emergencies. A significant number of patients who would benefit from lower level input either do not get seen in a timely fashion or are not seen at all. Incorporating triage and onward signposting for these cases would be really helpful rather than a refusal to review.'

It's difficult to find information on the ABMU website about referral pathways, including for urgent cases and this of itself is a reason for frustration even if the service itself worked ok on the only time I've used it in the last few years

Some respondents commented that a single point of entry would be beneficial for referrers.

'Single point of access for referrals would be useful- multiple services exist but they are difficult to identify and navigate for those of us who don't refer to them often and repeatedly.'

'Seamless CAMHS service with single point access.'

'SPOA! work as a team and deal with the presentations you are referred. Most presentations do not fit neatly into box so be flexible and work with NDD and sec CAMHS to mage the kids better. Service once seen is good - getting them in is a nightmare and is awful for your reputation!'

'Some consideration should be given to allow others to refer (Physicians associates, ANPs, School counsellors, HV etc.).

Some responses commented on the interface between primary and Secondary CAMHS

Specialist CAMHS may need to be based in hospitals but Primary CAMHS workers should try and see pts outside in the community [surgeries, clinics even homes].

'I am concerned that a lot of referrals about young people with depressive symptoms and self- harm problems are being triaged from secondary CAMHS to primary CAMHS with a further delay before they are seen. I understand this is probably due to demand in the secondary CAMHS service but it is very difficult to manage these children in primary care, especially if we have previously tried counselling, bibliotherapy options and are not able to initiate medication therapy without assessment by CAMHS.'

Findings

Many GPs responding to the DU questionnaire described an unresponsive service citing a lack of acceptance of referrals and poor communication of the outcome of assessments. Emphasis was placed on the need for a 7 day helpline and E-advice.

Acknowledgements

The Delivery Unit would like to extend thanks to the staff of Abertawe Bro Morgannwg and Cwm Taf University Health Boards for their co-operation and contributions during the review and to the General Practitioners who took time to complete the DU questionnaire.

The views of Children, young people families, carers and wider stakeholders are being sought by the CAMHS ED Network. These will be reported to the Health Board in a separate report.